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MIDLIFE MOTHERS IN TRANSITION: RELATIONSHIPS BETWEEN SELF-IN-RELATION AND PERCEIVED HEALTH STATUS

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MIDLIFE MOTHERS IN TRANSITION: RELATIONSHIPS BETWEEN SELF-IN-RELATION AND PERCEIVED HEALTH STATUS

By

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ABSTRACT

MIDLIFE MOTHERS IN TRANSITION: RELATIONSHIPS
BETWEEN SELF-IN-RELATION AND PERCEIVED HEALTH STATUS

By

Elizabeth Irene Price

Women organize and develop a sense of self within the context of their relationships. One goal of female development is to connect to others. The theoretical framework posits that as a woman moves through her life course her primary task is to "take care of" relationships. When care giving she must strike a balance between caring for others in the relationship and caring for self.

This study focused on the transition at midlife when a woman is faced with reordering a relationship that has required a great deal of care: the "mother-child" relationship. How a women reorders and balances this relationship may reveal something about her ability to stay healthy both emotionally and physically.

The convenience sample of 145 women were married mothers who had launched their last child from home within the 24 months prior to questionnaire completion. Data were collected from June 1993 to December 1993. Three hypotheses and five post hoc questions were investigated using both Pearson Product-Moment correlation coefficients, and analysis of variance. The instrumentation used included both tested standardized instruments and those newly developed by the researcher. Hypotheses which were supported indicated that a woman's orientation of care was related to her health status. The hypothesis which posited a relationship between a woman's health and a balance of her separate and

connected self was not supported. Implications for theory, research, and practice are included.

This dissertation was inspired by my mother Leona
who taught me to care
and is dedicated to my granddaughter Onahlea
whose generation must learn to care
for themselves as well as others

ACKNOWLEDGMENTS

After months of intense focus, the time has come for closure. Before embracing the future and a new beginning, it is with pleasure that I stop and express appreciation for the numerous and timely contributions make by both individuals and institutions that were critical to my growth and success.

First a very special thank you to all the women who gave of themselves by contributing to this research. Their willingness to allow "self" disclosure helped further the knowledge about women.

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I am grateful to Dr. Linda Beth Tiedje for the time spent listening and questioning as this work began as well as for her support and encouragement of the development of the finished product from a distance.

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For his encouragement and years of mentoring I am deeply indebted to Joseph Sheets, MD. He taught me to make a decision and follow through. His positive outlook on life helped me believe my goal was attainable.

I would like to recognize the financial support provided by the Sparrow Health System without which all of this would not have been possible. I look forward to contributing to the quality service provided to the community by this institution.

A special word to my co-workers at Lansing OB/GYN Associates. I could not have achieved this goal without their help. From proposal to data collecting to finished product I have felt their interest and support. I greatly appreciate their flexibility and willingness to accommodate my needs.

And the last shall be first. There are not words to express the depths of my feelings to my husband, my wonderful family, and special friends who love me...I love you too.

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CHAPTER I

INTRODUCTION

This study is based on the belief that a female self is primarily a self-in-relation (Surrey, 1991). This refers to the process of being-in-relation-to-others, of knowing oneself and others through a process of mutual relational interaction and caring. Much of the research done on self-in-relation to date has been done using adolescent girls and has been done in psychology.

Like adolescence, midlife is a time that relationships are reordered both with the self and with others. At midlife this reordering offers the opportunity to reawaken the self. It is a time for women to redefine self-in-relation to others. The changing events of midlife afford an opportunity to reassess how some women take care of "self" and "other" and how they reorder the relationships in their lives. Of interest is if they accomplish this without deleterious health outcomes.

Today the average woman lives one-third of her life past menopause. The concern is to make these later years happy and satisfying. A woman's sense of well-being and general health for the last third of her life are profoundly affected by the manner in which she makes the transition to changing life events at midlife. Therefore, this investigation will explore the impact of the self-in-relation theory on the health and well-being of midlife mothers.

Background of the Problem

Many accepted theories view self-development as a growth process that only occurs by separation from others. This does not seem to be

the self that fits women's experiences. Females do not separate from others, but learn to care for them. They give up themselves in relationships for the sake of relationship with the other (Surrey, 1991). If separation is the healthy orientation, then by default connection is the unhealthy one. How the self-in-relation delineates self and other relationships and the possible effects this may have on health is the question under review.

Historical Perspective

For a quarter of a century traditional definitions of health and well-being have been male defined. American researchers like Erikson (1959) and Levinson, Carrow, Klein, Levinson, and McKee (1978) have placed high value on individual autonomy, self-reliance, and independence. The goal of male defined human development was to separate one's self from "other". Erikson saw this development as the accomplishment of a sequence of life stages. At each life stage there was a normative psychosocial crisis. With the accomplishment of each stage the individual was to become gradually less dependent upon the "other", until as a healthy normal adult "he" achieved independence and an inner separate self.

Self for females is being conceptualized in new ways by such feminist theorists as Gilligan (1982) and Miller (1976). A female self is organized and develops most often in the context of relationships, i.e., the construct self-in-relation. This represents a shift in emphasis from separation to connection. In this model, relationships are seen as the basic goal of development, and the self-in-relation is at the core of the self-structure (Surrey, 1991). The expression of the "self-in-relation" theory accounts for the strongly developed need to

"take care of" in relationships. Through caring, females express an empathetic sense of connectedness to others and a much different pattern of development than do males. This need to "take care" has very early roots in female development.

The mother-daughter relationship is the prototype on which all others are built (Surrey, 1991). A female child learns through the interaction with her mother to listen to, feel with, and comment to the "other". This process of development through relationships continues as role relationships such as friend, wife, worker, and mother expand throughout the life course, until development comes full circle and the woman has learned the adult form of the relationship and becomes a mother herself. "The pathway of development includes both the outer, 'real' relationship and the inner sense of relationship. The goal of development is to 'become one's own mother'--that is, to internalize the attentive, listening, caring relationship to oneself" (Surrey, 1991, p.63).

Integration of Theories

The preceding theories suppose a single pathway to human development, one that is gender based. However, some researchers (Davis & Jones, 1992; Franz & White, 1985) have proposed a two pathway model that would interconnect the psychological variables of (a) independence, or the expression of the self, and (b) relationships, or the need for connections, for both genders. The interconnection of both variables, independence and relationships, is believed to "account for most of the interpersonal life-span change" (Franz & White, p.247). To use the Franz and White model to frame the knowledge found in the preceding gender based theories seems to be appropriate for this study of women in

midlife. It seems appropriate because the opportunity is there for a shift from the role of caregiver of others to a more egocentric role of care for self. Therefore, at midlife the psychological pull is toward independence and away from relations. But like any change, a pull back is needed to reach a redefined level of personal comfort when the transition is complete. This study proposes to explore the process of this shift in relationships that occurs at midlife and the impact that process may have on health. The need for knowledge about the patterns of a woman's life during her middle years has become increasingly urgent because of both health and social conditions.

Health Conditions

Women are living longer. There are 13 million women in the U.S. between the ages of 45 and 55 years and this number is expected to increase beyond 19 million by the year 2000 (U.S. Bureau of the Census, 1989). In less than a century, the time has doubled between when a woman bears her last child and her own death. To quote a report on the perimenopausal years by the National Institute of Health:

> The physical and psychological changes that occur during this part of a woman's life span are complex, and her health is measured by more than just the absence of disease. Research on the middle years of a woman's life must be a high priority and must take into account a woman's health in the broadest sense of the word (1992, p.21).

Midlife women ages 45-64 make an average of seven visits to the health care system a year, 25% more then midlife men (Adams & Benson, 1989). During the middle years, a woman's acute health care needs are 24% greater than men and her activities are restricted by illness 46% more often than men (Givens, 1979). Because as a society we are living longer and because health care is so costly, a better understanding of

factors that contribute to both the physical and psychological health of midlife woman is needed. This understanding could help meet the continued needs of women, and help contain health care costs.

Social Conditions

The definition of midlife for women who are mothers may not be so much chronological as developmental: the launching of the last child from the home (Neugarten, 1968). In this time when there is a changing pattern of relatedness, there is a loss of a major role identity: mother. As her everyday patterns are changed and she does not daily act out the role behaviors of mother, her sense of who she is may be threatened. This is especially true if the mother role is at the core of self. If she has played her role well in terms of her child, her goal will be accomplished and her child will leave home and move into society as a productive and secure individual. However, to achieve this goal she must redefine her self-in-relation to others and to herself. Therefore, one would expect the woman who feels her role as mother can be redefined comfortably to include adult/adult relationships with her children to make the transition with ease (Neugarten, 1979). She can let go and feel pride in the product and she will be able to move on with the reordering of her relationships. She will be able to mother herself more easily than the woman who experiences a great sense of loss and pain when she no longer has a child for whom to care.

The middle years are a period when important departures from the conditions of early adulthood begin. "Individuals move into their middle years by 'undoing' or reversing those events that originally defined their movement into adulthood" (Smith & Moen, 1988, p.506). For example, the decreasing centrality of the role of parent, the decreasing

importance of career achievement, and the loss of a mate selected in the early adult years are events which may herald the middle years of life.

Many aging and life course researchers have investigated the continued process of human development after young adulthood (Barnett & Baruch, 1978; Brooks-Gunn & Kirsh, 1984; Rubin, 1979). Using the developmental approach, the primary focus of research on women in their middle years has been to examine the experiences of menopause and the empty nest, both of which are assumed to be negative events. Neugarten's (1968) study of the mental process of midlife women is a notable exception. She found middle age to be a "period of heightened sensitivity to one's position within a complex social environment and the reassessment of self as the prevailing theme" (p.93). The mental processes of midlife for Neugarten were introspection and self-evaluation. Her vision may be explained in part by the interconnection of the psychological variables of independence and relationships described by Franz & White (1985). Transition points in the life course call for a greater or lesser degree of (a) self-expression or (b) relationships. For women who have spent much of their lives as primarily connected relational beings, the events that occur at midlife such as the experience of menopause and empty nest may potentially awaken the inner self and its need for expression.

In summary, for women the core of self-structure is self-in-relation to others. For mothers, the time when children leave home often coincides with midlife. For those women, two life events coincide with each other, i.e., redefining role relationships and dealing with physical aging. Because of this, this transitional intersection is

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intensified and therefore has a greater potential to be hazardous to a woman's physical and emotional health.

Theoretical Framework

The theoretical framework for this study draws heavily upon early research done by Miller (1976) and Gilligan (1982), and the subsequent development by Surrey (1991) of the construct self-in-relation. Much of the existing research to assess the self-in-relation has focused on adolescent girls and proposes connections as the primary and single pathway to female development. If one believes the separate self and the connected self are not polar opposites but dynamic and separate components of personality, and if one believes that times of transition require self-inventory, then a shift or reordering from the primary orientation of connection for women would seem logical at midlife. Using Franz and White's (1985) two path model to incorporate both the separate self and the connected self seems appropriate for women at midlife because life events that require a reordering of the self-in-relation are present: decreasing centrality of role of parent and career changes.

Family ecology is an appropriate discipline to study this reframing because the family is the social unit in which this process takes place. It is understood that the family unit is a system that must adapt to changes within the individual members. Indeed, although the entire family must adapt to the reframing of the "self-in-relation" process of the mother, that family adaptation process is beyond the scope of this study.

What can today's cohort of midlife women expect during this time? If they are mothers, they are entering the postparental period. This is

a time when they reflect on their life, its contribution to family and society. It is a time of deeply felt life transitions, the negotiation of which may affect both emotional and physical health status. Therefore, it is both needed and appropriate to examine this window of time in women's lives.

Conceptual Model

The conceptual model (see Figure 1) for this study was designed to view the process of the transition which occurs at midlife through a single measure of the self-in-relation. The antecedent self-in-relation is meant to hold all those life events and individual experiences prior to this moment in time and is out of the range of this study. The contextual variables were selected from a combination of literature review and personal clinical experience of the researcher. How and if the contextual variables were affected by the self-in-relation and health status at the midlife transition will be addressed in the discussion of the post hoc questions.

Statement of the Problem

This research seeks to examine the question: Is there a relationship between a woman's "self-in-relation" and her health status during the transitional phase of midlife?

Assumptions

1. A woman's sociohistory, culture, and environment are all important when attempting to accommodate transitions.
2. A woman is a semi-open, goal directed, dynamic, adaptive system. She can respond, change, develop, and act to modify her environment.

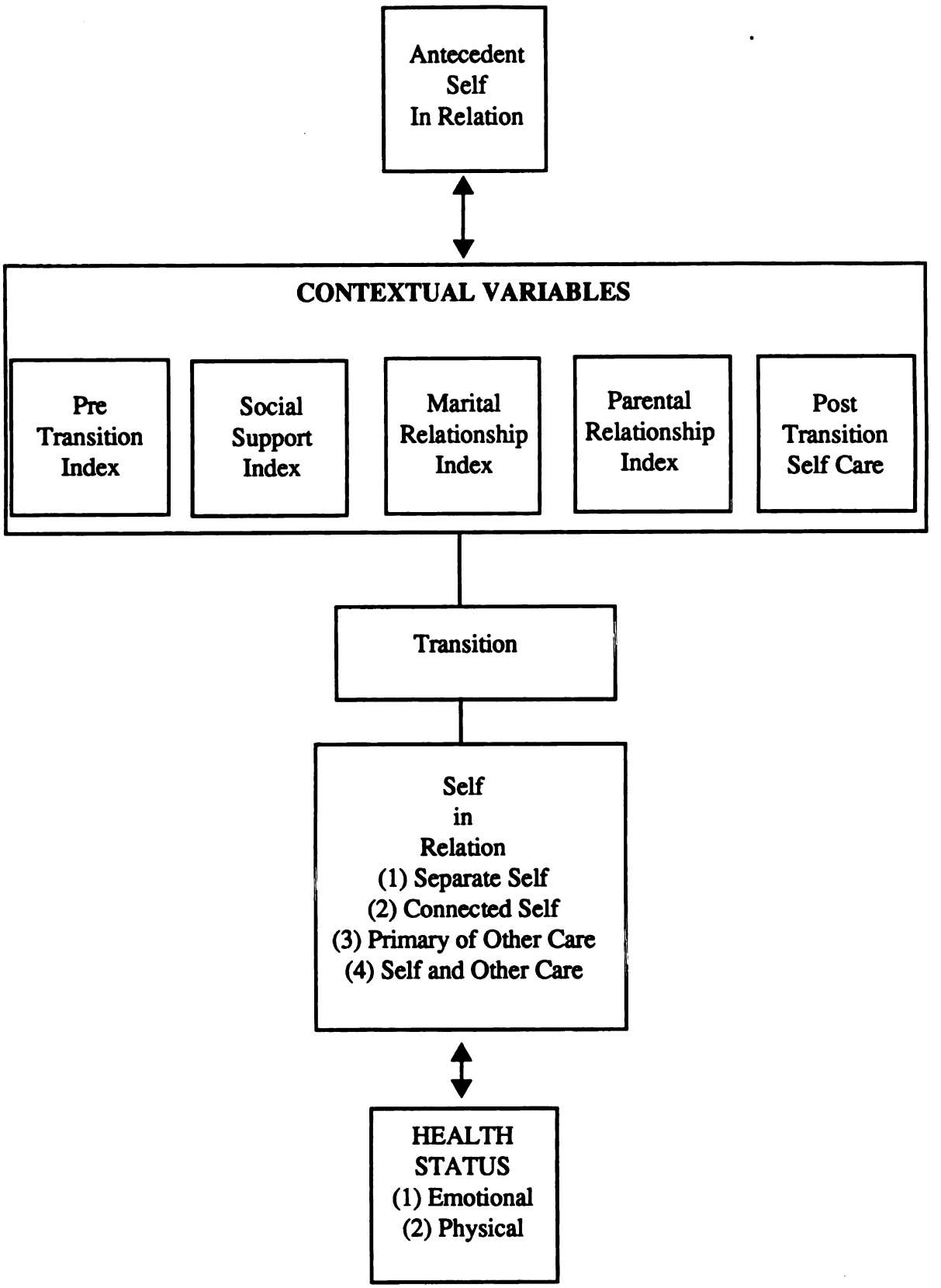

Figure 1
Conceptual model

3. A woman's psychological development is a dynamic and continuing process.
4. A woman's separate/objective self and connected/relational self are two distinct developmental pathways that seek balanced expression during the life course.
5. Transitions are inherent in a woman's development process.
6. A woman needs other individuals to achieve full potential as a human being.
7. Midlife is a time for a woman to reorder her previous roles and relationships.
8. Taking care of relationships is a primary responsibility for a woman in our society.
9. A woman relates to others primarily through a connected self.
10. Launching the last child from the home is a transition for a woman who is a mother.
11. Midlife transitions require a change in the form and content of relationships for a woman.
12. For a woman to be in a state of health, a certain amount of introspective thinking and self-discovery must be attended to in midlife.

Research Hypotheses

HO1. The more balanced a woman's separate/objective self with her connected/relational self at midlife, the better her health status.

HO2. The higher a woman's commitment to the primacy of other care, the more deficient her health status at midlife.

HO3. The higher a woman's commitment to self and other care, the better her health status at midlife.

Definition of Variables

Both theoretical and operational definitions of four major concepts are presented.

Transition

A transition is a bridge or a passage from one stage or time to another. It is a period of readjustment where lives, relationships, daily routines, and assumptions about the self, and roles undergo change (Schlossberg, 1986).

For this study, the transitional phase will be operationalized by having selected and limited the study sample to married women who have launched their last child from home within a narrow window of time, i.e., 24 months.

Midlife

Midlife is a transitory rather then a distinct phase of the life course. For mothers, it is usually the time in a woman's life when her last child leaves home. Within the life course, it is the antecedent of old age and the outcome of adulthood. For many married women one of its major results is an empty nest.

It is the time in life when a woman may become more egocentric, attending to activities of personal success, self-achievement, and mastery. She relearns the lesson of adolescence "That she must come of age by herself---she must find her center alone" (Lindberg, 1955, p.134). The operational definition of midlife for the women in this study will be the sociological event of launching the last child from home within the 24 month time period prior to completing the questionnaire.

Self-in-relation

Self-in-relation implies an evolutionary process of development primarily through relationships. It is a dynamic self that is open, flexible, and capable of change (Surrey, 1991). It is a self that "achieves articulation through participation in and attention to the relational process" (Kaplan, 1991, p.209). It is the "caring" voice responsible to take care of others and the care of self in relationships. It is the state of engrossment: to be responsible for, to pay attention to, to feel with the other in relation. The connected self (Gilligan, 1982) is "attuned to the affect of others, understanding and being understood by the other, and thus participating in the development of others" (Kaplan, p.208).

For this study the Self-in-Relation will be operationalized by using the Relationship Self Inventory (Pearson et al., 1985). It will include concepts from four scales. The first is The Separate Self (SS) defined as: Independence and separation. The second is The Connected Self (CS) defined as: Interdependency, connection with others, egalitarian interchange and concern for individuals, including themselves, in their own contexts. The third is the Primacy of Other Care (POC) in which care of others has priority over care of self, and fourth is Self and Other Care (SOC) in which self and others are treated as equally deserving of care.

Health Status

Health status "is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" according to The World Health Organization definition of health (Ware,

Brook, Davies, & Lohr, 1981). This research includes both emotional and physical concepts in the definition of Health Status.

Emotional health status. The emotional health status is a self-appraisal of happiness, which includes the degree to which an individual judges for herself her satisfaction with her life-as-a-whole. The operationalized measure of this concept is the Rand Corporation's 22-item Health Insurance Study-General Well-Being Scale (HIS-GWB) (Ware, Johnston, Davies-Avery, & Brook, 1979).

Physical health status. The physical health status is a self-perception of a state of optimal body functioning. This concept will be measured by three subscales: (a) perceived health status, (b) use of health care services, and (c) reported health behaviors which were developed for this research by the author.

Summary

The preceding has established the need to study the relationship of the self-in-relation and health of midlife women. The ground work has been laid to apply some existing theories to a sample of women to determine if there is a relationship between health and the psychological construct self-in-relation of married midlife mothers.

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CHAPTER II

REVIEW OF LITERATURE

The theoretical framework for this investigation draws upon a developmental perspective of the individual and family life cycles, coupled with a feminist approach to the psychological theory of female development. The family stage of launching young adults from the home defines transition for purposes of this study (Neugarten, 1968). How that transition impacts the self-in-relation and the health status of a mother in a marital relationship is the focus of this study.

The information in this chapter will be organized into four sections related to (a) adult development focusing on females and recent thinking of female psychological theories, specifically the self-in-relation, (b) the process of transition, (c) the general health status of midlife women, and (d) role theory with emphasis on the changes that occur at midlife for mothers.

Female Adult Development

A review of theories of adult development will be presented to allow a historical perspective of the knowledge that pertains to this research. The current thinking as it relates to female development is included because of the impact that thinking has on this study.

Adult Development

The bulk of work that comprises adult psychosocial development was traditionally based on the male experience. One of the most comprehensive theories of adult development was the life stage theory proposed by Erikson (1959). The developmental theory he proposed encompassed the entire life span and consisted of eight age-related life

stages. Each stage represented a crisis between primary developmental tasks, the positive resolution of which was necessary to move on to a subsequent stage. The adult stages proposed were: intimacy vs isolation, generativity vs stagnation, and ego integrity vs despair. Initially Erikson proposed that adolescent identity preceded intimacy for both males and females and that generativity was the major goal of the seventh life stage or mid-life. He later modified his stages for women. For a women, he proposed, the process of identity was not complete until she had committed herself to an intimate relationship and taken on the care of children. Therefore, for women, intimacy preceded identity and quite possibly engagement in "generative" behavior because of primary roles in childbearing and child rearing.

What was unique about Erikson's (1959) theory was the potential for continued growth and change throughout one's entire life. His proposal that there were various adult stages was both provocative and controversial. Though he addressed only the most global of psychosocial changes, his thinking offered an opportunity for further exploration of the adult stages of life.

Erikson's (1959) theory has been expanded by Franz and White (1985). They suggested that Erikson's model has neglected to account for the process of interpersonal attachment. Therefore, they proposed a two path model that filled a void in Erikson's theory. Their model included the development of individual identity, and interpersonal connections or attachment and posed these as equally important threads of human development. Their model was built on the work of Bakan (1966) and Parsons (1964) who found both orientations in men and women. Both

Bakan and Parsons concluded that the expression of identity and attachment was not only possible in all humans but was healthy.

Franz and White (1985) took Erikson's (1959) eight stages of development which they believed to be heavily dominated by the development of identity formation or individuation and created a separate but interconnected path which emphasized attachment. Erikson had suggested that his model be perceived as a helix, Franz and White thought the theory would be better served by perceiving it as a double helix.

> We believe, however, that to account fully for "healthy" human development,...the field might better be served by the model of a double helix in which two separate but interconnected strands of psychological individuation and attachment ascend in a spiral representing the life-cycle. Each stage represents an intrapsychic developmental change in both individuation and attachment; experiences in any one realm will have ramifications for the other. Like the twisted strands making up a rope. tension on one strand will pull the other. (p. 247)

Davis and Jones (1992) support the work of Franz and White (1985) that extended Erikson's (1959) theory of personality. They studied the mental health of 83 southern mother and daughter pairs. The psychological variables used were differentiation of self and attachment. The researchers created a model of daughter's attachment to mother and self-differentiation. The results showed that mothers and daughters scored similarly in their levels of attachment to each other and their mental health outcomes with one noticeable exception. Daughters showed significantly less differentiation of self than mothers. The researchers suggest this difference in self-differentiation is the result of life experience. More research is necessary to help determine if a relationship exists between a woman's

age and her differentiation of self. The finding of this study supported the position proposed by Franz and White (1985) that differentiation of self and attachment are two different strands of human development which are not mutually exclusive but interconnected.

Jung (1933) looked at adult development across the entire life cycle as well. Jung felt the personality could not reach its full growth by age 20 and theorized the next opportunity for change started about 40. Jung theorized that it was at this time that one moves from an external view of life based on control and achievement to one where peace is found from within. He used the term "individuation" for the developmental process that begins at midlife and extends over the remainder of a person's life; he indicated this occurred for both men and women.

Jung (1933) also proposed that each person has both a male and female personality. He believed that at different times during the life course one or the other personality gains strength and dominates individual behavior. He felt that middle age was the time the primary personality had been "exhausted" and it was at this time the secondary personality would emerge. This explained why middle-age men could more easily express their feminine side and why middle-age women could express their masculine side.

Levinson et al. (1978) built their theory on the work of Jung. Their conceptualization of the life cycle is based on age related developmental stages which move through a predictable set of developmental periods and tasks. The life structure evolves through a relatively orderly sequence during the adult years. The pattern is one of structure building/structure changing episodes which are the same for

all men. The structure building episode of middle adulthood is 40-60 years of age with 40-45 seen as the structure changing period. The orderly progression of periods stems from a recurrent change in the developmental tasks.

The transition or bridge from early to middle adulthood occurs at 40-45 years of age. Three major tasks must be dealt with during this midlife transition. They are: (a) bring to a close the early adulthood era, reappraise the past, and develop a desire to use one's remaining life time wisely; (b) take the first steps in modifying the life structure to move into middle adulthood shifting from the past to the future; and (c) complete the midlife individuation process which involves resolving four polarities specified as young/old, destruction/creation, masculine/feminine, and attachment/separateness. Each pair, though representing opposing tendencies, is not mutually exclusive. The belief is both polarities can be found within the core of each self. According to the theory of Levinson et al. (1978), the two polarities of particular importance in the individuation process at midlife are masculine/feminine and attachment/separateness.

Male Theory Applied to Female Development

In the 1980s theorists began questioning the male development theories of Erikson (1959), Jung (1933), and Levinson et al. (1978), in describing adult development. Roberts and Newton (1987) used Levinson's theory to study women's adult development. They reviewed unpublished dissertations. The impetus for this review was to help determine the scope of Levinson's theory, i.e. its application to women, because in the authors' view a comprehensive theory of women's adult development does not exist.

Using the interview methods proposed by Levinson et al. (1978), Stewart's dissertation (1977) cited in Roberts and Newton (1987) constructed the life stories of 11 middle class women during the age 30 transition to see if Levinson's theories were applicable for women. Stewart's findings supported Levinson's theory of adult development. However, she found the order in which women accomplished specific developmental tasks was more variable than for men. She observed it was more difficult for women than men to establish an adult life structure. She concluded that women differ from men in the way they develop their life dream and in ways of relating to significant others.

Another study dealing with midlife women was conducted by Droege (1982) cited in Roberts and Newton (1987). Her combined sample totaled 39 biographies of women. This review suggested that "women progressed through the same developmental periods as had the men in Levinson's study and at roughly the same ages" (p. 154). The differences found were not in events or their timing, but in the way a woman worked on the task and the outcome. For the sample dealing with midlife women, the life dream experienced was a "split dream," i.e. encompassing both traditional and nontraditional expectations. Several women felt they had not achieved their potential in either area.

Female Theory Applied to Female Development

Rubin (1979) interviewed 160 women between the ages of 35 and 54 who had spent their lives in the roles of wife and mother. She specifically focused on the time in midlife when "the motherhood role self destructs" (p.120). Rubin's study dealt with the problem women have with identity. When asked to describe themselves, one-fourth of her sample could not. They were only "someone" in relation to "someone"

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else. "A self exists in a social context; it grows and develops as part of an ongoing process of interaction with the social world" (Rubin, p. 60). Not being able to distinguish who they were occurred when their relationships began to change. For Rubin it was not the children leaving home, i.e. empty nest, but the loss of the role, i.e. empty life, that created the problem.

The underlying theme for adult growth and development as theorized by Neugarten (1968) is orderly, sequential change. She noted that as people age certain personality traits come to be of primary importance. "Middle age is a period of heightened sensitivity to one's position within a complex social environment; and that reassessment of the self is a prevailing theme" (p.93). Unlike the stage theorists, her theory allows for the impact of social change. Neugarten's research found that "middle age marks the beginning of a period in which latent talents and capacities can be put to use in new directions" (p.96). For mothers, the social change of middle age is the launching of children into the adult world, heralding a new round of growth and development.

Rubin and others (Barnett & Baruch, 1978) found women, but not men, define their age in terms of the timing of events within the family cycle. Middle age for mothers was marked by the launching of children from the home.

For Neugarten a stage theory approach to the study of adult development was oversimplified. Her individual-timing-life-cycle approach was much broader and more flexible; it allowed for development beyond adulthood.

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Feminist Theory Applied to Female Development

Miller (1976) proposed a gender specific developmental theory. She espoused the feminist thesis that "women have developed the foundations of extremely valuable psychological qualities, but sexual inequality devalues their importance" (p.26). Men and women in our society learn basic but fundamentally different ways of being in the world. As a result, women learn empathy and caring and develop a need for human connections. Men on the other hand learn to repress their interactive nature early and are rewarded for their development of an independent self.

Existing adult developmental theories are based on the male model and they have become the prescriptions of what should be, with the norm identified as individualization and individual achievement. Therefore, the concern women have for maintaining and nurturing relationships appears as a weakness rather then as a human strength. Miller (1976) identified what she calls the "interacting sense of self" in early infancy and believes it is present for both males and females. She feels the fact that boys are not allowed to learn to feel as the "other" feels or to attend to the emotions of the "other" is depriving boys of their full growth potential.

Chodorow (1978) expanded Miller's work by proposing that the female self is a result of the way daughters are parented. Women have this responsibility because women are universally responsible for early child care. Mothers create a different social environment for sons then for daughters. Mothers experience daughters as continuous with themselves, extensions that never fully separate.

> Girls emerge from this period with a basis for empathy built into their primary definition of self in a way that boys do not. From very early then, because they are parented by a person of the same gender...girls come to experience themselves as less differentiated than boys, as more continuous with and related to the external object-world, and as differently oriented to their inner object-world as well. (Chodorow, p.167)

Boys differentiate themselves from their mothers and establish clear ego boundaries. Therefore "the basic feminine sense of self is connected to the world, the basic masculine sense of self is separate" (Chodorow, 1978, p.169). Thus, femininity is defined by attachment and masculinity is defined by separation. The issue of attachment becomes a liability when a woman's failure to separate becomes defined as a failure to develop. Chodorow's solution emphasized a gender balance, by recognizing the gender difference and moving toward an androgynous nature for both men and women. Chodorow's view seems to place the influence for the development of these personality traits on the external environment, i.e. something that can be learned. Franz & White (1985) view all human beings as androgenous. They claimed within each of us is a separate and connected nature, the expression of which may be demonstrated at various times in the life course. They express the hope that by allowing for expression of both traits, individuals will not neglect their capacity for developing both their separate and connected nature.

The thesis proposed by Miller (1976) espoused the positive nature of the relational qualities of women to care and nurture. This thesis was further developed by Chodorow (1978) who saw these qualities as a direct outgrowth of the self-structure of woman and a product of the mother-daughter relationship. Gilligan (1982) expanded the idea still

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further and found women to speak with a "different voice", a "caring voice", when confronted with moral choices. But she concluded it is not a simple matter of a "caring voice", i.e. connected self, versus a "justice voice", i.e. separate self. There is interplay of both voices within the individual. Life transitions are times when the two voices converge. "As the events of women's lives and of history intersect with their feelings and thought, a concern with individual survival comes to be branded as selfish and to be counterposed to the responsibility of a life lived in relationships" (Gilligan, p.127). Gilligan's two voices, separate self and connected self, equate to the interconnected strands of identity development that Franz and White (1985) see as intertwined in each individual.

Gilligan (1982) proposed a life course development relationship theory for women that is grounded in interdependence with others and evolves through "taking care" activities. She held that for women there was fusion of identity and intimacy. She also said that women's standard of moral judgment comes from their assessment of self. Their standard of relationship is an ethic of nurturance, responsibility, and care. Gilligan has developed the following three levels of care giving: (a) care given is self-centered and self-protective, a coping strategy; (b) care is given to win the approval of others; and (c) care for self is seen as important and is practiced while still caring for others.

Gilligan's major work has been on young women and their struggle with identity issues. These findings cannot be equated with midlife women, however, the picture of the evolutional development of "taking care" that she proposes over the life course may be used to better understand the psychological development of midlife women. As a woman

moves through life and matures, she may change her level of care activities. A woman may learn to distinguish between the activities of helping and pleasing engaged in as a child and the activities of "taking care" of the "other" that are necessary to gain approval of others in adulthood. As the transition from childhood caring to adulthood caring requires a redefinition of care, so too may the transition to midlife caring.

Transitions

When the last child leaves the home, a woman may experience a sense of loss of what has been, an ending. Bridges (1980) emphasizes transition as a process that begins with endings. As each transition is an ending or loss, it is also an opportunity for new growth. The ending of a transition has four phases: (a) disengagement, the need to separate one's self from the main stream; (b) disidentification, when the individual loses a means of self-definition as with the loss of major roles; (c) disenchantment, the discovery that the world is no longer real; and (d) disorientation and emptiness. The second stage of a transition is often considered the "neutral zone". The neutral zone is the gap between the old and the new. It is necessary because it provides perspective; when it has passed, a new sense of self will be created. The final stage of the transition process is the new beginning, the rebirth. New beginnings grow out of genuine inner realignments rather then external shifts and are signaled by the feeling of something different. Viewed in this context, the transition process is seen as a loop in the life journey, a going out and away from the main flow for a time and then coming around and back. Transitions alter

roles, change relationships, change routines, and affect assumptions (Schlossberg, 1986).

Levinson et al. (1978) defined transition as the boundary zone between two psychological states of greater stability. Midlife transitions may reactivate some developmental issues of adolescence. The primary tasks of every transition period are to question and reappraise the existing structure, to explore various possibilities for change in self and the world, and to move toward commitment to the critical choices that form the basis for a new life structure in the ensuing stable period.

It is important to understand the transition process from the "old" life stage to the "new" life stage and its effect on the self-in-relation. At midlife a woman's value may be deeply imbedded in three basic roles: daughter, wife, and mother. When her last child leaves home, she is faced with choosing new role identities and relationships. When women have invested heavily in the mother role and they no longer have this major role as the focus of their lives, their sense of identity may be threatened. Women in this situation may become depressed and develop physical illness (Miller, 1976). Midlife typically entails a reevaluation and renegotiation of many relationships, especially the marital relationship and the maternal-child relationship.

General Health Status

The definition of health status for this study includes both subjective well-being and general physical health. This combination is well supported. The World Health Organization in its definition of health clearly integrates both the physical and psychological

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dimensions. Health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Ware et al., 1981, p.620) This definition has been widely used and is especially applicable when respondents are basically healthy. This section of the review of the literature examines general health status of midlife women in transition. The emotional and physical health issues will be presented in two separate sections.

Emotional Health Status

The social roles of women, e.g. wife, mother, paid worker, may or may not contribute to their health problems. Depner (1979) found women with multiple roles were no less healthy. In fact, Verbrugge (1985) pointed out that women in the United States with fewer roles presented in the poorest health state. The role of wife has been found to increase happiness and satisfaction slightly (Cleary & Mechanic, 1983); when the quality of the marriage was taken into account, the effect of the wife role is even greater, thus making for better health. However, when the marriage is not a happy one and there is consistent negative interaction with the husband, the health outcome for wives is often depression (Brown, 1984).

A link has been established between stress and health. As early as 1967 Holmes and Raye established a link between stressful life events and illness. For women, however, stress is not only due to the number of events happening but also to daily chronic stresses in life, e.g. role conflict, high household demands, and limited hours of leisure time and sleep (Bird & Freemont, 1991; Kessler & McLeod, 1984).

Thomas (1990) studied predictors of health status in a heterogeneous sample of 87 midlife women ranging in age from 39 to 60.

The predictors of health status included optimistic disposition, internal locus of control, education, income, employment outside the home, moderate exercise, and sleeping 7-8 hours per night. The results of the study found midlife is stressful for most women "particularly for those experiencing major life changes concomitantly with a high frequency of daily hassles" (p.69).

Black and Hill (1984) studied the well-being and satisfaction of women in their middle years. The sample of 232 married woman ranging in age from 46 to 61 completed a questionnaire. The questionnaire had been developed to study the influences of selected variables on the well-being of women who had experienced or who were anticipating the experience of the empty nest. According to the data, 90% of the women studied were "generally quite happy". The researchers were not surprised to discover these women were happy since their sample was composed of well educated, economically stable, married women with children. Our society values women who are successful in their roles as wife and mother. Their findings were consistent with other researchers (Axelson, 1960; Glenn 1975). It seems reasonable to assume that, during this stage, women who can begin to explore new self-satisfying alternatives of career and life styles after having fulfilled childrearing obligations would be healthy. But not all women can do this. How a woman chooses to invest her time when the last child leaves home may be strongly related to age. The older she is, the less likely she is to pursue outside interests particularly employment (Bradwick, 1980).

Mitchell and Helson (1990) advanced the hypothesis that the early 50s constitute the prime of life for women. In 1983 to look at this

question they conducted both a cross sectional and a longitudinal study. They concluded that healthier women were women who had launched their children, lived with partners, were autonomous, and balanced their masculine, i.e. justice, and feminine, i.e. caring, voices. The researchers felt this finding was consistent with Gilligan's (1982) theory about the relational orientation attributed to women.

Finally looking for generativity, the trait Erikson (1959) associated with the generative stage of adult development, Mitchell and Helson (1990) found the women committed to people, careers, and community service were the most psychologically healthy. The researchers compared this to Gilligan's (1982) definition of "mature care" which incorporates care for others and care for self. While each life stage has its problems, except for regrets related to their losses, this cohort of 50 year old women identified this time in life as "great".

According to data compiled over a generation ago by Glenn (1975) from six U.S. National surveys comparing parental and postparental families (N-1600), the postparental family stage of life for midlife women is somewhat happier than for those women who are the same age and still have children in the home. The researchers found that marital relationships were considerably more positive for postparental women. Glenn hypothesized that as women reorder their relationships, they initially look at the other important role in their lives, i.e. wife, and that they may be happier because they reinvest some of the extra time and energy they now have into this and other important roles. "Life at home becomes simpler, and the energy that went to children is redirected to the partner, work, and community or self-development"

(Mitchell & Helson, 1990, p. 453). Adelmann, Antonucci, Crohan, and Coleman (1989) studied the psychological well-being of empty nest women of different historical cohort groups and employment status. The sample consisted of two different age cohorts: the first was born around the turn of the century and the second cohort was born around 1920. The effect of the loss of the mother role on psychological well-being was hypothesized to be related to the cultural importance and socialized expectations placed on the role. However, it was also felt that positive job status at the time of the empty nest experience would buffer any perceived status loss. The findings support cohort membership and employment status as influencing a woman's well-being. The consequences of an empty nest, i.e. loss of the mother role, may depend more on life course and employment than on cohort membership. However, cohort membership was found to be important for women born around 1920. The strong orientation to the mother role for this group was associated with "immobilization" at midlife.

Physical Health Status

As a woman's mental health for too long has been male defined, so too have the issues which define her physical health. The health care system in the United States is built upon the medical model and medical care is provided to women mostly by men. Therefore men, not women, determine the primary health issues to be addressed at midlife. To date, for health care professionals the primary health concern for midlife women is menopause. However, DeLorey (1990) interviewed 120 midlife women not one of whom thought menopause was a midlife concern.

Women undergo great personal change during the years which surround menopause. Not all the changes which occur during this period are

negative. However, research continues to look for the negative. The view that biology is destiny has narrowed the meaning of a woman's life to her reproductive ability.

Brooks-Gunn and Kirsh (1984) identified health concerns for midlife women. It has long been felt there is a connection between the increased risks of heart disease and menopause. They saw heart disease as a critical issue to be addressed by the health care system for two reasons. The first was that most knowledge and treatment modalities are based on research findings gathered on male subjects. The second was that the social and cultural biases about women are so long standing as possibly to have clouded some of the statistics related to mortality and morbidity. In general, fewer diagnostic tests for heart problems are done on women with the same symptoms as men (Fiebach, Viscole, & Horwitz, 1990). The primary physical health concerns of midlife women are cancer, heart disease, menopause, onset of chronic illness, and substance abuse (Haynes, Levine, Scotch, Feinlab, & Kannell, 1978; Kopstein, 1978; Tishler, 1978; Wilsnack, 1984).

Role Theory

Human beings learn the rules of behavior through the process of socialization. These rules become the norms which define role behavior. "The cultural structure of a society, or of any social system within it is comprised of norms, which are clustered in terms of time, place, self, other, and function to form roles" (Bates & Harvey, 1975, p.92). Therefore, the pattern specific, behavioral expression of a cluster of internalized norms is role behavior.

Roles cluster together in terms of self and other to form statuses which constitute a two person relationship. Statuses cluster together

in terms of self and multiple others to form group positions. Social positions are either achieved, based on what the person can do, or ascribed, based on who the person is in terms of gender, age, or family connections. Roles generally involve a complex combination of both achieved and ascribed behavior sets. Finally, positions cluster together to form group structures such as family and community.

The concepts of self, role expectations, and role performance are central in role theory. The concept of self in role theory combines fairly constant cultural norms with the psychological variations in the individual personality. An organized system of role expectations is cognitive and serves as a significant guide and standard for appropriate conduct and behavior. Biddle and Thomas (1966) refer to the "shoulds" and "oughts" that are internalized as norms, while those that are overtly expressed are referred to as role demands.

The position a woman occupies changes over the course of the life cycle. The individual's life cycle can be viewed by looking at how roles, statuses, and positions are added to or deleted from behavior. Middle age begins a major alteration in a women's participation in society or an alteration in her expressed behavior relative to role, status, and position. This alteration is heralded if she is a mother by her children becoming adults and leaving home.

Mother Role

Mother is an ascribed position with many individual and cultural norms and demands. When children become adult and leave home, the behaviors which surround the mother's role change. The central role behavior involved in "care taking" is altered. Initially, the child's need to be cared for is great. Therefore, the mother may play out the

role behaviors at her expense, neglecting herself for the sake of the child.

When the child leaves home and his/her needs are not as great, a mother may feel a tremendous loss of purpose, and, if she has overinvested in the role, these feelings may be very acute. Even if she is able to view this time in her life as open to change and personal growth, the reordering of the relationship with her child is an awesome task--one which requires her to discover who she is and how she sees her future.

There is some empirical evidence that the role of mother contributes to a woman's well-being (Barnett & Baruch, 1985; Veroff, Douvan, & Kulka, 1981), although the results are mixed (McLanahan & Adams, 1987). Research has indicated the mother role, combined with others, brings both feelings of enhancement and feelings of conflict (Tiedje et al., 1990). The role of mother is made especially difficult in our society because there is the unrealistic expectation that one can shape a child in a chosen way (Lopata, 1971).

Mothers bear the primary responsibility for child care and feel responsible for parenting failures. Whereas multiple roles may feed positively into a woman's sense of well-being, problems with the mother role often may not be compensated for by other roles (Veroff et al., 1981).

Summary

The uniqueness of the female experience expressed in "...a woman is never not a woman..." (Erikson, 1968, p.290) combined with the social expectation for women to "take care" of relationships places them at risk for health problems at midlife. The event of launching the last

child from home is a transition and transitional changes are times of disequilibrium and uncertainty. Because the transitional period surrounding the physical launching of the last child from the nest is tied to strong affectional bonds, it is an integral part of the self-definition. The fear of what may be the outcome of the change and the individual's possible failure to achieve a comfortable adaptation to the new situation contribute to feelings of increased stress. When stress reaches intense levels, feelings of inadequacy and depression are the outcome. Therefore, to assess accurately a midlife woman's health status, both mental and physical health aspects of her varied life experience must be included.

This study builds on Gilligan's (1982) theory of changing care activities as women mature. It is based on the premise that midlife represents a time when a woman's need to balance her separate self and her connected self converge. How a woman reorders her relationships, how she seeks expression for her separate self and her connected self, and her subsequent state of health are the issues of study to follow.

CHAPTER III

METHODOLOGY

This study used a descriptive correlational design and is intended to provide information that will guide the care and counsel of midlife women and further research ventures. This chapter includes the following: (a) criteria for sample, (b) procedure, (c) data collection, (d) instrumentation, (e) proposed data analysis, and (f) limitations.

Criteria for Sample

Criteria for participation in this study were (a) women in marriage relationships and (b) women whose last child had left home within the last 24 months, i.e. gone off to college, gotten married, moved into an apartment and not returned to live permanently at home. Vacations, holidays, and weekend returns did not count. This time period was selected to provide ease in attaining a sample.

The sample size for this study was projected to be 130 women, i.e. at least 10 per variable. The 13 variables and the measures that will be used in this study are displayed in Figure 2.

The criteria for this study were selected in order to gather information from women during the time period when two transitions coexist: the individual's midlife age transition and the family transition of the last child leaving the home. It was thought being married was another relationship that might require reordering during this time. This was to be controlled for by omitting from the sample currently divorced, widowed, and never married mothers.

Variable Classes	Measures
Independent variable Self in Relation	The Relationship Self Inventory (RSI) 1. Separate Self (SS) 2. Connected Self (CS) 3. Primacy of Other Care (POC) 4. Self and Other Care (Pearson et al., 1985)
Dependent Variable: Health Status Emotional Health Status	Health Insurance Study - General Well-Being Scale (HIS-GWB) (Ware, et al., 1975)
Physical Health Status	Perceived Health Status (Spreitzer and Snyder, 1974) Use of Health Care Services (Price, 1974) Reported Health Behaviors (Price, 1993)
Contextual Variables Activities of Preparation for Transition	Pretransitional Index (Price, 1993)
Social Support	Social Suppot Index - Adapted from the PRQ (Brandt and Weinert, 1981)
Marital Relationships	Marital Relationship Index (Price, 1993)
Parental Relationships	Parental Relationship Index (Price, 1993)
Posttransition Care for Self	Posttransition Self Care (Price, 1993)

Figure 2
Classes of psychosocial variables and instruments used to measure them

Procedure

Requests for women to participate in this research took several forms. The first attempt to recruit women was to ask friends and coworkers if they knew women who met the criteria and would be interested in being part of the study. This approach was purposeful and the women recruited were self-selected.

The second approach involved placing advertisements in newsletters distributed by health care corporations, churches, businesses, and public schools. Both employees and volunteers of these organizations were targeted as possible respondents. The newsletter requests included the two key criteria questions and a phone number to which to respond if eligible and interested in participation. Requests were also made at regular meetings of women's groups and local health care clinics. One large grocery store chain was contacted; the managers agreed to place notices which introduced the researcher and included the criteria for study participation in the pay envelopes of all women employees between 40-60 years of age. If interested the employees were asked to contact the personnel office and leave their name and address. These names and addresses were then forwarded to the researcher.

The remainder of the women were recruited by a type of snowballing. Several local high schools were contacted and a request for a list of names of the June 1993 graduating seniors was made. The schools felt the only way they could provide this was to provide a list that was already public record so a copy of the commencement program was given to the researcher. Unless otherwise directed by a friend or an acquaintance who might have known the students on the list and knew who were last children leaving a two parent household, the researcher

arbitrarily selected a name from the list and began phone canvassing. The phone call consisted of a personal introduction to the mother and explanation for the call followed by several questions.

1. Do you meet the criteria?
2. Would you like to participate?
3. Do you know other mothers of students in the graduating class who also meet the criteria?
4. Do you have other family members or friends who might meet the criteria?

Usually within the first 10-15 phone calls a potential respondent was found. After one participant who met the criteria was found, the network spread quickly. This technique was used with one private and six public high schools.

Another way of recruiting women for the study was to include in the questionnaire a self-addressed stamped postcard to be given to a friend or relative who was thought to meet the study criteria and would be interested. Because the postcard return rate for the first one hundred questionnaires that were sent was so poor, the last 92 questionnaires did not include the postcard. There were 148 questionnaires returned (see Table 1). Phone calls to the homes of 1993 high school graduates and direct contact provided over 50% of the participants.

The techniques used to obtain a sample were broad in scope and encompassed a wide range of populations. The sample was obtained from a variety of sources in an attempt to sample a diverse group of individuals. This was intentional in the hope that a close approximation of the general population would be achieved.

Table 1. Sources of Study Population

Source	Number	Percent
Phone calls/high school	40	27
Direct contact	37	25
Newsletters	29	20
Women's meetings	12	8
Local business	12	8
Health care clinics	11	7
Postcard	7	5
TOTALS	148	100

Data Collection Procedures

Following approval of the research proposal by the University Committee on Research Involving Human Subjects (UCRIHS), each person who answered both questions "yes" and who agreed to participate in the study was sent a questionnaire. The average time to complete the questionnaire was expected to be 30 minutes. Included in the packet were a $2.00 bill and a self-addressed stamped envelope for return of the completed questionnaire. It was hoped the $2.00 would serve as incentive to complete the questionnaire and also as token payment for the woman's time and contribution to the research project. The completed questionnaires were received between June 1993 and December 1993.

Instrumentation

A summary of the instruments used to measure the constructs identified in this study is presented in Figure 2. These were combined to form a questionnaire composed of three sections. The two major sections are those related to the primary independent and dependent variables, i.e. The Relationship Self Inventory measuring the self-in-relation and instruments used to measure the health indicators. The health measures include The Health Insurance Study General Well-Being Questionnaire and measures designed by the researcher to evaluate a woman's physical health status. The next section consists of questions related to the contextual variables which have no direct bearing on the hypotheses. The remaining questions are designed to gather information of general demographics.

Each portion of the instrument will be described including instrument development, reasons for use in this study, and planned scoring techniques.

Relationship Self Inventory

The first portion of the questionnaire, (see Appendix A) The Relationship Self Inventory (RSI) (Pearson et al., 1985), was designed to measure the theoretical construct self-in-relation. The items included in this questionnaire clustered into four scales. They are the: (a) Separate Self (SS), (b) Connected Self (CS), (c) Primacy of Other Care (POC), and (d) Self and Other Care (SOC).

The Relationship Self Inventory was designed to validate the theories proposed by Miller (1976) and Gilligan (1982). Gilligan's methodology for studying female development was to use semistructured interviews on a small sample compiling her data in long and in-depth

narrative results. The researchers who developed the Relationship Self Inventory believe the self-in-relation to be a real and robust phenomenon which can also be measured by more traditional psychometric means.

The survey instrument consists of 60 items and the responses were on a five point Likert scale with responses ranging from "not like me at all" (1) to "very much like me" (5). Pearson et al. (1985) tested this instrument on 930 women and 228 men. The alphas for internal reliability, the mean scores, and the standard deviations for this study for all four scales parallel those obtained by Pearson et al. when testing the instrument during development (see Table 2).

The Relationship Self Inventory (RSI) was used in this study to operationalize the self-in-relation. In scoring the RSI a summed score for each scale was used. High scores on the Separate Self scale determine the degree to which a woman would describe herself as being more separate or independent of others. High scores on the Connected Self scale are indicative of how important interconnections with others are for women. High scores on the Primacy of Other Care scale provide a measure of the degree to which a woman is more often apt to place the needs of others before her own. Finally, high scores on the Self and Other Care scale allow for a measure of the woman's ability to care equally for herself while still caring for others.

Health Status

The second section of the questionnaire (see Appendix B) measures the construct health status. This measure is a combination of (a) the Health Insurance Study General Well-Being Scale (Ware et al., 1979), a 22 item instrument developed to measure emotional health status, and (b)

a six item measure of physical health status designed by the researcher for use in this study. The physical health status measure has three scales: (a) perceived health status, (b) use of health care services, and (c) positive and negative reported health behaviors. Intercorrelations between the indicators of emotional and physical health are presented in Table 3.

Following the presentation of the two subscales, the construction and scoring of the health status variable for this study will be discussed.

Emotional health status. The Health Insurance Study-General Well-Being (HIS-GWB) form A, was used to measure emotional health status in this study (Ware et al., 1979). The HIS-GWB was developed to be used in the Rand Health Insurance Study and was designed to investigate physical, mental, social, and general health perceptions of the health status on a general population of adults, 14 and older in the United States. For this study the HIS-GWB was the operational definition of emotional health status and used the Health Insurance Study's broad definition of health that included complete physical, mental, and social well-being not just the absence of disease. This definition adapted from the World Health Organization has expanded the definition of mental health to include positive states. This demonstrates an interest in the quality of life as the ability to achieve optimal functioning (Offer & Sabshin, 1974).

The HIS-GWB was selected because of its reliability, acceptance in the field, and ease of administration. The questionnaire is composed of 22 items and includes six scales designed to measure anxiety, depression, positive well-being, self-control, general health, and

Table 2. Comparison of Means, Standard Deviations and Cronbach's Alpha for Pearson et al. and Price Data on Relationship Self-Inventory

Relationship Self Inventory Scale	Pearson et al. (1985) N=320; Age 30-78			Price (1994) N=145; Age 39-62		
	Mean	SD	Alpha	Mean	SD	Alpha
Separate Self	2.5	.51	.77	2.4	.42	.76
Connected Self	4.1	.56	.76	4.2	.47	.73
Primacy of Other Care	3.2	.53	.68	3.4	.51	.70
Self and Other Care	3.8	.54	.78	3.8	.45	.76

Table 3. Intercorrelations Between Emotional Health Measure and Physical Health Measure

Variable: Emotional Health			Variable: Physical Health		
	Total Physical Health	Perceived Health Status	Use of Health Care Services	Positive Health Behaviors	Negative Health Behaviors
Emotional Health	.41*	.48*	.15*	.18*	-.06
Less Anxiety	.24*	.30*	.07	.12	-.05
Less Depression	.17*	.20*	.04	.07	-.14*
Self Control	.23*	.29*	.08	.11	-.03
Well-Being	.31*	.35*	.12	.15*	-.08
General Health	.55*	.61*	.29*	.21*	.04
Vitality	.37*	.48*	.11	.17*	-.00

*p<.05

vitality (Dupuy, 1972, 1973). Scoring for the HIS-GWB was done by reversing items 1, 4, 5, 7, 10, 11, 12, 16, 19, 20, 21, and 22 and then summing all scores to achieve a total score. Therefore, each subscale as well as the total scale was viewed as a positive scale and a high score on each subscale and the total scale was indicative of a favorable mental health status. This technique allowed the researcher to view each subscale knowing that high scores meant positive health outcomes, i.e. less anxiety and less depression.

The overall reliability and validity measures for the HIS-GWB were determined after being tested on 8,000 subjects (Ware et al., 1979). Reliability was estimated using test/retest and internal consistency reliability. Internal-consistency reliability coefficients for the HIS-GWB Total were above 0.90, the mean was 104.18, and the standard deviation was 15.68. Intercorrelations among the subscales were significant in this study (see Table 4).

Physical health status. For purposes of this study, physical health was measured using three indicators. Items found in the physical health measure can be found in Appendix B. These were questions H1, a woman's perception of her health; questions H2-H4, her use of health care services; and question H5, her reported negative and positive health behaviors. While it is understood there are disadvantages to self-reported health status, it has not been determined that the reports of health care providers are any better (Eisenberg, 1979).

Physical health measures were combined and scored as follows. The physical health measure had a total weight of nine which was a summed score of the three subscales. Possible responses to H1, the item measuring self-reported health perception, had a range of 1-4, therefore

it was 4/9ths of the total physical measure. Each response to the three items in the subscale use of health care services could receive a score of 0 or 1 with the highest total possible summed score being 3 and carrying a weight of 3/9ths. The weight assigned the subscale for reported health behaviors was 2/9ths. The negative behaviors were assigned the following values: use of cigarettes=1/3, use of alcohol=1/3, use of caffeine=1/3 summing to a total of one. The positive behaviors were assigned the following values: time spent sleeping=1/3, time spent exercising=1/3, and quality rating of nutritional intake=1/3 summing to a total of one. When summing for the total physical health score positive, behaviors were added to and negative behaviors were subtracted from the physical health score.

A single item measure of health status based on individual health perception has been used on both early adult and aging populations. Because there is an association between general health rating scores (the single-item measure) and other measures of health status and health/illness behavior, it was decided to use a single item measure of health status (Henley & Davis, 1967; Madow, 1967). For this study the item asks for a perception of health status in the last 24 months with a range of choices on a Likert scale from excellent (1) to poor (4).

The information retrieved from the use of health care services scale included: the number of upper respiratory illnesses, trips to the physician's office, and if hospitalization for any reason had been required in the last 2 years. These data were obtained because it was thought that by using a multidimensional approach to physical health a better overall picture of health status would be obtained.

For the scale of reported health behaviors, the woman was asked to check a response of increased, decreased, or stayed the same to a list of both positive and negative health behaviors. This was a single item (H5a-f) with six behaviors listed. Negative behaviors included use of cigarettes, alcohol, and caffeine while positive behaviors were time spent sleeping, exercising, and maintaining a quality diet. These items were chosen because they have been shown to be significant in determining health status (Brooks et al., 1979). There was a restricted range of responses on this variable accounting for the low correlations. The correlations among the physical health indicators are presented in Table 5.

Construction of the health status measure. To construct an overall measure of health for this study, emotional and physical health factors were combined in the health status scale. When necessary to make the scales positive, the items were reversed. To interpret this scale, higher scores meant better health.

The emotional health scale and the physical health scale were designed to parallel each other with equal importance and value. To do this the raw scores of both measures were converted to Z scores and then combined to create the health status score.

Selected Contextual Variables

This section of the questionnaire (see Appendix C) is made up of five indices that were developed by the researcher for all of the contextual variables except social support (see Figure 2). The items included in each index were selected after a careful study of the available literature. Each index looked at a different variable which might play a part in the transition process at midlife for women. These

Table 4. Dependent Variable Intercorrelations for Emotional Health (a)(Price, 1994)

1. Emotional Health Scale	1	2	3	4	5	6	7
2. Less Anxiety	.80*						
3. Less Depression	.75*	.56*					
4. Self-Control	.82*	.60*	.72*				
5. Well-Being	.86*	.57*	.65*	.70			
6. General Health	.55*	.29*	.18	.28*	.33*		
7. Vitality	.77*	.47*	.43*	.49*	.62*	.54*	

(a) present study
* P<.05

Table 5. Dependent Variable Intercorrelations for Physical Health (Price, 1994)

1. Physical Health Scale	1	2	3	4	5
2. Total Physical Health					
3. Perceived Health Status	.78*				
4. Use of Health Care Services	.82*	.33*			
5. Behaviors: Positive	.25*	.15	.09		
6. Behaviors: Negative	-.10	.10	-.03	.14*	

*P<.05

indices were (a) the pretransition--reflections relative to the time before the last child left home, (b) social support--relationships with friends and support individuals, (c) the marital relationship--a perception of the marital relationship that is reality based facilitating rebalancing, (d) the parental relationship--a perception of the parent/child relationship that is reality based facilitating rebalancing, and (e) the posttransition--rebalancing of role relationships with others and self.

Pretransition index. The pretransition index was made up of five items which gathered information about preparatory activities a woman might use to "get ready" for the leaving of her last child from home. The pretransition index included the following activities: reading, taking classes, counseling, and sharing concerns with friends and spouse. The five questions required yes or no responses allowing for a possible score of 0-5. The score was summed over the responses. The higher the score, the more the mother had prepared for the launching of her last child from home.

Social support index. The measure of social support used in this study was adapted from the Personal Resource Questionnaire. Brandt and Weinert (1981) developed a two-part social support measure which they tested on 149 adults. Part two contained 25 items that included five subscales. These subscales encompassed five dimensions of social support: (a) intimacy, (b) social integration, (c) worth, (d) assistance, and (e) nurturance. A seven point Likert scale measured the items from "strongly agree" (7) to "strongly disagree" (1). For the purposes of this study, one item from each of the seven subscales was selected arbitrarily to create an abbreviated version of the PRQ part 2

social support scale. The abbreviated version of the PRQ part 2 included all of the dimensions of social support believed by the original developers to be important. Sample items include "There is someone I feel close to who makes me feel secure" and "There is little opportunity in my life to be giving and caring to another person." The scores on this index were summed and a high score is indicative of a high level of social support. Cronbach's alpha for this index was .60.

Marital relationship index. The sample selection for this study included only married women. This was done because it was thought the husband/wife relationship would require rebalancing as well as the mother/child relationship at this life transition. Questions M1-M2 made up the Marital Relationship Index. Each item on this scale had three possible responses, each looking at the degree of change expected by the wife in the relationship. The range of responses were from "getting better" (1) to "getting worse" (3). Two factors were thought to influence health: the direction the relationship shifted as well as the accuracy with which the woman could predict the direction of the shift. When scoring this index, crosstabs were done between the expected direction of change for the marital relationship (M1) and the reported change in the relationship (M2). Crosstab placement allowed for group assignment. If a woman predicted accurately the direction of change in the marital relationship, her score was 3. If a woman's prediction was not accurate, but the change in the relationship was positive, the researcher assumed she was pleasantly surprised and scored a 2. However, if a woman's prediction of the change in marital relationship was neither accurate nor positive, the researcher assumed she was

disappointed and her score was a 1. Higher scores on this scale are expected to correspond to a better health status.

Parental relationship index. The Parental Relationship Index was developed to measure the degree of understanding a mother has about the quality of her relationship with her child. Like the Marital Relationship Index, health outcomes were expected to be influenced by both the direction of the relationship change and the woman's ability to predict accurately the change. The value here was for her to know the relationships in her life. The expectation was that the greater a mother's understanding, the better her adjustment and, therefore, the better her overall health. The items for this measure were P1-P2. Each item had three responses ranging from "getting better" to "getting worse". The responses for the Parental Relationship Index were calculated in the same manner as the Marital Relationship Index.

Posttransition self-care. Investigation of posttransition self-care was done by asking women if time given to the last child at home and others in the past would now be given to herself. It was expected that women who were satisfied with the transition would spend more time taking care of themselves and this self-care would contribute to a better health status. The item was on a five point Likert scale from "a great deal" (1) to "not at all" (5). When scoring this item was reversed, so that a high score indicated a greater level of self-orientation.

Analysis of Data

To determine scale reliability and internal consistency, Cronbach's alpha for this sample was computed on the independent variable self-in-relation (see Table 2). Intercorrelations between indicators of the

dependent variable, health status, were computed (see Table 3). The results for emotional health are presented in Table 4 and for physical health Table 5.

Descriptive statistics were then used to determine frequency distributions, and to calculate mean scores and standard deviations for the following: the independent variable self-in-relation (see Table 2); the contextual variables: pretransition index, social support, marital relationship index, parental relationship index, posttransition self-care (see Table 6); and the dependent variable health status (see Table 7). Pearson Product Moment correlation coefficients were used to determine the degree of association between the independent variable self-in-relation and the dependent variable health status. Correlations were also done using the contextual variables (pretransition index, the social support index, and posttransition self-care), and the dependent variable health status.

All of the calculations used a one-tailed test of significance. A level of .05 was accepted as significant. The one-tailed test and .05 significance levels were appropriate because the expected direction of the relationship is stated in the hypothesis. Analysis of variance was done to determine if differences existed between a women's self-in-relation orientation and her health and her ability to predict accurately the direction of change in close relationships with husband and child after the transition.

Table 6. Descriptive Statistics for Sample: Contextual Variables

Variable	N	Range	Mean	SD
Pre Transition Index	140	0-4	1.76	.83
Social Support Index	145	3.4-7.0	5.85	.80
Marital Relationship	144	1-3	2.60	.69
Parental Relationship	144	1-3	2.58	.66
Post Transition Self-Care	145	4-10	7.35	1.45

Table 7. Descriptive Statistics for Sample: Health Indicators

Variable	Range	Mean	SD
Health Status	-5.72-3.50	.00	1.68
Emotional Health	-2.72-2.03	.00	1.00
Less Anxiety	11-29	21.12	3.91
Less Depression	7-18	15.03	1.98
Self Control	7-18	14.49	2.48
Well-Being	8-23	16.49	3.15
General Health	7-18	14.17	2.13
Vitality	5-17	12.50	2.30
Physical Health	-3.72-1.65	.00	1.00
Perceived Health Status	1-4	3.32	.69
Use of Health Care Services	0-3	1.91	.72
Reported Health Behaviors			
Positive	0-1	.72	.15
Negative	0-.78	.35	.19

N=145

Limitations

1. The convenience sample used in this study limited generalizability.
2. No effort was made to select women of low socioeconomic status or minority groups whose developmental processes may be different from the primarily white sample participants. However, some women from these groups may appear due to the technique of snowballing.
3. This sample excludes midlife women who are divorced, have never been married, and who are not mothers.
4. The instruments used in this study were not all developed for use with midlife women.

CHAPTER IV

RESULTS

This research sought to determine if a correlation existed between a midlife woman's self-in-relation orientation and her emotional and/or physical health. In the first section of this chapter the data relating to sample description including size, geographic location, age, educational level, family income, employment status, and family composition will be discussed. The next section will discuss the three research hypotheses and how the data relate to each. Finally, selected questions relating to the contextual variables and the possible impact they have on this midlife transition will be explored.

Sample Description

A variety of ways were used to find women who met the criteria and were willing to participate in the study. The following sample description provides a picture of the women who comprise this sample.

Sample Size

From June 1993 to December 1993 a total of 192 questionnaires were sent to women who stated they met the criteria for inclusion in the study: (a) living in a marriage relationship, and (b) had their last child leave home within the last 24 months. Within the 6 month period a total of 148 questionnaires were returned, a return rate of 77%. Of the total number returned, 133 were from women who had launched their last child from home within the previous 24 months. Twelve completed the entire questionnaire, however, their last child had left home prior to the 24 month time period allowed by the sample criteria. The range for this group was 26 to 72 months. The remaining three questionnaires were

returned only partially completed, therefore they could not be included in the study sample. The 12 completed questionnaires which did not fall within the established time parameters were grouped together and scored separately. Because their mean and standard deviation scores were not statistically different from the sample of the 133 who met the time criteria, the decision was made to add the 12 to make a total of 145 questionnaires which were analyzed for this study.

Geographic Location

The majority of this sample (132) was recruited from Michigan. However, six other states were represented: Idaho (4), Rhode Island (3), North Dakota (2), Montana (2) California (1), Massachusetts (1). The majority of the sample lived in small urban communities. The exceptions were one woman who lived in North Dakota and the two women who lived outside Billings, Montana, in rural areas.

Age

The mean age of the sample was 49.9 years. The range of ages was from 39-62 years.

Educational Level

Only a small proportion (3%) of the sample had not finished high school, while 28% had high school diplomas, but no college. Approximately one third (33%) indicated they had some college, 36% had completed college, and some had postgraduate degrees. The group may have been more highly educated because the community in Michigan where most of the sample was drawn has access to a large university and two community colleges. For a breakdown of the sample by educational level, income, employment status, and occupation, see Table 8.

Table 8. Sample Characteristics

	Percent
EDUCATION	
Less than High School	2.8
High School	28.3
Vocational	17.2
Community College	15.9
Bachelor of Science Degree	17.2
Master of Science of Master of Art	16.6
Professional	2.0
	100.0
INCOME	
Under $14,999	.7
$15,000-$29,999	4.8
$30,000-$49,999	11.0
$51,000-$99,999	62.8
Over $100,000	15.2
Missing Data	5.5
	100.0
EMPLOYMENT	
Employed	90
Unemployed	10
	100
OCCUPATION	
Business and Office	43.4
Education	15.2
Health Occupations	14.5
Service Occupations	6.2
Homemaker	4.8
Sales	4.8
Other	11.1
	100.0

Family Income

When asked about their total household income, 63% reported the $50-99,999 range and 15% reported above $100,000. Therefore, over 75% of the participants reported annual household incomes above $50,000.

Employment Status

Working women comprise 90% of the sample. Of this group, 71% were employed more then 30 hours a week. Thirty seven of the working women reported increasing by 26% the number of hours they spent working after the last child left home. To the question D17, "Do you consider your employment to be? Just a job" (1), "A very important part of who you are?" (2), or "A career you love?" (3), working women in the study selected responses two and three 75% of the time. Of the 10% of the sample who identified themselves as not working, 9% stated they were unemployed and 1% reported they were retired. More then half (64%) of the respondents were employed in business and office staff positions. Care had been taken to recruit a sample from a variety of work places. However, the researcher feared a high preponderance of caring professions (e.g., nursing, social work) might skew the overall results because women who choose these careers may be more care oriented or need to be more connected than others. Therefore, to have more than 50% of the sample representative of traditional service, but not caring careers, provides diversity to the overall results.

Of the 145 women in the sample, 58 reported they spent time in volunteer activities before their last child left home. Fourteen spent more then 10 hours a week in volunteer activities, and 44 spent less then 10 hours a week in volunteer activities. Of those who volunteered before their child left home, after their child left home 12 increased

time spent, 9 decreased time spent, and the remainder, 37, reported no change in time spent on volunteer activities.

Family Composition

The majority of the sample (84%) were socialized in either two parent family structures (N=80) or two parent working families (N=42). A total of 32 women (22%) had been divorced at least once and were now remarried.

The mean number of children in each family was 2.5 with a range of 1-7. Family size was "just right" for 72% of the sample and "too many" for 5%. A total of 23% would have liked more children.

For this sample, the breakdown by sex of last children leaving home was 57% girls and 43% boys. When answering question D7 "number of children now living", several women chose to include in that number the children of second spouses by their former marriages when the women felt responsible for and cared about these children. Supporting this care orientation, 52% of the total sample felt a "great deal" of commitment to the mothering role with 37% admitting to "quite a bit" of commitment. Seventy-one percent of the women admitted experiencing "some" to "a great deal" of difficulty letting their last child go.

Hypothesis Testing

The following section will address the research hypotheses and will be organized in the following manner. First, the hypothesis will be stated. A discussion will follow of how the hypothesis was tested and findings presented. Finally a statement of support or rejection of the hypothesis based on the data will be made.

Hypothesis One

The first hypothesis is: The more balanced a woman's separate/objective self with her connected/relational self at midlife, the better her health.

To operationalize the concept balance, a difference score was calculated by subtracting separate self scores from connected self scores for each woman. This score then became the balance index. Based on the balance index score, individuals were placed into three groups with approximately 1/3 of the research sample in each group. Group one consisted of those women who had a high separate self and a low connected self orientation. The women in group two, those whose scores clustered around the group mean, were thought to be those individuals who would be most balanced or have equal or nearly equal expressions of the traits separate self and connected self. Group three were women who had high connected self and low separate self orientation. One way analysis of variance, followed by multiple comparisons of group means, were used to determine if there were differences among the three groups of women on the measures of emotional and physical health status. No differences were found (see Table 9).

To further test this hypothesis, a second approach was used. Scores on the variables separate self and connected self were used to divide the respondents into two groups, those above and below the mean. The women were placed into one of four groups based on where their scores fell on the two measures. Group A included women with scores that were above the mean on both measures. Group B was comprised of women who were above the mean on the separate self measure but below the mean on connected self. The women in group C scored high on connected

self and low on separate self, and group D had scores below the mean on both measures (see Table 10). Two groups with similar score directions were thought to reflect a balanced self. They were groups with high separate self/high connected self (A) and low connected self/low separate self (D). One way analysis of variance was done to determine if there were differences among these four groups on each of the health indicators. No significant differences were found (see Table 11).

Therefore, after trying two different approaches to operationalize the construct balance between the variables separate self and connected self and finding no identifiable differences when related to health status, hypothesis one could not be supported.

Hypothesis Two

The second hypothesis is: The higher a woman's commitment to the primacy of other care, the more deficient her health status at midlife.

To test the second hypothesis, zero-correlations were computed between the primacy of other care scale and the health indicators. The results of this analysis are presented in Table 12.

Several significant correlations were found. Scores on a woman's overall health status were negatively correlated with primacy of other care. When health status was broken down into emotional and physical health components, a woman's overall emotional health was found to be negatively affected by the effect of primacy of other care. The effect of primacy of other care is seen in her loss of vitality and a decreased sense of well-being. A negative correlation was also found between reported positive health behaviors and her primacy of other score.

Table 9. Means and (S.D) for Health Indicators by Balance Index

Health Variables	Balancing Index Groups Group 1 N=47	Group 2 N=50	Group 3 N=48	F Ratio
Health Status	-.14 (1.49)	.09 (1.72)	.05 (1.82)	.2603
Emotional Health	-.17 (.98)	-.01 (1.01)	.18 (.99)	1.4333
Physical Health	.03 (.92)	.10 (1.02)	-.13 (1.06)	.6241

NOTE: There were no statistically significant differences between the groups.

Table 10. Distribution of 145 Participants According to Typology of High and Low Scores on Separate and Connected Self Scales

Connected Self	Separate Self High	Low
High	A N=28	C N=45
Low	B N=43	D N=29

N=145

Table 11. Means and (S.D.) for Health Indicators by Location in Balance Self Typology

Health Variables	Group A N=28	Group B N=43	Group C N=45	Group D N=29	F Ratio
Health Status	-.10 (1.81)	.03 (1.73)	-.16 (1.54)	.30 (1.71)	.4847
Emotional Health	-.14 (1.12)	.13 (.92)	-.15 (.95)	.18 (1.06)	1.0360
Physical Health	.04 (1.03)	-.09 (1.08)	-.02 (.99)	.12 (.89)	.2754

NOTE: There were no significant differences between the groups

Table 12. Correlations Between a Woman's Health Status and Relationship Self-Inventory Scores

Health Variable	SS	CS	POC	SOC
Health Status	-.00	.09	-.15*	.15
Emotional Health	-.02	.20*	-.14*	.20*
Less Anxiety	.06	.15*	-.11	.15*
Less Depression	-.02	.14*	-.07	.12
Self-Control	.01	.18*	-.13	.16*
Well-Being	.01	.20*	-.17*	.18*
General Health	-.14*	.10	.01	.12
Vitality	-.06	.11	-.16*	.16*
Physical Health	.02	-.06	-.11	.06
Perceived Health Status	-.01	-.04	-.09	.03
Use of Health Care Services	.03	-.03	-.06	.03
Reported Health Behaviors (Positive)	.05	-.22*	-.19*	.07
(Negative)	-.01	-.06	-.02	-.07

N=145; *p<.05

SS=Separate Self
CS=Connected Self
POC=Primacy of Other
SOC=Self Other Care

These correlations were modest in magnitude; however, because they were found to be statistically significant, hypothesis two was supported.

Hypothesis Three

The third hypothesis is: The higher a woman's commitment to self and other care, the better her health status at midlife.

Correlations were done between the self and other care scale and the health status variable. Table 12 presents the zero-order correlations. The overall health status of the sample was not significantly correlated with the self and other care scale. The physical health scale did not correlate significantly with the self and other scale. But as expected, the emotional health of the women in the study was most affected by the self and other scale. Significant correlations were found on the emotional health scale and the subscales of anxiety, self-control, well-being, and vitality. These correlations were small to moderate; however, they do demonstrate a relation between emotional health and the ability for a woman to give care to herself as well as others. Therefore, hypothesis three was supported.

Post Hoc Exploratory Analysis of Selected Variables

Analysis was undertaken to address the question of possible relationships between each of the contextual variables and the health status of midlife mothers who have launched their last child from the home. Table 13 displays the correlations that were found between the variables.

Although a number of significant correlations appear, they are small in magnitude. Five questions of particular interest to the researcher were formulated as ways to organize the exploratory analysis.

Question 1

Among the women in the sample, is there a relationship between involvement in activities to prepare for the separation from her last child and her health status?

Self-control was the only health indicator that was found to be significantly correlated with the pretransition index (see Table 13). Self-control was found to be negatively related to activities done to prepare for the separation. It might be that feelings of being out of control push the need to be involved in activities which help a woman feel she can gain control over a life event that is often surrounded by conflicting feelings. None of the other health status variables were found to be significantly related to the pretransition index.

Question 2

For this sample, does the perceived amount of social support provided during the transition of launching the last child from home relate positively to a woman's health?

The social support index was significantly related to only one health measure--the emotional health scale for well-being (see Table 13). Because a greater degree of correlation was expected, further analyses were undertaken. In these analyses, the individual items of the social support scale were correlated with the health indicators. Out of 24 correlations, two significant relations were found. The first was "I can't count on my relatives and friends to help me with problems" (SS3) which was correlated with the physical health status variable (r=.23). This item had been recorded. Therefore, the higher the score the more important social support. This finding was consistent with the expected outcome.

The other item "I spend time with others who have the same interests that I do" (SS4) correlated positively with the emotional

Table 13. Correlations Between a Woman's Health Status and Selected Contextual Variables

Health Variables	PRETRAN INDEX	SOCIAL SUPPORT	POSTINX
Health Status	-.09	.06	.08
Emotional Health	-.09	.09	.14*
Less Anxiety	-.13	-.03	.08
Less Depression	-.05	-.01	.17*
Self-Control	-.18*	.12	.11
Well-Being	-.01	.19*	.23*
General Health	-.06	.09	.02
Vitality	.02	.01	.00
Physical Health	-.06	.02	-.00
Perceived Health Status	-.06	-.02	-.04
Use of Health Care Services	-.08	.06	.01
Reported Health Behaviors (Positive)	.01	.01	.19*
(Negative)	-.12	.06	.06

N=145; *p<.05
Pretran Index
Pretransition Index
Social Support Index
Posttran=Post Transition Self Care

health status variable (r=.21). Again this might be expected (Surrey, 1991) because emotional growth for women is through connections.

Question 3

Does a woman's ability to predict with accuracy the direction of marital relationship change at the time her last child leaves home impact her health status significantly?

It was thought that accurate prediction of the direction of change in the relationship would be positively reflected in health indicators (see Table 14). To look at this relationship, the variable "marital index" was used to create three groups: (a) those for whom the marriage was less positive than expected following the transition (b) those for whom the marriage was more positive than expected (c) those who accurately predicted how the marriage would be following the transition.

To analyze the relationship between these two variables, oneway anovas were done with each of the health indicators to determine if differences could be found between the groups (see Table 14). The health indicators which had group differences that were statistically significant were health status, emotional health, less depression, self-control, well-being, physical health, perceived health status, and use of health care services. Differences were found between women in group one, those who did not accurately predict the relationship change and were assumed to be disappointed, and between groups two and three. Group two, included the women who did not predict accurately but erred in a negative direction so were assumed to be pleasantly surprised with the outcome. Group three included the women who possessed a realistic understanding of where the relationship stands. The one exception to this was the measure of health perception where only groups one and three were found to be different.

Table 14. Oneway ANOVA Analysis of Marital Index of Self-Perceived Accuracy of the Marital Relationship

	Means and Standard Deviations			
	Group 1 N=14	Group 2 N=27	Group 3 N=103	F Ratio
Health Status	-1.42	.30	.10	
	(2.68)	(1.45)	(1.47)	6.0715*
Emotional Health	-.78	.18	.05	
	(1.28)	(.99)	(.92)	5.1229*
Anxiety	19.50	21.30	21.27	
	(5.08)	(3.88)	(3.75)	1.3032
Depression	13.36	15.22	15.20	
	(2.68)	(1.67)	(1.86)	5.8849*
Self Control	12.36	14.74	14.69	
	(3.30)	(2.58)	(2.20)	6.0546*
Well-Being	13.43	17.04	16.74	
	(3.63)	(3.04)	(2.91)	8.0286*
General Health	13.71	14.56	14.13	
	(2.58)	(2.10)	(2.08)	.7780
Vitality	11.57	13.07	12.49	
	(2.28)	(2.09)	(2.33)	2.0073
Physical Health	-.64	.12	.05	
	(1.58)	(.92)	(.90)	3.2944*
Perceived Health Status	2.86	3.33	3.38	
	(1.03)	(.62)	(.63)	3.7024*
Use of Health Care Services	1.57	2.07	1.91	
	(.93)	(.82)	(.64)	2.2999*
Reported Health Behaviors				
Positive	.79	.70	.72	
	(.16)	(.20)	(.14)	.7680
Negative	.34	.36	.35	
	(.14)	(.20)	(.20)	.0480

Group 1=(marriage less positive than expected)
Group 2=(marriage more positive than expected)
Group 3=(those who predicted accurately)

Question 4

Does a woman's ability to predict with accuracy the direction of parental relationship change at the time of separation impact her health status significantly?

For this analysis the variable "parental index" was created. To create this index three groups: (a) those women who found their parental relationship to be less positive than they had expected, (b) those woman who found the parental relationship to be more positive than they had expected, and (c) those woman who had accurately predicted the direction the relationship would take when the child left home (see Table 15).

Oneway anovas were done to look at differences that might exist between those women who could predict accurately the direction of the change in mother-child relationships and those who were assumed to be disappointed with the relationship outcome or who were assumed to be pleasantly surprised by the changes in the relationship since the last child had left home (see Table 15). Significant differences existed between those women in group one and women in both groups two and three. The health indicator related to emotional health that was found to be significantly different between women in group one and women in groups two and three was less depression. Perceived health status was the physical health difference found to be significantly different between groups two and three. It appeared that if a woman could accurately predict the direction her parental relationship would take after her child left home or if the relationship got better than she predicted it would, her health status was better. However, women who were unable to predict accurately and who were assumed by the researcher to be disappointed with the change in the relationship were less healthy. Women who could predict accurately or who were assumed by the researcher

Table 15. Oneway ANOVA Analysis of Parental Index of Self-Perceived Accuracy of the Parental Relationship

	Means and Standard Deviations			
	Group 1 N=14	Group 2 N=30	Group 3 N=100	F Ratio
Health Status	-.82	-.18	.17	
	(1.56)	(1.78)	(1.64)	2.3863
Emotional Health	-.53	-.10	.10	
	(.99)	(1.03)	(.98)	2.7291
Less Anxiety	20.36	21.00	21.26	
	(4.55)	(3.76)	(3.91)	.3389
Less Depression	13.79	15.30	15.13	
	(2.89)	(1.74)	(1.86)	3.2578*
Self Control	13.00	14.33	14.74	
	(3.11)	(2.23)	(2.41)	3.1725*
Well-Being	14.86	16.30	16.77	
	(3.84)	(2.82)	(3.12)	2.3563
General Health	13.07	14.00	14.35	
	(2.37)	(2.38)	(1.99)	2.3542
Vitality	12.14	11.83	12.75	
	(1.61)	(2.91)	(2.15)	2.0396
Physical Health	-.29	-.07	.07	
	(.98)	(.99)	(1.00)	.8712
Perceived Health Status	3.07	3.10	3.43	
	(.62)	(.71)	(.07)	3.8704*
Use of Health Care Services	1.79	2.00	1.90	
	(.80)	(.69)	(.72)	.4510
Reported Health Behaviors				
Positive	.71	.74	.72	
	(.13)	(.20)	(.14)	.4719
Negative	.29	.33	.36	
	(.19)	(.22)	(.19)	.9663

Group 1=(parental relationship less positive than expected)
Group 2=(parental relationship more positive than expected)
Group 3=(those who predicted accurately)

to be pleased with the change in the relationship were less depressed and perceived their health as better.

Differences were also found between groups one and three on the subscale self-control. Women who could predict the direction of change in the relationship had greater self control then those who could not predict accurately or whose prediction was less positive then expected.

Question 5

In this sample, is there a relationship between a woman's health and increased time spent on self-care activities by mothers after their last child leaves home?

This question was answered by looking at only one item PC4 (see Table 16).

Table 16. Correlations Between A Women's Health Status and Her Involvement In Posttransition Self-Care

Health Variable	Increased Time Spent on Self
Health Status	.08
Emotional Health	.14*
Less Anxiety	.08
Less Depression	.17*
Self-Control	.11
Well-Being	.23*
General Health	.02
Vitality	.00
Physical Health	-.00
Perceived Health Status	-.04
Use of Health Care Services	.01
Reported Health Behaviors (Positive	.19*
(Negative)	.06

Thirteen correlations were done between this item and the health indicators and four were found to be significant. It appears, in general, a mother's health status is improved after her last child leaves home if she devotes time and attention to herself. Positive correlations were found to exist between a mother's emotional health, her sense of well-being and practicing positive health behaviors. She was also found to be less depressed.

CHAPTER V

DISCUSSION

This study looked at the health status of upper middle class, middle aged women who had launched their last child from home and how they relate to others as evidenced by their expression of their separate self and their connected self. Also examined were a woman's health and a series of contextual variables: (a) involvement in activities to prepare for separation from her last child leaving home, (b) the amount of social support she perceives during the transition, (c) her ability to predict direction of change in her marital relationship, (d) her ability to predict directional change in her parental relationship, and (e) the increased time she spends in self-care activities after her child leaves home. The sample was chosen to superimpose two transition points (a) midlife, a time of reflection and reclaiming of the self and (b) the task of reordering the primary relationship of mother and child.

The literature reviewed prior to this research identified two different schools of thought about this period in a woman's life. Strong evidence can be found in support of a unidirectional pathway that is nongender specific for adult development (Erikson, 1959; Levinson et al., 1978). This single pathway places individuation and separation at the heart of growth and emotional health.

Franz and White (1985) expanded the single pathway theory of adult development to a double helix model. Their model included both individuation (separate self) and communion (connected self). They disagreed with contemporary feminist theorists (Gilligan 1982; Surrey

1991) instead proposing an adult theory of development that applies to both genders.

Gilligan (1982) took exception to the earlier thinking (Erikson, 1959; Levinson et al., 1978) and has proposed a theory that is not only gender specific, but which suggests there is strength and value to the female path of adult development. She saw emotional health as achieved through the expression of both a separate self and a connected self and believed this expression took the form of caring for self and others.

Surrey (1991) moved Gilligan's theory a step further and proposed a self-in-relation hypothesis that stated to grow and be healthy a woman did not need to disconnect. All growth for women is achieved through connections.

Both Gilligan and Surrey have used qualitative methods for their research designs and have only small samples on which to base their findings. The Relationship Self Inventory (RSI) measures Gilligan's (1982) levels of care as four different expressions of the self-in-relation (Surrey, 1991). These expressions were seen in how separate a woman saw herself from others, i.e. her separate self, how connected she felt to others, i.e. her connected self, how much others' needs took precedence over her own, i.e. primacy of other care, and how she managed to care for herself as well as care for others, i.e. self and other care.

This study used the RSI on a sample of 145 married women to determine if a woman's self-in-relation orientation indeed correlated with her health status. The sample selected for this study was experiencing a life transition event, i.e. last child leaving home, and was involved in relationship changes.

It seems appropriate to apply Gilligan's model developed when working with adolescent girls to midlife women because during both periods in a woman's life the process of self-expression is examined. Gilligan determined that at adolescence a young girl disconnects with the self and disavows knowledge of her own self-needs. If at adolescence her self-voice is lost or "goes underground" (Gilligan, 1990) and only her caring voice is expressed, then at midlife, because the taking care needs for women as mothers are lessened, perhaps the self-voice again emerges.

> It is not surprising to learn that there are two times of crisis in a woman's life: when she enters that social role in adolescence, and when it abandons her at around fifty. Perhaps one day, we will have changed society enough so women are never asked to submerge a true self. Until then, those early years are the best guide to the person we can become in that last third of life. (Steinem, 1992, p.89)

Midlife is a time to focus on self--to reconnect to the self. How a midlife woman does this is of import for younger women as she is a role model for the future. How she does this is also important for health care providers since both her emotional and physical health may be negatively affected depending on her ability to accomplish this transition with ease.

Discussion of the Research Findings

Discussion of the findings of this study will include: (a) a critical look at the sample, (b) reviewing the outcome of the tested hypotheses, (c) a commentary related to the post hoc analysis of data, and (d) conclusions drawn by the researcher on the findings of this research. The format for this discussion will be patterned after the presentation of data analysis in Chapter IV.

Sample Description

A sample that is as highly educated and affluent as this one does not lend itself to generalization to other populations. The findings seem to reflect a very self-actualized (Maslow, 1970) group of women with knowledge and resources at their disposal to care for themselves and others.

Age and cultural identity may have contributed to the findings of this study. Neither were controlled and allowing for a younger or older population and/or a sample reflecting known cultural diversity might have produced very different results.

The high percentage of working women in this study may contribute to differences in expressions of separate and connected selves because the very act of working provides opportunity for an increased number of connected strands and relationships. Working women may see themselves as more connected than nonworking women. Because they have fewer roles, nonworking women may have a poorer health status (Verbrugge 1985). The possibility that this is the case with this sample is strengthened by the fact that those women who worked felt much self-worth and value in their role as worker.

The 84% of the sample who were raised in two parent families may contribute to the feelings of high sense of connection. The need to take care of relationships and to sacrifice self to maintain relationships may also be reflected in the long standing marriages of 78% of the women in the sample.

Why did almost 25% of the women in the sample see the number of children in their lives as not enough? Perhaps the wish to have had more children is a reflection of past generational norms or really a

wish to do it over--better, and may have been an expression of the reflective nature of midlife for women.

Hypotheses Testing

Three hypotheses were proposed and two of the three were supported by the findings of the study. The first hypothesis which correlated health indices with a balanced separate and connected self may not have been supported due to the fact that the measures were not sensitive enough and/or the sample size not large enough, or diverse enough to discern a difference. The construct balance as developed for this research proposed equal amounts of the two personality traits separate self and connected self as an indicator of a state of health. However, the construct may not be balance in equal amounts but rather balance in terms of what is comfortable for the individual women. It is not clear how much self-expression and how much connected expression is needed to provide an inner harmony.

The second hypothesis which related a woman's commitment to others to the detriment of her health was found to be supported. A woman's identity develops in the context of connections and she judges herself by a standard of responsibility and care. The dynamic here is the primacy of which others. Which other is not clearly delineated in the Relationship Self Inventory. Will a mother place her children's primacy of other needs before her own more then she would someone else? In future studies, specific others would need to be identified and controlled.

Hypothesis three relating to self and other care was supported because women who cared for themselves as well as others were found to

be healthier with more self-control, a better sense of well-being, low anxiety and more vitality.

These findings are only specific to the sample under study. A different sample, a different transition period, a more narrowly defined period of time around the transition event might provide more information and greater understanding to the question of individuation and connectedness for women in our society.

Post Hoc Analysis

The following discussion is related to the post hoc analysis of selected questions of interest to the researcher. What if any relationship existed between the contextual variables and the health indicators for the sample population?

Question 1. Among the women in the sample, is there a relationship between involvement in activities to prepare for the separation from her last child and her health status?

Anticipated transitions are usually rehearsed and planned (Schlossberg, 1986). However, when looking for preparatory activity in this sample of women, little was found. A normal and expected role transition is not stressful or crisis-ridden and, conversely, only events which upset the sequence and rhythm of the expected life cycle lead to difficulties (Neugarten, 1979). Though expected, this is one of those events in life where there are feelings of great conflict because of the strong affectional bonds between mother and child and because of the identification with the mother role and the part this plays in self-definition. Perhaps because this sample was well educated, the women did not see the need to prepare for the event prior to launching. This might be due to the value of their education and affluence; they may think they should look forward and be happy about this adventure for

their child as well as for themselves. But they might be denying feelings of loss and sadness. Maybe it is not socially acceptable to admit to others you have concerns or "can't handle" the separation. We prize independence and self-control; to need others is evidence of a weakness, a flaw, (Thomas, 1990).

Question 2. For this sample, does the perceived amount of social support provided during the transition of launching the last child from home relate positively to a woman's health?

Question two explored the relationship of social support to a woman's health during this transitional period. Gilligan (1982) espoused that connections with others increase feelings of well-being and knowing someone cares reduces stress. If this is true, then at times of change reaching out to others for support would be likely. This was supported but with only a weak correlation for the subscale well-being.

The researcher believed that social support would play a much greater role at this time in a woman's life. Perhaps the fact the social support scale was used in an abbreviated form, even though inclusive of the constructs believed to be important by the developers, lessened its sensitivity. The decision to use an abbreviated version was made in consideration of respondent time and would be reconsidered for further use of the instrument. When applying transition theory to this variable, perhaps this transition is of such magnitude that the process of disengagement and the need to pull away from others and into one's self is the phenomenon occurring here (Bridges, 1980).

Question 3. Does a woman's ability to predict with accuracy the direction of the marital relationship change at the time her last child leaves home impact her health status significantly?

The third question dealt with change in the marital relationship and a realistic understanding of the true nature of the relationship. The marital index was created to look at differences between groups of women and their ability to predict direction change. The sample was poorly distributed on this variable. Few (N=7) women reported their marriages had "gotten worse" since their last child left home (see Table 14).

Glenn (1975) found a positive effect on the wife's marital happiness when the children leave home. It would be important to see longitudinal data on this sample to determine if two things happen in the postparental phase.

1. If the marriage relationship is seen as "better", is that "better" sustained?
2. As women reorder relationships, if the wife role is placed second to caring for herself, does the husband's perception of "better" decrease?

Brown (1984) found women in unhappy marriages experience more depression. The women in this sample who did not accurately predict the direction of change in their marriage relationship were more depressed, more out of control, and had a lesser sense of well-being. Those women who predicted their marriage relationship change accurately experienced overall better emotional and physical health.

Midlife can be a tumultuous time for marriage relationships. The middle years are a time when marriages dissolve (Smith & Moen, 1988). More and more midlife couples will experience divorce before they

experience widowhood (Glick, 1984). A woman who has a realistic understanding of where the relationship is probably will make it through the transition at midlife in better health.

Question 4. Does a woman's ability to predict with accuracy the direction of the parental relationship change at the time of separation impact her health status significantly?

Only a small number (N=5) of mothers in the sample reported the relationship with their last child at home was bad, i.e. "got worse" and "gotten worse" (see Table 15). This finding may reflect the particular sample or it may speak to the importance of the mother role. This relationship carries with it a great deal of responsibility because mothers in our society are considered to be most responsible for how their children turn out (Veroff et al., 1981). If a mother is launching a child who has not met expectations, the mother may be faced with guilt and anxiety.

Parental relationships for this study were dealt with in the same manner as the marital relationship by creating a new variable: the parental index. In this study, being able to predict accurately the direction of change in the relationship reflected positively on a women's physical health perception, her sense of self-control, and significantly less mental depression.

The researcher was surprised to find fewer significant differences between the health indicators and the parental index than with the marital index. Believing this to be the primary relationship, the reverse was expected. It may be the importance of this relationship is so close to a woman's core that she tends to be less realistic about the level of intimacy shared.

Question 5. In this sample, is there a relationship between a woman's health and increased time spent on self-care activities by mothers after their last child leaves home?

Question five explored relationships between a woman's health and time devoted to activities for self (see Table 16). Responses to this question would indicate a relationship exists between the time and energy a woman spends on herself after her last child leaves home, and her health status. Women in this sample who spent more time on self-care activities also had more positive health indicators. Maybe the increased time she spends on positive health behaviors such as exercising leads to the physiological body responses which bring about feelings of well-being and improved body image both of which contribute to improved emotional health. The positive correlation between less depression and time spent on self-care may reflect feelings related to a parenting job well done.

CHAPTER VI

SUMMARY AND IMPLICATIONS

This chapter will be organized in three sections. First a summary of the study will be presented. The second section will be devoted to implications for existing theory, proposed research, and practice issues. A short conclusion follows.

Summary

This research looked at the possible relationship between a mother's health status during her midlife transition and her self-in-relation. This was a descriptive study of a self-selected sample of 145 married women. These women had launched their last child from home and agreed to complete a questionnaire designed to study the expression of their self-in-relation at a time in their lives when relationships are being reordered. When children no longer have intense caring needs, more time which could be devoted to self is available to women. The reflective nature of midlife provides the background for this introspection. The researcher believed balanced expressions of self and other care would prove to be healthy.

Data were collected from June 1993 to December 1993. The study used a survey questionnaire which included the following instruments (a) Relationship Self Inventory, (RSI) (b) the Health Insurance Study General Well-Being Scale (HIS-GWB), and (c) physical health measures created by the researcher.

Three hypotheses were proposed for this study. The first looked at the health of midlife women and the balanced expression of her separate and connected self. No support could be found for this hypothesis.

However, the second and third hypotheses were supported. These hypotheses proposed a direction for the self-in-relation against the scales of primacy of other and self and other care. These findings help demonstrate that when a woman is involved in giving to others to the exclusion of her own self, her health will suffer. When she is able to give freely to herself as well as to others and is able to view her activity of self-care as positive, her overall health is better. To summarize the findings related to the proposed hypotheses, it appears for this sample that a balanced self, i.e. equal expressions of separate and connected self, is not related to health status at midlife. However, overinvestment in meeting the care needs of others could be health damaging, while self-care coupled with the care of others appears to be related to health.

The results of this study are consistent with the earlier work of life course researchers who determined that transition is a time to reassess the self (Neugarten, 1979). Using a quantitative measure of Gilligan's (1982) female development theory, the Relationship Self Inventory, this research supports the use of this instrument to assess the four expressions of the self-in-relation for some women.

Implications

Theory, research, and practice implications will be presented.

Theory

The theory base used to investigate the health status of midlife women at a time of transition integrated the theories of Franz and White (1985), Gilligan (1982), and Surrey (1991). The integration was accomplished by applying the Franz and White double helix model of

nongender specific adult development to Gilligan's female caring "voice" model and used Surrey's definition of self-in-relation.

By applying the view of adult development proposed by Franz and White (1985) to the more narrow gender specific approach to female development as proposed by Gilligan, (1982) and Surrey (1992) (a sample of midlife married women) this researcher believed gains could be made in understanding the self-in-relation of midlife women and how the expression of self at midlife may have a bearing on their health status. It was thought the Franz and White model had application here because of its broader appeal to adult development. The fact that Gilligan's theory is gender specific and her results specific to adolescent girls limits its application. However, Gilligan's work with adolescent girls has implications for this study because both adolescent girls and midlife women are experiencing transitions related to caring. Gilligan believes adolescent girls are taking on the caring roles which the researcher believes midlife women are letting go. The self-in-relation construct emphasizes the shift from separation to connection and assumes a woman does not need to disconnect to grow. Surrey (1991) believes all self-growth takes place through connection. The application of this theory to the health of midlife women pushes for greater knowledge and understanding of female development.

Midlife women have one third of their lives ahead of them and face a life transition point when launching their last child from home. The more information that can be gleaned regarding the process of change that life course transitions bring as well as study of the impact of that change on the health status of midlife women, the more we might help create an environment of healthy transitions for midlife women that

supports and strengthens self growth. That quest was the impetus of this inquiry.

While not conclusive, the data obtained in this study support theories of Gilligan (1982) and Surrey (1991) that growth for women is achieved through connections. The findings that identify women with high expressions of connected self to be in better health than women who express high separate self contribute to the existing theory base that believes self-expression for women can and does occur through connections. The findings related to primacy of other care lend support to Gilligan's assertion that a source of psychological stress for women is the need to give up a relationship with self for the sake of relationships with others. However, support for the reestablishment of a relationship with self at midlife may be seen in the women whose major orientation at this time was self and other care. This group was healthy and comfortable expressing self through connection.

This study is a first step in determining if shifts in the self in relation are gender specific as proposed by Gilligan (1982) or gender neutral as proposed by Franz and White (1985). This question will require much more study and will only be understood by using as a sample midlife men in transition. Because of the way the data were collected for this study, it was not possible to determine if individual shifts in the self-in-relation occur over time as proposed by Davis and Jones (1992). Logic supports the notion that shifts do occur over time. Are there gender specific patterns of shifts? This question gives the gender issue as viewed by the two theories a different twist. Only much study and interest in the question will help humankind gain insight.

Research

Replication of this research with a sample that is more representative of the population as a whole would provide greater generalizability. The racial, ethnic, religious, educational and economic variables need greater variability. A sample of just professional care givers, i.e. nurses, might prove interesting in light of the fact that female care givers may do better at this time in their lives. They may have established greater skills in connecting because over their life course they have connected both personally and professionally. Therefore, they may be more adept both in reaching out to new connections and adjusting comfortably to the relationships that are changing. Perhaps a study of the coping strategies for care givers would provide insights into health care practice directions.

Other studies might include women who have never had children using an age marker as the definition of midlife. Or women who have a large number of children and this is the last one versus women who have only one or two children might be compared. Another question of interest may be how a mother launches her first child. Maybe by the time the last one leaves, the majority of the anticipatory preparation has taken place and a cross section sample would not demonstrate the separation process. It would be valuable to look at women who have never been married but who have children, women who are divorced at the time the last child leaves home, and women who are widowed at the time the last child leaves home.

A research question could be related to working versus nonworking mothers, and working mothers happy in their jobs and those who are not.

The relationship with working, the life transition of launching the last child, and health has much to be explored.

To replicate the study with the fathers would permit looking at gender differences in separate and connected orientations which would shed light on family function. Another way to look at gender differences would be to study just mothers and daughters in this process and just mothers and sons.

If this research could be done again, it would be most helpful to use multiple time points. The sample could be followed over time before the child leaves home, at the time of separation, and a follow up when the transition process is complete. Shifts in the separate and connected self could be plotted over time for each individual.

The entire midlife time frame for women is rich with research needs. While the topic of health, midlife women, and the psychological self have not suffered from a lack of research, much of the research has dealt with the loss of biological function, i.e. menopause, and has left women with the view that this time is negative and the doorway to old age. Further research into the many factors that contribute to a midlife woman's health status is necessary to help clarify the role the expression of separate self may play at this life transition.

The instruments used in this study were a combination of established methods and newly developed measures created by the researcher. The Relationship Self Inventory (RSI) (Pearson et al., 1985) and the Health Insurance Study (HIS-GWB) (Ware et al., 1979) proved to be reliable and user friendly instruments. The RSI is a quantitative measure of Gilligan's (1982) theory and has application in many areas of female development. This researcher would use this

measure to see if changes occur over time in the expressions of separate and connected self and if the health of women is affected based on the changes.

Although the data gathered for this study were both quantitative and qualitative in nature, only the quantitative findings were analyzed. In the future, the remaining data will be reviewed and further analysis will be conducted to understand more of this transition as experienced by the midlife women in this sample.

If this study were to be repeated, other ways to conceptualize the concept of balance might be considered, e.g. using The Self Other Care scale as the measure of a balance state.

The following is a list of other suggestions that might be considered for changes in the questionnaire.

1. The various measures used in this study to create the physical health scales were selected from the literature. There are other questions, i.e. seat belt use, that might be included and which might provide greater insight.
2. Because self-control was so often significant as a finding, a standardized measure for self-control should be added.
3. A different measure of social support could be found, however, if the PRQ part two (Brandt & Weinert, 1981) is used, other questions might be selected or the complete PRQ part two should be used.
4. The measures of both marital and parental relationships could be conceived as Likert scales with a greater range of choices. By using these measures as continuous variables, correlational directions could guide analysis.

5. Questions should be directed at the perception of the marriage relationship by the women at the time they complete the questionnaire. This would provide a relative starting point and be more meaningful when asking "getting better" and "getting worse" questions.
6. Question development to provide further inquiry into the role changes posttransition is needed to determine just how self-care contributes to health.
7. A scale to measure feelings of guilt might help to understand what is the emotional cost of giving time to self. The concepts of grief and loss might also have application to this changing relationship.

Practice

Health professionals have the opportunity to assess the expression of the self-in-relation and the possible impact that expression might have on the health status of the client when midlife women use the health care system. They need only be made aware. In the future, findings from this research study might be used to educate physicians and nurses regarding the relationship between a midlife woman's health status and the experience of launching the last child from home. A clue to her ability to make this transition with ease may be found in her self-in-relation orientation. A history form might be created for use in health care settings that includes a list of expected life course transition events. This tool might help to anticipate those events which may negatively or positively influence a women's health and provide direction of care and counsel for the female client.

The need to find and make available various activities to prepare for this transition will help a women feel in control and is important to maintaining her health. Helping women understand the process of transition and providing individual attention or group support may be helpful. This could be accomplished by speaking to health professionals to heighten their understanding and awareness and to lay groups of woman to provide anticipatory guidance and support. By disseminating this information to the community at large, health care professionals are both promoting health and preventing illness.

The health care profession is dominated largely by women. It is appropriate that female health professionals act as role models and work to dispel the myths about women in midlife. Health professionals need to empower women and help them find strength in their connections.

Conclusion

The cross sectional design of this research allowed for only a single snapshot in the lives of well educated, economically stable, midlife women. Greater understanding will be gained only as longitudinal studies are done on more diverse samples of both men and women to determine how changes over time in the self-in-relation orientation are expressed.

Appendix A

RELATIONSHIP INVENTORY (RSI)

READ EACH OF THE STATEMENTS BELOW AND DECIDE HOW EACH ONE DESCRIBES YOU. USING THE RATING SCALE OF 1 - "NOT LIKE ME AT ALL" TO 5 - "VERY MUCH LIKE ME," CHOOSE THE MOST APPROPRIATE RESPONSE.

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
1. I often try to act on the belief that self-interest is one of the worst problems facing society.					
2. A close friend is someone who will help you whenever you need help and knows that you will help if they need it.					
3. I cannot choose to help someone else if it will hinder my self-development.					
4. I want to be responsible for myself.					
5. In making decisions, I can neglect my own values in order to keep a relationship.					
6. I find it hard to sympathize with people whose misfortunes I believe are due mainly to their shortcomings.					
7. I try to curb my anger for fear of hurting others.					
8. Being unselfish with others is more important than making myself happy.					
9. Loving is like a contract: if its provisions are not met, you wouldn't love the person anymore.					
10. In my everyday life I am guided by the notion of "an eye for an eye and a tooth for a tooth."					
11. I want to learn to stand on my own two feet.					

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
12. I believe that one of the most important things that parents can teach their children is how to cooperate and live in harmony with others.					
13. I try not to think about the feelings of others when there is a principle at stake.					
14. I don't often do much for others unless they can do some good for me later on.					
15. Activities of care that I perform expand to both me and others.					
16. If what I want to do upsets other people, I try to think again to see if I really want to do it.					
17. I do not want others to be responsible for me.					
18. I am guided by the principle of treating others as I want to be treated.					
19. I believe that I have to look out for myself and mine, and let others shift for themselves.					
20. Being unselfish with others is a way I make myself happy.					
21. When a friend traps me with demands and negotiation has not worked, I am likely to end the friendship.					
22. I feel empty if I'm not closely involved with someone else.					
23. Sometimes I have to accept hurting someone else if I am to do the things that are important in my own life.					

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
24. In order to continue a relationship it has to let both of us grow.					
25. I feel that my development has been shaped more by the persons I care about than by what I do and accomplish.					
26. People who don't work hard to accomplish respectable goals can't expect me to help when they're in trouble.					
27. Relationships are a central part of my identity.					
28. I often keep quiet rather than hurt someone's feelings, even if it means giving a false impression.					
29. When someone offers to do something for me, I should accept the offer even if I really want something else.					
30. The worst thing that could happen in a friendship would be to have my friend reject me.					
31. If I am really sure that what I want to do is right, I do it even if it upsets other people.					
32. Before I can be sure I really care for someone I have to know my true feelings.					
33. What it all boils down to is that the only person I can rely on is myself.					
34. Even though I am sensitive to others' feelings, I make decisions based upon what I feel is best for me.					

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
35. Even though it's difficult, I have learned to say no to others when I need to take care of myself.					
36 I like to see myself as interconnected with a network of friends.					
37. Those about whom I care deeply are part of who I am.					
38. I accept my obligations and expect others to do the same.					
39. I believe that I must care for myself because others are not responsible for me.					
40. The people whom I admire are those who seem to be in close personal relationships.					
41. It is necessary for me to take responsibility for the effect my actions have on others.					
42. True responsibility involves making sure my needs are cared for as well as the needs of others.					
43. The feelings of others are not relevant when deciding what is right.					
44. If someone asks me a favor I have a responsibility to think about whether or not I want to do the favor.					
45. I make decisions based upon what I believe is best for me and mine.					
46. Once I've worked out my position on some issue I stick to it.					
47. I believe that in order to survive I must concentrate more on taking care of myself than on taking care of others.					

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
48. The best way to help someone is to do what they ask even if you don't really want to do it.					
49. Doing things for others makes me happy.					
50. All you really need to do to help someone is to love them.					
51. I deserve the love of others as much as they deserve my love.					
52. You've got to look out for yourself or the demands of circumstances and of other people will eat you up.					
53. I cannot afford to give attention to the opinions of others when I am certain I am correct.					
54. If someone does something for me, I reciprocate by doing something for them.					
55. Caring about other people is important to me.					
56. If other people are going to sacrifice something they want for my sake I want them to understand what they are doing.					
57. When I make a decision it's important to use my values to make the right decision.					
58. I try to approach relationships with the same organization and efficiency as I approach my work.					
59. If I am to help another person it is important to me to understand my own motives.					
60. I like to acquire many acquaintances and friends.					

Appendix B

ANXIETY SCALE (HIS-GWB)

THE NEXT QUESTIONS ARE ABOUT HOW YOU FEEL AND HOW THINGS HAVE BEEN GOING WITH YOU. FOR EACH QUESTION CIRCLE A NUMBER FOR THE ANSWER WHICH BEST APPLIES TO YOU.

2. Have you been bothered by nervousness or your "nerves" (during the past 12 months)?

1. ☐ Extremely so - to the point where I could not work or take care of things
2. ☐ Very much so
3. ☐ Quite a bit
4. ☐ Some - enough to bother me
5. ☐ A little
6. ☐ Not at all

6. Have you been under or felt you were under any strain, stress or pressure (during the past 12 months)?

1. ☐ Yes - almost more than I could stand or bear
2. ☐ Yes - quite a bit of pressure
3. ☐ Yes - some - more than usual
4. ☐ Yes - some but about normal
5. ☐ Yes - a little
6. ☐ Not at all

9. Have you been anxious, worried or upset (during the past 12 months)?

1. ☐ Extremely so - to the point of being sick or almost sick
2. ☐ Very much so
3. ☐ Quite a bit
4. ☐ Some - enough to bother me
5. ☐ A little
6. ☐ Not at all

12. Did you feel relaxed, at ease or high-strung, tight, or keyed-up (during the past 12 months)?

1. ☐ Felt relaxed and at ease the whole 12 months
2. ☐ Felt relaxed and at ease most of the time - seldom or never felt high-strung
3. ☐ Generally felt relaxed but at times felt fairly high strung
4. ☐ Generally felt high-strung but at times felt fairly relaxed
5. ☐ Felt high-strung, tight or keyed-up most of the time - seldom or never felt relaxed
6. ☐ Felt high-strung, tight or keyed-up the whole 12 months

15. Were you generally tense or did you feel any tension (during the past 12 months)?
    1. ☐ Yes - extremely tense, most or all of the time
    2. ☐ Yes - very tense most of the time
    3. ☐ Not generally tense, but did feel fairly tense several times
    4. ☐ I felt a little tense a few times
    5. ☐ My general tension level was quite low
    6. ☐ I never felt tense or any tension at all

DEPRESSION SCALE (HIS-GWB)

8. Have you felt depressed (during the past 12 months)?
   1. ☐ Yes - to the point that I felt like taking my life
   2. ☐ Yes - to the point that I did not care about anything
   3. ☐ Yes - very depressed almost every day
   4. ☐ Yes - quite depressed several times
   5. ☐ Yes - a little depressed now and then
   6. ☐ No - never felt depressed at all

13. Have you felt so sad, discouraged, hopeless or had so many problems that you wondered if anything was worthwhile (during the past 12 months)?
   1. ☐ Extremely so - to the point that I have just about given up
   2. ☐ Very much so
   3. ☐ Quite a bit
   4. ☐ Some - enough to bother me
   5. ☐ A little
   6. ☐ Not at all

	All of the time (1)	Most of the time (2)	A good bit of the time (3)	Some of the time (4)	A little of the time (5)	None of the time (6)
17. Have you felt downhearted and blue (during the past 12 months)?						

SELF-CONCEPT SCALE (HIS-GWB)

7. Have you been in firm control of your behavior, thoughts, emotions, or feelings (during the past 12 months)?

1. ☐ Yes, definitely so
2. ☐ Yes, for the most part
3. ☐ Generally so
4. ☐ Not too well
5. ☐ No, and I am somewhat disturbed
6. ☐ No, and I am very disturbed

11. Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel or of your memory (during the past 12 months)?

1. ☐ Not at all
2. ☐ Only a little
3. ☐ Some - but not enough to be concerned or worried about
4. ☐ Some and I have been a little concerned
5. ☐ Some and I am quite concerned
6. ☐ Yes, very much so and I am very concerned

	All of the time (1)	Most of the time (2)	A good bit of the time (3)	Some of the time (4)	A little of the time (5)	None of the time (6)
21. Have you been feeling emotionally stable and sure of yourself (during the past 12 months)?						

POSITIVE WELL-BEING SCALE (HIS-GWB)

1. How have you been feeling in general (during the past 12 months)?
   1. ☐ In excellent spirits
   2. ☐ In very good spirits
   3. ☐ In good spirits mostly
   4. ☐ I have been up and down in spirits a lot
   5. ☐ In low spirits mostly
   6. ☐ In very low spirits

5. How happy, satisfied, or pleased have you been with your personal life (during the last 12 months)?
   1. ☐ Extremely happy - could not have been more satisfied or pleased
   2. ☐ Very happy most of the time
   3. ☐ Generally satisfied - pleased
   4 ☐ Sometimes fairly satisfied, sometimes fairly unhappy
   5. ☐ Generally dissatisfied, unhappy
   6. ☐ Very dissatisfied or unhappy most or all of the time

	All of the time (1)	Most of the time (2)	A good bit of the time (3)	Some of the time (4)	A little of the time (5)	None of the time (6)
19. Has your daily life been full of things that were interesting to you (during the past 12 months)?						
22. Have you felt cheerful, lighthearted (during the past 12 months)?						

GENERAL HEALTH SCALE (HIS-GWB)

3. How often were you bothered by any illness, bodily disorder, aches or pains (during the past 12 months?

1. ☐ Every day
2. ☐ Almost every day
3. ☐ About half of the time
4. ☐ Now and then, but less than half of the time
5. ☐ Rarely
6. ☐ None of the time

10. Did you feel healthy enough to carry out the things you like to do or had to do (during the last 12 months)?

1. ☐ Yes, definitely so
2. ☐ For the most part
3. ☐ Health problems limited me in some important ways
4. ☐ I was only healthy enough to take care of myself
5. ☐ I needed some help in taking care of myself
6. ☐ I needed someone to help me most or all of the time

14. Have you been concerned, worried or had any fears about your health (during the past 12 months)?

1. ☐ Extremely so
2. ☐ Very much so
3. ☐ Quite a bit
4. ☐ Some, but not a lot
5. ☐ Practically never
6. ☐ Not at all

VITALITY SCALE (HIS-GWB)

4. How much energy, pep, or vitality did you have or feel (during the past 12 months)?

1. ☐ Very full of energy - lots of pep
2. ☐ Fairly energetic most of the time
3. ☐ My energy level varied quite a bit
4. ☐ Generally low in energy, pep
5. ☐ Very low in energy or pep most of the time
6. ☐ Drained, sapped

16. Did you feel active, vigorous or dull, sluggish (during the past 12 months)?

1. ☐ Very active, vigorous every day
2. ☐ Mostly active, vigorous - never really dull, sluggish
3. ☐ Fairly active, vigorous - seldom dull, sluggish
4. ☐ Fairly dull, sluggish - seldom active, vigorous
5. ☐ Mostly dull, sluggish - never really active, vigorous
6. ☐ Very dull, sluggish every day

	All of the time (1)	Most of the time (2)	A good bit of the time (3)	Some of the time (4)	A little of the time (5)	None of the time (6)
18. Have you felt tired, worn out, used up, or exhausted (during the past 12 months)?						
20. Have you been waking up feeling fresh and rested (during the past 12 months)?						

PHYSICAL HEALTH STATUS

THIS SECTION OF THE QUESTIONS ARE CENTERED ON YOUR PHYSICAL HEALTH IN THE LAST 12 MONTHS.

H1. How do you think your health has been in the last 24 months (choose one):
1. ☐ Excellent
2. ☐ Good
3. ☐ Fair
4. ☐ Poor

H2a. Have you been hospitalized in the past 24 months?
1. ☐ No
2. ☐ Yes

If Yes, how many days? (write in): _____

H3. Have you had more visits to the doctor's office or clinic in the last 24 months than you think is average for you in the years previous?
1. ☐ Yes
2. ☐ No

H4b. Is this above your average in years previous for a 24-month period?
1. ☐ Yes
2. ☐ No

H5. Since your last child left home has your (check one for each):

	Increased (1)	Decreased (2)	Stayed The Same (3)	Does Not Apply (4)
H5a. Use of cigarettes				
H5b. Use of alcohol				
H5c. Use of caffeine				
H5d. Time spent sleeping				
H5e. Time spent exercising				
H5f. Quality of nutritional intake				

Appendix C

PRE TRANSITION INDEX

THE FOLLOWING QUESTIONS ASK YOU TO REFLECT ON THE TIME IN YOUR LIFE BEFORE YOUR LAST CHILD LEFT HOME. ANSWER EACH BY PLACING AND "X" IN THE RESPONSE BOX THAT EXPRESSES/MOST EXPRESSES YOU.

AC1. During the time before your child left home did you do any of the following to "get ready" for the separation? (Select as many choices as apply.)

AC1a. Read books:

1. ☐ Yes
2. ☐ No

AC1b. Attend classes related to adjustment, coping, dealing with changing relationships and adult children:

1. ☐ Yes
2. ☐ No

AC1c. Seek professional counseling:

1. ☐ Yes
2. ☐ No

AC1d. Discuss your feelings and concerns with female friends:

1. ☐ Yes
2. ☐ No

AC1e. Discuss your feelings and concerns with your spouse:

1. ☐ Yes
2. ☐ No

SOCIAL SUPPORT INDEX

THE FOLLOWING QUESTIONS DEAL WITH FRIENDS AND SUPPORT PEOPLE OUTSIDE OF FAMILY MEMBERS AND THE CONTRIBUTION THEY MAKE TO YOUR LIFE. CHECK ONE FOR EACH.

	Strongly Disagree (1)	Disagree (2)	Some-what Disagree (3)	Neutral (4)	Some-what Agree (5)	Agree (6)	Strongly Agree (7)
SS1. There is someone I feel close to who makes me feel secure.							
SS2. People let me know that I do well at my work (job, homemaking) .							
SS3. I can't count on my relatives and friends to help me with problems.							
SS4. I spend time with others who have the same interests that I do.							

	Strongly Disagree (1)	Disagree (2)	Some-what Disagree (3)	Neutral (4)	Some-what Agree (5)	Agree (6)	Strongly Agree (7)
SS5. There is little opportunity in my life to be giving and caring to another person.							

MARITAL RELATIONSHIP INDEX

THE NEXT SEVERAL QUESTIONS DEAL WITH YOUR RELATIONSHIP WITH YOUR HUSBAND AND YOUR LAST CHILD TO LEAVE HOME. SELECT THE RESPONSE THAT BEST REPRESENTS THE QUALITY OF THE RELATIONSHIP.

M1. Before your last child left home, did you expect your marital relationship would:

1. ☐ Get better
2. ☐ Stay the same
3. ☐ Get worse

M2. Since your last child left home, would you say your marital relationship has:

1. ☐ Gotten better
2. ☐ Stayed the same
3. ☐ Gotten worse

PARENTAL RELATIONSHIP INDEX

P1. Before your last child left home, did you expect your parental relationship with that child would:

1. ☐ Get better
2. ☐ Stay the same
3. ☐ Get worse

P2. Since your last child left home, would you say your parental relationship with that child has:

1. ☐ Gotten better
2. ☐ Stayed the same
3. ☐ Gotten worse

POST TRANSITION SELF CARE

THIS SECTION OF THE QUESTIONNAIRE ASKS YOU TO REFLECT ON WHAT LIFE AND RELATIONSHIPS HAVE BEEN LIKE SINCE YOUR LAST CHILD LEFT HOME.
CHECK ONE FOR EACH.

	A Great Deal (1)	Quite A Bit (2)	Some (3)	Just A Little (4)	Not At All (5)
PC4. Since your last child left home to what extent have you devoted more time to yourself doing the things you like to do?					

Appendix D

Dear Midlife Woman:

This letter is by way of introduction of myself and the midlife transition study. I am a registered nurse and a PhD student at Michigan State University in the College of Human Ecology, Department of Family and Child Ecology. I am interested in studying the changing nature of women's relationships during their middle years and the effect these changes have on their health.

Midlife women have one third of their lives ahead of them and the information you provide will help me gain insight relative to how women see themselves during this time.

I very much appreciate your willingness to participate in my study, and to give approximately thirty minutes of your time to complete the enclosed questionnaire. A self-addressed and stamped envelope is provided to return the questionnaire along with a small token ($2.00) of my appreciation for your participation. All information obtained will be confidential, your name removed and data reported in aggregate and identified by code number only.

You will also find in this packet of material a postcard addressed to me and containing the qualifying questions for participation in the study. I would very much appreciate your cooperation in helping me to locate other women whom meet the criteria to be included in this research project. If you know anyone who you think would take the time to fill out the questionnaire please give them the postcard to send to me and I will send them a questionnaire.

Even after receiving this questionnaire, you are free to discontinue participation in the research project at any time simply by not returning the instrument. However, you indicate your voluntary agreement to participate by completing and returning this questionnaire.

Included on this form are my address and phone number. Please, if you have any questions or need any additional information do not hesitate to call or write.

Thanks again,

Elizabeth Price, R.N.

CONSENT FORM

"Yes" answers to the following two questions are necessary to be a participant in this study.

1. ARE YOU PRESENTLY IN A MARRIAGE RELATIONSHIP? YES NO

2. HAS YOUR LAST CHILD LEFT HOME WITHIN THE PAST 24 MONTHS (gone off to college, gotten married, moved into an apartment) and NOT RETURNED TO LIVE PERMANENTLY (vacations, holidays, and weekends do not count)? YES NO

You have answered yes to both questions and have previously indicated a desire to take part in my research project. If you still wish to participate in the study please sign you name in the space provided below and complete the questionnaire.

Thank you.

NAME_____

ADDRESS_____

_____

MIDLIFE WOMEN IN TRANSITION

MICHIGAN STATE UNIVERSITY
COLLEGE OF HUMAN ECOLOGY
DEPARTMENT OF FAMILY AND CHILD ECOLOGY

Respondent ID_____

STATEMENT OF CONFIDENTIALITY:

This questionnaire is confidential and completely voluntary. If you should come to any question that you do not wish to answer, skip it and go on to the next question.

INSTRUCTIONS

Please read each question carefully and follow all the instructions. If there are no instructions, always answer the next question.

Some questions ask you to write in numbers or fill in other information. However, most questions ask you to select the response that is most like you and to place an "X" in the appropriate box.

EXAMPLE QUESTION:

	Very True (1)	Pretty True (2)	Somewhat True (3)	Not Very True (4)	Not At All True (5)
I enjoy walking in the rain.					

Please use a pencil or pen to complete this questionnaire. Begin on the top of the next page. Again, I want to express my appreciation for you willingness to share this information with me.

PLEASE RETURN YOUR COMPLETED QUESTIONNAIRE IN THE ENVELOPE PROVIDED TO:

Midlife Transition Study
c/o Elizabeth Price
2545 St. Joe Highway
Grand Ledge, MI 48837

THE FOLLOWING QUESTIONS ASK YOU TO REFLECT ON THE TIME IN YOUR LIFE BEFORE YOUR LAST CHILD LEFT HOME. ANSWER EACH BY PLACING AN "X" IN THE RESPONSE BOX THAT EXPRESSES/MOST EXPRESSES YOU.

AC1. During the time before your child left home did you do any of the following to "get ready" for the separation? (Select as many choices as apply.)

AC1a. Read books:
1. ☐ Yes
2. ☐ No

AC1b. Attend classes related to adjustment, coping, dealing with changing relationships and adult children:
1. ☐ Yes
2. ☐ No

AC1c. Seek professional counseling:
1. ☐ Yes
2. ☐ No

AC1d. Discuss your feelings and concerns with female friends:
1. ☐ Yes
2. ☐ No

AC1e. Discuss your feelings and concerns with your spouse:
1. ☐ Yes
2. ☐ No

Other (write in):_____

	A Great Deal (1)	Quite A Bit (2)	Some (3)	Just A Little (4)	Not At All (5)
AC2. During the time preceding your last child leaving home, to what degree did you think your adjustment to this change in relationship would be difficult?					
AC3. To what degree did you commit yourself to the activities of mothering?					
AC4. To what degree has it been difficult for you to "let go" of the active parenting role as your child/children have grown to adults?					

	Very Important (1)	Quite Important (2)	Important (3)	A Little Important (4)	Not Important (5)
AC5. During the time your child/children were growing up, how important do you think being a "mother" was to you?					

THE FOLLOWING QUESTIONS DEAL WITH FRIENDS AND SUPPORT PEOPLE OUTSIDE OF FAMILY MEMBERS AND THE CONTRIBUTION THEY MAKE TO YOUR LIFE. CHECK ONE FOR EACH.

	Strongly Disagree (1)	Disagree (2)	Some-what Disagree (3)	Neutral (4)	Some-what Agree (5)	Agree (6)	Strongly Agree (7)
SS1. There is someone I feel close to who makes me feel secure.							
SS2. People let me know that I do well at my work (job, home-making).							
SS3. I can't count on my relatives and friends to help me with problems.							

	Strongly Disagree (1)	Disagree (2)	Some-what Disagree (3)	Neutral (4)	Some-what Agree (5)	Agree (6)	Strongly Agree (7)
SS4. I spend time with others who have the same interests.							
SS5. There is little opportunity in my life to be giving and caring to another person.							

THE NEXT SEVERAL QUESTIONS DEAL WITH YOUR RELATIONSHIP WITH YOUR HUSBAND AND YOUR LAST CHILD TO LEAVE HOME. SELECT THE RESPONSE THAT BEST REPRESENTS THE QUALITY OF THE RELATIONSHIP.

M1. Before your last child left home, did you expect your marital relationship would:
1. ☐ Get better
2. ☐ Stay the same
3. ☐ Get worse

M2. Since your last child left home, would you say your marital relationship has:
1. ☐ Gotten better
2. ☐ Stayed the same
3. ☐ Gotten worse

P1. Before your last child left home, did you expect your parental relationship with that child would:
1. ☐ Get better
2. ☐ Stay the same
3. ☐ Get worse

P2. Since your last child left home, would you say your parental relationship with that child has:

1. ☐ Gotten better
2. ☐ Stayed the same
3. ☐ Gotten worse

THE FOLLOWING QUESTIONS TELL SOMETHING ABOUT YOUR LIFE COURSE AND FAMILY HISTORY.

D1. Your date of birth: _____/_____/_____
month day year

D2. What was your approximate total household income during the last year (choose one):

1. ☐ under $14,999
2. ☐ $15,000 - $29,999
3. ☐ $30,000 - $49,999
4. ☐ $50,000 - $99,999
5. ☐ over $100,000

D3. What was the highest grade or class you completed in school (choose one):

1. ☐ Less than 12 years
2. ☐ High school graduate or equivalent
3. ☐ Vocational/special training
4. ☐ Community college degree
5. ☐ Bachelors degree
6. ☐ Masters degree
7. ☐ Professional degree: Ph.D., MD, JD

D4. What is your occupation? (write in):

_____

D5. Have you ever been divorced?

1. ☐ Yes
2. ☐ No

D6. Number of children born alive (write in): _____

D7. Number of children now living (write in): _____

D8. Have you had a child who died?

1. ☐ Yes
2. ☐ No

D9. Approximately how many months has it been since your last child left home? (write in): _____

D9a. Was your last child to leave home a:
1. ☐ Girl
2. ☐ Boy

D10. Do you think the number of children you had was (choose one):
1. ☐ Just right
2. ☐ Too many
3. ☐ Not enough

D11. Have you experienced or are you experiencing menopause?
1. ☐ No
2. ☐ Yes

If yes, Surgical: _____ Age (year): _____
Biological: _____ Age (year): _____

D12. Were you sterilized as a means of birth control earlier in your life?
1. ☐ No
2. ☐ Yes

If yes, Age: _____ Year: _____

D13. Before your last child left home, how harmonious was your relationship?
1. ☐ Not at all harmonious
2. ☐ Somewhat harmonious
3. ☐ Harmonious
4. ☐ Very harmonious

D13a. When your last child left home what were your feelings? (write in):_____

_____

_____

_____

D13b. What were your thoughts? (write in):_____

_____

_____

_____

D14. Are you presently (choose one):

1. ☐ Employed
2. ☐ Retired
3. ☐ Disabled
4. ☐ Not employed outside the home

D15. If employed, how many hours a week do you work outside your home (choose one):

1. ☐ Less than 10
2. ☐ 10-20
3. ☐ 20-30
4. ☐ More than 30
5. ☐ Other (write in): _____

D15a. If you are a volunteer, how many hours a week do you spend in volunteer activities (choose one):

1. ☐ Less than 10
2. ☐ 10-20
3. ☐ 20-30
4. ☐ More than 30
5. ☐ Other (write in): _____

D16. Since your last child left home has the time you've spent as an employee (choose one):

1. ☐ Increased
2. ☐ Decreased
3. ☐ Stayed the same
4. ☐ Does not apply

D16a. Since your last child left home, has the time you've spend as a volunteer (choose one):

1. ☐ Increased
2. ☐ Decreased
3. ☐ Stayed the same
4. ☐ Does not apply

IF YOU ARE EMPLOYED AS A PAID WORKER OUTSIDE THE HOME ANSWER THE NEXT QUESTION. IF YOU ARE NOT EMPLOYED OUTSIDE THE HOME PLEASE CONTINUE WITH QUESTION D18.

D17. Do you consider your employment to be (select as many statements as appropriate):

1. ☐ Just a job (paycheck)
2. ☐ A very important part of who you are
3. ☐ A career you love.

D18. Is your mother living?

1. ☐ Yes
2. ☐ No

If No, when did she die? Year: _____

D19. Is your husband retired?

1. ☐ No
2. ☐ Yes

If Yes, when did he retire? Year: _____

D20. When you were growing up was your family constellation (choose one):

1. ☐ Traditional - Father bread winner, Mother homemaker
2. ☐ Single parent/working mother
3. ☐ Both parents working
4. ☐ Other (write in): _____

THIS SECTION OF THE QUESTIONNAIRE ASKS YOU TO REFLECT ON WHAT LIFE AND RELATIONSHIPS HAVE BEEN LIKE SINCE YOUR LAST CHILD LEFT HOME. CHECK ONE FOR EACH.

	A Great Deal (1)	Quite A Bit (2)	Some (3)	Just A Little (4)	Not At All (5)
PC1. To what extent do you think your role is changing with your child/children as they begin their lives on their own?					
PC2. To what extent do you feel satisfied about the changes in the relationship between you and your children?					

	A Great Deal (1)	Quite A Bit (2)	Some (3)	Just A Little (4)	Not At All (5)
PC3. To what extent would you like your relationship with your child to remain the same as it was before he/she left home?					
PC4. Since your last child left home to what extent have you devoted more time to yourself doing the things you like to do?					

PC5. How do you view this post parental time in your life (choose one):

1. ☐ Time of endings
2. ☐ Time for uncertainty
3. ☐ Time of emptiness - lost
4. ☐ Time for self growth
5. ☐ Time to build new relationships

THIS SECTION OF THE QUESTIONS ARE CENTERED ON YOUR PHYSICAL HEALTH IN THE LAST 24 MONTHS.

H1. How do you think you health has been in the last 24 months (choose one):

1. ☐ Excellent
2. ☐ Good
3. ☐ Fair
4. ☐ Poor

H2a. Have you been hospitalized in the past 24 months?

1. ☐ No
2. ☐ Yes

If Yes, how many days? (write in): _____

H2b. If your answer to H2a. is Yes, what were you hospitalized for? (write in):_____

_____

_____

H3. Have you had more visits to the doctor's office or clinic in the last 24 months than you think is average for you in the years previous?

1. ☐ Yes
2. ☐ No

H4a. How many colds or upper respiratory infections have you had in the last 24 months? (write in): _____

H4b. Is the number of colds or upper respiratory infections that you have had above your average in years previous for a 24-month period?

1. ☐ Yes
2. ☐ No

H5. Since your last child left home has your (check one for each):

	Increased (1)	Decreased (2)	Stayed The Same (3)	Does Not Apply (4)
H5a. Use of cigarettes				
H5b. Use of alcohol				
H5c. Use of caffiene				
H5d. Time spent sleeping				
H5e. Time spent exercising				
H5f. Quality of nutritional intake				

THE NEXT QUESTIONS ARE ABOUT HOW YOU FEEL AND HOW THINGHAVEBEEN GOING WITH YOU. FOR EACH QUESTION PLACE AN "X" IN THE RESPONSE BOX FOR THE ANSWER THAT BEST APPLIES TO YOU.

1. How have you been feeling in general (during the past 12 months)?
   1. ☐ In excellent spirits
   2. ☐ In very good spirits
   3. ☐ In good spirits mostly
   4. ☐ I have been up and down in spirits a lot
   5. ☐ In low spirits mostly
   6. ☐ In very low spirits

2. Have you been bothered by nervousness or your "nerves" (during the past 12 months)?

1. ☐ Extremely so - to the point where I could not work or take care of things
2. ☐ Very much so
3. ☐ Quite a bit
4. ☐ Some - enough to bother me
5. ☐ A little
6. ☐ Not at all

3. How often were you bothered by any illness, bodily disorder, aches or pains (during the past 12 months?

1. ☐ Every day
2. ☐ Almost every day
3. ☐ About half of the time
4. ☐ Now and then, but less than half of the time
5. ☐ Rarely
6. ☐ None of the time

4. How much energy, pep, or vitality did you have or feel (during the past 12 months)?

1. ☐ Very full of energy - lots of pep
2. ☐ Fairly energetic most of the time
3. ☐ My energy level varied quite a bit
4. ☐ Generally low in energy, pep
5. ☐ Very low in energy or pep most of the time
6. ☐ Drained, sapped

5. How happy, satisfied, or pleased have you been with your personal life (during the last 12 months)?

1. ☐ Extremely happy - could not have been more satisfied or pleased
2. ☐ Very happy most of the time
3. ☐ Generally satisfied - pleased
4 ☐ Sometimes fairly satisfied, sometimes fairly unhappy
5. ☐ Generally dissatisfied, unhappy
6. ☐ Very dissatisfied or unhappy most or all of the time

6. Have you been under or felt you were under any strain, stress or pressure (during the past 12 months)?

1. ☐ Yes - almost more than I could stand or bear
2. ☐ Yes - quite a bit of pressure
3. ☐ Yes - some - more than usual
4. ☐ Yes - some but about normal
5. ☐ Yes - a little
6. ☐ Not at all

7. Have you been in firm control of your behavior, thoughts, emotions, or feelings (during the past 12 months)?

1. ☐ Yes, definitely so
2. ☐ Yes, for the most part
3. ☐ Generally so
4. ☐ Not too well
5. ☐ No, and I am somewhat disturbed
6. ☐ No, and I am very disturbed

8. Have you felt depressed (during the past 12 months)?

1. ☐ Yes - to the point that I felt like taking my life
2. ☐ Yes - to the point that I did not care about anything
3. ☐ Yes - very depressed almost every day
4. ☐ Yes - quite depressed several times
5. ☐ Yes - a little depressed now and then
6. ☐ No - never felt depressed at all

9. Have you been anxious, worried or upset (during the past 12 months)?

1. ☐ Extremely so - to the point of being sick or almost sick
2. ☐ Very much so
3. ☐ Quite a bit
4. ☐ Some - enough to bother me
5. ☐ A little
6. ☐ Not at all

10. Did you feel healthy enough to carry out the things you like to do or had to do (during the last 12 months)?

1. ☐ Yes, definitely so
2. ☐ For the most part
3. ☐ Health problems limited me in some important ways
4. ☐ I was only healthy enough to take care of myself
5. ☐ I needed some help in taking care of myself
6. ☐ I needed someone to help me most or all of the time

11. Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel or of your memory (during the past 12 months)?

1. ☐ Not at all
2. ☐ Only a little
3. ☐ Some - but not enough to be concerned or worried about
4. ☐ Some and I have been a little concerned
5. ☐ Some and I am quite concerned
6. ☐ Yes, very much so and I am very concerned

12. Did you feel relaxed, at ease or high-strung, tight, or keyed-up (during the past 12 months)?

1. ☐ Felt relaxed and at ease the whole 12 months
2. ☐ Felt relaxed and at ease most of the time - seldom or never felt high-strung
3. ☐ Generally felt relaxed but at times felt fairly high strung
4. ☐ Generally felt high-strung but at times felt fairly relaxed
5. ☐ Felt high-strung, tight or keyed-up most of the time - seldom or never felt relaxed
6. ☐ Felt high-strung, tight or keyed-up the whole 12 months

13. Have you felt so sad, discouraged, hopeless or had so many problems that you wondered if anything was worthwhile (during the past 12 months)?

1. ☐ Extremely so - to the point that I have just about given up
2. ☐ Very much so
3. ☐ Quite a bit
4. ☐ Some - enough to bother me
5. ☐ A little
6. ☐ Not at all

14. Have you been concerned, worried or had any fears about your health (during the past 12 months)?

1. ☐ Extremely so
2. ☐ Very much so
3. ☐ Quite a bit
4. ☐ Some, but not a lot
5. ☐ Practically never
6. ☐ Not at all

15. Were you generally tense or did you feel any tension (during the past 12 months)?

1. ☐ Yes - extremely tense, most or all of the time
2. ☐ Yes - very tense most of the time
3. ☐ Not generally tense, but did feel fairly tense several times
4. ☐ I felt a little tense a few times
5. ☐ My general tension level was quite low
6. ☐ I never felt tense or any tension at all

16. Did you feel active, vigorous or dull, sluggish (during the past 12 months)?

1. ☐ Very active, vigorous every day
2. ☐ Mostly active, vigorous - never really dull, sluggish
3. ☐ Fairly active, vigorous - seldom dull, sluggish
4. ☐ Fairly dull, sluggish - seldom active, vigorous
5. ☐ Mostly dull, sluggish - never really active, vigorous
6. ☐ Very dull, sluggish every day

	All of the time (1)	Most of the time (2)	A good bit of the time (3)	Some of the time (4)	A little of the time (5)	None of the time (6)
17. Have you felt downhearted and blue (during the past 12 months)?						
18. Have you felt tired, worn out, used up, or exhausted (during the past 12 months)?						
19. Has your daily life been full of things that were interesting to you (during the past 12 months)?						
20. Have you been waking up feeling fresh and rested (during the past 12 months)?						
21. Have you been feeling emotionally stable and sure of yourself (during the past 12 months)?						
22. Have you felt cheerful, lighthearted (during the past 12 months)?						

READ EACH OF THE STATEMENTS BELOW AND DECIDE HOW EACH ONE DESCRIBES YOU. USING THE RATING SCALE OF 1 - "NOT LIKE ME AT ALL" TO 5 - "VERY MUCH LIKE ME," CHOOSE THE MOST APPROPRIATE RESPONSE.

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
1. I often try to act on the belief that self-interest is one of the worst problems facing society.					
2. A close friend is someone who will help you whenever you need help and knows that you will help if they need it.					
3. I cannot choose to help someone else if it will hinder my self-development.					
4. I want to be responsible for myself.					
5. In making decisions, I can neglect my own values in order to keep a relationship.					
6. I find it hard to sympathize with people whose misfortunes I believe are due mainly to their shortcomings.					
7. I try to curb my anger for fear of hurting others.					
8. Being unselfish with others is more important than making myself happy.					
9. Loving is like a contract: if its provisions are not met, you wouldn't love the person anymore.					
10. In my everyday life I am guided by the notion of "an eye for an eye and a tooth for a tooth."					
11. I want to learn to stand on my own two feet.					

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
12. I believe that one of the most important things that parents can teach their children is how to cooperate and live in harmony with others.					
13. I try not to think about the feelings of others when there is a principle at stake.					
14. I don't often do much for others unless they can do some good for me later on.					
15. Activities of care that I perform expand to both me and others.					
16. If what I want to do upsets other people, I try to think again to see if I really want to do it.					
17. I do not want others to be responsible for me.					
18. I am guided by the principle of treating others as I want to be treated.					
19. I believe that I have to look out for myself and mine, and let others shift for themselves.					
20. Being unselfish with others is a way I make myself happy.					
21. When a friend traps me with demands and negotiation has not worked, I am likely to end the friendship.					
22. I feel empty if I'm not closely involved with someone else.					
23. Sometimes I have to accept hurting someone else if I am to do the things that are important in my own life.					

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
24. In order to continue a relationship it has to let both of us grow.					
25. I feel that my development has been shaped more by the persons I care about than by what I do and accomplish.					
26. People who don't work hard to accomplish respectable goals can't expect me to help when they're in trouble.					
27. Relationships are a central part of my identity.					
28. I often keep quiet rather than hurt someone's feelings, even if it means giving a false impression.					
29. When someone offers to do something for me, I should accept the offer even if I really want something else.					
30. The worst thing that could happen in a friendship would be to have my friend reject me.					
31. If I am really sure that what I want to do is right, I do it even if it upsets other people.					
32. Before I can be sure I really care for someone I have to know my true feelings.					
33. What it all boils down to is that the only person I can rely on is myself.					
34. Even though I am sensitive to others' feelings, I make decisions based upon what I feel is best for me.					

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
35. Even though it's difficult, I have learned to say no to others when I need to take care of myself.					
36. I like to see myself as interconnected with a network of friends.					
37. Those about whom I care deeply are part of who I am.					
38. I accept my obligations and expect others to do the same.					
39. I believe that I must care for myself because others are not responsible for me.					
40. The people whom I admire are those who seem to be in close personal relationships.					
41. It is necessary for me to take responsibility for the effect my actions have on others.					
42. True responsibility involves making sure my needs are cared for as well as the needs of others.					
43. The feelings of others are not relevant when deciding what is right.					
44. If someone asks me a favor I have a responsibility to think about whether or not I want to do the favor.					
45. I make decisions based upon what I believe is best for me and mine.					
46. Once I've worked out my position on some issue I stick to it.					
47. I believe that in order to survive I must concentrate more on taking care of myself than on taking care of others.					

	Not like me at all (1)	(2)	(3)	(4)	Very much like me (5)
48. The best way to help someone is to do what they ask even if you don't really want to do it.					
49. Doing things for others makes me happy.					
50. All you really need to do to help someone is to love them.					
51. I deserve the love of others as much as they deserve my love.					
52. You've got to look out for yourself or the demands of circumstances and of other people will eat you up.					
53. I cannot afford to give attention to the opinions of others when I am certain I am correct.					
54. If someone does something for me, I reciprocate by doing something for them.					
55. Caring about other people is important to me.					
56. If other people are going to sacrifice something they want for my sake I want them to understand what they are doing.					
57. When I make a decision it's important to use my values to make the right decision.					
58. I try to approach relationships with the same organization and efficiency as I approach my work.					
59. If I am to help another person it is important to me to understand my own motives.					
60. I like to acquire many acquaintances and friends.					

THE REMAINDER OF THE QUESTIONS ARE OPEN ENDED AND ALLOW YOU TO RELATE IN YOUR OWN WORDS HOW YOU HAVE FELT AND WHAT THE EXPERIENCE HAS BEEN LIKE FOR YOU.

OE1. How have you spent time on yourself since your last child left home? (write in):

OE2. How has the balance of time spent caring for yourself versus caring for others changed since your last child left home? (write in):

OE3. What kinds of things do you do just for yourself now that your last child has left the home? (write in):

OE4. Think back when you were in your early twenties. What was the dream you had for your life then? (write in):

OE5. You have on the average one third of your life left to live. What would you say is your dream for your future? (write in): _____

_____

_____

_____

_____

_____

OE6. Please share with me any comments regarding this time in your life and/or any comments about the questionnaire (write in): _____

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_____

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Thank you for taking the time to contribute to this research project.

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