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EQUITY, ANDROGYNY, AND ROLE CONFLICT IN THE MARRIAGES OF MEDICAL STUDENTS AND OF MEDICAL HOUSE STAFF

By

Meredith Ford Taylor

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ABSTRACT

EQUITY, ANDROGYNY, AND ROLE CONFLICT IN
THE MARRIAGES OF MEDICAL STUDENTS AND
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Equity theory postulates that in personal relationships one experiences equity and feels content to the extent that one perceives oneself as giving as much as one receives. Defined as a perceived imbalance between what one gives and receives, inequity is assumed to produce efforts to restore equity. It was hypothesized that in the case of marriages involving medical trainees, the medical spouse would typically experience overbenefit (getting more) and that the non-medical spouse would experience underbenefit (giving more).

Sex-role socialization theory led to the hypothesis that female medical trainees experience greater overbenefit than males, because the women are departing further than the men from their traditional spouse role. Further, it was proposed that the medical women's overbenefit would be contingent upon the degree of conflict that they perceive between what they should be doing as a wife and what they are doing. This was operationally defined as role conflict.

It was further hypothesized that level of psychological androgyny would predict the wife role expectations held by the medical women. The degree of equity anticipated for husbands of medical women was hypothesized to vary contingent upon the role conflict he perceives for his wife. Also, his level of androgyny was expected to predict his level of expectations for his wife.

Sixty-four women, 41 medical students and 23 house staff, of the Medical School of University of Wisconsin (Madison) and their spouses agreed to participate in the study. A matching sample of male medical students, house staff, and their spouses was obtained. All subjects received questionnaires composed of (1) the Traupmann-Utne-Hatfield (1978) Scale, to measure equity; (2) the Bem Sex-Role Inventory, to measure androgyny; (3) the Taylor Role Questionnaire developed for this study, to measure expectations and role conflict; (4) the Spanier Dyadic Adjustment Scale, to measure marital satisfaction; and (5) nine open-ended questions to evaluate anticipated restoration of equity in the future. The questionnaires were separately posted to each spouse and returned by mail. 231 persons completed the study out of 234 who had agreed by telephone to take part.

The hypothesis that medical spouses would perceive over-benefit and non-medical spouses would perceive underbenefit was confirmed. Women in medicine did not perceive themselves as more overbenefited than men, nor were their husbands experiencing more underbenefit than female spouses. Instead, the persons experiencing

more inequity were males in medicine (overbenefit) and their non-medical wives (underbenefit).

Results requiring measurement of role conflict, or difference between performance and expectation for the wife, were hampered by the failure of the Taylor Role Questionnaire to achieve adequate reliability for difference scores for three of its four Subroles. The reliable Subrole, Emotional/Sexual/Supportive Partner, yielded a small but statistically significant correlation between role conflict and perceived inequity, as predicted.

Androgyny failed to predict any variable as hypothesized. It did not predict expectation level and it did not predict the difference between performance and expectation (role conflict score).

Post hoc analyses revealed that although non-medical wives reported more inequity, they viewed themselves as no less happy than the other women.

Although the literature indicates that medical training is stressful for women, in this study a greater degree of potential strain was exhibited in the marriages of men in medicine and their non-medical wives. Conclusions suggested an increased focus on these partners and consideration of fundamental changes which would alter the stress level presently inherent in medical education.

To

Margaret Ford Taylor

and

Frank William Taylor

Much Loved Parents, Role Models, and Supporters

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I am also extremely grateful to the subjects who participated in the study. They were almost invariably sympathetic and cooperative, and they defied the stereotype of the medical trainee who is too overburdened to volunteer for anything. Nevertheless, I know it took real effort to make the time.

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As a postscript, I refer any reader who has come this far to Appendix A, which is a short tale about how this study probably began.

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INTRODUCTION

Roles for Women and Potential Role Conflict

In the United States today the majority of married women work outside the home. In March, 1977, over 22 million married women were in the work force. Of these women, half were mothers with children under the age of eighteen (U.S. Department of Labor, 1978b). There is perhaps no better illustration of the fact that at least statistically, the "typical" married woman is no longer following her traditional social role.

This change, however, does not imply an abandonment of the traditionally expected roles for women. It would be more accurate to say that "appropriate behavior" for women has become a controversial subject, one which can generate confusion and conflict, especially for the woman herself.

In the traditional framework, the woman's first responsibility of course was to the three roles of wife, housewife, and mother. Any work outside the home took place before marriage (Lewis, 1978). Over the years, most American women have worked as a matter of necessity, because the family needed money and one income was not sufficient (U.S. Department of Labor, 1978a). In many cases the job was of relatively low status and low pay. In this instance (still often true) the woman's primary commitment continued to be to the family--her role as worker was, in a sense,

to be "better" in the roles of wife and mother. In this way she was more or less within traditional expectations.

The career employed woman, however, is in a different situation. Her work involves her at a professional level in something which she finds intrinsically satisfying. A career is not just "for the family," it requires an investment of energy and psychological commitment. It may also require far more than 40 hours per week.

At this point the conflict of "appropriate" roles for women may begin. Alpenfels (1962) expressed it: "The woman who has a profession but no husband or children nevertheless continues to feel somewhat less than a woman. And the woman who has both a husband and children but no profession continues to feel somewhat less than a person" (p. 85). But presumably the issue is not either/or, but how to manage all of the potential roles of career worker, wife, housewife, and mother. The conflict, however, can remain. Citing Coser and Rokoff (1971), Cummings (1977) commented " . . . women are caught in a double bind. If they have small children and continue to work, they are considered unfit mothers. If they stay home to care for them, they are considered unfit careerists" (p. 71). As St. John-Parsons (1978) pointed out, it is still assumed that for a woman the family will always come first. It is also assumed that for a true career person (i.e. a man) the career will come first.

Sales (1978) defined this double bind as an example of <u>role conflict</u>: "any situation in which incompatible expectations

are placed on a person because of position membership" (p. 159). She distinguished between two forms of role conflict. The first can be construed as somewhat the more psychological and internalized, though there are certainly ample social pressures to support it. The "good" woman is expected to be nurturant, self-sacrificing, passive, and emotionally available. The "good" career person, however, may be expected to be competitive, analytic, aggressive, and to make independent judgments. One can try to compartmentalize life, but as Sales (1978) expressed it, "It is hard for a woman who is independent and assertive at work to become the compliant wife on her return" (p. 159).

Sales (1978) identified a second kind of role conflict which is rooted more in the logistics of daily life. Someone must perform the tasks inherent in the roles of wife, housewife, and mother, be it husband, wife, or a paid housekeeper. The solution to this dilemma has predominantly been that the wife/mother assumes the role of career person in addition to the other three roles. This is true both for working class women and for professional women (Bryson, Bryson, & Johnson, 1978; Lein, et al., 1974; St. John-Parsons, 1978). As a result, despite the remarkable energy displayed by these women (Gump, 1972), they are likely to feel seriously pressured. It is obvious that the more demanding the career role, the more commitment in time and energy it will require, and the more heavy the feeling of "role overload" (Sales, 1978) is likely to become.

Literature related to the dual-career marriage has also described the phenomenon of the "two-person career," i.e. a profession so demanding that the efforts of both the individual and his/her spouse are required to be really successful in the career (Hunt & Hunt, 1977; Papanek, 1973). As women enter the professions which have traditionally been seen as "two-person," the conflict between their fulfilling the expectations of their career and the traditional feminine roles could be seen to approach a maximum level.

The Woman Physician

The practice of medicine has traditionally been viewed as one of these "two-person" careers (Coombs, 1971). There has been extensive examination of the time demands of medical study and the practice of medicine and the impact of these demands on the medical student of either sex (Campbell, 1973; Coombs & Boyle, 1971). It has become something of a truism to view medical school as an intensive socialization period, with considerable psychological stress on the individual future physician. It is also generally recognized that medicine as a career is extremely demanding. The high rates of suicide, alcoholism, and drug abuse among physician populations have been attributed at least in part to the high pressure atmosphere of medicine (a'Brook, et al., 1967; British Medical Journal, 1964; Craig & Pitts, 1968; Dublin & Spriegelman, 1947; Fox, 1957; Ostermann, 1967; Steppacher & Mausner, 1974).

There has also been some examination of the impact of the medical career on the physician's marriage (Berman, 1979; Coombs, 1971). The ideal wife of a physician has been described as very nearly the perfect partner for a "two-person career"--one who is warm and supportive, and yet who functions very capably for long periods of time without interacting much with her husband (Coombs, 1971). Somewhat surprisingly, there is no comprehensive body of research on physician marriages. A recent article titled "Forgotten Persons: Physicians' Wives and Their Influence on Medical Career Decisions" (Skipper & Gliebe, 1977), underlined the minimal examination of these relationships. A recently published volume on the socialization processes in medical school may go some distance toward remedying this lack (Coombs, 1978).

In medicine, as in the other high status professions, women have traditionally been in a minority (Astin & Bayer, 1972; Joreen, 1970; U.S. Department of Labor, 1976). Only recently have their numbers increased to substantial proportions of medical school entering classes. In 1965, women formed 8% of the entering classes. In the 1974-1975 school year, women formed 22% of the entering classes (U.S. Department of Labor, 1976). There has been a corresponding increase in the research literature examining various aspects of the experience of women medical students and women physicians.

In examining the personality characteristics of female medical students, they have been demonstrated as a group to be unusually well adjusted and psychologically healthy. This has held

true both when the women were compared to a normative sample of other women and when they were compared to their peer group of male medical students (Cartwright, 1972a; Cartwright, 1972b; Fruen, Rothman, & Steiner, 1974; Hutchins, Reitman, & Klaub, 1967; Shapiro, 1971). In fact for a time it was commonly acknowledged (Barclay, 1973) that medical schools "liked female applicants better" because they were better qualified!

Despite this impressive array of credentials in both academic skills and personality configuration, it is generally agreed that most women in medical school experience marked psychological stress, amounting almost to a life crisis (Campbell, 1973; Lopate, 1968). Empirical and theoretical work has traced this stress to a number of roots. In the first place, women in medicine are entering a profession that has been traditionally male identified and, despite the shift in ratio of the sexes, continues to be male dominated. A woman in any male identified profession may be perceived as deviant and the sanctions applied to deviant persons may be applied to her (Abramowitz, Weitz, Schwartz, Amira, Gomes, & Abramowitz, 1975; Nadelson & Notman, 1972). Women in medical school have traditionally seen few women on the staff and therefore have had few role models to follow (Roeske & Lake, 1977). Women students are potentially high achievers, and yet if they surpass their male peers they may be caught in the classic double bind in which women are rewarded for achieving as much as possible and yet simultaneously told that surpassing men will stamp

them as unfeminine and unlovable (Chesler, 1972; Horner & Walsh, 1973). Women in medical school may also face sexist comments which most directly denigrate women patients, but by obvious extrapolation denigrate all women (Batt, 1972; Campbell, 1973; Howell, 1974; Spiro, 1975). Women in medical school may also face exclusion from the traditional "old boy" network of informal contacts that can provide learning experiences and professional contacts for career advancement (Epstein, 1970). Finally, female medical students may experience discrimination based on expectations that they will enter certain clearly delimited specialties (Ducker, 1978) and that they will practice less than their male counterparts.

This issue of female versus male productivity in medicine has long been under scrutiny. A recent review article reported conflicting data on the percentage of women physicians who continued in full time practice all their professional lives (Nemir, 1978). Studies have found that full time practice of women physicians correlated inversely with number of children and similar measures of family responsibility (Heslop, Molloy, & Waal-Manning, 1973; Ulyatt & Ulyatt, 1973; Woodside, 1974). Reduced rates of full time practice will hardly be surprising as long as multiple commitments are a reality for professional women, especially if the male half of the dual-career marriage rarely assumes half of the parenting responsibility.

Most of these stresses experienced by women in medical school could be classified as varieties of role conflict, as previously described. These must be dealt with, in addition to the

basic stress which every medical student assumes as he or she attempts to assimilate a vast quantity of technical material and to achieve a professional identity. A dual-career marriage in which the wife is a medical student or house staff member could be taken as an extreme example of the career pressures exerted on persons in dual-career relationships.

Research on Marital Satisfaction

Before examining research on the dual-career marriage and factors affecting perceived satisfaction in such a marriage, it is appropriate to briefly review the factors seen as affecting marital satisfaction in general. The broad field of research in marriage and marital satisfaction is complex and burgeoning at an increasing rate each year. The issue of evaluating marital satisfaction or marital adjustment accurately or even considering it to be a theoretically valid or unitary phenomenon has been the subject of controversy (Craddock, 1974; Laws, 1971; Marini, 1976; Spanier, 1976). This study will take Spanier's (1976) pragmatic viewpoint that, for purposes of research, it continues to be useful to attempt to measure marital satisfaction or adjustment as reported by the individuals involved, even though this may be strongly affected by social desirability factors.

Marital adjustment has been examined at length and significant correlations have been obtained with a large number of variables including self-reported personality variables (Hurley & Silvert, 1966), demographic similarities (Luckey, 1960a),

congruence of spouses' perceptions of themselves (Kotlar, 1965), congruence of spouses' perceptions of their mates (Hurley & Silvert, 1966), a combination of personality and demographic factors (Bentler & Newcomb, 1978), and many other areas. Two findings which are especially likely to have impact on this study are the general reports that level of marital satisfaction or adjustment tends to decrease over the number of years married (Crago & Thorp, 1968; Luckey, 1966), and that marital satisfaction tends to decrease with the advent of children (Hurley & Palonen, 1967; Rollins & Cannon, 1974). On the basis of these findings, this study will attempt to achieve a sample population in which the variables of number of years married and number of children are equated between the two groups being examined and compared, couples in which the woman is the physician or medical student and couples in which the man is the physician or medical student. These variables will also be examined to evaluate their impact on marital satisfaction (Hypothesis 15). This study will combine several areas of marital research by focusing upon roles and personality variables, and by employing an interactive theory about relationships.

Equity Theory and Dual-Career Relationships

The persons in a dual-career marriage bring a variety of personal resources and coping strategies to bear upon their professional and personal lives. This study will attempt to focus upon the impact of working/professional life on marriage and private

life. A recently expanded theory in social psychology appears to be well suited for application to dual-career relationships. Equity theory, as summarized by Walster, Walster, & Berscheid (1978) is an attempt to develop a general theory of social behavior that will integrate a variety of previous theories, explain previously accumulated empirical data, and predict further behavior. Equity theory "attempts to integrate the insights of reinforcement theory, cognitive consistency theory, psychoanalytic theory, and exchange theory" (Walster, Walster, & Berscheid, 1978, p. 2). Equity theory at its simplest states that in a relationship, if one gives as much as one gets, one experiences equity and feels content. However, if one either gives more or gets more, one will experience inequity and feel distress. The fundamental propositions of equity theory as they apply to this study are:

Proposition I. Individuals will try to maximize their outcomes (where outcomes equals rewards minus costs).

Proposition III. When individuals find themselves participating in inequitable relationships, they will become distressed. The more inequitable the relationship, the more distress the individual will feel.

Proposition IV. Individuals who discover they are in an inequitable relationship will attempt to eliminate their distress by restoring equity. The greater the inequity that exists, the more distress they will feel, and the harder they will try to restore equity.

Equity theory appears to be potentially very useful in the examination of dual-career relationships. In such relationships the woman (and sometimes the man) is stepping outside her (or his) traditionally assigned role behaviors. This study will give major emphasis to the women's roles and their possible role conflict. As the woman and her spouse deal with the multiple requirements of dual-career family life, it is highly likely that the woman cannot complete all aspects of her traditional roles as wife, housewife, and mother as elaborately as a woman can who does not work outside the home. Simple lack of time suggests that adding the career role will require that less time be given to the traditional roles. This could be perceived by either partner as role conflict: career role versus traditional roles. One or both partners may perceive less performance within the traditional roles as a "failing," experience inequity as a result, and seek to restore equity.

For this reason, equity theory also appears well suited to an examination of the marriages of all medical students and physicians. With the prevailing theme of "sacrifice" used to describe them, medical spouses could well be expected to experience inequity (Coombs, 1971). In fact, all persons involved in "two-person careers" could be expected to perceive inequity in the relationship. This would be true, of course, only if the individuals ceased to regard themselves as a unit, and considered themselves as separate persons. At such a time, an arrangement in which one person's entire occupation is to provide the support functions which enable another person to work is likely to be viewed as

inequitable. The growth of the feminist movement which encourages development for women as individuals would tend to increase the perception of inequity in such cases.

Equity theory predicts that if there is perceived inequity there is an attempt to restore equity. Is this hypothesis of inequity correct? In an attempt to restore equity, how is this done?

Extensions of Equity Theory

At this point it is essential to review some of the already achieved elaborations of equity theory. In the first place, an equitable relationship exists if the person scrutinizing the relationship concludes that the participants are receiving equal relative gains from the relationship. The "scrutineer" (the word used by Walster, et al., 1978) may be an outside observer or either of the participants, and scrutineers very commonly disagree about what constitutes equity or inequity.

Equity theory also postulates that where inequity is perceived, individuals will try to restore equity (Proposition IV). There are two ways to restore equity: by restoring actual equity and by restoring psychological equity. Restoring actual equity would involve altering the actual gains of one or both partners. Restoring psychological equity would involve exaggerating or distorting reality, to give the scrutineer the impression that the inequitable relationship is, in fact, equitable.

Equity theory as presented by Walster, Walster, and Berscheid (1978) attempted to proceed into the area of intimate relationships, but they acknowledged that this is the most theoretical and speculative of the kinds of relationships examined. The majority of the empirical verifications of equity theory involved social psychology experiments in which the "relationship" between the participants was fleeting and equity could be evaluated as present or absent on the basis of very limited interactions. There has been some effort to extend research into the area of intimate relationships. In a recent study, Traupmann (1978) applied equity theory by asking a group of 100 newly-wed couples to evaluate their perceived equity and marital satisfaction. As equity theory had predicted, those who felt equity in their relationship were happiest. Those who perceived inequity but felt they were getting more than they were giving were next happiest, and those who perceived inequity and felt they were giving more and gaining less were least happy.

As Walster, Walster, and Berscheid stated in their volume (1978), intimate relationships are varied and complex. In an ongoing intimate relationship it will be much more difficult to calculate inequity. Participants in casual relationships may expect specific repayment for each favor. Intimates may tolerate long term imbalances, confident that they have an unlimited future to set things straight. Intimates also become the possessors of increasingly powerful rewards and punishments. And as a relationship grows, the variety of potential rewards and punishments

increases. Walster, Walster, and Berscheid (1978) theorized that the variety of resources could be viewed from the framework of Uriel Foa and associates (Donnenwerth & Foa, 1974; Foa, 1971; Teichman, 1971; Turner, Foa, & Foa, 1971). In this theory the resources of interpersonal exchange fall into six classes (1) love, (2) status, (3) information, (4) money, (5) goods, and (6) services. Walster, Walster, and Berscheid (1978) hypothesized that intimates exchange not only those items which are obviously and universally of value (such as money) but also highly symbolic and particularistic items. One of the most intriguing and relatively unexplored areas is how intimates decide what is the "fair exchange" for what.

Walster, Walster, and Berscheid (1978) also raised the important point that intimates, through identification and empathy, come to define themselves as a unit. In this way gains are linked for the two persons--they are a unit, a couple, not two individuals. The equity theorists felt that the crucial issue is whether in any given situation the people are interacting as individuals or as a unit.

In the instances of the medical marriage and the dual-career marriage there are undoubtedly many times when a couple acts as a unit and they perceive themselves as such. However, under the high level of stress induced and with medical school absorbing such a substantial amount of the medical student/house staff spouse's time, it will be hypothesized in this study that parties in the medical marriage will often perceive themselves as individuals, and experience some degree of inequity.

Influence of Role Conflict on Perceived Equity/Inequity

A mediating variable for the experiencing of inequity may be role conflict, as defined by Sales (1978) and described previously. Medical students or house staff spouses are expected to behave in certain ways as spouses and in certain ways as medical students or house staff. The medical environment exerts pressure to be "doctors first" (Coombs, 1971). If students/house staff obey this pressure, their expected behavior as spouse is likely to suffer, possibly leading to perceived inequity. They may perceive the inequity themselves (I am letting my spouse down) or it may be perceived by the spouse (My spouse is letting me down) or both may be true. Since women, as noted earlier, are expected as part of the traditional feminine role to <u>always</u> "put the family first," their potential distress and perception of role conflict is even greater than that for men.

Walster, Walster, and Berscheid (1978) also summarized some relevant findings regarding the ways people restore equity. Research done by Morgan and Sawyer (1967), Benton (1971), and Traupmann (Note 5) suggested that strangers find even momentary inequities distressing, while intimates do not. This would seem to support the earlier theory that intimates construe their life together over a longer time span, in which there will be ample opportunity for things to "even out." For this reason it will be emphasized that subjects in this study are to evaluate the <u>present</u>.

From the framework of equity theory and from the impact of traditional sex roles and potential role conflict, the following hypotheses emerge.

Hypotheses Concerning Equity/Inequity

Hypothesis 1

In medical student and medical house staff marriages there will be some conflict for all married persons between the role of spouse and the role of medical student/house staff. From the resulting failure to live up to some expectations about the relationship, both spouses will perceive inequity at the present time in their relationship. Medical students and house staff will perceive themselves as overbenefited (i.e. getting more than they are giving) and spouses will perceive themselves as underbenefited (giving more than they are getting). Some exceptions to this will be noted in Hypothesis 3. Perceived equity/inequity will be operationally defined as each individual's score on the Traupmann-Utne-Hatfield (1978) Scale (TUH). Scores above zero are considered as perceived overbenefit and scores below zero are considered as perceived underbenefit. A score of zero is considered a perception of complete equity.

Hypothesis 2

As noted in the research review, female medical students/house staff are likely to perceive themselves as deviating even more from their traditional role as spouse than are male students/house staff. For this reason it is hypothesized that female married

medical students/house staff will perceive more inequity in their marriages than will male married medical students/house staff. As before, the medical student or house staff member will feel over-benefited and the spouse underbenefited. On the Traupmann-Utne-Hatfield (1978) Scale, female married medical students/house staff should have even higher positive scores than their male counterparts. The spouses of female married medical students/house staff should have even lower negative scores on the TUH than the spouses of male medical students/house staff. Possible exceptions to this are noted in Hypothesis 3.

Hypothesis 3

Equity theory suggests that when persons are strongly identified with each other, there is less perception of inequity. As a rough correlate of identification, it is hypothesized that medical students or house staff whose spouses are either medical students or house staff or other physicians will perceive less inequity than will medical students/house staff who are not part of a "dual-medical couple." Accordingly, on the Traupmann-Utne-Hatfield (1978) Scale, female medical students and house staff married to "non-medical" spouses will have a higher positive score than do female medical students and house staff who are part of a "dual-medical couple." Non-medical is defined as a person who is neither a house staff member, nor a medical student, nor another physician.

In turn, male medical students and house staff married to "non-medical" spouses will also have a higher positive score on the TUH than do male medical students/house staff who are part of a dual-medical couple.

Hypothesis 4

Following the results of Traupmann (1978), persons who report equity should report most marital satisfaction, while those reporting increasing amounts of inequity should report decreasing marital satisfaction. Those reporting inequity and overbenefit should report the next most satisfaction, while those reporting inequity and underbenefit should report least marital satisfaction.

Marital satisfaction will be operationally defined as each individual's score on the Dyadic Adjustment Scale developed by Spanier (1976). Equity/inequity will continue to be operationally defined as the score on the Traupmann-Utne-Hatfield (1978) Scale.

Hypotheses Interrelating Equity, Role Conflict and Androgyny

Hypothesis 2 is contingent upon several assumptions: that the married woman in medical school/house staff training perceives herself as not fully performing the traditional female spouse role, that she is not entirely comfortable with this, and that as a result, she (and possibly her spouse) feels she is not fulfilling expectations as a wife. The expectations could be her own about herself, or her spouse's expectations about her, or both.

There are, in effect, at least two contributing portions of this potential failure to meet expectations. One is the level of expectations within the minds of the wife and her spouse as to what a "wife" should do. The other portion is her level of performance as perceived by both wife and husband. If either wife or husband perceive that she is not meeting the level of expectations that they hold for the "wife role," they are likely to view this as a result of the time demands of the medical education setting. In fact, this is quite a realistic viewpoint (Robinson, 1978). Within this study, it will be assumed that most of the discrepancy between expectations in the wife role and performance of the wife role will be attributed to the fact that the wife is involved in medical education. There will be an effort to evaluate this directly. This attribution of the discrepancy to activity in medicine falls within the definition of role conflict.

It is possible that for some married female medical students and house staff there will be no role conflict no matter how high their expectations of themselves in the feminine spouse role are. These would be the "superwomen" who perform all aspects expected in both the feminine spouse role and the medical role. These persons would experience no role conflict.

Another mediating variable, however, may operate on the level of expectations which exist within the minds of the women and their spouses. Personality research has developed the concept of psychological androgyny, which postulates that a single individual may possess characteristics which are considered traditionally

masculine and also traditionally feminine (Bem, 1974; Spence, Helmreich, & Stapp, 1975). Research suggests that the androgynous individual, one who possesses a high number of qualities from both sex-role categories, may be a flexible, adaptable, and healthy individual (Bem, 1975; Bem & Lenny, 1976; Bem, Martyna, & Watson, 1976). One could postulate that, focusing upon female medical students and house staff, their level of androgyny would have an effect upon the expectations they place on themselves as wives. In the first place, it should be clearly stated that any group of female medical students and house staff is likely to be more androgynous than an average population of young women in that age group. But within a population of women medical students/house staff, there can still be a considerable range. Both of these assumptions will be examined empirically.

Androgyny literature suggests that the androgynous individual moves freely in and out of behaviors considered typical for his or her sex (Bem & Lenney, 1976). One can, by extrapolation, hypothesize that since the androgynous female medical student or house staff member has heavy time commitments in her more "masculine" role as a medical person (achievement oriented, requiring independent judgment, etc.), she might comfortably lower her expectations for some of her feminine spouse role commitments. To put it another way, a flexible stance may be the best way to minimize role conflict. A woman might begin medical school with expectations for herself that to take really good care of her family in the feminine role, she will bake her own bread and do all

the family laundry. In the "superwoman" approach, she would continue to do these things despite being in medical school, and avoid role conflict in that way. With a flexible set, she might decide it was still sufficient care for the family to buy good bakery bread, and have her husband do the laundry. In this way, she too would avoid perceiving role conflict, but in quite a different fashion.

For the "feminine" female medical student (one with a greater number of stereotypically feminine attributes and a fairly low number of stereotypically masculine attributes), her self-image might make it more likely that she would begin with and probably maintain a higher level of feminine spouse role expectations than her androgynous colleague. This might be, in part, a reaction, since she would almost certainly view many of her medical activities as "masculine" and might want to continue her traditionally feminine behavior to maintain consistency in her view of herself. If this were the case, the "feminine" female medical student/house staff member has an uncomfortable set of choices. She must either be a "superwoman" or through sheer time pressure, not complete some of the aspects of her traditional spouse role, and experience the role conflict.

Thus, the perceived discrepancy between expectations and performance could be influenced both by level of androgyny (operating on the level of expectations) and by level of performance. A woman with a high femininity score and high level of expectations for the traditional female spouse role would perceive

no discrepancy if she were able to maintain a high level of performance of the feminine role. Therefore, she would perceive no conflict between being a wife and being in medical education. An androgynous woman might have a lower level of expectations for herself within the traditional female spouse role and be able to perform up to those expectations. Therefore, she too would perceive no conflict between being a wife and being a medical student/house staff member. For the purposes of this study, the discrepancy between expectation and performance will be assumed to be largely due to the time pressures exerted on the women by being involved in medical education. Therefore, this discrepancy score will be considered a measure of the role conflict perceived between the roles of wife and medical student/house staff.

Hypothesis 5

Level of role conflict will predict level of inequity. The greater the discrepancy between expectations and performance, the greater the perceived inequity. Level of expectations and level of performance will be operationally defined as the answers to section (A) of each question on the Taylor Role Questionnaire (TRQ). Level of performance will be operationally defined as the answers to section (C) on each question on the TRQ. A discrepancy score will be calculated (part C minus part A for each question) and this will be operationally defined as the role conflict score. In this fashion, a positive score would indicate performance greater than level of expectations, while a negative score indicates performance below the level of expectations.

For all female medical students/house staff and their spouses, the greater the degree of perceived role conflict and the more negative the score, the greater should be the degree of perceived inequity.

Hypothesis 6

The androgyny scores for the female medical students and house staff will be compared to the androgyny scores for Bem's (1974) population of Stanford undergraduates and the other women within the study. It is hypothesized that the level of androgyny for the medical women will be significantly higher than it will be for the other two groups. Androgyny will be operationally defined as a high level of both the masculinity and femininity scores on the Bem Sex-Role Inventory (BSRI). A masculine sex-role type will be operationally defined as an individual with a high score on the masculinity scale and a low score on the femininity scale. A feminine sex-role type would be the reverse. An individual with low scores on both scales would be operationally defined as an undifferentiated sex-role type. Because of the potential difficulties in determining what should constitute a "low" or "high" level on the scales, multiple regression techniques will be used in this study to evaluate the influence of the masculinity and femininity scales on the BSRI. See the Measures section of this paper and Bem and Watson (Note 1) for more discussion.

It is hypothesized, therefore, that the mean scores on both the masculinity and femininity scales of the BSRI will be significantly higher for the sample of female medical persons, when

comparing them to the sample of women undergraduates from Stanford and to the non-medical women in this study.

Hypothesis 7

Androgynous female medical students and house staff should have lower expectations of "feminine" spouse role behavior of themselves than feminine female medical students and house staff. Masculinity and femininity scores on the BSRI will be used to determine whether increasing scores on both the masculinity and femininity scales predict a lower level of expectations of feminine spouse role behavior. Feminine spouse role expectations will continue to be operationally defined as the score of section (A) of each question on the TRQ.

Hypothesis 8

It is possible that some women medical students/house staff who hold high expectations for their feminine spouse role performance can be "superwomen" and perform up to the level of any degree of expectation. It is more likely, however, from the pragmatic limit of number of hours in the day, that performance level in the feminine spouse role is roughly comparable for all women medical students/house staff, regardless of their expectations or degree of androgyny. For this reason, it is hypothesized that the performance level for the feminine spouse role will show no significant differences for all women medical students/house staff, regardless of their scores on the Bem Sex-Role Inventory. Performance on the feminine spouse role will continue to be

operationally defined as the answers to part (C) of each question on the Taylor Role Questionnaire. Accordingly, the masculinity and femininity scores on the BSRI should not significantly predict the performance level.

Hypotheses Concerning Level of Androgyny of Spouses

The marital satisfaction research on the whole suggests that spouses influence each other powerfully. A good deal of recent research on marriage has focused on the ways this influence is exerted, defining it as the use of power within the family or conflict resolution in the family (Bahr & Rollins, 1971; Barry, 1970; Cromwell & Olson, 1975; Olson & Rabunsky, 1972; Richmond, 1976; Rollins & Bahr, 1976). Other research on marriage suggests that spouses select each other on the basis of having similar attitudes (Byrne & Blaylock, 1963; Levinger & Breedlove, 1966) and values (Coombs, 1966; Murstein, 1970; Murstein, 1976). Consequently it is assumed that husbands and wives will resemble each other in their expectations for the feminine spouse role, and that they will influence each other toward similar expectations. In the same way, they should mutually influence each other's perceptions of role conflict and equity.

If her level of androgyny enables a wife to adopt a more flexible stance towards her feminine spouse role, the attitude of her husband can have a great impact on her working outside the home (Parnes, Jusenius, Blau, Nestil, Shortlidge, & Sandell, 1976). Successfully bringing off a dual-career marriage requires

flexibility, understanding, and a capacity to accommodate to changing conditions (Rostow, 1965) from both spouses. These may include role reversals at times (Birnbaum, 1975; Hoffman & Nye, 1974; Rapoport & Rapoport, 1971). An inflexible and traditionally "masculine" attitude, at least about maintaining a sense of control, has been shown to be inversely correlated with the wife having a career (Winter, Steward, & McClelland, 1977). In fact, that study commented "Since women's career level is predicted by Self-Definition scores of both women themselves (Stewart, 1975; Stewart & Winter, 1974) and of their husbands, it seems likely that Self-Definition involves a general freedom from ascribed roles, both for one's self and for others" (Winter, et al., 1977, p. 164). All of these descriptions of flexibility and freedom from ascribed roles strongly suggest the androgynous individual described by Bem and Lenney (1976). Therefore, it could be hypothesized that increasingly androgynous husbands will have declining expectations for their wives in the feminine spouse role. There should also be a corresponding impact on his perceptions of role conflict and his perceptions of equity within the relationship.

Hypothesis 9

Therefore, the masculinity and femininity score on the Bem Sex-Role Inventory for the husbands of the female medical students/ house staff should predict their expectations of their wives' feminine spouse role behavior. Increased masculinity and femininity scores (increased androgyny) should predict decreasing

expectations for the female spouse role. This might be due in part to the willingness of androgynous husbands to assume with comfort some of the traditionally feminine behaviors that their wives do not have time to do. This could range from doing the laundry to taking care of the children. Expectations for the feminine spouse role continues to be operationally defined as the answers to part (A) of each question on the TRQ.

Hypothesis 10

If the previous hypotheses are confirmed, all women medical students/house staff will be performing at roughly equivalent levels and their level of expectations of themselves for the feminine role will be predicted by their scores on the BSRI. Accordingly, the masculinity and femininity scores for the BSRI should also predict significantly the discrepancy score (role conflict score) on the TRQ. An increase in both masculinity and femininity scores should predict less discrepancy score, or, a shift from negative scores to less negative or positive scores.

Hypothesis 11

For the husbands of the women medical students/house staff as well, their masculinity and femininity scores on the BSRI should also predict their perceived discrepancy score for their wives on the TRQ. Increasing androgyny should predict less role conflict.

Hypothesis 12

Hypothesis 9 is predicted, in part, on the assumption that husbands and wives influence each other by exchanging their views and values. Accordingly, a husband who perceives a certain discrepancy between his expectations for his wife and her performance level will be likely to influence his wife's view of the discrepancy between her own expectations for herself and her performance. In turn, her views will influence his, and, of course, both processes occur simultaneously. This will be examined empirically by correlating the difference scores for husbands and wives among the sample of female medical students/house staff and their spouses. A significant positive correlation is predicted.

Hypothesis 13

If Hypothesis 10 and 11 are confirmed and the masculinity and femininity scores on the BSRI significantly predict the discrepancy score (role conflict score) on the TRQ and if Hypothesis 4 is confirmed, such that there is a significant correlation between the role conflict score and both equity/inequity score and the marital satisfaction measure (Spanier), then the androgyny measures should be significant predictors of the equity/inequity score and of the marital happiness score.

Hypotheses Concerning Restoration of Equity

Equity theory research has found that in a state of perceived inequity, persons attempt to restore equity, either in actuality or psychologically. It has also been

found that in experimental situations, people commonly try to restore actual equity only when they can do so exactly to an even level (i.e. leaving neither participant overbenefited or underbenefited). If they can only approximate restoring equity in reality, they tend to restore equity psychologically. For example, if they have wronged someone and cannot make it "just right" they may denigrate the victim, "oh well, he had it coming."

There is little evidence on whether intimates will seek to restore equity in actuality or psychologically. There is some evidence that partners seek to restore actual equity. Unfortunately, much of this is anecdotal. Among research studies, Komarovsky (1971) examined 58 families in which the husband lost his job during the 1937-38 depression. Komarovsky found that in 13 of the 58 families, when the husband lost his job, he began to lose his authority. Two forms of major change occurred. In one group, the couple's relationship evolved to become more egalitarian so that, for example, the man began, for the first time, to take on household duties. In the second group, in a few cases the husband's and wife's status were reversed.

Walster, Traupmann, and Walster (Note 8) looked at how a person's perceptions of equity should color his or her attitudes toward extra-marital sex. In general, their results supported equity theory, in showing that underbenefited partners, as compared to overbenefited partners or equitably treated partners, were willing to engage in extra-marital sex much sooner in the time span of their relationships.

In situations involving intimates, one will probably know too much about the other partner and be too much invested to achieve psychological equity by denigrating the victim. For intimates who perceive relatively little inequity, restoration of equity in the near future may be possible, especially considering the wide range of interchangeable resources at the disposal of intimates. If an enormous "debt" of inequity has been accumulated, however, restoration of an exact equity would seem much more difficult. In this case, an attempt to restore psychological equity would seem more likely.

In the case of medical marriages the most likely rationalization to restore equity appears to be the "pie in the sky" approach (Berman, 1979; Coombs, 1971). In other words, the medical person and his or her spouse will anticipate that after medical school and residency, the doctor will be more available in the spouse role. There is also the prospect of other inputs in the form of increased income and prestige. These latter may be realistic expectations, but the hope of more "spouse time" probably is not (Berman, 1979; Coombs, 1971).

Hypothesis 14

Medical students/house staff and their spouses who report more perceived inequity should more often envision increased time, attention, and other "spouse-role" activities after completion of medical school and residency. Individuals (both medical students/house staff and their spouses) who perceive less inequity should

anticipate that future interactions as spouses will continue much as they are at present.

Amounts of perceived equity/inequity will continue to be operationally defined as the individual's score on the Traupmann-Utne-Hatfield (1978) Scale. Anticipated changes in the marriage following medical education will be operationally defined as responses to the questions #8 and #9 of the open-ended questionnaire (Appendix I). These will be judged by independent raters to provide a score for the amount of increase in "spouse-role" activities anticipated.

Individuals who perceive inequity above the median level for their group (grouping students/house staff and spouses separately) will expect greater increases in spouse-role behavior than will persons with perceived inequity below the median level for their group.

Hypothesis Concerning Demographic Variables

Hypothesis 15

The marriage literature reviewed above suggests that marital satisfaction may be influenced by number of years married and number of children. It is hypothesized that within this sample, these factors will have relative little power to predict marital satisfaction, as defined by the Spanier (1976) Dyadic Adjustment Scale.

An Attempt to Estimate Predictive Power

Hypothesis 16

Among all the variables being examined in this study, a regression equation will be employed to estimate the relative power of these factors in influencing marital satisfaction for the persons in this study. Marital satisfaction will continue to be operationally defined as the score on the Spanier Dyadic Adjustment Scale.

METHOD

Subjects

Subjects were drawn from the population of 44 married female medical students and 26 married female house staff members at the University of Wisconsin Medical School, Madison, Wisconsin, and the spouses of these women. From the 163 male married medical students and 178 male married house staff at this school, a matching sample was generated, with an attempt to match the female sample on the basis of year in medical education, status (if a medical student) in the Independent Study Program (ISP), number of years married, number of children, and occupation of spouse.

The match proceeded in the following fashion. Initially all women within a year in medical school were contacted, and their consent obtained. From that data, an attempt was made to obtain a matching group within that medical year. Once all women within a given medical school year had been contacted and given their consent, a list was made giving the ISP status, the number of years married, number of children and occupation of the husband for each couple. Then with one "target" couple in mind from the female list, a couple was selected at random from the list of married male medical students within the same year in medical school. If this couple agreed to participate in the study, information was obtained from them about number of years married, number of children and

wife's occupation. (ISP status was known and ISP couples were always called first in the attempt to match another ISP couple.) Often this male-identified couple did not match the female-identified "target" couple but instead was a good match for another female-identified couple on the list. On that basis it was accounted "a match" and another male-identified couple within the medical year was contacted at random in the continuing attempt to match the "target" couple. Once a "target" couple was matched, of course, the next unmatched female-identified couple became the "target couple."

This method was relatively successful, but less than perfect. At the end of a list of female-identified couples in a class, one or two might remain unmatched. Two additional attempts were made per couple to attempt to match them; if these were unsuccessful, the attempt was abandoned because the number of male-identified couples was becoming too much greater than the number of female-identified couples.

For the residents the match attempt was somewhat different. Residents were identified by specialty in the available directory, not by year in training. Accordingly, all female-identified couples in a specialty were contacted and then the attempt was made to match with male-identified couples within the same specialty on the basis of number of children, number of years married, and position in training (i.e., whether in an early year or a later year in the residency). There were only 10 female residents not part of a dual-medical marriage, and the match was quite

successful, resulting in only one "extra" male-identified couple due to difficulty in matching.

Within both resident and student groups, the first priority was given to matching on the number of children. If this was accomplished fairly easily then a roughly comparable number of years married and the occupation of the spouse were the next priorities, in that order. These variables were emphasized because of the marriage literature which suggests that marital satisfaction changes with the birth of children and to some degree simply through passage of time. Since some of the students and the house staff were in effect already part of both male-identified and female-identified groups because they were married to each other, the sample size was reduced accordingly.

Names, addresses and phone numbers of the students and house staff were obtained through the office of Dr. John Anderson, Assistant Dean of Students at the University of Wisconsin Medical School. Procedures for obtaining subjects were developed in consultation with Dr. Anderson, and had his consent. Dr. Anderson's office was also able to supply marital status for the students and house staff, the names of their spouses, whether or not students were in ISP, and the area of specialty for the house staff subjects.

Procedure

The students/house staff and their spouses were contacted by phone at their residences and the study described briefly to

them along the lines of the Introduction/Consent Form which forms Appendix C. This included the information that subjects would be asked not to discuss the questionnaire with the spouse until both had completed it, that the questionnaire would be sent to one spouse at a time, and that couples would be paid $10.00 as a way of thanking them for participating. The initial phone contact also noted that confidentiality would be observed. Any areas of interest or concern about the study were explored with the potential subject; the only reservation being a detailing of specific hypotheses. Subjects were uniformly very understanding about the fact that explaining exact hypotheses might bias their answers. As may be imagined from the high ratio of persons agreeing to participate to persons contacted, the potential subjects were, in general, extremely cooperative. A number indicated that being paid was not necessary. One dual-medical couple went so far as to insist that they would not participate if they had to be paid.

If the individuals agreed to participate in the study, they were asked to consult their spouse to see if she or he was also willing. In some cases this required a second phone call to determine if the spouse wanted to participate. After both spouses agreed to take part, the questionnaire was mailed to one. Which spouse received the questionnaire first was determined by the convenience of the persons involved. In some cases one partner had heavy time commitments within the next ten days while the other one

did not, and so forth. After the questionnaire was returned by the first spouse it was mailed to the second spouse.

The questionnaire consisted of (1) a request for some general demographic information, (2) the Bem Sex-Role Inventory, (3) the Taylor Role Questionnaire which was generated for this study, (4) the Traupmann-Utne-Hatfield (1978) Scale, (5) the Dyadic Adjustment Scale created by Spanier (1976), and (6) nine open-ended questions regarding experience as a medical student or house staff person or the spouse of one. These instruments are described in the Measures section.

If a partner had not returned the questionnaire by mail within ten days from the time he or she should have received it, an attempt was made to contact the subject by phone. If the person could not be reached, calls were continued until he or she was contacted. If the subject still did not return the questionnaire within an additional ten days, he or she was again contacted by phone. This process was repeated as necessary. As will be seen below, this method was quite productive. In a few cases the individual could not be contacted by phone for extended periods, and in that case a letter was mailed to his home address.

Of the 44 married women medical students, all 44 were contacted. Two refused to participate in the study, and one had to be eliminated by reason of being a friend of the investigator and knowing too much about the study. All the rest agreed to participate in the study. All of these women and their spouses completed the study.

Of the 26 married women house staff, all were contacted. Two refused to participate and one had to be eliminated by reason of being a friend of the investigator and knowing too much about the study. The remaining 23 women agreed to participate. All 23 of these couples completed the study.

Among the male medical students (who were not married to another person in medicine), 49 were contacted by telephone. Of these, 41 couples agreed to participate in the study. Thirty-nine couples completed the study, and of the remaining two couples, one spouse in each had completed the study.

Among the male house staff (who were not married to another person in medicine), 23 were contacted. Of these, 12 couples agreed to participate in the study. Eleven couples completed the study, and of the remaining couple, one spouse had completed it.

There were 25 couples in which both partners were involved in medicine either as student, resident, or MD. All of these dual-medical couples completed the study.

Among the couples refusing to participate in the study, a number gave no reason for refusal. One person was extremely concerned about the confidentiality of the results and refused on that basis. One student and one resident indicated they were simply too busy. Two students indicated they were willing but couldn't spare the time until some weeks had passed (in one case this amounted to two months!). Two student couples refused and one resident couple refused because the couples were divorcing. Two resident couples and one student couple agreed initially to

participate and then refused after one partner felt uncomfortable upon reading the questionnaire.

The subject pool resulting consisted of the following couples: 39 couples with a male medical student and a non-medical spouse, 29 couples with a female medical student and a non-medical spouse, 6 medical student-medical student marriages, 5 medical student-resident marriages, and 2 female student-male MD marriages. The remaining couples were 10 couples with a female resident and a non-medical spouse, 11 couples with a male resident and non-medical spouse, 10 marriages between two residents, and 2 female residents married to male MD's. In this case "resident" is used loosely to refer to any member of the house staff, whether or not he or she is officially referred to as an intern (first year post medical school) or a resident. MD means that a person is in practice and not in training; obviously all the house staff persons are MD's. A "non-medical" spouse is a person who is neither a medical student, a member of the house staff, or an MD in practice. These spouses included a substantial number of nurses and others directly involved in medical care. This brings the sample to a total of 114 couples. There were in addition three "unpaired" persons, whose spouses did not complete the study: one wife of a male medical student, one male medical student whose wife was not in medicine, and one wife of a resident, to bring the total sample to 231 persons. Of these, 25 couples were dual-medical couples.

The mean age for the 88 students in the sample was 25.6 years, with a minimum age of 22 years and a maximum age of 43 years.

Medical students had been married for a mean of 4.3 years, with a minimum length of marriage of 1 year, and a maximum length of marriage of 25 years. Number of years married was rounded to the nearest number of whole years; no subject had been married for less than six months. Medical students had a mean of 0.5 children, with a minimum of no children and a maximum of 5 children.

The mean age for the 69 non-medical spouses of medical students was 27.3 years, with a minimum age of 22 years and a maximum age of 54 years. The non-medical spouses of medical students had been married for a mean of 4.7 years, and had a minimum length of marriage of one year and a maximum length of marriage of 25 years. These non-medical spouses had a mean of 0.6 children, with a minimum of no children and a maximum of 5 children.

The mean age for the 48 residents in the sample was 28.8 years, with a minimum age of 26 years and a maximum age of 35 years. Residents had been married for a mean of 4.9 years, with a minimum length of marriage of one year and a maximum length of marriage of 16 years. Residents had a mean of 0.3 children, with a minimum of no children and a maximum of three children.

The mean age of the 22 non-medical spouses of residents was 29.8 years, with a minimum of 25 years and a maximum of 52 years. The non-medical spouses of residents had been married for a mean of 6.3 years, with a minimum length of marriage of 2 years, and a maximum length of marriage of 16 years. These spouses had a mean of 0.5 children, with a minimum of no children and a maximum of 3 children.

For the four MD's, the only group not included in the groups described above, their mean age was 31.5 years, with a minimum of 26 years and a maximum of 35 years. They had been married for a mean of 8.7 years, with a minimum of 2 years and a maximum of 16 years. The MDs had a mean of 0.5 children, with a minimum of no children, and a maximum of one child.

After receipt of the questionnaire from the second spouse, the couple was sent a letter thanking them for their participation and enclosing a check for $10.00. The letter also explained that an additional letter would be forthcoming after the data were analyzed, containing a brief summary of the hypotheses of the study and the results. The subjects were invited either then or at any time to contact the investigator for more information about the study. The letter sent with the check forms Appendix K.

After analysis of the data, a letter was again sent to all subjects, summarizing the hypotheses and results of the study, and again inviting contact if there was any desire for more information. This final letter forms Appendix L.

Once questionnaires were received, names were removed and replaced by a code.

Measures

For the study, each subject was mailed a questionnaire consisting of 9 parts in all. The first portion was simply a general instruction sheet, which requested that the subject read and sign the first of the two copies of the Introduction and Consent

Form enclosed and then retain the second copy. The instruction sheet also repeated the instructions given by telephone: to please fill out the form in the order given, to complete a section at a sitting, not to "labor over" the form and to mail it back to the investigator when finished. A large self-addressed, stamped envelope was enclosed with each questionnaire.

The subject was also asked not to discuss his or her answers with the spouse until both had finished the study. Finally, it was noted that the investigator would telephone if the form were not received within roughly ten days. This instruction sheet forms Appendix B.

The second section of the questionnaire consisted of the Introduction and Consent Form itself. This introduction briefly outlined the purpose of the study and some of the investigator's interests. It repeated most of the instructions on the instruction sheet (Appendix B), and added that after forms were received back from both partners, a check for $10.000 would be mailed to the couple as a way of thanking them for participating. It also requested no discussion of the study with friends or colleagues until June 1, 1979, in the hope of not influencing the answers of any other subjects.

The Introduction also briefly described the nature of the questions and information on the rest of the questionnaire. This information had also been repeated during the initial telephone contact to obtain consent to send the questionnaire.

Finally, the Introduction and Consent Form emphasized limits of possible benefit from participating in the study and the confidentiality of the material. The investigator offered to send a copy of the results of the study and answer any questions that might emerge during the course of the study. Subjects were told that they were free to withdraw from the study at any time. The last portion of the form was a standard authorization for participation in the project. The Introduction and Consent Form forms Appendix C.

The next portion of the questionnaire was titled General Information and requested basic demographic information, including the occupations of the subject's parents, his position in birth order in his family of origin, number of years married, number and ages of children and the like. These items were requested in hope of performing post hoc analyses to examine the effect of various demographic variables. These analyses are not included in the present study. From the literature review on marriage, number of children, their ages, and number of years married were of particular interest. This information sheet forms Appendix D.

The next portion of the questionnaire was titled for convenience Section A, and consisted of the two pages of the Bem Sex-Role Inventory (BSRI). This comprises Appendix E. This measure was developed to evaluate the psychological concept of androgyny, i.e., that an individual could possess attributes both traditionally assigned to males and traditionally assigned to females. Each individual receives a masculinity score and a

femininity score, derived from the mean of the twenty items identified as respectively masculine and feminine. In her present method of scoring the scale, Bem suggests calculating the masculinity and femininity scores for each subject, obtaining the medians for the masculinity and femininity scores based on the total sample, sexes combined, and then classifying subjects according to whether their masculinity and femininity scores fall above or below the medians. Persons with a masculinity score above the median and a femininity score below the median would be classified as masculine; persons with the reverse would be classified as feminine. Persons with both scores above the median would be classified as androgynous, and persons with both scores below the median would be classified as undifferentiated (Bem, 1977).

The drawback of using this scoring method, however, is that it places persons who receive scores on two continuous variables into categories that are dichotomous. For this reason, in this study the raw scores of the masculinity and femininity score and the product of these scores will be used in multiple regression equations to determine if the masculinity and femininity scores have predictive power as is hypothesized in this study. This use of the scores with multiple regression techniques is actually recommended by Bem and her colleague (Bem & Watson, Note 1).

The next section of the questionnaire was the Taylor Role Questionnaire (TRQ). It forms Appendix F. It was the author's wish to employ an instrument that would evaluate both the behavior

a wife felt she should be displaying and the behavior she was presently displaying. In a similar fashion an instrument was needed to report expectations for the wife and perceived performance by the wife, from the point of view of her husband. It was also desirable to evaluate the degree that each spouse thought the wife's career affected her behavior in the traditional role.

In a review of available instruments, none was available which met these rather specialized requirements. A number of instruments have examined the areas of expected roles for husbands and wives and discrepancies between expectations and performance in role (Craddock, 1974; Crago & Tharp, 1968; Hurvitz, 1960; Larson, 1974; Quick & Jacob, 1973; Tharp, 1963). However, these instruments did not focus upon the wife alone and did not assess impact of the wife's career. Therefore, the Taylor Role Questionnaire was devised. The scales cited above were consulted in an attempt to include all the areas traditionally encompassed within the role of wife. This included both task-focused aspects and the emotionally supportive role which has been traditionally assigned to wives (Parsons & Bales, 1955). Some items were also directly suggested by the literature on dual-career marriages. For example, Bryson, Bryson, & Johnson (1978) found that even though dual-career couples attempted to divide child care tasks evenly, they continued to be viewed as primarily the wife's responsibility. A key "test" was the fact that the wife almost always was the spouse who left work to care for a child who became ill.

The TRQ suffers from drawbacks owing its newly created status. Its intent on the whole was to evaluate discrepancies between expectations for traditional wife behaviors and the performance of them. Some biasing of responses was implied because there were no questions posed such as "I expect my wife to change the oil in the car," or "I expect myself to mow the lawn." It is possible that in couples in which there is substantial role reversal of the traditional tasks, that this scale would not assess dissatisfaction with self or spouse accurately.

Nevertheless, one assumption of this study was that while some individuals may be attempting to alter their expectations of themselves or their spouse away from the stereotypical female role, such a stereotype tends to linger on and to be subtly influential. This in part explains the general instruction on the TRQ to describe oneself (or spouse) in part (A) of each question as the "ideal spouse." It was somewhat contradictory to word each part (A) later on in the scale "I expect myself . . ." since it is by no means inevitable that persons expect themselves to be the ideal spouse. However, the intent of using the word "ideal" was to reduce some tendency of persons to say, in effect, "I had better expect only what I know I can (be or) get," and to give them a more free rein to express wishes that they might ordinarily attempt to suppress. This is based on an assumption that within the medical marriage, spouses are continually living with and coping with an unpleasant level of deprivation and at the same time often wishing it were not so. Nevertheless, at some pragmatic level spouses also must expect

certain things and it was a measurement of the difference between that expectation in the present (with its tinges of wishful thinking) and performance in the present that was desired.

This wording may need to be re-worked or otherwise adapted to a more effective approach. A number of subjects commented upon the "ideal" versus "expectation" contradiction, as they found it confusing or unrealistic. One subject offered the useful suggestion of attempting to evaluate expectations before medical school and then during medical school and the residency, to observe the possible shifts in expectations.

Because the TRQ was given to all persons in the study, its wording had to be changed to make it appropriate to the status of the individual subject. The TRQ was given to male medical persons and their non-medical wives in part to equalize the amount of time required by all subjects to complete the study and in part to permit post hoc examinations of hypotheses about the male medical person and his wife which are not included in the present study.

For female medical persons, their part (D) of each question asked about the influence of their status as a medical student or intern/resident on their behavior. For males with a female medical person as a spouse, their part (D) of each question asked about the influence of her medical status on her behavior.

For females who were not in medicine, their part (D) asked about the influence of their occupation on their behavior. For their husbands, part (D) again asked about the influence of the wives' occupations.

For those women whose occupation was to be at home in the role of wife and mother, part (D) had to be either deleted or re-worded for it to make sense. It was re-worded to ask about the influence of the husband's medical status on their behavior. For the husbands of homemaker wives, their section (D) reflected this change. To avoid an extremely cumbersome Appendix F (amounting to 42 pages), the full length TRQ is included only in the version for the female medical person. The initial two pages, appropriately labelled, are included for each of the other five versions of the questionnaire.

To evaluate the reliability of the TRQ, the 21 questions were broken down into four subroles: Homemaker (consisting chiefly of task-oriented behaviors), Emotional/Sexual/Supportive Partner, Social Partner, and Child Care. See Table 1 for a detailing of items included. Since part (A) and part (C) of each question were to be examined separately and then a difference score amounting to (C) minus (A) was to be derived and also examined in other hypotheses, the subroles were examined for the reliability of part (A) and part (C) separately.

The items to be included in each subrole were derived from both the logic of their content and a non-systematic review of the data which suggested that items 10 and 12 did not reflect association with any of the subroles. On this basis, coefficient alpha or internal consistency was computed for each of the four subroles. both for part (A) and for part (C). These standardized item alphas are presented in Table 2.

TABLE 1.--Items Included Within Subroles of the Taylor Role Questionnaire (Wording Given for Wife's Form).

Subrole	Item No.	Wording
I. Homemaker	1.	I expect to do the cooking.
	2.	I expect to do the household cleaning.
	3.	I expect to do the laundry.
	4.	I expect to do the clothing maintenance (mending, dry cleaning, etc.).
	5.	I expect to do the grocery shopping.
	6.	I expect to do the other shopping (not grocery).
II. Emotional/Sexual/ Supportive Partner	7.	I expect to show affection towards my husband.
	8.	I expect to respond to affectionate overtures from my husband.
	9.	I expect to respond to sexual overtures from my husband.
	11.	I expect to spend time alone with my husband at home--talking or doing things together.
	14.	I expect to listen to what is troublesome in my husband's life, and to share his joys, too.
	15.	I expect to be supportive and encouraging of my husband.
	17.	I expect to express appreciation for the things my husband does for me.
III. Social Partner	13.	I expect to go out socially with my husband and mix with other couples or friends generally.
	16.	I expect to help maintain the contacts with our extended family (parents and in-laws, brothers, sisters, etc.).

TABLE 1.--Continued.

Subrole	Item No.	Wording
IV. Child Care (not answered by couples without children)	18.	I expect to provide the child care for our children.
	19.	I expect to be responsible for the care given to our child(ren), though I may not give it personally.
	20.	If our child(ren) is/are ill, I expect to take care of it.
	21.	I expect to be the disciplinarian for our children.

TABLE 2.--Standardized Item Alphas: Internal Reliability of the Four Subroles of the Taylor Role Questionnaire.*

Subrole I: Homemaker	Subrole II: Emotional/Sexual/ Supportive Partner	Subrole III: Social Partner	Subrole IV: Child Care
A	A	A	A
.80	.86	.43	.78
C	C	C	C
.75	.83	.37	.79

*A = responses to part (A) of each question on the TRQ; expectations for the wife.

C = responses to part (C) of each question on the TRQ; performance by the wife.

On the basis of these reliability estimates, it appeared that Subrole III, Social Partner, was not a sufficiently reliable scale to receive emphasis in the formulation of conclusions. Since it was formed of only two items, it was probably too short a scale to achieve high internal consistency. Subrole IV, Child Care, was also open to question, in part because the 34 couples with children composed such a small percentage of the total of 114 complete couples. Subrole II, however, Emotional/Sexual/Supportive Partner, showed sufficiently high internal consistency to be used with rather more confidence. Subrole I, Homemaker, appeared to show enough internal consistency to be interpreted with some caution.

Predictions within this study depended upon reliability estimates for both the scores of parts (A) and (C) for each question, and upon the reliability of the difference scores generated by subtracting (A) from (C).

The correlations between parts (A) and (C) for each subrole are shown in Table 3. In a multi-trait, multi-method approach to investigating perceptions about the wife's role, a correlation between part (A), expectations, and part (C), performance, would be desirable. It would indicate that indeed these were two different perspectives on the same part of the wife's role.

For this study, however, the optimal result would have been some correlation between parts (A) and (C) but not a large one. In this fashion it would be indicated that these were two perspectives on the same aspect of the wife's role, but the difference score would still have adequate reliability.

TABLE 3.--Correlation Coefficients Between Subrole Scales of the Taylor Role Questionnaire (TRQ).

	IA	IC	IIA	IIC	IIIA	IIIC	IVA	IVC
IA		.66	.37	.02	.27	.10	.52	.49
IC			.17	.22	.17	.26	.54	.62
IIA				.23	.48	.09	.40	.35
IIC					.14	.44	.28	.30
IIIA						.46	.25	.30
IIIC							.15	.08
IVA								.84
IVC								

With the internal consistency figures shown in Table 2 and the correlations shown in Table 3, the standard formula for reliability of difference scores was used to estimate reliability for discrepancy scores for each subrole.

For Subrole I, Homemaker, the difference score was estimated to have a reliability of 0.34, too low for use with much confidence. For Subrole II, Emotional/Sexual/Supportive Partner, the difference score had a reliability estimate of 0.80 which was high enough to be used in examining hypotheses. For Subroles III and IV, Social Partner, and Child Care, the reliability estimate for their difference scores was zero. This was due to the poor reliability for the separate scores on Subrole III and the very high correlation between parts (A) and (C) on Subrole IV.

These reliability estimates limited the conclusions that could be drawn from any test involving the TRQ difference scores.

The next section of the questionnaire was labelled Section C, and forms Appendix G. This is the Traupmann-Utne-Hatfield (1978) Scale, which was developed by members of the research team of the Walster, et al. (1978) book on equity theory. The scale was developed to measure the level of equity intimate couples perceive in their relationships. Reliability and validity data are available on an earlier form of the scale (Traupmann-Utne-Walster [1977] Scale) which confirm its reliability and construct validity (Traupmann, Peterson, Utne, & Hatfield, Note 7). However, this earlier version of the scale required that each respondent calculate his or her inputs to the scale for each of roughly 20 areas, then

to calculate his/her partner's inputs for the 20 areas, then to calculate his/her outcomes for each of the 20 areas and finally to calculate the partner's outcomes for the 20 areas. Afterward the experimenters performed the necessary computations to determine the perceived level of equity or inequity. As this was incorporated into a face to face interview format, it was feasible for the Traupmann, et al. research team; but even they found it cumbersome. It was clearly impractical for incorporation into a pencil and paper questionnaire in this study that was already of substantial length. On that basis, an unpublished revision of the scale, the Traupmann-Utne-Hatfield (1978) Scale was used. This repeats the 25 areas of the 1977 Scale and the instructions for response, but is different in that the respondent is requested to make the "calculation" internally as to whether in this area the partner or the respondent is "getting a better deal," or whether respondent and partner are equal for this area.

On pre-tests of a revised version of the 1977 Scale with samples of male and female college students, Traupmann, Utne and Hatfield found that when asked to calculate mentally "who gets a better deal" over only four very broad areas labelled Personal, Emotional, Day-to-Day, and Opportunities Gained and Lost, the validity of a scale this brief was confirmed. In essence, the experimenters found that requesting the subject to "do the calculating" internally was as effective as the more laborious 1977 Scale (Traupmann, Hatfield, & Wexler, Note 6). For this study the longer 25 area version of the scale was chosen rather than the four

area version, in the interest of potentially finer post hoc analysis of the relationship dynamics of the couples studied. The portions requesting a rating of "How important is this to you?" were not used to weight responses by the subjects because they had not been used previously in the calculation of reliability and validity for the other versions of the scale.

The next portion of the questionnaire was labelled Section D for the subjects' convenience and forms Appendix H. This is the Dyadic Adjustment Scale, created by Spanier (1976) as a tool for assessing the quality of marriage and other similar dyads. It was included in the study to provide a measure of marital satisfaction with well standardized reliability and validity. In this way the relationship between equity/inequity scores and a marital satisfaction measure could once again be explored for this sample population, and the predictive validity of the Taylor Role Questionnaire could be examined.

The next to last portion of the questionnaire was labelled Section E and forms Appendix I. It consisted of nine open-ended questions regarding the experience of the respondent as either a person in medical education or the spouse of such a person, or both. Respondents were told they could make their answers as long or as short as they desired. In fact, some respondents did not complete this section at all, although this was unusual. These questions were phrased to elicit the ways in which the respondents might perceive overbenefit or underbenefit "accumulating" in their lives, and their ideas about how in the future this inequity (if it was

perceived) might be restored. Analysis of this portion of the questionnaire requires training of independent raters, and as will be noted in the discussion of results, this was not possible at the time of the present study.

The final portion of the questionnaire as mailed to the subjects was labelled the Stress Adjustment Scale. This forms Appendix J, and is included only because it could conceivably have affected answers to the other portions of the questionnaire. This scale was a pilot measure for Ms. Dorothea Torstenson, who is a research colleague of the investigator and a researcher interested in studying the effects of stress on medical students from the viewpoint of family organization theory. Ms. Torstenson was an official co-investigator for the study during review by the University of Wisconsin, Madison, Center for Health Sciences, Committee for the Protection of Human Subjects; and her name is mentioned as such in the Introduction and Consent form.

RESULTS

Statistical Treatment of the Data

All significance levels given in this study were for two-tailed tests.

Hypotheses Concerning Equity/ Inequity

Hypothesis 1.--For Hypothesis 1, a number of analyses of variance were performed. In a comparison of the entire sample, medical spouses were compared with non-medical spouses. The hypothesis was confirmed, as medical spouses saw themselves as significantly overbenefited on the TUH, in comparison to the non-medical spouses ($p < .004$). The mean for medical spouses was 0.94, versus -2.64 for the non-medical spouses. To see if separating out the dual-medical couples would alter this effect and to see if separating out the house staff and their spouses would alter the effects, further analyses were made. With the dual-medical couples removed, medical spouses saw themselves as significantly overbenefited ($p < .002$) compared to their non-medical spouses. The revised mean of 1.89 for medical spouses substantially exceeded the -2.64 mean for the non-medical spouses. Obviously the dual-medical spouses had lower mean scores on equity/inequity than their medical colleagues. Table 5 shows that the dual-medical mean score (-0.76) actually was one of slight underbenefit, although the

underbenefit was greater among the men (-1.04) than among the women (-0.48).

Removing all house staff couples and leaving only couples composed of medical students and their non-medical spouses, medical spouses saw themselves as significantly overbenefited ($p < .02$) as compared to their non-medical spouses. The mean for the medical student spouse was 2.23. For the non-medical spouse the mean was -2.22. See Table 4.

Hypothesis 2.--For Hypothesis 2, another series of analyses of variance were performed. On a direct comparison of all persons in medicine, comparing males versus females, the difference in equity/inequity scores was not significant. Interestingly enough, the direction of the scores was the reverse of that predicted. The mean for males was 1.82, while the mean for females was -0.09.

Removing the dual-medical couples, a comparison of all persons in medicine by sex revealed a similar but statistically insignificant result ($p < .11$). For the spouses within these non-dual couples (i.e., non-medical persons married to medical students or to house staff), the difference was significant ($p < .02$) but opposite to the predicted direction. Female spouses perceived themselves as more underbenefited than did male spouses. In fact, the mean for male spouses was one of very modest overbenefit.

TABLE 4.--Traupmann-Utne-Hatfield (1978) Scale Scores Comparing Medical Spouses and Non-Medical Spouses.

	Medical Spouse			Non-Medical Spouse			Probability Level
	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.	N	
Total Sample	0.94	8.52	140	-2.64	9.69	91	$p < .004$
Students and Residents and Their Non-Medical Spouses	1.89	8.91	90	-2.64	9.69	91*	$p < .002$
Students and Their Non-Medical Spouses	2.23	8.94	69	-2.19	9.27	69	$p < .005$
Residents and Their Non-Medical Spouses	0.76	8.92	21	-4.05	10.99	22*	$p < .124$

*Unequal N of residents and spouses due to inclusion of three persons in the sample without their spouses.

TABLE 5.--Traupmann-Utne-Hatfield (1978) Scale Scores (Females versus Males).

	Females			Males			Probability Level
	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.	N	
All Medical Persons	-0.09	8.66	64	1.82	8.36	76	$p < .19$
Medical Persons with Non-Medical Spouses	0.15	9.79	39	3.22	8.02	51	$p < .11$
Non-Medical Spouses	-4.71	10.79	52	0.13	7.22	39	$p < .02$
Medical Students with Non-Medical Spouses	0.45	9.57	29	3.53	8.34	40	$p < .16$
Non-Medical Spouses of Medical Students	-3.28	10.14	40	-0.69	7.85	29	$p < .26$
Dual-Medical Couples	-0.48	6.72	25	-1.04	8.48	25	$p < .79$

Removing the residents and their spouses, and continuing the same series of tests, in comparing medical students by sex, the difference was non-significant. The means once again were the reverse of the predicted direction.

For the non-medical spouse of the medical student, the trend continued, although statistical significance was not reached in the comparison by sex ($\bar{\sigma}$ = -0.69, $\bar{\varphi}$ = -3.28).

Given these values from one-way analyses, it was not surprising that (on a two-way analysis of variance of couples, with dual-medical couples excluded) medical persons were significantly ($p < .004$) overbenefited and females were significantly ($p < .004$) underbenefited, as shown in Table 6.

Hypothesis 3.--In an analysis of variance comparing the pooled groups of dual-medical couples and non-dual couples, across sex, no statistically significant difference was found. However, in a two-way ANOVA comparing medical persons who have non-medical spouses, the non-medical spouses, and dual-medical persons, the main effects for medical status and for sex were significant. These means were in the direction predicted, as medical spouses were overbenefited compared to the non-medical spouses. For females, dual-medical spouses had a mean between the other two groups. For the male group of dual-medical persons, the dual-medical spouses included four MD's, who were the only medical persons who were not in training. As a post hoc test, data were analyzed both with and without the scores from these MD's. With

TABLE 6.--Traupmann-Utne-Hatfield (1978) Scale Scores: Medical Students and House Staff and Their Non-Medical Spouses.

Sex	Medical Spouses			Non-Medical Spouses		
	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.	N
Female	0.15	9.79	39	-4.71	10.80	52
Male	3.22	8.02	51	0.13	7.22	39

Main effect for sex significant, $p < .004$.
Main effect for medical status significant, $p < .004$.

the MD's included, dual-medical spouses had a mean score below that for the non-medical male spouses. Removing four male MD's, however, shifted the mean for dual-medical males from -1.04 to 0.14, almost identical to the 0.13 mean for male non-medical spouses.

In the one-way ANOVAs suggested by this hypothesis, female medical students and house staff who are dual-medical spouses were not significantly different from female students/staff who were married to non-medical spouses. Among the male persons in medicine (MD's included), the dual-medical husbands felt significantly underbenefited compared to the male medical persons married to non-medical spouses, as predicted. Among the male persons in medicine with the MD's removed (so that the comparison was between two student/house staff groups), the difference approached significance ($p < .06$) and once again the mean was greater for non-dual males.

In summarizing the findings for Hypotheses 1, 2, and 3, the prediction that, in comparison to each other, medical spouses would feel overbenefited and non-medical spouses would feel underbenefited was strongly confirmed. In regard to sex differences, however, it was the medical males married to non-medical women who felt the most overbenefited, and their spouses who felt the most underbenefited. As shown in Table 7, it was this contrast that accounted for the main effects of sex and medical status. In dual-medical couples both partners felt somewhat underbenefited, although the difference between partners was slight.

A post hoc analysis of variance of discrepancy scores on the Taylor Role Questionnaire was performed to further probe these

TABLE 7.--Traupmann-Utne-Hatfield (1978) Scale Scores Comparing Medical Persons, Non-Medical Persons, and Dual-Medical Couples.

Sex	Medical Persons (Non-Dual)			Dual-Medical Couples			Non-Medical Spouses		
	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.	N
Female	0.15	9.88	39	-0.48	6.72	25	-4.71	10.80	52
				MD's In					
				-1.04	8.48	25			
Male	3.22	8.02	51				0.13	7.22	39
				MD's Out					
				0.14	8.40	21			

Main effect for sex significant, $p < .02$.
Main effect for medical status significant, $p < .01$.

results. Statistically significant differences in perceived role conflict were found. Role conflict was operationally defined as the discrepancy between perceived performance minus perceived expectations on the TRQ. For the TRQ Subrole II, Emotional/Sexual/Supportive Partner, the difference was significant ($p < .04$). Women married to medical spouses had a mean score of -4.35. Dual-medical women had a mean score of -5.24 and medical women with non-medical spouses had a mean score of -7.10. For Subrole I, Homemaker, and for Subrole III, Social Partner, the means fell in the same direction, although the probability levels differed as given in Table 8. Interpretation of these values, however, is weakened by the poor reliability of these difference scores.

For the spouses of these women, there were significant differences only on the Homemaker Subrole, where men in medicine married to non-medical women saw themselves as significantly "ahead." See Table 9. Apparently the women in medicine did perceive role conflict as defined in this study, but rather than feeling uncomfortable and overbenefited, they took it in stride. Of course, role conflict as defined here was based on the traditional wife role.

Hypothesis 4.--A Pearson r was calculated on the entire sample, correlating the score on the Spanier Dyadic Adjustment Scale and the absolute value of the score on the TUH, such that greater amounts of inequity (either overbenefit or underbenefit)

TABLE 8.--Taylor Role Questionnaire Scores for All Females: Role Conflict Score (Performance Minus Expectations).*

Subrole	Describing Themselves			Probability Level
	Non-Medical Women N=52	Dual-Medical Women N=25	Medical Women with Non-Medical Spouses N=39	
I: Homemaker	2.63	-0.32	-1.64	$p < .0001$
II: Emotional/Sexual/ Supportive Partner	-4.35	-5.24	-7.10	$p < .04$
III: Social Partner	-1.13	-2.20	-2.21	$p < .02$

*All one-way analyses of variance.

TABLE 9.--Taylor Role Questionnaire Scores for All Males: Role Conflict Score (Performance Minus Expectations).*

Subrole	Describing Their Wives			Probability Level
	Medical Men with Non-Medical Spouses N=51	Dual-Medical Men N=25	Non-Medical Men N=39	
I: Homemaker	2.65	0.08	-0.44	$p < .007$
II: Emotional/Sexual/ Supportive Partner	-0.76	-1.32	-1.08	$p < .94$
III: Social Partner	0.10	0.92	-0.03	$p < .19$

*One-way analyses of variance.

were correlated with the marital satisfaction score. A correlation was found of -0.30 ($p < .0001$).

This result confirmed the theoretical premise that either perceived overbenefit or perceived underbenefit is not a comfortable position in a marital dyad. It also supported the construct validity of the Traupmann-Utne-Hatfield (1978) Scale.

Hypotheses Interrelating Role Conflict, Equity, and Androgyny

Hypothesis 5.--For the sample of female medical persons and their spouses, a Pearson r was calculated to determine the possible correlation between the discrepancy scores of the Subroles of the TRQ and the absolute value of the score on the TUH equity/inequity measure. Two significant correlations were found, for Subrole II, Emotional/Sexual/Supportive Partner, at -0.19 ($p < .02$) and for Subrole III, Social Partner at -0.17 ($p < .03$). The correlation for Subrole III, Social Partner, however, has relatively little meaning as the reliability level of this discrepancy score was so poor (see Measures section). The correlation for Subrole II suggested that, as predicted, when the discrepancy score increased its numerical value (implying the woman was coming closer to or surpassing expectations), perceived inequity diminished. For Subrole I, Homemaker, there was a correlation of -0.14 ($p < .07$). The correlation was not computed for Subrole IV, Child Care, because of its greatly reduced sample size (16 couples with children).

These findings tended to support the construct validity of the TRQ. For this group of individuals it would be logical to have

less investment in a wife's performance of the task-oriented behaviors in Subrole I, Homemaker, than in her performance of the emotionally oriented aspects of Subrole II. However, the predictive power of the discrepancy score on Subrole I was weakened due to the fairly high correlation between part (A) and part (C), and the resulting reliability estimate of 0.34 for that discrepancy score. Therefore, the lack of correlation may be due in part to this low reliability. Persons who are women in medicine or their spouses would also be more likely to find Subrole II, Emotional/Sexual/ Supportive Partner, more important than Subrole I, and apparently this was the case. Because this correlation accounted for less than 4% of the shared variance of the measures, this point should not be overemphasized.

Hypothesis 6.--In a comparison of the means and standard deviations on the Bem Sex-Role Inventory (BSRI), the 64 female medical persons had a mean masculinity score of 4.78, with a standard deviation of 0.48. For the femininity score, their mean score was 5.02, with a standard deviation of 0.38.

For 279 Stanford University undergraduate women in Bem's (1974) sample, the mean masculinity score was 4.57, with a standard deviation of 0.69, and the mean femininity score was 5.01, with a standard deviation of 0.52.

For the 52 non-medical women in this study, their mean masculinity score was 4.37, with a standard deviation of 0.76, and

their mean femininity score was 5.21, with a standard deviation of 0.51.

Student's t-tests were performed and the statistical significance evaluated, taking into account the differences in variance between the samples. Medical women's mean masculinity and femininity scores significantly ($p < .02$) exceeded those of both the undergraduate women and the non-medical women in the study. Therefore, the hypothesis was confirmed.

The small BSRI standard deviations among the medical women seem noteworthy, and sharply decreased the likelihood that the Bem scores could have predictive power.

Hypothesis 7.--A multiple regression equation was calculated four times, with the dependent variable being each of the four Subrole scores for part (A) of each of the TRQ questions, and the independent variables being (1) BSRI masculinity score; (2) BSRI femininity score; and (3) the product of those two scores. None of the resulting beta weights attained significance, so Bem scores were not significant predictors and in this sample increasing androgyny did not significantly predict the level of expectations of feminine spouse behavior for the female medical persons.

Hypothesis 8.--For all women in medicine, a multiple regression equation was again calculated, with each of the four Subrole scores of the TRQ for part (C) as the dependent variable and the BSRI scores as the independent variables. As had been

hypothesized, the Bem scores did not significantly predict level of performance.

Hypotheses Concerning Level of Androgyny of Spouses

Hypothesis 9.--Four multiple regression equations were performed using as dependent variables each of the four Subrole scores for part (A) of the TRQ. The sample examined included the female medical persons and their spouses, and beta weights were determined to see if the BSRI scores were significant predictors in the case of husbands, wives, or both. The only significant predictors were status as husband or wife. The androgyny measure continued to have no predictive power.

To examine the reason for the husband/wife difference, a post hoc ANOVA was performed, examing the (A) scores on the four Subroles with comparisons by sex. For all four Subroles the women expected significantly more of themselves than did their husbands. This did not contradict anything previously hypothesized. It supported the assumption that women in medicine continue to be influenced by the traditional expectations for women. Further post hoc analyses would be desirable, however, to see if this finding is true only among women in medicine, or if it is true for women in general. See Table 10 for a complete presentation of data for these one-way analyses.

Hypotheses 10 and 11.--Since Hypothesis 7 was not confirmed, it was improbable that Hypothesis 11 would be confirmed. Four

TABLE 10.--Female Medical Persons and Their Spouses: TRQ_A Scores--Level of Expectations.

Subrole	Females (N = 64)		Males (N = 64)		Probability Level
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	
I: Homemaker	27.59	4.47	23.70	4.29	$p < .00001$
II: Emotional/Sexual/ Supportive Partner	43.09	3.30	37.77	5.20	$p < .0001$
III: Social Partner	10.55	2.01	9.34	2.08	$p < .002$
IV: Child Care (N = 16 each sex)	18.06	3.43	15.50	3.50	$p < .05$

multiple regression equations were calculated, with the discrepancy scores (C minus A) on each of the four TRQ Subroles as dependent variables and the Bem scores and status as husband or wife as independent variables. As in Hypothesis 9, the androgyny measure had no predictive significance. The low reliability of discrepancy scores on Subroles III and IV weakened, of course, the likelihood that difference scores on these Subroles would respond as had been theorized. However, even the relatively more reliable Subrole II, Emotional/Sexual/Supportive Partner, discrepancy score was not predicted by the Bem scores.

There was, however, significant prediction by status as spouse. Post hoc one-way analyses of variance were performed on the four Subroles. As shown in Table 11, in Subrole II, Emotional/Sexual/Supportive Partner, and in Subrole III, Social Partner, the woman in medicine saw herself as doing a "much worse job" than her husband perceived her as doing. Yet despite a significant correlation between their own perceived inequity and the TRQ discrepancy scores (Hypothesis 5), these women did not perceive themselves as greatly overbenefited (letting down husband). This could be explained several ways. A possibility is that this measure of discrepancy was limited because it was based on the traditional role only. If these women value themselves for less traditional behaviors and their husbands do likewise, their discrepancy in these areas may not markedly influence overall happiness or satisfaction.

TABLE 11.--Female Medical Persons and Their Spouses: TRQ_{C-A} Scores--Performance Minus Expectation (Role Conflict).

Subrole	Females (N = 64)		Males (N = 64)		Probability Level
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	
I: Homemaker	-1.13	4.29	-0.23	4.29	$p < .25$
II: Emotional/Sexual/ Supportive Partner	-6.38	4.95	-1.17	6.87	$p < .00001$
III: Social Partner	-2.20	2.03	-0.38	2.33	$p < .00001$
IV: Child Care (N = 16 each sex)	-0.50	2.13	-0.44	2.53	$p < .95$

Second, it has been determined in a number of studies that the husband's perceptions are more predictive of marital satisfaction and adjustment than are the wife's perceptions (Barry, 1970; Luckey, 1960a). This finding may be reflected in this study by a high expectation by the wife for being emotionally available to her spouse. The husbands may be somewhat more realistic about the extent to which they expect their wives to be emotionally available. Accordingly, the husbands did not feel "let down" by the wives, and possibly this accounted for the fact that neither medical wives nor their husbands perceived much inequity.

Hypothesis 12.--A Pearson r was calculated for the discrepancy scores of female medical persons and their spouses for each of the three Subroles of the TRQ which hold substantial sample size. Two of these correlations were significant. For Homemaker, the correlation was 0.50 ($p < .0001$). For Emotional/Sexual/Supportive Partner, the correlation was 0.29 ($p < .02$).

Hypothesis 13.--In light of the fact that Hypotheses 10 and 11 were rejected and that the Bem scores had no predictive power in hypotheses tested thus far, it was unlikely that Hypothesis 13 would be confirmed. In two regression equations the BSRI scores for female medical persons and their spouses failed to significantly predict either the Dyadic Adjustment Scale score or the absolute value of the score on the Traupmann-Utne-Hatfield (1978) Scale.

Hypothesis 14.--Analysis of this hypothesis requires access to independent raters who can evaluate the written responses to the open-ended questionnaire while remaining blind to the hypotheses of the study and the equity/inequity scores of the individuals. Such raters were not accessible at the time of the present quantitative analysis. A post hoc analysis of these written answers is planned.

Hypotheses Concerning Demographic Variables

Hypothesis 15.--A multiple regression equation was calculated with data from the entire sample. The dependent variable was the Spanier Dyadic Adjustment Scale score and the independent variables were number of years married, number of children, and status as either medical student, intern/resident/spouse of a student or spouse of a resident. Individuals in dual-medical couples were identified by their medical status if they were students or residents. None of the independent variables in combination did not significantly predict the Spanier score. This confirmed the hypothesis that within this sample these demographic variables were not strongly influential.

An Attempt to Estimate Predictive Power

Hypothesis 16.--On the basis of the preceding hypotheses, a multiple regression equation was calculated for the entire sample. The dependent variable was the score on the Dyadic Adjustment Scale and the independent variables were the absolute value of the score

on the Traupmann-Utne-Hatfield measure, the four discrepancy (role conflict) scores on the TRQ, and the three possible BSRI scores, masculinity, femininity and the product of the masculinity and femininity scores.

In the resulting equation five of the variables achieved a significant F level at $p < .05$. Three were significant at better than the $p < .01$ level. In order, these were the role conflict score on Subrole II (Emotional/Sexual/Supportive Partner), the femininity score on the BSRI, and the absolute value of the equity/inequity score on the Traupmann-Utne-Hatfield (1978) Scale. For all the independent variables, standardized beta weights, F values, and simple correlations with the dependent variable are presented in Table 12.

Discussion

The Taylor Role Questionnaire

The present findings suggest that the Taylor Role Questionnaire had satisfactory internal consistency for three of its four Subroles. However, the reliability of discrepancy scores was low for Subrole I (0.34) and essentially zero for Subroles III and IV. Accordingly, only Subrole II, Emotional/Sexual/Supportive Partner, has moderately high internal consistency for both responses to parts (A) and (C), and also for the discrepancy score calculated by subtracting (A) from (C). Subrole II received some construct validation by showing significant correlations, as predicted, in Hypotheses 5 and 12.

TABLE 12.--Relative Predictive Power for Variables in this Study: Dependent Variable--Marital Satisfaction (Score on Spanier Dyadic Adjustment Scale).

Independent Variable	Standardized Beta Weight	Simple Correlation to Dependent Variable	F	Probability Level
Discrepancy Score on TRQ Subrole II (Emotional)	.31	.31	18.85	$p < .01$
Femininity Score on BSRI	.28	.39	13.12	$p < .01$
Absolute Value of Inequity Score (TUH)	-.19	-.26	10.33	$p < .01$
Product of Masculinity and Femininity Scores on BSRI	.20	.13	5.137	$p < .05$
Masculinity Score on BSRI	-.21	-.13	4.63	$p < .05$
Discrepancy Score on TRQ Subrole I (Homemaker)	-.10	-.05	2.28	$p < .05$
Discrepancy Score on TRQ Subrole III (Social)	.03	.23	0.24	$p < .05$
Discrepancy Score on TRQ Subrole IV (Child Care)	-.003	.02	0.003	$p < .05$

Hypotheses Concerning Equity/ Inequity

The significant findings of Hypotheses 1, 2, 3, and 4 supported the view that within the medical marriage the medical spouse tends to feel that he or she is "getting a better deal" while the non-medical spouse feels he or she is "getting a poorer deal." Although true as an overview, this sense of overbenefit seemed to come most strongly from the male medical student married to a non-medical wife, and the sense of underbenefit came largely from the non-medical wives of interns/residents (Table 5).

The predictions that women in medicine would feel even more overbenefited than their male counterparts and that their spouses would feel more underbenefited than the wives of medical persons were not confirmed. Within the sample women perceived themselves as significantly underbenefited as compared to men. This was due to (a) the greater sense of underbenefit perceived by the non-medical wives, (b) the relatively small sense of overbenefit experienced by the female medical persons with non-medical spouses, and (c) the underbenefit (though very small) perceived by women in dual-medical couples.

Inevitably there are many possible reasons for these findings, and without further exploration they must remain speculative. However, the present data suggest that women in medicine and their spouses, either in medicine or not, have adjusted relatively well to the situation and are not in fact distressed by the wife's career role. The main exceptions to this rule were the dual-medical

MD husbands. Their mean inequity score averaged much lower than any other group examined, although there was a considerable range within this group. Since these persons were no longer in training, perhaps the element of identification with a medical student/house staff wife has been reduced, and they felt entitled to more from their wives. The literature on medical socialization suggests that after residency training is finished, physicians work as hard or even harder than they did when they were residents. Perhaps these four men have followed that pattern and now experience themselves as needing more from their wives and also putting more into the relationship in terms of income and prestige. All of these factors could increase their perceived inequity.

The finding that, on the whole, the women in medicine and their husbands perceived rather little inequity was surprising in view of the fact that these women had high expectations for themselves in the female spouse role and saw themselves as failing to reach those expectations (Tables 10 and 11). For women in medicine and their spouses there was also a significant ($p < .02$) correlation, although small (-0.19), between discrepancy scores on the more reliable Subrole II, Emotional/Sexual/Supportive Partner, and amount of perceived inequity.

The assumption that discrepancy between performance and expectations was attributed to being in medicine received empirical support. Part (D) of each question asked "To what extent is your behavior (in this area) influenced by . . . (your occupation [for non-medical wives]/being a medical student or intern/

resident [for medical wives])?" In t-tests comparing the means of answers to this question, medical women had significantly higher scores for Subroles I, II, and III. In other words, as compared to the non-medical wives working outside the home, being in medicine had greater impact upon the wife role than other occupations had.

By contrast, the husbands of medical and non-medical women saw a significant difference only for Subrole II, Emotional/Sexual/ Supportive Partner. On that Subrole husbands viewed medicine as having more impact than other occupations.

Evidently there is a flaw in the logic which hypothesized that a woman who sees herself as not performing the behaviors she expects of herself must experience this as inequity, i.e., getting more from her spouse than she is giving. Perhaps the correlation between discrepancy score and perceived inequity was due to husbands alone, rather than their wives. A number of other explanations are also possible. As noted above, perhaps these women are holding up rather unrealistically high expectations for themselves. They are likely to be high achievers; perhaps they set high goals for themselves in these areas as well. However, it may be that not meeting these goals is simply not overwhelmingly important to these women, so it does not induce feelings of distress or guilt, or any of the other emotions that might be imagined to accompany perceived inequity.

In addition, the women's spouses perceive less discrepancy between expectation and performance than do their wives. The wives

must be aware of their husbands' points of view; perhaps the wives' perceptions of inequity in fact has more to do with their husbands' sense of the level to which they are "failing at the job" than their own. This would be in accord with the marriage research previously cited, showing that the most powerful predictors of marital satisfaction and adjustment were the husbands' perceptions about the relationship (Barry, 1970; Luckey, 1960a).

It is also possible that these women see themselves as making contributions to their marriage that were untapped by the TRQ. These might be aspects outside the traditional wife role, but such non-traditional inputs are likely to be extremely important for these couples. In that way a lack of input from the wife in the more traditional aspects could be balanced back to equity.

In contrast to the women in medicine and their spouses, the non-medical wives and their medical husbands are, by the definitions of equity theory, experiencing distress. This difference may be attributable to the fact that for almost all men married to women in medicine, they have an active career and often one of equal status. Of course, roughly 40% (25 of 64) of the women in medicine in this study were married to other physicians or future physicians. An unsystematic inspection of the data suggested that non-medical wives were much more likely to be cast in the role of the support person of the two-person career than were the husbands of women in medicine. These wives were more likely to be in a job which was apparently to support the couple, rather than a job which provided a distinctive and active career.

It is equally possible that this support role prevented the wife from being a homemaker and starting a family if that were her preference. In line with these possible reasons for perceived inequity, it will be especially interesting to examine the open-ended questions, in particular to review what these wives state that they miss most and what changes they anticipate subsequent to medical training.

The finding that non-medical wives felt underbenefited and their husbands felt overbenefited is also interesting in light of an examination of the Spanier marital adjustment scores for these groups. As shown in Table 13, two post hoc analyses of variance compared the groups of (1) medical persons married to non-medical persons, (2) dual-medical persons, and (3) non-medical spouses, for each sex. The women showed no significant differences in marital happiness or adjustment scores. There was a statistically significant difference ($p < .02$) among the males. Non-medical spouses had the highest mean score (115.1), medical spouses were next highest (110.8), and dual-medical males were lowest (107.8). The MD's mean was 111.3.

Obviously the non-medical women felt strongly under-benefited (as confirmed in Hypotheses 1, 2 and 3) but did not describe themselves as significantly less happy in their marriages, despite a significant inverse correlation (-0.30) between marital happiness score and perceived equity/inequity score (Hypothesis 4). This incongruity may be partially attributed to the relatively modest correlation, since it accounts for only 9% of the shared

TABLE 13.--Dyadic Adjustment Scale Scores Comparing Medical Persons, Non-Medical Persons, and Dual-Medical Couples.

Sex	Medical Persons (Non-Dual)			Dual-Medical Couples			Non-Medical Spouses			Probability Level
	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.	N	
Female	112.18	11.85	39	110.80	11.38	25	112.46	11.73	52	$p < .84$
Male	110.75	11.36	51	107.76	9.96	25	115.05	8.71	39	$p < .02$

variance despite its statistical significance. A number of other explanations are possible. This could be an area in which responses are biased by the knowledge that it is more socially acceptable and desirable to describe one's marriage as happy. The Spanier scale assesses marital satisfaction quite overtly, and was so characterized in the initial telephone contact with potential subjects. It is also possible that underbenefited spouses, despite the instructions of this study, justified their present inequity to themselves with a rationale that it would be balanced out by future rewards, and therefore the marriage on the whole leaves them content.

Finally, a number of authors have pointed out that while married women report symptoms and problems, such as feelings of depression, being unhappy most of the time, sometimes feeling like they are about to go to pieces, and being bothered by pains and ailments, to a greater extent than do unmarried women, they also report that they are happy more often than do unmarried women (Bernard, 1972a, 1972b; Donelson, 1977). How is this apparent paradox possible? One explanation is that these women are on the whole happy and fulfilled in spite of their problems, or in the instance of this study, despite their perceived inequity. They have been taught to value the nurturant role of wife, and possibly the role of the support partner in the two-person career, and to find that satisfying. Alternatively, perhaps these women are confusing "happiness" with adjustment to the expectations held by themselves and the society. Having married, which they understood to be the only appropriate thing for a woman, they are trying to

adjust to marriage and please their husbands. They may interpret their conformity to societal expectations as a signal of assurance of happiness and health (Bernard, 1972a, 1972b; Donelson, 1977). For the non-medical wives this could be very much the case, because to "marry a doctor" is in many ways the ultimate success in conforming to the expectations of this society. It might be paraphrased: "I must be happy. I'm married, aren't I, and my husband's going to be a doctor." If this is true, the literature on the physician marriage suggests that such a basis for satisfaction may not be very reliable.

In contrast to the medical/non-medical couple, for dual-medical couples their equity/inequity scores are much closer to equity and they are less likely to experience distress. However, since both partners perceive a small amount of underbenefit, these dual-medical couples apparently suffer from a sense of "not enough to go around." Each spouse, especially the males, seems to think that the other one really should be doing a little more. This does not seem surprising in the light of the complex life-style required by dual-career marriages.

It should be noted that throughout this study there is a distinct possibility of response bias, since the researcher presented her interests very openly in the initial telephone contact with subjects and also in all the introductory information. This included a direct statement that her prime interests were in women, in this case women in medicine and non-medical wives, and in dual-career marriages. Some of the professed contentment of women

in medicine and their spouses, as displayed on the Traupmann-Utne-Hatfield (1978) Scale, might be attributed to an effort to "look good." However, such an effort would likely have also extended to the males in medicine and to their wives.

Hypotheses Interrelating Role Conflict, Equity, and Androgyny

The attempt to predict scores on the Taylor Role Questionnaire from the androgyny scores of the Bem Sex-Role Inventory encountered two methodological problems. In the first place the very low internal consistency values of the TRQ expectation scores for Subrole III, Social Partner, were such that predicting them would have been unlikely even if the theoretical premise were entirely correct. Furthermore, the low reliability level for Subrole I discrepancy scores and the zero reliability level for Subrole III and Subrole IV discrepancy scores suggest again that predicting them would have been unlikely even with accurate theory.

The second methodological problem was that the range of the Bem scores was so limited for the female medical persons that it would have been difficult to predict any other score from these minor differences.

Given these methodological problems, it was difficult to evaluate whether the theoretical construct is totally at fault or not. In post hoc analyses, numerous regression equations were constructed to see if the Bem scores would significantly predict expectation, performance, or discrepancy scores for either the sample of non-medical women, or the sample of all women in the

study. Of course at least the scores for Subrole II, Emotional/Sexual/Supportive Partner, should have been reliable enough to be predicted. A number of the TRQ scores were predicted at statistically significant levels by Bem scores, but these varied greatly depending on the sample being examined. Also in several cases there was a more or less spurious significance, since the "significant" independent variable had very little simple correlation with the dependent variable. While it appears from Hypothesis 14 that at least the femininity score may have some predictive power for marital adjustment, androgyny does not appear to have a strong effect on role expectations or performance.

There are at least two possible theoretical explanations for this lack of predictive power. Kaplan (1979) pointed out that while Bem (1975, 1976) implied that situationally appropriate behavior, flexibility, effectiveness, and integration are being measured by finding a balance between masculinity and femininity, this is a possible but not a necessary outcome. To put it another way, one can have high levels of both masculine and feminine attributes and apply them in inappropriate, counterproductive, and poorly integrated ways. Kaplan and her therapy practicum students gave the BSRI to their incoming clients and found that, for these women, androgyny represented what they termed a dualistic stage. Here the masculine and feminine attributes remained polarized and each trait was independent of the other. The individual in such a situation can choose to apply (appropriately or inappropriately) either masculine or feminine attributes in any given situation.

Kaplan looked forward to a further development which she termed a hybrid stage in which ". . . anger is tempered by love, rather than love being incompatible with anger; (and) dependency is tempered by assertiveness, rather than assertiveness being threatened by the recognition of one's dependency needs" (pp. 226-227). In short, increasing androgyny may predict an individual who is flexible enough to alter her expectations for herself in the feminine spouse role, but this is not necessarily going to be the case.

Second, as Orlofsky (Note 2) stated ". . . sex roles may not be a unitary phenomenon (comprising closely related personality traits, interests, attitudes and role behaviors) as traditional conceptions and even some current conceptions seem to presume . . ." (p. 11). Spence (Note 3) pointed out that many sex-role behaviors are only weakly related to masculine and feminine personality traits. For example, behaviors with strong social norms such as sex-typing of career choice, sexual preference, and even attitudes toward the roles of men and women tend to be closely related to gender but weakly related to within-sex differences in masculine and feminine personality traits (Spence, Note 3). By these accounts it is far from theoretically certain that increased androgyny would indeed predict a decrease in expectations for the feminine spouse role.

From this study it also appears that the significantly more "traditionally feminine" woman in medicine who is very uncomfortable deviating from a traditional role probably does not exist. It is

certainly possible that the rigors of pre-medical training have eliminated such persons long before medical school.

Hypotheses Concerning Level of Androgyny of Spouses

The hypothesis that increasing androgyny in husbands would predict decreasing expectations for feminine spouse role behavior was rejected. A very recent study by Orlofsky (Note 2) on psychological androgyny and male-female attraction in fact suggested that even persons who are androgynous continue to describe as their ideal partner someone who is sex-typed. In his study, masculine-typed males described as ideal partners women closer to the androgynous range than did androgynous males. Androgynous men described as ideal partners women who were feminine, rather than androgynous. If the more androgynous male finds the more feminine female attractive, it seems possible, but by no means certain, that he would also find an increase rather than a decrease in feminine spouse role behavior desirable.

This is, of course, only one possible reason for the rejection of the hypothesis. It is also possible, as noted above, that these expectations are simply not strongly tied to an individual's level of psychological androgyny.

An Attempt to Estimate Predictive Power

The regression equation of Hypothesis 16 suggested that in the present sample demographic factors such as number of children or years married were not predictive of marital satisfaction level.

Instead three of the variables examined in this study had predictive significance at $p < .01$ and at least modest correlations with the dependent variable, marital satisfaction score. These three variables were the BSRI femininity score ($r = .39$), the discrepancy score or role conflict score on the TRQ for Emotional/Sexual/Supportive Partner ($r = .31$), and the absolute value of the score on the Traupmann-Utne-Hatfield (1978) Scale ($r = -.26$). As the femininity score had shown such inconsistent predictive power in regression equations involving all the women in the sample, further post hoc analysis will be required to explain its influence. It is possible that an increasing femininity score among men is predictive of increasing marital satisfaction for them. It could be argued that this would suggest a more emotionally sensitive and adept man, who might be a better partner and part of a happier marriage.

The correlation between the role conflict score for Emotional/Sexual/Supportive Partner and marital satisfaction suggests that this portion of the wife role may have been seen as important by the entire sample.

The influence of the inequity score has already been discussed, but it is interesting to note once again that it has predictive power for the marital happiness score. The finding that non-medical wives experience inequity and yet report themselves as happy remains unexplained. Perhaps further post hoc analysis will reveal stronger influences from the BSRI femininity

score or the role conflict score which outweigh the influence of the equity/inequity score.

Conclusions

The results of this study suggest that while the medical marriage may never be easy, the view that it holds more difficulties for the woman in medicine than the man is probably incorrect. It seems that the focus of future research should probably center upon the male in medicine and his non-medical wife, as they are experiencing inequity at its greatest level. However, this will require careful exploration, as the women in this study reported themselves as equally happy in their marriages, while among the men the dual-medical husband was least happy, the medical husband with a non-medical wife reported himself next happiest, and the non-medical husband with a medical wife reported himself happiest.

This study originally postulated that persons who experience a considerable amount of inequity will anticipate a "balancing" time for restoration of equity later in the marriage. This was to be examined in this study because such restoration of equity, if it is expected in terms of increasing time and attention from the medical spouse, is unlikely. The disappointment of such an expectation could be a serious strain upon a medical marriage.

In the absence of analysis of the open-ended questions, this hypothesis remains untested. After these data are examined there should be considerably more information which could help

persons in the medical marriage examine realistically their future plans.

While this study attempted to pinpoint factors in relationships and personality variables that would influence the way couples dealt with medical education, it did not approach the more clinical area of how to actively assist couples in this coping process. There are evidently two ways to go about this: assist the couples to change their less successful behaviors, or alter the way medical education is presently structured. One of the subjects in the study commented that he and his wife managed their life style by being part of a group of dual-career couples who met socially, exchanged child care, and generally provided a supportive network. Such successful support systems deserve research attention.

From the other viewpoint, another subject remarked pointedly, "Why doesn't someone change the system to reduce the stress, instead of studying ways to cope with it?" Why not, indeed? At present the system of medical education shows little sign of altering, and in fact has little impetus to do so while there are many applicants for few places, both in medical school and the more desirable residencies. There seems to be relatively little consideration of the idea that time to be a spouse or parent might make one a better physician, or a doctor who lived longer and suffered less from the ills that plague the profession (Stuff, Note 4). Until persons within the profession and medical educators are more open to that viewpoint, future research in this

area will, of necessity, focus upon factors which influence stress and the ways to cope with it.

NOTES

NOTES

[1]Bem, S. L., & Watson, C. Scoring packet: Bem Sex-Role Inventory. Unpublished manuscript, April 1976. Available from Department of Psychology, Uris Hall, Cornell University, Ithaca, New York 14863.

[2]Orlofsky, J. Psychological androgyny and male-female attraction. Paper presented at the meeting of the American Psychological Association, New York, September, 1979.

[3]Spence, J. T. Traits, roles, and the concept of androgyny. Paper presented at the conference on Perspectives in the Psychology of Women, Michigan State University, East Lansing, May, 1977.

[4]Stuff, P. Myths regarding practice patterns, productivity, and careers: Research review. Paper presented at the first annual meeting of Women in Medicine in Wisconsin, Marc Plaza Hotel, Milwaukee, Wisconsin, May 10, 1979.

[5]Traupmann, J. Equity restoration and friendship. Unpublished manuscript. University of Wisconsin, Madison, 1975.

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APPENDICES

APPENDIX A

A CAUTIONARY TALE

APPENDIX A

A CAUTIONARY TALE

Once upon a time a young woman could not decide if she wanted to go to medical school or to graduate school. She felt she was probably interested in becoming a psychotherapist in either case, so she sought out persons to tell her about both. She was concerned about combining a career and a family life for herself.

At her local college counseling center she spoke to a psychiatrist, who told her he "did not know a single woman psychiatrist who was happily married." He also stated he was glad he personally had married a teacher and not a dumb nurse (like his classmates), because now his son was smart enough to get into medical school. When the young woman pointed out that apparently his wife and child existed in his view only for his benefit, he was surprised.

The young woman did not go to medical school. In the broadest sense, this study is dedicated to all persons, past, present and future, who are changing the world so that it will be harder to see it as he did.

APPENDIX B

GENERAL INSTRUCTION SHEET

APPENDIX B

GENERAL INSTRUCTION SHEET

MEDICAL EDUCATION AND MARRIAGE STUDY

General Instructions:

Please first read the enclosed Introduction and Consent Form.

Then sign your name to both copies of the form, and retain one for yourself, and return one copy to the study. Your partner will do the same.

Fill out the rest of the questionnaire at your leisure. It is recommended that you fill out the questionnaire in the order given, and that you complete a section at a sitting. You may notice that similar information is asked in several different ways--please bear with that. Do not "labor over" completing the questionnaire--the entire process should take roughly an hour. When you have finished the questionnaire, just put in into the enclosed envelope and mail it back.

Please do not discuss the contents of the questionnaire with your spouse until you have both finished it.

Thank you very much for participating in the study. If I have not received the form back from you in roughly ten days, I will be contacting you by telephone. If you have any questions, don't hesitate to call me, Meredith Taylor, 233-8882.

APPENDIX C

INTRODUCTION AND CONSENT FORM

APPENDIX C

MEDICAL EDUCATION AND MARRIAGE

INTRODUCTION AND CONSENT FORM

The purpose of this study is to utilize certain personality theories and theories about relationships to look at the impact of medical education on the marriages of medical students, medical house staff, and their spouses. Medical students and house staff were selected as a group to be studied partly because theirs is a particularly demanding and time consuming profession, both as a student and as a practitioner. It is hoped that this study will increase understanding of the kinds of stress medical education places on marriage, and will enable couples to tolerate the stress more comfortably. Meredith Taylor and Dorothea Torstenson are the principal investigators for this study. There are several aspects of this study, and the portion with Meredith Taylor as principal investigator will give some special emphasis to the activities of the female spouse, and to the female medical students or house staff and their spouses. This is because female medical students/ house staff are usually part of a dual-career marriage (both spouses involved in a career). Although of course many male students/house staff are also part of a dual-career marriage, women within marriage and dual-career relationships are two of Ms. Taylor's areas of special interest.

For the study you and your spouse will be asked to complete a questionnaire, described below. You will have roughly a week's time to complete it. As it states on the forms themselves, just fill them out at your leisure. It is recommended that you finish a section at one sitting, and you are asked to finish them in the order given. Please don't discuss the questions or your answers with your spouse until both partners have finished the study. This is to avoid influencing each other's answers. In addition, please don't discuss the study with your friends or colleagues, since they may also be taking part. The study will be completed by roughly June 1, 1979, so you could discuss it freely after that time.

Roughly a week after you have received the packet in the mail, you will be contacted by Meredith Taylor or Dorothea Torstenson by telephone. She will check on whether you have finished the questionnaire and have had a chance yet to mail it back. As soon as the forms are received from both partners, a check for $10.00 per couple will be mailed to you, as a way of thanking you for your participation. The funds will be supplied by the investigators and Michigan State University.

In the questionnaire you will be asked (1) some general information about yourself (age, education, etc.), (2) to describe yourself, (3) to describe what the wife of the couple is expected to do under ideal circumstances, and what she can actually do right now, (4) to describe your marriage in more general terms, looking especially at "give and take," (5) to evaluate how satisfied you are with your marriage right now, (6) to comment on some open-ended questions about the effect of medical education on your marriage, and (7) to estimate some of the stress you have experienced, and your adjustment to it. This may seem to be a large number of areas, but completing the questionnaire should take no more than an hour or so.

We are very hopeful that this study will help other persons in medicine and couples to adapt to medical school and practice, and to foster satisfying and rewarding marital relationships. We must in fairness state that this is not intended as a counseling or workshop situation, and your particular relationship may not benefit directly from the study. It is quite possible, however, that you will find the time and thought invested useful to your relationship.

After the forms are completed, the data from the study will be pooled and analyzed. For the analysis of data, your answers will be identified by code, not by name. This same data may be used again in the light of different theories, and we would like your permission to use your data in the future. For this study and for any future analysis of data, your responses will be confidential and reported only in summaries. For the present study it is possible that we may wish to contact you for a follow-up interview. We would like your permission to do this. Your participation in any further interviewing is, of course, always up to you.

After the study is completed, we would be happy to send you a copy of the results and/or explain in detail the theories behind the study. We are available to discuss any issues that come up during the study, if you so desire. You are free to withdraw from the study at any time.

Please sign the authorization below.

Authorization: I, _____, have read the above and decide
(name of subject)
to participate in the research project above. My signature also indicates that I have received a copy of this consent form.

_____ _____
Signature Date

_____ 233-8882 or 263-6100
Signature of Principal Investigator Telephone

Please sign and retain the second copy of this form. Just tear it out of the staple.

APPENDIX D

DEMOGRAPHIC GENERAL INFORMATION SHEET

APPENDIX D

DEMOGRAPHIC GENERAL INFORMATION SHEET

GENERAL INFORMATION

(PLEASE PRINT)

1. Your name _____

2. Your date of birth _____

3. Today's date _____

4. Your sex _____

5. Number of years you have been married _____

6. Do you have any children? _____

   If yes, what are their ages and sexes _____
   (If insufficient room, please use the back.)

7. Is this your first marriage? _____

   If not, please give the length of your previous marriage(s), when they ended, and whether they ended through anullment, divorce, or death. _____

   _____
   (If insufficient room, please use the back.)

8. In the family in which you grew up, what was your father's occupation? _____ Your mother's? _____

9. Did your parents separate, either through death or divorce? _____ If so, how old were you? _____

10. Where were you in the birth order in your family? (i.e. middle child with older sister and younger brother, etc.)

11. Your occupation _____
    Spouse's occupation _____

12. If you were/are a medical student at UW, were/are you an ISP student? _____

13. What level of education have you completed? _____

_____

14. What level of education has your spouse completed? _____

_____

If any item provides insufficient space, please use the back.

APPENDIX E

BEM SEX-ROLE INVENTORY

APPENDIX E

BEM SEX-ROLE INVENTORY

SECTION A

On the following page, you will be shown a large number of personality characteristics. We would like you to use those characteristics in order to describe yourself. That is, we would like you to indicate, on a scale from 1 to 7, how true of you these various characteristics are. Please do not leave any characteristic unmarked.

Example: sly

Mark a 1 if it is NEVER OR ALMOST NEVER TRUE that you are sly.

Mark a 2 if it is USUALLY NOT TRUE that you are sly.

Mark a 3 if it is SOMETIMES BUT INFREQUENTLY TRUE that you are sly.

Mark a 4 if it is OCCASIONALLY TRUE that you are sly.

Mark a 5 if it is OFTEN TRUE that you are sly.

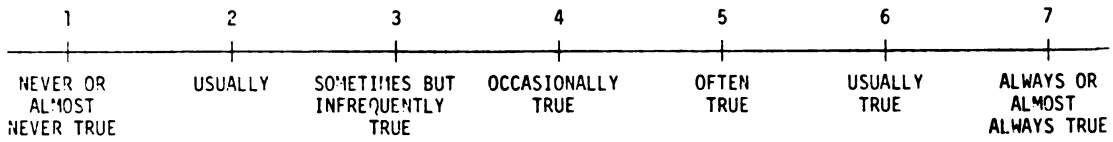
Mark a 6 if it is USUALLY TRUE that you are sly.

Mark a 7 if it is ALWAYS OR ALMOST ALWAYS TRUE that you are sly.

Thus, if you feel it is sometimes but infrequently true that you are "sly," never or almost never true that you are "malicious," always or almost always true that you are "irresponsible," and often true that you are "carefree," then you would rate these characteristics as follows:

Sly	3
Malicious	1

Irresponsible	7
Carefree	5



Self reliant	
Yielding	
Helpful	
Defends own beliefs	
Cheerful	
Moody	
Independent	
Shy	
Conscientious	
Athletic	
Affectionate	
Theatrical	
Assertive	
Flatterable	
Happy	
Strong personality	
Loyal	
Unpredictable	
Forceful	
Feminine	

Reliable	
Analytical	
Sympathetic	
Jealous	
Has leadership abilities	
Sensitive to the needs of others	
Truthful	
Willing to take risks	
Understanding	
Secretive	
Makes decisions easily	
Compassionate	
Sincere	
Self-sufficient	
Eager to soothe hurt feelings	
Conceited	
Dominant	
Soft-spoken	
Likable	
Masculine	

Warm	
Solemn	
Willing to take a stand	
Tender	
Friendly	
Aggressive	
Gullible	
Inefficient	
Acts as a leader	
Childlike	
Adaptable	
Individualistic	
Does not use harsh language	
Unsystematic	
Competitive	
Loves children	
Tactful	
Ambitious	
Gentle	
Conventional	

APPENDIX F

TAYLOR ROLE QUESTIONNAIRE

APPENDIX F - TAYLOR ROLE QUESTIONNAIRE

VERSION FOR FEMALE MEDICAL STUDENTS OR HOUSE STAFF

SECTION B

In this section we will be asking about the activities and expectations for the wife in the couple. On the whole this section asks only about things often traditionally expected of wives. At the end of the section there will be a space for comments. If you feel that important areas were not covered in the section as it stands, please make note of the things that were omitted in the "Comments" portion.

This section also omits any mention of expectations and activities for the husband. Clearly there is a full set of these for husbands as well, but in this study we chose to focus on the wife, and hope future research will focus on the husband in equal depth.

Every individual has certain ideal expectations of the way he or she will behave as a spouse. In this section we would like you to describe how you would like to be as a spouse, and what at the present time you are able to do. While it is likely that no spouse ever meets their ideal, we would like you to describe in part (a) of each question your ideal for yourself. In part (b) of each question, we would like you to estimate how much the activity described matters to you, and in part (c) we would like you to describe how you are right now.

For each question, simply circle the number that is the best answer.

1. (a) I expect to do the cooking.

   Always 7 6 5 4 3 2 1 Never

   (b) How much does this matter to you?

   Crucial 7 6 5 4 3 2 1 Not Important

   (c) Presently I do the cooking.

   Always 7 6 5 4 3 2 1 Never

   (d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

   Completely 7 6 5 4 3 2 1 Not At All

2. (a) I expect to do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

3. (a) I expect to do the laundry.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the laundry.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

4. (a) I expect to do the clothing maintenance (mending, dry cleaning, etc.).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the clothing maintenance.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

5. (a) I expect to do the grocery shopping.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the grocery shopping.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

6. (a) I expect to do the other shopping (not grocery).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the other shopping.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

7. (a) I expect to show affection towards my hsuband.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do show affection toward my husband.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

8. (a) I expect to respond to affectionate overtures from my husband.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do respond to affectionate overtures from my husband.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

9. (a) I expect to respond to sexual overtures from my husband.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do respond to sexual overtures from my husband.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

10. (a) I expect to take the initiative in sexual activity.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do take the initiative in sexual activity.

Always 7 6 5 4 3 2 1 Not At All

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

11. (a) I expect to spend time alone with my husband at home--talking or doing things together.

Often 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do spend time alone with my husband at home--talking or doing things together.

Often 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

12. (a) I expect to go out socially with my husband--such as to a movie or dinner.

Often 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do go out socially with my husband--such as to a movie or dinner.

Often 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

13. (a) I expect to go out socially with my husband and mix with other couples, or friends generally.

Often 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do go out socially with my husband and mix with other couples, or friends generally.

Often 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

14. (a) I expect to listen to what is troublesome in my husband's life, and to share his joys too.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do listen to what is troublesome in my husband's life, and share his joys too.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

15. (a) I expect to be supportive and encouraging of my husband.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I am supportive and encouraging of my husband.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

16. (a) I expect to help maintain the contacts with our extended family (parents and in-laws, brothers and sisters, etc.).

As Much as Possible 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do help maintain the contacts with our extended family.

As Much as Possible 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

17. (a) I expect to express appreciation for the things my husband does for me.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do express appreciation for the things he does for me.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

The following questions are only for couples with children.

18. (a) I expect to provide the child care for our child(ren).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do provide the child care for our child(ren).

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

19. (a) I expect to be responsible for the care given to our child(ren), though I may not give it personally.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I am responsible for the care given to our child(ren), though I may not give it personally.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

20. (a) If our child(ren) is/are ill, I expect to take care of it.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently, if our child(ren) is/are ill, I take care of it.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

21. (a) I expect to be the disciplinarian for our child(ren).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I am the disciplinarian for our child(ren).

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

Comments: (Please use back if needed.)

VERSION FOR HUSBANDS OF FEMALE MEDICAL STUDENTS
OR HOUSE STAFF

SECTION B

In this section we will be asking about the activities and expectations for the wife in the couple. On the whole this section asks about things often traditionally expected of wives. At the end of the section there will be a space for comments. If you feel that important areas were not covered in the section as it stands, please make note of the things that were omitted in the "Comments" section.

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Every individual has certain ideal expectations of the way his or her spouse will behave. In this section we would like you to describe how you would like your spouse to be, and what at the present time she is able to do. While it is likely that no spouse ever performs at the ideal level, we would like you in part (a) of each question to describe your ideal spouse. In part (b) of each question, we would like you to estimate how much the activity described matters to you, and in part (c) we would like you to describe how your spouse is right now.

For each question, simply circle the number that is the best answer.

1. (a) I expect my wife to do the cooking.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the cooking.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

2. (a) I expect my wife to do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the household cleaning.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by being a medical student or intern/resident?

3. (a) I expect my wife to do the laundry.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the laundry.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

4. (a) I expect my wife to do the clothing maintenance (mending, dry cleaning, etc.).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the clothing maintenance.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

VERSION FOR MALE MEDICAL STUDENTS OR HOUSE STAFF

(WIVES EMPLOYED OUTSIDE THE HOME)

SECTION B

In this section we will be asking about the activities and expectations for the wife in the couple. On the whole this section asks about things often traditionally expected of wives. At the end of the section there will be a space for comments. If you feel that important areas were not covered in the section as it stands, please make note of the things that were omitted in the "Comments" section.

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For each question, simply circle the number that is the best answer.

1. (a) I expect my wife to do the cooking.

   Always 7 6 5 4 3 2 1 Never

   (b) How much does this matter to you?

   Crucial 7 6 5 4 3 2 1 Not Important

   (c) Presently she does the cooking.

   Always 7 6 5 4 3 2 1 Never

   (d) To what extent is her behavior (in this area) influenced by her occupation?

   Completely 7 6 5 4 3 2 1 Not At All

2. (a) I expect my wife to do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the household cleaning.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by her occupation?

Completely 7 6 5 4 3 2 1 Not At All

3. (a) I expect my wife to do the laundry.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you.

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the laundry.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by her occupation?

Completely 7 6 5 4 3 2 1 Not At All

4. (a) I expect my wife to do the clothing maintenance (mending, dry cleaning, etc.).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Never

(c) Presently she does the clothing maintenance.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by her occupation?

Completely 7 6 5 4 3 2 1 Not At All

VERSION FOR WIVES OF MALE MEDICAL STUDENTS
OR HOUSE STAFF

(WIVES EMPLOYED OUTSIDE THE HOME)

SECTION B

In this section we will be asking about the activities and expectations for the wife in the couple. On the whole this section asks only about things often traditionally expected of wives. At the end of the section there will be a space for comments. If you feel that important areas were not covered in the section as it stands, please make note of the things that were omitted in the "Comments" portion.

This section also omits any mention of expectations and activities for the husband. Clearly there is a full set of these for husbands as well, but in this study we chose to focus on the wife, and hope future research will focus on the husband in equal depth.

Every individual has certain ideal expectations of the way he or she will behave as a spouse. In this section we would like you to describe how you would like to be as a spouse, and what at the present time you are able to do. While it is likely that no spouse ever meets their ideal, we would like you to describe in part (a) of each question your ideal for yourself. In part (b) of each question, we would like you to estimate how much the activity described matters to you, and in part (c) we would like you to describe how you are right now.

For each question, simply circle the number that is the best answer.

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   (b) How much does this matter to you?

   Crucial 7 6 5 4 3 2 1 Not Important

   (c) Presently I do the cooking.

   Always 7 6 5 4 3 2 1 Never

   (d) To what extent is your behavior (in this area) influenced by your occupation?

   Completely 7 6 5 4 3 2 1 Not At All

2. (a) I expect to do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by your occupation?

Completely 7 6 5 4 3 2 1 Not At All

3. (a) I expect to do the laundry.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the laundry.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by your occupation?

Completely 7 6 5 4 3 2 1 Not At All

4. (a) I expect to do the clothing maintenance (mending, dry cleaning, etc.).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not At All

(c) Presently I do the clothing maintenance.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by your occupation?

Completely 7 6 5 4 3 2 1 Not At All

VERSION FOR MALE MEDICAL STUDENTS OR HOUSE STAFF

(HOMEMAKER WIVES)

SECTION B

In this section we will be asking about the activities and expectations for the wife in the couple. On the whole this section asks about things often traditionally expected of wives. At the end of the section there will be a space for comments. If you feel that important areas were not covered in the section as it stands, please make note of the things that were omitted in the "Comments" section.

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For each question, simply circle the number that is the best answer.

1. (a) I expect my wife to do the cooking.

   Always 7 6 5 4 3 2 1 Never

   (b) How much does this matter to you?

   Crucial 7 6 5 4 3 2 1 Not Important

   (c) Presently she does the cooking.

   Always 7 6 5 4 3 2 1 Never

   (d) To what extent is her behavior (in this area) influenced by your being a medical student or intern/resident?

   Completely 7 6 5 4 3 2 1 Not At All

2. (a) I expect my wife to do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the household cleaning.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by your being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

3. (a) I expect my wife to do the laundry.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the laundry.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by your being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

4. (a) I expect my wife to do the clothing maintenance (mending, dry cleaning, etc.).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently she does the clothing maintenance.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is her behavior (in this area) influenced by your being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

VERSION FOR WIVES OF MALE MEDICAL STUDENTS OR HOUSE STAFF

(HOMEMAKER WIVES)

SECTION B

In this section we will be asking about the activities and expectations for the wife in the couple. On the whole this section asks only about things often traditionally expected of wives. At the end of the section there will be a space for comments. If you feel that important areas were not covered in the section as it stands, please make note of the things that were omitted in the "Comments" portion.

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For each question, simply circle the number that is the best answer.

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   Always 7 6 5 4 3 2 1 Never

   (b) How much does this matter to you?

   Crucial 7 6 5 4 3 2 1 Not Important

   (c) Presently I do the cooking.

   Always 7 6 5 4 3 2 1 Never

   (d) To what extent is your behavior (in this area) influenced by your husband being a medical student or intern/resident?

   Completely 7 6 5 4 3 2 1 Not At All

2. (a) I expect to do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the household cleaning.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by your husband being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

3. (a) I expect to do the laundry.

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the laundry.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by your husband being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

4. (a) I expect to do the clothing maintenance (mending, dry cleaning, etc.).

Always 7 6 5 4 3 2 1 Never

(b) How much does this matter to you?

Crucial 7 6 5 4 3 2 1 Not Important

(c) Presently I do the clothing maintenance.

Always 7 6 5 4 3 2 1 Never

(d) To what extent is your behavior (in this area) influenced by your husband being a medical student or intern/resident?

Completely 7 6 5 4 3 2 1 Not At All

APPENDIX G

TRAUPMANN-UTNE-HATFIELD (1978) SCALE

APPENDIX G

TRAUPMANN-UTNE-HATFIELD (1978) SCALE

SECTION C

Introduction:

In this section we are interested in the give-and-take that goes on in marriage. We'd like to ask you some questions about the kinds of things you put into your marriage, and the kinds of things you get out of it.

Clearly, we know that most people don't ordinarily keep careful track of exactly what they're giving and getting from their marriages. They certainly don't pull their relationship apart and think about the various aspects of their marriage, one by one. But in order for us to get some idea of what goes on in marital relationships, we have to ask you and the others in the study to <u>spell out</u> some of the give-and-take that naturally occurs.

We will look at some of the critical areas in any marriage. When you glance over the list, the underlined headings will give you a sense of the ground we will cover. First we'd like to ask about your and your partner's personal characteristics--like your looks and intelligence (Items 1 - 4). Then we cover your emotional assets and liabilities (Items 5 - 15). Finally, we cover daily sorts of concerns that come up in a long-term relationship (Items 16 - 25) for a total of 25 areas.

For each of the 25 areas, you will be asked to make two ratings. The first is

> Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?
>
> -3. My partner is getting a much better deal.
> -2. My partner is getting a somewhat better deal.
> -1. My partner is getting a slightly better deal.
> 0. We are both getting an equal deal.
> +1. I am getting a slightly better deal.
> +2. I am getting a somewhat better deal.
> +3. I am getting a much better deal.

The second rating for each area will be

How important is this area to you?

8. Extremely important	4. Slightly unimportant
7. Very important	3. Fairly unimportant
6. Fairly important	2. Very unimportant
5. Slightly important	1. Extremely unimportant

Circle the number that is the best answer.

AREAS INVOLVED IN THE MARITAL GIVE AND TAKE

PERSONAL CONCERNS

Social Grace

1. Social Grace: Some people are sociable, friendly, relaxed in social settings. Others are not.

   Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

   -3. My partner is getting a much better deal.
   -2. My partner is getting a somewhat better deal.
   -1. My partner is getting a slightly better deal.
    0. We are both getting an equal deal.
   +1. I am getting a slightly better deal.
   +2. I am getting a somewhat better deal.
   +3. I am getting a much better deal.

   How important is this area to you?

8. Extremely important	4. Slightly unimportant
7. Very important	3. Fairly unimportant
6. Fairly important	2. Very unimportant
5. Slightly important	1. Extremely unimportant

Intellect

2. Intelligence: Some people are intelligent and informed.

   Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
 0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Appearance

3. Physical Attractiveness: Some people are physically attractive.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
 0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

4. Concern for Physical Appearance and Health: Some people take care of their physical appearance and conditioning, through attention to such things as their clothing, cleanliness, exercise, and good eating habits.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

EMOTIONAL CONCERNS

Liking and Loving

5. Liking: Some people like their partners and show it. Others do not.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

6. Love: Some people feel and express love for their partners.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
 0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Understanding and Concern

7. Understanding and Concern: Some people know their partner's personal concerns and emotional needs and respond to them.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
 0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Acceptance

8. Accepting and Encouraging Role Flexibility: Some people let their partners try out different roles occasionally, for example, letting their partner be a "baby" sometimes, a "mother," a colleague or a friend, an aggressive as well as a passive lover, and so on.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Appreciation

9. Expression of Appreciation: Some people openly show appreciation for their partner's contributions to the relationship--they don't take their partner for granted.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Physical Affection

10. Showing Affection: Some people are openly affectionate--touching, hugging, kissing.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Sex

11. Sexual Pleasure: Some people participate in the sexual aspect of a relationship; working to make it mutually satisfying and fulfilling.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

12. Sexual Fidelity: Some people live up to (are "faithful" to) their agreements about extra-marital relations.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Security/Freedom

13. Commitment: Some people commit themselves to their partners and to the future of their relationship together.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

14. Respecting Partner's Need to be Free and Independent Person: Some people allow their partners to develop as an individual in the way that they choose: for example, they allow their partners freedom to go to school or not; to work at the kind of job or career they like; to pursue outside interests; to do things by themselves or with their friends; to simply be alone sometimes.

    Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

    -3. My partner is getting a much better deal.
    -2. My partner is getting a somewhat better deal.
    -1. My partner is getting a slightly better deal.
     0. We are both getting an equal deal.
    +1. I am getting a slightly better deal.
    +2. I am getting a somewhat better deal.
    +3. I am getting a much better deal.

    How important is this area to you?

    8. Extremely important
    7. Very important
    6. Fairly important
    5. Slightly important
    4. Slightly unimportant
    3. Fairly unimportant
    2. Very unimportant
    1. Extremely unimportant

Plans and Goals for the Future

15. Plans and Goals for the Future: Some people plan for and dream about their future together.

    Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

    -3. My partner is getting a much better deal.
    -2. My partner is getting a somewhat better deal.
    -1. My partner is getting a slightly better deal.
     0. We are both getting an equal deal.
    +1. I am getting a slightly better deal.
    +2. I am getting a somewhat better deal.
    +3. I am getting a much better deal.

How important is this area to you?

8.	Extremely important	4.	Slightly unimportant
7.	Very important	3.	Fairly unimportant
6.	Fairly important	2.	Very unimportant
5.	Slightly important	1.	Extremely unimportant

DAY-TO-DAY CONCERNS

Day-to-Day Maintenance

16. Day-to-Day Maintenance: Some people contribute time and effort to household responsibilities such as grocery shopping, making dinner, cleaning and car maintenance. Others do not.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3.	My partner is getting a much better deal.
-2.	My partner is getting a somewhat better deal.
-1.	My partner is getting a slightly better deal.
0.	We are both getting an equal deal.
+1.	I am getting a slightly better deal.
+2.	I am getting a somewhat better deal.
+3.	I am getting a much better deal.

How important is this area to you?

8.	Extremely important	4.	Slightly unimportant
7.	Very important	3.	Fairly unimportant
6.	Fairly important	2.	Very unimportant
5.	Slightly important	1.	Extremely unimportant

Finances

17. Finances: Some people contribute income to the couple's "joint account."

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
 0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Sociability

18. Easy-to-Live-With: Some people are easy to live with on a day-to-day basis: that is, they have a sense of humor, aren't too moody, don't get drunk too often, and so on.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
 0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

19. Companionship: Some people are good companions, who suggest interesting activities for both of them to do together, as well as going along with their partner's ideas about what they might do for fun.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
 0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

20. Conversation: Some people tell partners about their day's events and what's on their minds . . . and are also interested in hearing about their partner's concerns and daily activities.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
 0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

21. Fitting In: Some people are compatible with their partner's friends and relatives; they like the friends and relatives, and the friends and relatives like them.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Decision-Making

22. Decision-Making: Some people take their fair share of the responsibility for making and carrying out decisions that affect both partners.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

Remembering Special Occasions

23. Remembering Special Occasions: Some people are thoughtful about sentimental things, such as remembering birthdays, your anniversary, and other special occasions.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important
7. Very important
6. Fairly important
5. Slightly important
4. Slightly unimportant
3. Fairly unimportant
2. Very unimportant
1. Extremely unimportant

OPPORTUNITIES GAINED AND LOST

Opportunities Gained

24. Chance to be Married: Marriage gives many people the opportunity to partake of the many life experiences that depend upon being married; for example, the chance to become a parent and even a grandparent, the chance to be included in "married couple" social events, and finally, having someone to count on in old age.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important	4. Slightly unimportant
7. Very important	3. Fairly unimportant
6. Fairly important	2. Very unimportant
5. Slightly important	1. Extremely unimportant

Opportunities Foregone

25. Opportunities Foregone: Marriage necessarily requires people to give up certain opportunities, in order to be in this relationship. The opportunities could have been other possible mates, a career, travel, etc.

Considering what you put into your marriage in this area, compared to what you get out of it, and what your partner puts in compared to what (s)he gets out of it, how does your marriage "stack up"?

-3. My partner is getting a much better deal.
-2. My partner is getting a somewhat better deal.
-1. My partner is getting a slightly better deal.
0. We are both getting an equal deal.
+1. I am getting a slightly better deal.
+2. I am getting a somewhat better deal.
+3. I am getting a much better deal.

How important is this area to you?

8. Extremely important	4. Slightly unimportant
7. Very important	3. Fairly unimportant
6. Fairly important	2. Very unimportant
5. Slightly important	1. Extremely unimportant

APPENDIX H

SPANIER (1976) DYADIC ADJUSTMENT SCALE

APPENDIX H

SPANIER (1976) DYADIC ADJUSTMENT SCALE

SECTION D

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	____	____	____	____	____	____
2. Matters of recreation	____	____	____	____	____	____
3. Religious matters	____	____	____	____	____	____
4. Demonstrations of affection	____	____	____	____	____	____
5. Friends	____	____	____	____	____	____
6. Sex relations	____	____	____	____	____	____
7. Conventionality (correct or proper behavior)	____	____	____	____	____	____
8. Philosophy of life	____	____	____	____	____	____
9. Ways of dealing with parents or in-laws	____	____	____	____	____	____

	Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
10. Aims, goals and things believed important	____	____	____	____	____	____
11. Amount of time spent together	____	____	____	____	____	____
12. Making major decisions	____	____	____	____	____	____
13. Household tasks	____	____	____	____	____	____
14. Leisure time interests and activities	____	____	____	____	____	____
15. Career decisions	____	____	____	____	____	____

	All the Time	Most of the Time	More Often Than Not	Occas-sionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation or terminating your rela-tionship?	____	____	____	____	____	____
17. How often do you or your mate leave the house after a fight?	____	____	____	____	____	____

	All the Time	Most of the Time	More Often Than Not	Occa-sionally	Rarely	Never
18. In general, how often do you think that things between you and your partner are going well?	____	____	____	____	____	____
19. Do you confide in your mate?	____	____	____	____	____	____
20. Do you ever regret that you married?	____	____	____	____	____	____
21. How often do you and your partner quarrel?	____	____	____	____	____	____
22. How often do you and your partner "get on each other's nevers"?	____	____	____	____	____	____

	Every Day	Almost Every Day	Occa-sionally	Rarely	Never
23. Do you kiss your mate?	____	____	____	____	____

	All of Them	Most of Them	Some of Them	Very Few of Them	None of Them
24. Do you and your mate engage in outside interests together?	____	____	____	____	____

How often would you say the following events occur between you and your mate?

	Never	Less Than Once a Month	Once or Twice a Month	Once or Twice a Week	Once a Day	More Often
25. Have a stimulating exchange of ideas	____	____	____	____	____	____
26. Laugh together	____	____	____	____	____	____
27. Calmly discuss something	____	____	____	____	____	____
28. Work together on a project	____	____	____	____	____	____

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks.

(Check yes or no)

	Yes	No	
29.	____	____	Being too tired for sex.
30.	____	____	Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5	6
.	.	.	.	.	.	.
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describe how you feel about the future of your relationship? Place a check beside your answer.

____ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

____ I want very much for my relationship to succeed, and will do all I can to see that it does.

____ I want very much for my relationship to succeed, and will do my share to see that it does.

____ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

____ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

____ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

APPENDIX I

OPEN-ENDED QUESTIONNAIRE

APPENDIX I

OPEN-ENDED QUESTIONNAIRE

SECTION E

This is a section of open-ended questions, for you to provide some additional answers that represent your experience in your own words. Please make them as long or as short as you wish, and use the back or additional paper if you prefer.

We want to be certain we understand these answers, so

PLEASE PRINT, TYPE, OR MAKE A GREAT EFFORT TO WRITE CLEARLY

1. What do you feel the impact of medical school or your status as intern/resident has been on your marriage?

2. Do you feel medical school/residency has been an added stress factor on your marriage?

3. Every major life change requires readjustments in the way you live. In the medical school/residency context, most people have to give up something which they "miss most." What do you think you miss most?

4. If your answer to #3 above was more related to your life as an individual than to your life as half of a couple, what do you think you miss most that relates to your marriage?

5. For Question 5, partners who are in medical school/residency, or MDs should answer part (a) and partners who are not should answer part (b).

   (a) What does your spouse do as an occupation?

   Does it make your situation (working in medicine) any easier, or harder?

   (b) What is your occupation?

   Do you think your position makes things any easier, or harder for your spouse?

   Does your spouse's occupation make things easier, or harder for you in your job?

6. Briefly describe what would be a typical day for you.

7. How much time do you and your spouse spend together in an average week?

   What kind of time is it--"close" (talking together might be an example), or a little more separate (both reading in the same room might be an example)?

8. Do you anticipate any changes in your marriage after you (your spouse) finishes his/her residency? What kind of changes?

   (If you both are medical students/house staff, you might want to mention changes that would occur as first one of you and then the other finished.)

9. If you felt that in this situation (being a medical student or intern/resident, or the spouse of one) you had to give things up, do you foresee any ways in which it will be "made up" to you?

APPENDIX J

STRESS ADJUSTMENT SCALE

APPENDIX J

STRESS ADJUSTMENT SCALE

Please rate each of the following items by circling the response that best describes your present life situation.

	VERY STRESSFUL	STRESSFUL	MINIMALLY STRESSFUL	NOT STRESSFUL
1. Household responsibilities	VS	ST	SS	NS
2. Housing situation	VS	ST	SS	NS
3. Money	VS	ST	SS	NS
4. Personal autonomy/independence	VS	ST	SS	NS
5. Your occupation or work (includes student, homemaker)	VS	ST	SS	NS
6. Ouality of communication with partner	VS	ST	SS	NS
7. Amount of time spent with partner	VS	ST	SS	NS
8. Sexual relations	VS	ST	SS	NS
9. Relationships with friends	VS	ST	SS	NS
10. Relationships with relatives (outside of immed. family)	VS	ST	SS	NS
11. Relationships with your children (if applicable)	VS	ST	SS	NS

Please rate each of the following items on the basis of its importance to your life satisfaction.

	VERY IMPORTANT	IMPORTANT	MINIMALLY IMPORTANT	NOT IMPORTANT
1. Household responsibilities	VI	IM	SI	NI
2. Housing situation	VI	IM	SI	NI
3. Money	VI	IM	SI	NI
4. Personal autonomy/independence	VI	IM	SI	NI
5. Your occupation or work (includes student,homemaker)	VI	IM	SI	NI
6. Ouality of communication with partner	VI	IM	SI	NI
7. Amount of time spent with partner	VI	IM	SI	NI
8. Sexual relations	VI	IM	SI	NI
9. Relationships with friends	VI	IM	SI	NI
10. Relationships with relatives (outside of immed.family)	VI	IM	SI	NI
11. Relationships with your children (if applicable)	VI	IM	SI	NI

If you were married prior to medical school, please complete the rest of this survey.

Please rate each of the following items on the basis of the adjustment that was required when one or both of you entered medical school.

	MAJOR CHANGE	SOME CHANGE	MINIMAL CHANGE	NO CHANGE
1. Household responsibilities	MC	SC	LC	NC
2. Housing situation	MC	SC	LC	NC
3. Money	MC	SC	LC	NC
4. Personal autonomy/independence	MC	SC	LC	NC
5. Your occupation or work (includes student, homemaker)	MC	SC	LC	NC
6. Quality of communication with partner	MC	SC	LC	NC
7. Amount of time spent with partner	MC	SC	LC	NC
8. Sexual relations	MC	SC	LC	NC
9. Relationships with friends	MC	SC	LC	NC
10. Relationships with relatives (outside immed.family)	MC	SC	LC	NC
11. Relationships with your children (if applicable)	MC	SC	LC	NC

Please rate each of the following items on the basis of how successfully you think you have mastered the changes indicated above.

	MASTERED & GROWN	MASTERED	TOLERABLE	WORSE THAN BEFORE
1. Household responsibilities	MG	MA	TO	WO
2. Housing situation	MG	MA	TO	WO
3. Money	MG	MA	TO	WO
4. Personal autonomy/independence	MG	MA	TO	WO
5. Your occupation or work (includes student, homemaker)	MG	MA	TO	WO
6. Quality of communication with partner	MG	MA	TO	WO
7. Amount of time spent with partner	MG	MA	TO	WO
8. Sexual relations	MG	MA	TO	WO
9. Relationships with friends	MG	MA	TO	WO
10. Relationships with relatives (outside immed. family)	MG	MA	TO	WO
11. Relationships with your children (if applicable)	MG	MA	TO	WO

APPENDIX K

FIRST LETTER TO SUBJECTS

APPENDIX K

FIRST LETTER TO SUBJECTS

321 Island Dr., Apt. 6
Madison, WI 53705
Jun , 1979

Dear

First of all I would like to thank you again for your cooperation and help with the Medical Education and Marriage Study. You are very busy people and I have been impressed and gratified by your willingness to make the time to take part.

Enclosed you will find your check. For the sake of simplicity I have made it payable to only one partner but it and my thanks are certainly intended for both.

My present plan is to send all of you by mail a brief summary of my hypotheses about the study and the results of the analysis of my data. I will be sending that as soon as the analysis is completed and I hope that will be sometime in July or perhaps August. If you are planning to move before that time and haven't given me your new address, you might want to contact me so I will send the results to your new home. Otherwise, I will assume letters will be forwarded. Some of you may want more information than is provided in the summary of results, and I will encourage you at that time to contact me by mail or phone and ask for more details.

If you are very curious now (between about June 1 and the time data is analyzed) about my hypotheses and ways I developed the study, please feel free to write or call now. We can talk on the phone or set up a time to meet.

Thanks again.

Sincerely,

Meredith F. Taylor

APPENDIX L

SECOND LETTER TO SUBJECTS

APPENDIX L

SECOND LETTER TO SUBJECTS

343 Island Dr., Apt. 3
Madison, WI 53705

Dear

First of all, I would like to thank you once again for your participation. You may feel you have already been thanked enough, but you will realize what a remarkable group you comprise when I tell you that out of nearly 120 couples who agreed to do the study, only three failed to complete it. I received almost universal interest and sympathy (for the plight of the researcher and graduate student) and I am very grateful.

The official title of the study is "Equity Theory, Androgyny, and Role Conflict in the Marriages of Medical Students and of Medical House Staff." In essence, I combined a theory about relationships, a portion of personality theory and rather fundamental ideas about sex-role socialization to create my hypotheses.

I will first outline the hypotheses very generally, and then fill in some details. At its simplest, I hypothesized that medical education would be a hard time for any married couple; that it would be harder for women in medicine and their spouses than for men in medicine and their spouses, and that it would be hardest of all for the women and their spouses if they were attempting to maintain a traditional model for marriage.

For hypotheses about how the couples might feel about their relationship, I drew from equity theory. Equity theory was developed by Elaine Hatfield and G. William Walster here at the University of Wisconsin. It theorizes that in any relationship, if one gives as much as one gets, one experiences equity and feels content. However, if one either gives or gets more, one will feel discontent and seek to restore equity, in one way or another. I hypothesized that medical persons were likely to experience overbenefit (getting more than giving) and all non-medical persons were likely to experience underbenefit (giving more than getting) under the pressure of medical education. I attempted to measure this (and all other questions about equity) with the Traupmann-Utne-Hatfield (1978) Scale, which was the section on which you indicated "who gets a better deal." This hypothesis was quite strongly

confirmed; medical persons do feel overbenefited and their spouses feel underbenefited.

I had further related hypotheses. I predicted women medical persons would feel they "got too much" even more than male medical persons. I also predicted their spouses would feel they "got even less" than the female spouses of men in medicine. I predicted this on the basis of sex-role theory. My idea was that while at this point the society seems to be moving away from the traditional model of marriage, that is still how most of us were raised and it may still be a strong influence. By a traditional model of marriage, I mean several overlapping concepts: the wife takes care of the home and children while the husband works; also the wife is the emotional and socially adept partner while the husband makes decisions and acts as a leader, etc. In any case, I predicted that since women in medicine might have difficulty fulfilling the "at home" roles, they might feel that they were not giving enough in the relationship. Hence the prediction developed that they would feel more over-benefited. Males in medicine might not be able to offer a great deal in the "husband" role at home either, but I hypothesized that since it was traditional for the husband to be the "breadwinner" and work hard outside the home, that this would be less troublesome to both spouses.

This hypothesis was rejected. There were no significant differences on equity between male/female medical persons or between male/female spouses. However, when I pooled all persons into a division by sex as well as medical/non-medical, it became clear that women felt significantly underbenefited compared to men. Most of this was because males in medicine felt so overbenefited and their non-medical spouses felt so underbenefited. This was contrary to my prediction.

I had also hypothesized that "dual-medical couples" (both partners either physicians or in medical training) would experience less inequity than other couples. On the whole this was confirmed, although it was not clear that dual-medical couples were signif-icantly different from couples with the wife in medicine and the husband not in medicine.

In dual-medical couples both partners feel slightly under-benefited, the men more than the women. I interpreted this as a feeling of "not quite enough to go around," which certainly seems reasonable considering the hectic life of a dual-medical couple.

Most of my other hypotheses focused upon the women in medicine and their spouses. I feel apologetic about omitting the men and their spouses, but my grounding in sex-role theories made me feel much more clear about what to attempt to predict among the women and their spouses. I hypothesized that medical women might <u>not</u> feel they were overbenefited for one of two reasons. First they

(and/or the spouse) might have altered their level of expectations about what they should be doing to be "the kind of wife I feel good about being/being with," or simply have had those expectations at a very down to earth level in the first place. So in that case, achieving the expected goal for "wife-like" behavior might be reasonable and do-able in addition to keeping up with medical education.

Second, I hypothesized that some women (and their spouses) might have very high expectations for themselves and bring it off. That would mean (to take a somewhat far-fetched example) managing to still serve a four course dinner promptly at 7:00 each night, no matter what.

So, I tried to measure how people saw their expectations of themselves (or spouse) and also how they saw the "performance" level. I theorized that a high difference score between expectation and performance would be attributed to the woman being in medicine, and that a high difference score would predict more feelings of inequity. A statistically significant correlation between discrepancy scores and amount of inequity was found, although it was not a very powerful one.

I also felt that discrepancy and inequity should correlate with the measure of marital happiness. Therefore, you completed both the instrument describing expectations for yourself (or spouse) and the level of performance for yourself or spouse, and the marital satisfaction measure. These measures did correlate significantly as anticipated, but again it was not a very powerful correlation.

Finally, I used an aspect of personality theory to attempt to predict which persons, among female students/house staff and their spouses, would have the easiest time re-adjusting their expectations for what the wife "should be doing," or who would have least need to readjust. Personality theory has developed the concept of psychological androgyny, which proposes that attributes identified as stereotypically masculine or feminine are not polar opposites, but are independent of each other. The theory and some follow-up research suggests that individuals high on both are flexible and adaptable. Accordingly, I hypothesized that an increase in androgyny would predict a decline in expectations for self or spouse, and also a decline in the discrepancy score (difference between expectations and performance). This hypothesis was rejected. Although the women in medicine are quite androgynous, the androgyny scores had no power to predict expectations held either by wives or husbands.

Any explanation of results which disconfirm hypotheses is always a little suspect, since one untested theory is as good as the next. For my hypotheses concerning equity/inequity, I would hazard a number of guesses. The first is that the level of investment in a

quite egalitarian marriage is high in Madison and within this medical school. It is possible that I highlighted this awareness by presenting my study as one which focused on women. In any case, apparently the male medical person is aware that his wife may be playing "second fiddle," and he is concerned about it. The wives seem equally aware. As a secondary factory within this idea, I would hypothesize that more women spouses are supporting the family in "marking time" jobs than are the male spouses of female medical persons. In this way, female spouses might feel underbenefit now, though the scale may "balance" over time.

One other point is worth mentioning. When I examined the scores on the marital satisfaction measure, all subgroups of women came out with scores which were essentially the same. In other words, although the non-medical wives felt quite underbenefited, they did not report themselves as less happy. Among the men, differences were statistically significant but fairly small. The men who described themselves as happiest were non-medical men married to medical wives. The next happiest were the medical men married to non-medical wives. The least happy were the men in dual-medical marriages. Obviously the relationship between perceiving inequity and seeing one's self as happy is not as simple and straightforward as one might assume.

The open-ended questionnaire is a potential source of direct information from you on how you see who has experienced overbenefit and underbenefit. It was also intended to draw from you comments on how the balance of equity might be restored over time if it is out of balance now. I use this tentative language because analysis of such data requires using unbiased raters who are blind to the hypotheses of the study. I did not have access to such persons at the moment and was forced to postpone that analysis. However, there is a good chance I will be able to finish in the near future.

This study became quite complicated. At its close I had sixteen hypotheses and tested fifteen of them. For this reason this summary is a fast overview of the results. I hope you will contact me if you are interested in hearing more details about it.

As a closing note, I would like to share with you both my sense of satisfaction and my sense of frustration with this project. I have had feelings during the year of this study that I was taking a very complex phenomenon and fitting it into a number of rather rigid theories that, in truth, only explain a small portion of what is happening in the lives of real people. In some ways, I see that as the fundamental dilemma of social science research, especially for dissertations, as something small enough to handle becomes removed from reality. If I could do this study with indefinite time and funds, I would begin with unstructured interviews and ask all of

you what you see as making marriage plus medicine stressful, how you coped with it, what worked the best, and what you would like to see changed.

My only consolation for myself is that I at least made a beginning in an area I see as interesting and important. I would also present to you very openly one of my biases: that medicine, as it now exists, does not allow people enough time to be human. Specifically, it does not acknowledge that a person who has time to be an affectionate spouse and parent might be a better doctor because of it. This is not, of course, a phenomenon limited to medicine by any means. At the moment, the society as a whole rewards "achievement" more than "nurturance." If this is to shift in any way within medicine, it is very likely that only the persons within the field can do it. If my research either now or in the future can provide you with any leverage to do the job, I will be most happy to supply it.

I would like, once again, to invite you to contact me if you would like any further information about the study. If you are interested in the specific research I used, I will be happy to give you the citations.

My thanks, one last time, and my good wishes.

Sincerely,

Meredith F. Taylor