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Life events, social support, and adjustment in women : a field study.

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LIFE EVENTS, SOCIAL SUPPORT, AND ADJUSTMENT IN WOMEN: A FIELD STUDY

A Dissertation Presented

By

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ABSTRACT

Life Events, Social Support, and Adjustment in Women:

A Field Study

(March, 1977)

Elizabeth Dunbar Dickey

The purpose of this exploratory study was to provide additional information on the apparent connections between life events (stress) and both physical and emotional illness. Previous studies have focused primarily on males. There was reason to believe that females are also vulnerable to the effects of stress, and that an improved understanding of the issues might have implications for conceptualizations of emotional dysfunction and for treatment efforts of a psychotherapeutic nature.

Specifically, there were several questions toward which this study was directed. The interrelationships among three variables, life events (stress), social support, and emotional adjustment were central to the study. A secondary variable, general life satisfaction, was also studied. An attempt was made to develop a better understanding of stress in women's lives from both quantitative and qualitative points of view. Additionally, social support was investigated in an attempt to understand both the sources of support reported by women, and the variables which appear to influence high and low social support. Lastly, personality adjustment and general life satisfaction were investigated as dependent variables.

The study involved 200 female residents of Northern New England, who were primarily from New Hampshire. Two forms of data collection were employed: a mail questionnaire, and individual interviews which were conducted with a small sub-sample of 23 women.

Questionnaire data were tabulated to indicate the proportion of women reporting high stress who also had high values on each adjustment measure (suggesting poor adjustment). Additionally, social support was treated as an intervening variable in an effort to consider the extent to which it buffered women from the effects of stresses as related to personality adjustment. Demographic factors were examined in relation to the three central variables in an attempt to identify trends in the data. Life satisfaction was considered in relation to possible interactions with both the demographic factors and the three variables of central interest in the study.

The results of the investigation supported the relationships postulated between life events (stresses) and adjustment; generally speaking, the high stress values were associated with poor adjustment on three dimensions: psychoticism, extraversion, and neuroticism. The postulated buffering effects of social support did not develop in the empirical data, though they were supported by the interview data. General life satisfaction was associated both with low stress and several demographic variables.

A sizeable number of women participating in the study reported high life stresses. This may be true of women in general, and it is suggested that greater clinical sensitivity be directed toward the

environmental, change-related events with which woman must cope. In addition, prior evidence exists in which stress has been connected to physical illness and psychiatric symptoms, while social support has been identified as a buffer. A possible avenue for future therapeutic exploration with female clients who present adjustment problems could involve consideration of their life stresses and the nature of their social support systems. If stresses were determined to be contributing factors in adjustment difficulties, therapeutic treatment could, in part, be directed toward the development of effective coping responses. Thus, clinical attention could be directed toward acknowledging the "real" stresses female clients experience while deemphasizing intrapsychic phenomena. Further clinical attention might clarify the buffering effects of social support, which remain inconclusive in this research, and could provide a better understanding of the usefulness of social support as a clinical concept with preventative implications for both men and women.

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CHAPTER I

INTRODUCTION

Background

The National Institute of Mental Health estimated that in 1968 twenty-one billion dollars were spent dealing with mental illness in the United States (Conley, Conwell, and Willner, 1970). This figure would suggest that many people are confronting stress in their lives, and are seeking professional services to help them cope effectively.

Social science researchers, health care givers, and lay people are involved in attempts to understand the many issues related to mental health and successful coping. Research in the field addresses itself to a range of important concerns including: 1) the etiological factors involved in emotional illness; 2) the epidemiological issues, especially as they relate to the differential incidence of mental illness among women as compared with men; and 3) the preventive steps that can be taken to assure people of healthy behavioral options. All of these considerations have relevance to the current study, and are related to the following brief review of sociological and psychological research on mental illness and women.

With respect to data on the incidence of emotional illness among males and females in America, Chesler (1970) cites the various service-giving institutions which are used by people undergoing severe emotional stress; they include: 1) state and county hospitals; 2) private

hospitals; 3) general psychiatric wards; 4) out-patient facilities such as community mental health centers; 5) Veterans' Administration in- and out-patient services; and 6) private therapeutic treatment. Chesler's interpretation of considerable data drawn from National Institute of Mental Health reports lead her to conclude "that more women than men have been involved in a dramatically increasing way in . . . psychiatric treatment facilities in America from 1964 through 1968" (p. 310).

While some have criticized Chesler's work (Bart, 1974; Guttentag, Salasin, Legge, & Bray, 1975), other investigators' findings support her conclusions to a large degree. Gove and Tudor (1973), in reviewing data from studies done between the Second World War and 1970 in North America and Western Europe, found more women than men were:

1) involved in first admissions to mental hospitals;
2) found to be mentally ill in community surveys;
3) admitted to general hospitals for psychiatric reasons;
4) involved in private outpatient psychiatric care;
5) treated for mental illness in outpatient clinics.

Gove and Tudor (1973) concluded: "In summary, all of the information on persons in psychiatric treatment (my emphasis) indicates that more women than men are mentally ill" (p. 823).

Surveying the relevant literature on sex differences and the incidence of mental illness is indeed provocative but remains inconclusive. Convincing as Gove and Tudor's findings are, one must remember they generally involve comparisons of men and women in treatment, and as such, cannot be generalized to include those people not in mental

health care. A recent study by Radloff (1975), however, throws some interesting light on the "incidence" question, and has sociological and psychological implications. Two interview surveys, one done in Kansas City, Missouri in 1972-73, and the second in Washington County, Maryland in 1971-73, were conducted on individual respondents (age 18 or over) within randomly selected households determined to be representative of the communities. Married women, both housewives and workers, were found to be more depressed than married men; among the never-married and widowed, however, men were found to be more depressed. Gove (1972) reviewed studies of mental illness, looking at both marital status and sex, and found total agreement among all the data that higher rates of dysfunction existed for women among the married. Further consideration of the contribution of marriage to emotional stress among women has been offered by Bernard (1973). She emphasized the limited psychological returns of the housewife role as compared with the working husband's activities; this disparity, Bernard suggested, contributes to the difficulties of married women.

While some investigators look to marriage as one source of women's emotional difficulties, others emphasize socialization. At a recent meeting of the National Association for Mental Health, considerable attention was directed toward the high rate of depression among women (New York Times, October 24, 1975). An explanation for the problem suggested at the conference, and also proposed by Radloff (1975) in her article, is that women learn to be helpless as a function of socialization processes.

Psychological studies on women's emotional functioning often involve personality dimensions. For example, several researchers have reported that women indicate lower self-esteem than men (Bardwick, 1971; Berger, 1968; Jarrett & Sheriff, 1953; Rosenkrantz, Vogel, Bee, Broverman, and Broverman, 1968). On a related dimension, there is evidence that women have a more negative self-image than men (Guerin, Veroff, and Feld, 1960; McKee and Sheriffs, 1959; 1975). Research in an area with additional implications for mental health suggests that women are very susceptible to depression (Radloff, 1975; Silverman, 1968).

Moving from a psychological framework to one more sociological, some investigators have looked into issues surrounding adult sex roles and their relationship to mental health. Gove and Tudor (1973) have suggested that, as constituted, the adult female sex role has many qualities which contribute to and may explain higher incidence of mental illness in women. Hochschild, in an extensive review of the socialization literature (1973), proposes that girls learn to value boys more than they value themselves. Goldberg, (1968) in a study in which 140 college female respondents were asked to evaluate articles in "masculine" disciplines (law and city planning) and "feminine" disciplines (art, history and dietetics) came up with interesting findings. The articles were authored by either Joan T. McKay or John T. McKay. The students, in evaluating the articles on such dimensions as professional competence, persuasiveness, and profundity, found John McKay more impressive in 44 out of 54 comparisons. Some social scientists would suggest that women are prejudiced against women, and Goldberg's findings would seem to support this view.

Sociological and psychological research on mental illness is of considerable importance considering the vast number of people who appear to be experiencing emotional problems and seeking professional assistance. However, our attempts to understand this complex problem and to improve our delivery of treatment continue to fall short. As we've seen in our brief review, the relevant research is often inconclusive. Nonetheless, it does contribute to continuing progress. We have seen that women in America and Western Europe appear to have very high rates of emotional illness. This phenomenon has been variously attributed to socialization processes, restrictive sex roles, and marriage. Those of us concerned with promoting mental health for women need to attend to these issues. The necessity for further research in the area is undeniable, particularly for studies with an epidemiological and etiological slant which would have implications for both those concerned with direct treatment and with prevention of illness.

In the past several years we have seen a surge of interest in the general area of "the psychology of women," including sex differences, socialization, and sex roles. In many universities, courses have been developed to specifically cover and study these concerns. Books surveying the relevant literature have been published (Bardwick, 1971; Maccoby and Jacklin, 1974; Sherman, 1971). Journals, specifically geared to an understanding of women, have recently begun publication (e.g., Psychology of Women Quarterly, 1976; Sex Roles, 1975; Signs, 1975). As noted by Parlee (1975), two recent major developments, specifically in psychology, signal new attention to the study of women; the Annual Review of Psychology (Mednick & Weissman, 1975) has its first chapter on the

"psychology of women," and the American Psychological Association has a new subunit, Division 35, The Psychology of Women. Clearly there is considerable action in the social sciences around women, their status, functioning, health and development. Nonetheless, as we have mentioned, conclusions in these areas are hard to come by with any confidence. Parlee (1975), in her excellent survey of the current work being done on the psychology on women, cites the frequent methodological problems of the studies as a contributor to the confused state of our knowledge. There is an active interest in and concern for women in psychology today. However, among other things, a theory of women's optimal functioning, its development and maintenance simply hasn't emerged. Similarly, our understanding of women and mental illness, its rates, causes and strategies for prevention is slim. The understanding and assumptions that do exist are often points of disagreement. For example, in a now classic study, Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970), found their sample of mental health professionals to have a double standard of mental health based largely on sex role stereotypes, and to value male attributes as characteristic of the 'healthy adult' over those of females.

The conflicting data and conclusions would suggest that social science direct itself toward developing a better understanding of emotional functioning and health for women. However, despite developing interest, recent research finds that women continue to be studied by psychological investigators less than men. Schwabacher (1972) found that in 1970 and 1971 issues of the Journal of Personality and Social Psychology, 53 single sex studies were on exclusively male samples,

while 13 were on females. The question presents itself, how can we begin to systematically fill in the information gaps in our current knowledge of women's behavior and personality? And, can this process contribute to the social change which appears so necessary for women today?

Statement of the Problem

Having taken a brief look at the mental health of women in America, let us step back to a broader perspective for a moment. Modern conceptualizations of mental health and illness by professionals as well as lay people have commonly focused on genetic and developmental influences. This perspective, inherited from Freud, promoted the viewing of people in social isolation; attributions as to health or illness rarely took into account society, or the social systems that are part of daily living.

Early Twentiety Century sociologists, particularly Durkheim (1966), Simmel (1950), and Weber (1958), did attend to the general impact of modern society upon its citizens. Further, the theoretical work of social psychologists Cooley (1902) and Mead (1934)--the symbolic interactionist position--asserted the significance of individuals to one another; we learn about ourselves from what we imagine others think of us. The work of Harry Stack Sullivan (1953), with his emphasis on interpersonal relationships as a primary source of anxiety and dysfunction in individuals, did much to broaden our perspective. In addition, with a particular interest in adolescence, Erikson (1963) attempted to move psychoanalytic thinking away from its preoccupation with inner realities toward an acknowledgement of social/cultural influences on identity development.

In recent years, some therapists and others concerned with the applied areas in mental health have begun to confront more directly the contributions of society and its members to the well-being of others. Prominent among those concerned with the impact of social variables upon human emotional functioning is Gerald Caplan of Harvard's Medical School. He has currently been working on the idea of social support systems in the natural environment (Caplan, 1974, Caplan and Killilea, 1976). Originating from a concern with epidemiology in a public health framework, Caplan has become an advocate of prevention of mental illness as compared with the more traditional intervention approach. In reviewing research on susceptibility to disease, Caplan (1974) points to the work of Cassel (1973), who upon examining a sizeable amount of human and animal research wrote: "the circumstances in which increased susceptibility to disease would occur would be those in which, for a variety of reasons, individuals are not receiving any evidence (feedback) that their actions are leading to desirable and/or anticipated consequences" (p. 1).

To follow Caplan's thinking on this subject, the apparent isolation or confusion around communication with others, the lack of information about how people perceive and experience each other, the unclear delineation of expectations and messages from those around, make it very difficult for individuals to negotiate the world; making appropriate discriminations between friendliness and hostility, feeling relaxed and safe, become impossible. People, in order to protect themselves, operate in a state of arousal or anxiety. In Caplan's words: "the resulting physiological depletion and fatigue increase . . . susceptibility

to a wide range of physical and mental disorders" (p. 2). Social support, in Caplan's terms, functions as a buffer. A "support system implies an enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychological and physical integrity of the individual over time" (p. 7).

Returning to our concern with women, their functioning and especially their emotional health, we find ourselves asking about their social environment, their relationships, and support systems. Do these elements contribute to adaptive behavior for women? Do they serve as intervening variables, making the coping process for women easier? We don't know the answers to these questions, but they are being raised with greater frequency. Note, for example, Jessie Bernard's 1976 Invited Address to Division 9 of the American Psychological Association, "Homosociality, Solidarity, and Sex," in which she considered these issues. Surely it is time to gather evidence and attempt to answer these questions, thus adding to our social science picture of female functioning.

Purposes

In the previous sections we suggested the importance of optimal emotional functioning. We briefly reviewed what appears to be the higher incidence of emotional illness and stress in women as compared with men, and their subsequent greater use of health services. Further, we introduced the concept of social support as developed by Gerald Caplan, and suggested its contribution to healthy functioning. Lastly, we considered the lack of research in these areas that can be applied to women.

In this study it was our intention to investigate the relationship of social support systems to emotional functioning in women. Further,

we collected additional data which related more generally to women and their environment. Specifically, we considered the following questions:

1) What is the relationship between social support and healthy functioning?

2) Is there evidence that social support functions as a buffer between the individual and environmental stresses?

3) What is the relationship between the seeking out of social support and various demographic factors, i.e., age and education?

4) Which persons in the social network appear to be the most called upon, helpful sources of social support?

5) What are some predictors of high life stresses among women?

6) What are some predictors of women who effectively employ social support as a buffer?

This study was intended to serve as a pilot investigation into several relatively unexplored aspects of women's lives. As such, the study functioned as an initial attempt at data gathering, and as a vehicle for the development of hypotheses to be used in future investigations.

Educational and Psychological Implications

This study has meaning for many who concern themselves with both individual and community health and welfare. To quote Robert Caplan:

> Our goal of promoting well being and positive health implies that we must discover in the social environment those positive factors (like social support) [my emphasis] which may act as a buffer between stress and strain and thus reduce illness. As these positive factors are discovered, we must learn how to provide them in adequate amount to those individuals who need the help (1975, p. 2).

The division of labor between those concerned with education and those concerned with psychology becomes blurred when dealing with such a notion as support. Social support assumes two major functions: 1) practical support or assistance, for example in the form of financial assistance; and 2) emotional or psychological support in the form of caring, friendship and nurturance (Caplan, 1975). Both of these processes would appear to have meaning for those in education, particularly if schools do become centers of affective learning as well as that which rests more in the cognitive domain. Furthermore, those of us concerned with psychology must continue to find new ways of promoting health both in preventionary and interventionary ways, anticipating the negative impact of stress before it occurs and alleviating it when dysfunction has developed.

Thus, it is our conviction that by understanding the relationship of the variables involved in this study we will be in a better position to encourage the productive use of social support systems in the environment. Mental health workers can view these phenomena as naturally-occurring resources from which learning can take place and to which people can be referred. Additionally, informal caregivers who come in the form of friends, neighbors, and family members, may come to recognize the unique contributions they can make within the social environment. And, most importantly, individuals in times of stress may learn to use their social support systems in a most preventive manner: to increase their coping abilities prior to the onset of serious dysfunction.

Outline of the Study

The research reported in this dissertation is structured around the support systems of a group of women, most of whom live in small cities and towns of New England. The sample of 200 women was drawn from a larger group, all of whom had attended some educational experience (typically a conference or a workshop) at Keene State College, Keene, New Hampshire, between 1974 and 1976.

We surveyed the sample of 200 women as to demographic data and the nature of their support systems. From that initial group of participants, we drew a small sub-sample for the purpose of individual interviews.

In Chapter Two, which follows, we review literature relevant to the study. Specifically, we consider optimal functioning for women and appropriate definitions of mental health, support systems in the social environment, and the interrelationship between these elements. Attention is also directed toward the recent feminist movement in America, with a specific look at women's support and consciousness raising groups as they are discussed in the literature.

Chapter Three, the methodology section, elaborates on the details of the study. Descriptions of the sample, the participants who were personally interviewed, the process of their selection, and a discussion of the instruments (appended) takes place here; in addition, details of the study design, and data analysis are presented.

Results of the study are reviewed in Chapter Four, with all relevant findings reported. In Chapter Five the results are discussed,

and related to the current literature. Additionally, consideration is given to the implications of this investigation for further related studies.

C H A P T E R I I

LITERATURE REVIEW

Introduction

Presented in this chapter is an elaboration of selected theoretical and research issues that are of special importance to the study. We will consider further the topics of mental health and illness for women, some definitions and some possible determinants. As a related issue, we will consider the apparent differential rates of mental illness for men and women in different diagnostic categories. Additionally, attention will be directed toward the social environment; some studies which attempt to illuminate the relationship of social support to effective coping behavior will be reviewed. Lastly, consideration will be given to the current feminist movement in the United States, its origins, and its functions, both manifest and latent.

Conceptions of Mental Health

(a) Sex-role stereotypes

Definitions of mental health vary widely, and often depend upon who *does* the defining and who *is being* defined. Broverman et al. (1970) found that their sample of clinical professionals had very different definitions of mental health for men as compared with women. The definitions paralleled sex-role stereotypes (i.e., healthy men are aggressive while healthy women are passive), and this finding was consistent

in both male and female mental health workers. Additionally, definitions of healthy adult, sex unspecified, typically paralleled "healthy male" and were not compatible with "healthy female." Thus, six or seven years ago there was apparently a double standard in the conceptions of mental health held by a number of clinicians. Unfortunately, the degree to which these earlier attitudes are currently prevalent is difficult to assess.

It is assumed that the social changes of the late 1960's and early 1970's, which emphasized the range of inequities between the sexes, have affected informal and formal mental health caregivers, their attitudes and value systems. This assumption, however, is largely undocumented.

(b) Androgyny

Publication of articles suggesting new sex-role models and conceptions of mental health has begun. Sandra Bem, a researcher particularly concerned with sex-roles, has proposed the notion of androgeny as a solution to many of the emotional and behavioral traps of traditional sex role stereotypes (1974, 1975a & 1975b). Androgynous persons manifest qualities that are both stereotypically male and female. Thus, for example, androgynous males embody personality characteristics and behaviors which are typically thought of as feminine (i.e., gentleness) while at the same time being assertive. Bem's interpretation of her research suggests that androgynous persons have more behavioral options and aren't limited to responding stereotypically to life's events. Approximately 35 percent of the Stanford University students Bem has

studied have androgynous personalities and, in her opinion, have more effective coping skills than their non-adrogynous contemporaries. According to Bem, androgynous persons can deal with a wider range of situations as they have more behavioral options; as such, they embody a new definition of mental health (1975b).

Kaplan (1976) offered a second perspective on the value of androgeny, and arrived at some recommendations for therapy with women based on an androgenous model. Thus, women can be encouraged to recognize the legitimacy of both their feelings of anger (which are not a part of the traditional female sex-role stereotype) and their feelings of dependency (which are generally expected of women).

Factors Influencing Mental Health and Illness

While Bem's position is that both men and women need to increase their behavioral repertoires and the number of emotional qualities they can reflect, some researchers have confined their consideration of mental health more specifically to women. In considering this issue, several factors need clarification before discussing factors which influence mental health and illness for women.

(a) Prevalence of mental illness for women

First is the epidemiological or prevalence question. Are more women mentally ill than men? This is indeed a difficult question. We know from previous research (Hollingshead and Redlich, 1968) that mental health is apparently related to social class. Specifically, factors such as the prevalence of illness, diagnostic assignments, and

choice and duration of treatment were found to be differentially affected by social class. What is the possibility that sex has a differential impact on these factors?

In Chapter I we reviewed some recent studies which suggest that women are more generally represented among the mentally ill than men, in Western Europe and North America. These considerations of the prevalence of mental illness among males and females typically draw on quantitative data and statistics. Interpretation of these data and calculations must be approached with the greatest care. Guttentag, Salasin, Legge, and Bray (1975) cite many of the problems in drawing conclusions about the prevalence question in their exhaustive review of all recent empirical studies which have relevance to the issue. Consideration must be given to the types of data being interpreted; are they raw data or do they represent rates of illness, and as such are they adjusted to reflect sex differences in the population? Are the data "utilization" figures which are then only representative of persons coming for treatment? Or, do they represent community surveys, in which all people have an equal chance of being studied? In relation to these concerns, are women more likely than men to seek treatment for emotional discomfort? Do women respond to stress in a way that differs from men? Perhaps women simply exhibit more affect.

Guttentag et al. (1975) have done a massive survey of data on sex differences in utilization rates of publicly supported mental health facilities. Additionally, they reviewed community surveys and general epidemiological studies. Among their findings is that men may have higher rates of emotional illness than women in most diagnostic categories.

This interpretation is in contrast to earlier findings in the area of sex differences and rates of mental illness (see Bernard, 1972; Gove & Tudor, 1972). Guttentag et al. make a very good case for their comment "that no conclusions may be drawn concerning the relative prevalence of general mental illness among men and women. Before any comparisons may be made between the relative risk of men and women for mental illness, the type of mental illness must be explicitly stated" (p. 16).

(b) Depression in women

Following the work of Guttentag and her colleagues, we find that in most age categories women show higher rates of mental illness than men for affective, depressive and neurotic disorders. More specifically, a larger number of females (than males) are diagnosed as depressed in the United States. The most common diagnosis for women in State and County mental hospitals is schizophrenia. However, Guttentag et al. report that in all other types of facilities, depression is the leading diagnosis for women. Depression is also the leading diagnostic category for women studied in community surveys (Radloff, 1975; Weissman, 1975).

Some tentative conclusions can be drawn about women's vulnerability to depressive disorders. Of primary concern is that women appear to be at greater risk than men within this diagnostic classification. Thus, while rates of mental illness may be roughly equal between males and females, symptomatology does appear to be related to sex. Weissman (1975) of the Yale University Depression Unit, in a review of community studies, comments that "the degree of symptoms found in community studies appear to reflect actual (sex) differences and are not an artifact of response bias" (p. 6).

Guttentag (1975), in an excellent article on the effects of sexism, interprets some of the relevant data on the question of women and their risk for depression. She suggests a connection between "both the direct and indirect effects of sexism to symptomatology" (p. 1).

While empirical studies of the effects of sexism on the mental health of women are lacking, this postulated relationship is worth considering. Of additional interest are two other theoretical explanations for women's vulnerability to depression. One particular construct, learned helplessness (originated by Seligman, 1975) has won endorsement by many persons currently doing research in this area. Guttentag et al. (1975), Radloff (1975) and Weissman (1975) have all suggested that women learn to be helpless. This phenomenon is considered to be a function of socialization processes; women are encouraged to be passive and do not develop effective problem-solving skills. When combined with women's pre-existing lack of power within the social structure, these two phenomena render many women into ineffective problem-solvers who do not exhibit coping skills, much less mastery of life situations.

Guttentag et al. cite a second possible explanation for the greater vulnerability of women to depression. They propose an additive stress model in which stressful occurrences, generally external to persons, i.e., illness, moving, job change, and poverty, are cumulative. Thus, the number of stresses a person is exposed to is directly affecting the strain they feel. Combining the postulated learned helplessness with the additive stress model provides a framework for considering the complex questions surrounding women and their vulnerability to depression.

(c) Stress

Quite recently there has been considerable research relating stressful events to a range of physical illnesses including coronary heart disease, depression, and accidents (Dohrenwend & Dohrenwend, 1974; Myers, Lindenthal, Pepper & Ostrander, 1972; Rahe, 1972; Vinokur & Selzer, 1973). A smaller number of studies have considered the relationship of stress to emotional problems (Dohrenwend, 1973; Myers, Lindenthal, and Pepper, 1975; Qaykel, Myers, Dierelt, Klerman, Lindenthal, and Pepper, 1969).

To measure stress, many of these studies have used the Schedule of Recent Events (Holmes & Rahe, 1967), or a modification of the schedule, an instrument which taps a variety of life events. The schedule generates the number, and type of life stresses; additionally, responses to the instrument can be summed, thus creating a measure of individual stress magnitude. A measure of this last dimension could be helpful in determining the additive stress factor, and as such could be used to predict illness and, more specifically, depression in women.

An Intervening Variable: The Social Environment

In Chapter I we introduced the notion of social support, and briefly discussed its relationship to effective coping. This association has been discussed by several people working in the field (Antonovsky, 1974; Caplan, 1974; Caplan & Killilea, 1976; Todd, 1974). Gerald Caplan (1974), in discussing the relationship between general susceptibility to illness and social support, has commented that:

> The essential pathogenic element appears to be that relevant messages about expectations and evaluations of an

> individual's behavior are not being consistently communicated, or else that the individual is unfamiliar with expectations and the evaluative cues of those around him--including the signals that enable him to anticipate the friendliness or hostility of others (p. 1).

The degree to which social support intervenes or affects susceptibility to illness, or general environmentally induced stress, was demonstrated in a survey study by Robert Caplan et al. (1975) of approximately 2,000 male workers. They proposed two kinds of social support which act as buffers between environmental stress and individual strain: one, tangible support, such as money, medical care, and transportation; and, two, emotional support such as friendship, advice, affection, sympathy, and understanding.

Caplan and his colleagues were interested in identifying job stresses and ways of dealing with them. Their hypothesized relationship between job demands and stress was confirmed by their findings. Further, their expected relationship between job demands, stress, and social support was also confirmed. Thus, it appears that social support from a variety of sources (on the job from supervisors and fellow workers, and at home from family) is apparently a buffer between job stress and strain.

Continuing a consideration of sound support as an intervening variable, an interesting study was done by Voth and Orth (1973) in which factors influencing the recovery of psychiatric patients were investigated.

> Inspection of the effects of human support on patient change suggests a positive relationship between these two variables.

> Comparing patients who were lacking in human support with those who had such support revealed significant differences. It follows that good human supports from family and friends should facilitate psychic repair and maturation during treatment (p. 83).

In an unrelated study, but one which has implications for the usefulness of social support and the vulnerability of women to depressive disorders, Warren (1975) conducted a community survey of the use of informal helpers by males and females. She studied working people and the individuals they sought out in times of difficulty. Interestingly, Warren found that blue-collar males sought assistance from their wives 58.2 percent of the time, while blue-collar females sought out their husbands only 40.5 percent of the time. This difference in the use of helping systems was significantly greater than that found in white collar spouse systems. A further finding in Warren's study is that blue-collar men turn to their co-workers for assistance 34.6 percent of the time, while their female counterparts turn to their co-workers only 18.9 percent of the time. And, perhaps most interestingly, Warren found that blue-collar women are most likely to turn to their pastors for support when they are experiencing stress.

While the Warren study does not confirm the effectiveness of social support systems, it does illustrate an interesting point. Consider, for a moment, the women Guttentag et al. (1975) have described as being most at risk for a depressive disorder.

> It is the single parent mother, who is poorly educated and has a low income and who has no one with whom to share the burden of raising and supporting a family, who is experiencing

> the greatest life stresses. That these life stresses lead to mental illness is suggested by the fact that separated/divorced individuals show high rates of mental illness. Next in order of stress are married working mothers in low job levels (p. 13). [my emphasis]

Thus, the women Guttentag et al. consider the second most at risk for depressive disorders may also be the women who, in Warren's study, did not use their "available" social support systems.

In sorting out these complex issues it is unclear what is cause and what is effect. Are the support systems of the women we are concerned with inadequate? Or, are women simply less likely to make use of those which are available? And, to what degree are those problems also true of middle class women, whose stresses may be less but who also may have need for social support?

Returning, momentarily, to the constructs of learned helplessness and additive stress, it does seem reasonable that the woman described above by Guttentag et al. is susceptible to depression. And further, it is possible that she is representative of many women (or, at the most, she is an extreme example) across socio-economic classes, who need to both develop more effective coping skills and learn to be less helpless.

To further illustrate the use of social support systems, we will consider two studies of life crises. Croog, Lipson, & Levine (1972) studied a group of 345 men having experienced their first myocardial infarction, and their use of helping systems. Among their findings was the relative lack of importance attributed to community services by the ill; indeed, family were found to provide considerable care for

the patient. However, contributing equally were people outside of kin categories, i.e., neighbors, and friends. Aside from contact with doctors and ministers, patients in the sample reported very little contact with professionals.

A few recent, unrelated, studies have provided further information of relevance to the postulated relationship between life events or stresses, social support, and emotional/physical health and illness. Cohler (1974) investigated mothers of young children who were in psychiatric hospitals, and considered the quality of their social relations and quantity of life stresses. Lem and Lem (1976) studied a sample of college undergraduates for the purpose of exploring their stresses, social supports, and both physical and emotional well-being. McKinley (1973) in a study of help-seeking behavior in eighty-seven working class Scottish families, found differential rates in the use of health and welfare services depending upon the density of families' social behaviors; service under-utilizers had more <u>available</u> relatives, often living in the same house, or in close geographic distance. Health and Welfare Service users had less access to relatives. A final study related to coping with life crisis is that of Nuckolls et al. (1972), who investigated issues arising from pregnancy complications in one hundred and seventy women. For women determined to have high life stress both before and during pregnancy, those with good psychosocial assets had one-third the pregnancy complications of those with poor psychosocial assets.

The last study to be described in this sub-section illustrates the practical aspects of social support. Lee (1969) investigated the

processes surrounding the obtaining of abortions prior to their legalization. Generally speaking, many women in Lee's sample of approximately 85 who had had abortions found abortionists through informal information systems made up of other women. Though Lee was not specifically concerned with the socially supportive aspects of this communication network, her data do suggest that many women did share their abortion experiences with each other. Drawing any conclusions from Lee's study relative to the supportiveness of such conversations would be inappropriate. However, the obtaining of an abortion is even now a stressful experience for women and was likely to be even more stressful prior to its legalization. Additionally, illegal abortions often carried a stigma--they were not necessarily acceptable procedures. Conversations about where to seek an abortion, who was a good and reliable abortionist, and the various procedures involved, could serve to illustrate tangible support, i.e., information. Further conversations involving sympathy and affection could reflect more the emotional support we have described.

To summarize, we have briefly considered the notion of support systems, and their general helpfulness to people in negotiating their lives. We've mentioned the research by Caplan (1975) on occupational stress, which suggests the helpfulness of social support in reducing worker strain and illness. Warren's study of sex differences in the uses of informal helping has also been considered. Finally, we mentioned Lee's (1969) study of abortion seekers as an illustration of another kind of informal support women gave each other.

Feminism and Women's Groups

Throughout our consideration of various kinds of social support we have generally encountered only non-systematic, spontaneous, unplanned forms of social support. This may well be consistent with our focus on informal helping, as distinguished from that which is more formal (and as such generally stems from professional caregivers, doctors, therapists, etc.).

The current feminist movement in the United States provides us with an example of a rather unique form of social support women's groups. In the late 60's and early 70's, women's groups were initially described as consciousness-raising (CR) groups. Their focus was on alerting participants to the various forms of sexism to be encountered within the social climate of that time, and preparing each other to confront these problems directly. "The goal of the consciousness-raising groups is to change the social structure through the individual" (Kirsch, 1974).

Freeman (1975) suggests that by 1971 consciousness-raising groups were becoming obsolete and outdated. The educative function which had originally characterized consciousness raising groups had been informally taken over by the media, who were at that time very busy publicizing women's liberation, its values and politics. Women originally interested in CR groups began to move in several different directions, but particularly toward action projects.

Women's groups still exist today, however they are commonly called support groups (SG). Five years ago these groups had a social

change function, and were primarily organized through feminist network contacts. As such, they were excellent examples of informal social support systems. Today's women's support groups have a very different flavor. Their primary function appears to be providing members with emotional support which, as we've defined it, includes advice, encouragement, affection, and sympathy. As such, these groups do resemble attempts at personal therapy as suggested by Kirsh (1974) in her discussion of women's groups.

Interestingly, many current women's support groups continue to be organized informally, through feminist network contacts. However, some attempts have been made by institutional structures such as colleges, mental health centers, and women's centers, to systematize and sponsor the groups. As such, some women's support groups are now examples of more formal social support. Within these structures, women's support groups often have a therapeutic emphasis and are generally time-limited (typically eight to twelve weeks).

Most research on women's groups has been qualitative and as such, generally descriptive. There has been no attempt, that we know of, to clarify the differences between the various kinds of women's groups. In relation to the study being proposed, however, the history of women's group types is salient.

Initially, women's groups sprang up on their own, with no institutional support. There are no data to document how many women have participated in these experiences. What is remarkable, though, is that without any sources of financial assistance, without sponsorship,

government funds or foundation support, certainly hundreds of thousands of women availed themselves of these informal experiences. Today, the picture is somewhat different, as women's groups are more frequently initiated and supported by institutional structures.

For the purposes of this study, both women's consciousness-raising and support groups appear to illustrate a rather extensive and grass roots movement toward informal helping and caring. The initial consequences and intentions of these two kinds of feminist groups may well be separate topics which we could consider as latent and manifest functions. Merton (1968) suggests that manifest functions are those consequences consciously intended, or at least perceived by participants. Latent functions are those consequences which are neither consciously intended nor perceived by participants.

It is conceivable that the original consciousness-raising groups had a manifest function of social change toward greater equality between the sexes. However, a latent function of the groups appears to have been more along a personal support dimension. And, by 1972, this had been made explicit, with many women's groups being termed "support groups."

Following Gerald Caplan's lead on the value of social support in warding off illness, it is possible that many women's groups did originally perform this support function latently. That is, by providing each other with helpful feedback, information, and caring, women participants may well have learned (and may still be learning) how to more effectively negotiate the world, discriminate safely from threat,

accurately read the environment around them, and deal with feelings or helplessness. This possible increase in their coping effectiveness, and its potential impact on depression among women, deserve further investigation by those of us concerned with the primary prevention of mental illness in women. Surely if there are naturally occurring social aggregates which have taken on effective "training" functions for women, we need to understand them, use them, and above all offer them our support.

In this literature review we have considered both potential courses and effects of emotional dysfunction in women. Further, we have considered the facilitative role of social support systems which occur in the environment. In Chapter Three are elaborated the methods used in this study of life stresses, social support, and emotional functioning in a sample of two hundred women.

CHAPTER III

METHODOLOGY

Sample

The participants in the study were 200 women who attended various workshops and conferences at Keene State College, Keene, New Hampshire between 1974 and 1976. This arrangement was with the expressed permission of individuals of the college who were responsible for women's programming under the auspices of WERC (Women's Educational Resource Center) and WISE (Women's Information Service in Education).

The women in the sample ranged in age from approximately twenty through eighty-one. All lived in New England, primarily in small towns and cities of New Hampshire, Massachusetts, and Vermont.

On the basis of information collected from the administration of a questionnaire to the 200 women in the sample, it was possible to determine those women with conscious-raising or support group (CRORSG) experience and to determine the names of women who would be willing to be interviewed. In a second phase of the study, from among women willing to be interviewed, we selected 24 persons who were personally interviewed.

Instruments

Two forms of data collection were used in this study: mail questionnaires and interviews.

(a) Mail Questionnaire

The mail questionnaire (a final copy of the questionnaire is presented in Appendix B_2) was intended to provide data on several areas significant to the purposes of the study. Specifically, the questionnaire was the central method for investigating the relationships between successful coping with stress, the use of social support systems and adjustment in women. The questionnaire has four parts.

Part A is largely demographic, dealing with such issues as occupational position, marital status, educational experience, and therapeutic experience.

Part B the Schedule of Recent Events (Holmes & Rahe, 1967) covers the stresses experienced by participants in the past year. It provides a survey of these stresses, and a score for each participant, which represents the magnitude of their life stresses.

Part C deals with both a qualitative and quantitative assessment of persons in the social environment to whom participants turned for support. Additionally, Part C attempts to tap several attitude dimensions which were salient to the purposes of the study.

Part D of the mail questionnaire is a previously validated measure of personality, the Eysenck Personality Questionnaire (EPQ) by Eysenck & Eysenck (1975). The EPQ is a 90 item forced-choice questionnaire which has four sub-scales: psychoticism (P), Extraversion (E), Neuroticism (N) and Lie (L). Data collected from the EPQ was used to relate individual personality patterns to life stress and social support.

(b) Interview Schedule

Additional data was collected in individual interviews with twenty-four women. Personal interviews provided for the elaboration of experiences, feelings and facts not possible within the format of a mail questionnaire. There were several purposes for the interviews; 1) a desire to collect data of a more qualitative nature; 2) an interest in creating an opportunity for verbal exchange which would allow for the following of ideas through a conversation; and 3) a conviction that the interviews would provide "new" data and ideas untapped in the more structured format of the questionnaire, and this would lend itself to further investigations into our areas of interest.

The interview schedule was generated after a preliminary analysis of the survey data. This allowed for inclusion of questions in the interviews that provided data complementary to the purposes of the study, though perhaps data not sufficiently generated by the questionnaire itself.

In providing a structure for the elaboration of some of the central issues in this study, the interviews were important. Participants were asked about their social environment, their relationships and support systems. (This was partially accomplished by an abbreviated network map [Bott, 1969; Tolsdorf, 1974]). The interviews helped to round out the results of the study, and contributed some suggestions to those of us concerned with identification of buffers in the social environment. Perhaps those buffers will help people cope with stress and strain, and may well serve a preventive function in the reduction of illness. The interview schedule is presented in Appendix C.

Procedure

(a) Instrument Construction and Validation

The study involved the use of two instruments, a mail questionnaire and an interview schedule. Both of these instruments were pilot tested before their use in the data collection phase of the study. Two groups were involved in the piloting procedure: 1) professionals with competence in the critiquing of such instruments, and 2) a number of women similar to those in the sample being investigated. Comments and feedback from these people guided instrument revisions.

(b) Mail Questionnaire Implementation

After the instrument was successfully piloted and revised, the process of implementing the data collection phase of this study began.

A) A letter (Appendix A) introducing and explaining the study was mailed to 350 potential participants prior to the onset of the research. The letter was sent on Keene State College letterhead paper and preceded the arrival of the questionnaire by about one week.

B) The Cover Letter, Questionnaire, and Post Card (Appendices B_1, B_2, and B_3) were mailed together to the 350 women. This second letter again detailed the nature of the study; it assured participants of their anonymity and made an altruistic appeal for their cooperation.

To increase the percentage of returned questionnaires, four techniques were employed. One, the questionnaire package was mailed so that it arrived toward the end of the week. Two, an addressed, stamped return envelope was enclosed. Three, an elaborate set of follow-up procedures was initiated. And, lastly, all letters were typed on Keene

State College letterhead stationery, and indicated institutional sponsorship of the study. The procedures employed in this study have been widely used in survey research and found to be successful in obtaining high return rates (Warwick and Lininger, 1975). They were particularly important to the study because of the sensitivity of some of the questionnaire items which we felt would adversely affect the return rate. In order to make generalizations from the findings of this study, a high questionnaire return rate was essential; therefore, every effort was made to encourage respondents to participate in the study.

The follow-up procedures were begun with an addressed, stamped card enclosed with the mailed questionnaire. Participants were asked to fill out the card with their names and addresses, and to mail the card at the same time they returned the completed questionnaire. Additionally, the card posed two questions. One determined if they have participated in women's groups (CR or SG) and the second inquired about their willingness to be personally interviewed by the experimenter or her colleague. This procedure allowed for several helpful processes: 1) a running tally of those who responded was maintained, while assuring the total anonymity of the returned questionnaires; 2) a list was generated which indicated those respondents who had and had not participated in women's group experiences; and 3) a second list was developed which contained the names of those willing to be personally interviewed.

Individuals who had not returned the post card within twenty days of the questionnaire mailing became the people to be followed-up. Thus, we assumed that by not returning the post card they had also not

returned the questionnaire. Women in this situation who had telephones were contacted by the experimenter and asked to complete the questionnaire as quickly as possible. Those not having telephone numbers were not followed up and were dropped from the sample.

(c) Interview Implementation

Phase Two of the study, the Personal Interview, was initiated by a Cover Letter (Appendix C) on letterhead stationery of the Antioch Graduate School, Keene, New Hampshire, where the experimenter is a member of the faculty. The letter was followed by a telephone contact, and an interview appointment was arranged. The interviewees were asked for permission to tape record the sessions, and with the exception of three participants, all interviews were taped; interview sessions required from forty minutes to one hour for completion.

Interviews were conducted with twenty-three of the women who participated in the original mail survey. One interview, however, was discarded as both interviewers felt it was highly contaminated by the respondent's desire to produce socially acceptable responses.

(d) Social Support Scores

A Social Support Score (SSS) was calculated for women who participated in the study. Five items from the questionnaire were involved in the social support score analysis, including items: 24, 29, 34, 35, and 38. (These can be reviewed by referring to Appendix B_2.) Each item reflected either qualitative or quantitative aspects of social support. To assess whether all items contributed equally to the SSS, the coefficient alpha was calculated. The measure of homogeneity was .47.

The following procedure was employed to determine the SSS, with good social support yielding low values.

1) For questionnaire item 24, each sub-item was coded as follows: 1 (very helpful), 2 (helpful), 3 (somewhat helpful), 4 (not helpful, not applicable, and blank). The nine sub-items were summed, producing a value for question 24 that ranged from 9 to 36.

2) For questionnaire item 29, the scoring procedure was identical to that employed in item 24.

3) The scoring of item 34 was as follows: 1 (not difficult), 2 (rarely difficult), 3 (somewhat difficult), 4 (difficult), 5 (very difficult, not applicable, and blank). The nine sub-items were summed, producing a value for question 35 that ranged from 9 to 45.

4) For item 35, a value ranging from 9 to 45 was also possible. The scoring was consistent with that reflected in the questionnaire. That is, 1 (all), 2 (most), 3 (some), 4 (few), 5 (none), with blanks scored as zeros. The selected response was multiplied by nine to produce a value to be included in the SSS.

5) The scoring of item 38 was identical to that of item 35, with the exception that the values indicated in the questionnaire were reversed to maintain the relationship between low values and good social support.

6) Responses to the five items were summed, producing the Social Support Score. Missing data on items 35 and 38 were treated as missing cases (i.e., these women were not included in the SSS analysis).

CHAPTER IV

RESULTS

Introduction

In this chapter we will systematically describe the data collected with the survey questionnaire and from the personal interviews. First, we will present demographic information on the sample of women studied. Second, we will report information about the women who had participated in women's group activities. Third, we will report the results of our study of life satisfaction. Fourth, we will review data related to social support, life stress, and personality. Fifth, we will present data collected in the personal interviews dealing with social support. Percentages, cross-tabulations, and correlations were the primary modes of analysis. In the final section of this chapter, we will report our study of predictors of several outcome measures (life satisfaction, life stress, social support, psychoticism, extraversion, and neuroticism).

The questionnaire was mailed to three hundred and fifty women living in Northern New England, primarily in New Hampshire and Vermont. Two hundred questionnaires were completed and returned in the mail. The return rate of questionnaires was fifty-seven percent.

The personal interviews were conducted with a sample of twenty-three volunteers from the initial group of two hundred respondents. Twelve of the women interviewed had experiences in women's groups.

Demographic Data

Some demographic results are summarized in Table 1. About 66 percent of the women were between the ages of 26 and 45, though women in the age range from 18 to 81 were represented in the sample. About 58 percent of the sample reported being married, while 14 percent were divorced, and 11.5 percent were single. Of the 200 participants in the study, roughly 79 percent had children. The sample was a highly stable one with regard to geographic mobility; about 72 percent of the women had lived in their current areas of residence for more than three years. Sixty-one percent of the sample reported being employed outside the home.

Item eight on the questionnaire, dealing with employment, was drawn from Hollingshead's Two Factor Index of Social Position (1963). Of the seven types of occupations listed in question eight, a high percentage (43 percent) of the employed women (61 percent of the sample) were in level two jobs. About 56 percent of the employed women reported being in either level one or two positions. This would suggest that in the sample were a number of highly skilled, competent women who were part of the labor force. The majority of other employed women (35 percent) reported jobs at levels three and four.

The women in the study were also asked about their income and educational levels. Income was rather evenly distributed from $0 to over $20,000. With regard to education, slightly more than half (54 percent) of the women had not completed college, while 46 percent had.

Of the study participants, 53 percent considered themselves to be feminists, and 51 percent had been in formal counseling or therapy.

TABLE 1

PERCENTAGE OF RESPONSES TO THE DEMOGRAPHIC QUESTIONS

Question	Percentage of Responses (N=200)
1. What is your present age?	
(1) 25 or below	14.0
(2) between 26-35	41.5
(3) between 36-45	24.5
(4) between 46-55	11.5
(5) between 56-65	6.5
(6) over 65	2.0
2. What is your present marital status?	
(1) divorced	14.0
(2) living with opposite sex person	4.5
(3) living with same sex person	3.5
(4) married	58.0
(5) separated	6.5
(6) single	11.5
(7) widowed	2.0
3. Do you have children?	
(1) yes, 1	16.2
(2) yes, 2	27.8
(3) yes, 3	19.7
(4) yes, 4	9.6
(5) yes, 5 or more	5.6
(6) no	21.2
Omits = 2	
6. How long have you lived in the area in which you are currently a resident?	
(1) less than one year	8.0
(2) between one and three years	20.0
(3) more than three years	72.0
7. Are you presently employed outside the home?	
(1) yes	61.3
(2) no	38.7
Omits = 1	

TABLE 1 (Continued)

Question	Percentage of Responses (N=200)
8. Seven types of occupations are listed below. Which one describes your job?	
(1) executives, proprietors of large concerns, dentists, lawyers, physicians, teachers at universities and colleges	13.2
(2) managers and proprietors of medium-sized businesses, and medium level professionals (e.g., personnel managers, nurses, social workers)	43.0
(3) administrative personnel of large concerns, owners of small independent businesses	14.0
(4) owners of little businesses, clerical and sales workers	21.5
(5) skilled workers	2.5
(6) semiskilled workers	1.7
(7) unskilled workers	4.1
Omits = 79	
9. What was the gross income reported on your 1975 income tax return?	
(1) $0-4,000	16.9
(2) $4,001-8,000	12.7
(3) $8,001-12,000	16.9
(4) $12,001-16,000	18.0
(5) $16,001-20,000	13.2
(6) over 20,000	22.2
Omits = 11	
10. What is the highest educational level reached by you?	
(1) some elementary school	0
(2) completion of elementary school	0
(3) some high school	2.0
(4) completion of high school	18.0
(5) partial college or professional training	34.5
(6) completion of college or professional degree	26.0
(7) completion of a graduate degree	19.5

TABLE 1 (Continued)

Question	Percentage of Responses (N=200)
17. Do you consider yourself a feminist?	
(1) yes	52.8
(2) no	18.3
(3) unsure	28.9
Omits = 3	
18. Have you ever been in formal counseling or therapy?	
(1) yes	50.8
(2) no	49.2
Omits = 1	
19. When did your last formal counseling or therapy take place?	
(1) more than four years ago	20.0
(2) between two and four years ago	20.0
(3) between one and two years ago	10.0
(4) within the past year	50.0
Omits = 100	

It is possible that our sample was not representative of American women in general on these two dimensions. While national figures on such questions are unavailable for comparisons, it is conceivable that a higher proportion of our sample both espoused feminism and had counseling/therapy experience than would be the case nationally. Of those women who had been in therapy or counseling, 50 percent had done so in the past year. This information is particularly relevant to some of the later data analysis, as it provides a baseline from which to begin interpretations.

A final question, which provided information on the attitudes of women in the sample, dealt with the issue of discrimination. The results are reported in Table 2. Forty-two respondents (21 percent) reported having not experienced any form of discrimination as women. Interestingly, the three most frequently indicated areas of discrimination related to women and the world of work.

To provide additional insights into the data, women in the sample were divided into two age groups: over 35, and 35 and under. The demographic results of the two age groups were compared. However, age did not significantly divide the sample on any of the demographic questions with the exception of time of therapy. The results are summarized in Table 3. A higher percentage of the younger women had received therapy in the last year.

It was particularly interesting to note that age did not significantly differentiate the sample on the question about their espousal of feminism. This is especially meaningful given the wide age-range

TABLE 2

PERCENTAGE OF WOMEN REPORTING VARIOUS FORMS OF DISCRIMINATION

Question	Percentage
16. Below are listed several situations in which women have reported discrimination. Please circle any of these situations in which you have experienced discrimination.	
(1) career counseling	30.5%
(2) college/graduate school	11.5%
(3) employment seeking	31.5%
(4) job promotion	23.0%
(5) salary	35.5%
(6) credit applications	30.0%
(7) housing	12.0%
(8) I have never experienced discrimination	21.0%

TABLE 3

RELATION BETWEEN THERAPY RECENCY AND AGE

Question	Age	
	Older Than 35 (N=42)	35 or Less (N=98)
18. When did your last formal counseling or therapy take place?		
(1) more than 4 years ago	38.1%	6.9%
(2) between two and four years ago	15.7%	22.4%
(3) between one and two years	9.5%	10.3%
(4) within the last year	35.7%	60.3%
$\chi^2 = 19.22$ with 3df	$p < .001$	

of persons participating in the study (20 percent of participants were 46 years of age or older). One possible explanation for this finding is that women of different ages may have different views or definitions of "feminism." A second possible explanation of this interesting result is that the current American feminist movement may have affected women of all ages, rather than just young women.

Women's Group Experience

Of the women in our sample, 57 percent reported having had experiences in women's groups. We were interested in motivational factors that might influence women to participate in such groups. The results are summarized in Table 4. "To increase self-knowledge" was rated as "very important" by an overwhelming number of respondents (76.4 percent). Three other motivational factors were also endorsed by over 30 percent of the women as being "very important." These are: "to put more meaning in life," "to learn about other women and their lives," and "to consider some problems I was having." These data suggest that women in our sample had some distinct purposes and expectations in mind when they entered women's groups.

Only one motivational difference was found between women over 35 from those 35 and under. The younger women were more likely to have joined a women's group "to consider some problems I was having" than older women. (The percentages were 45.0 percent and 26.2 percent, respectively).

TABLE 4

AN ANALYSIS OF THE REASONS FOR WOMEN JOINING WOMEN'S GROUPS
(N=114)

Reasons	Omits	Rating			
		Very Important	Important	Somewhat Important	Not Important
(1) to do something different	15	9.1%	19.2%	33.3%	38.4%
(2) to make new friends	14	11.1%	26.0%	37.0%	26.0%
(3) to learn about other women and their lives	7	36.4%	43.9%	15.9%	3.7%
(4) to increase self-knowledge	4	76.4%	18.2%	5.5%	0.0%
(5) to have a new social activity	19	5.1%	13.3%	36.7%	43.9%
(6) to put more meaning in life	12	38.8%	32.0%	16.5%	11.7%
(7) to consider some problems I was having	9	33.3%	33.3%	20.0%	13.3%
(8) to satisfy my curiosity	16	4.0%	12.1%	30.0%	52.5%
(9) to get help making some important decisions	16	19.2%	27.3%	24.2%	32.3%
(10) to deal with my loneliness	9	20.0%	16.2%	21.9%	41.9%

Life Satisfaction

When asked to rate their overall life satisfaction, 3.5 percent of the women indicated they were extremely satisfied, 26.1 percent were very satisfied, 31.7 percent were satisfied, 33.2 percent were somewhat satisfied and 5.5 percent were not at all satisfied. Next, the women were sorted into two groups: those satisfied, and those less than satisfied or dissatisfied with their lives. In Table 5 are reported questionnaire results which were significantly different between the two groups. Differences were obtained on matters pertaining to marital status, geographic mobility, participation in formal counseling or therapy, and the recency of such an experience.

A questionnaire item (#20) was directed toward collecting data related to satisfaction on specific dimensions. These findings are also reported in Table 5, with the sample divided between women satisfied and those dissatisfied with life. Levels of satisfaction on many life dimensions, including relations with female friends and the primary relationship, are significantly associated with general life satisfaction. Other important satisfaction variables which are related to general life satisfaction include one's self-understanding, one's career, relationships with male friends, and one's sex life. Lastly, general life satisfaction was significantly related to one's satisfaction with the emotional support received from others, and relations with one's children.

Interestingly, of all the factors given satisfaction ratings in question twenty, relationship to parents was the only one not related significantly to level of life satisfaction.

TABLE 5

RELATIONSHIPS BETWEEN SELECTED QUESTIONS AND LEVEL OF SATISFACTION

Question	Level of Satisfaction	
	Satisfied (N=122)	Dissatisfied (N=77)
2. What is your present marital status?		
(1) divorced	9.0	22.1
(2) living with opposite sex person	4.9	3.9
(3) living with same sex person	4.1	1.3
(4) married	67.2	44.2
(5) separated	1.6	14.3
(6) single	10.7	13.0
(7) widowed	2.5	1.3
χ^2 = 23.46 with 6 df	p <.001	
Omits = 1		
6. How long have you lived in the area in which you are currently a resident?		
(1) less than one year	4.9	11.7
(2) between one and three years	15.6	26.3
(3) more than three years	79.5	61.0
χ^2 = 8.31 with 2 df	p <.01	
Omits = 1		
17. Have you ever been in formal counseling or therapy?		
(1) yes	42.1	63.6
(2) no	57.9	36.4
χ^2 = 7.85 with 1 df	p <.01	
Omits = 2		

TABLE 5 (Continued)

Question	Level of Satisfaction: Satisfied (N=122)	Level of Satisfaction: Dissatisfied (N=77)
19. When did your last formal counseling or therapy take place?		
(1) more than 4 years ago	32.0	8.2
(2) between 2-4 years ago	24.0	16.3
(3) between 1-2 years ago	12.0	8.2
(4) within the past year	32.0	66.3
χ^2 = 14.28 with 2 df	p <.01	
Omits = 101		
20. Below are listed several aspects of women's lives. At the present time, how satisfied are you in each of the areas listed below?		
A. Relations with female friends		
(1) very satisfied	33.6	18.2
(2) satisfied	44.3	34.8
(3) somewhat satisfied	18.0	41.6
(4) not satisfied	4.1	6.5
(5) not applicable	0	0
χ^2 = 15.52 with 3 df	p <.001	
Omits = 1		
B. Primary relationship		
(1) very satisfied	44.1	7.8
(2) satisfied	35.6	22.1
(3) somewhat satisfied	10.2	20.8
(4) not satisfied	5.1	28.6
(5) not applicable	5.1	20.8
χ^2 = 55.15 with 4 df	p <.001	

TABLE 5 (Continued)

Question	Level of Satisfaction	
	Satisfied (N=122)	Dissatisfied (N=77)
C. Understanding of yourself		
(1) very satisfied	25.6	6.6
(2) satisfied	47.9	23.7
(3) somewhat satisfied	21.5	48.7
(4) not satisfied	4.1	21.1
(5) not applicable	.8	0
χ^2 = 41.57 with 3 df	p <.001	
Omits = 2		
D. Your career		
(1) very satisfied	19.0	1.4
(2) satisfied	32.4	17.1
(3) somewhat satisfied	24.8	20.0
(4) not satisfied	14.3	52.9
(5) not applicable	9.5	8.6
χ^2 = 36.06 with 4 df	p <.001	
Omits = 25		
E. Relationships with male friends		
(1) very satisfied	12.9	5.2
(2) satisfied	57.8	23.4
(3) somewhat satisfied	19.8	22.1
(4) not satisfied	7.8	42.9
(5) not applicable	1.7	6.5
χ^2 = 44.44 with 4 df	p <.001	
Omits = 7		

TABLE 5 (Continued)

Question	Level of Satisfaction	
	Satisfied (N=122)	Dissatisfied (N=77)
F. Your sex life		
(1) very satisfied	26.7	9.1
(2) satisfied	47.5	14.3
(3) somewhat satisfied	12.5	31.2
(4) not satisfied	10.8	40.3
(5) not applicable	2.5	5.2
$\chi^2 = 49.70$ with 4 df	$p < .001$	
Omits = 3		
G. Emotional support you receive from others		
(1) very satisfied	23.5	3.9
(2) satisfied	51.3	19.5
(3) somewhat satisfied	17.6	53.2
(4) not satisfied	7.6	19.5
(5) not applicable	0	3.9
$\chi^2 = 52.35$ with 4 df	$p < .001$	
Omits = 4		
H. Relationships with your children		
(1) very satisfied	36.3	11.0
(2) satisfied	36.3	34.2
(3) somewhat satisfied	4.4	27.4
(4) not satisfied	5.3	11.0
(5) not applicable	17.7	16.4
$\chi^2 = 30.18$ with 4 df	$p < .001$	
Omits = 14		

The results of two final questionnaire items which relate indirectly to life satisfaction and the nature of interpersonal relationships are reported in Table 6. The majority of women in the sample (79 percent) indicated a desire to change some aspect of their relationships. The most frequently suggested changes included a desire for: more honesty, improved communication, greater mutuality/equity, and more independence/self reliance. Analysis of data for women of different age groups also revealed some interesting results. These data are reported in Table 7. More women over 35 years of age placed priority on achieving greater "closeness", while those 35 and under were more frequently concerned with "improving communication."

Life Stress

Two distinct attempts were made to assess current stresses in the lives of women. The results of the first attempt are reported in Table 8. Three stress areas were cited as being major problems by at least one quarter of the women. They are: emotional discomfort (30 percent), financial concerns (26 percent), and disharmony with husband/partner (25 percent).

Cross-tabulations were calculated on this stress data by dividing the sample on several salient dimensions. These included age, reported life satisfaction, and participation in women's groups. Response patterns on the three major stresses did not differ significantly in relation to age. However, when the sample was divided between those reporting satisfaction with life and those reporting less than satisfaction, significantly different response patterns were observed in

TABLE 6

PERCENTAGE OF RESPONSES TO QUESTIONS REGARDING THE CHANGING OF INTERPERSONAL RELATIONSHIPS

Question	Percentage of Responses (N=200)
36. Is there anything about your relationships with others that you would like to change?	
(1) yes	78.9
(2) no	21.1
Omits = 6	
37. What changes do you want to see in your relationships?	
(1) improved communication	20.3
(2) greater confidence on my part	3.3
(3) more closeness	25.5
(4) more honesty	17.6
(5) more mutuality/equity	17.6
(6) more independence on my part	5.2
(7) greater attention to my sexuality	2.0
(8) more assertiveness on my part	3.3
(9) more relationships	5.2
Omits = 47	

TABLE 7

RELATION BETWEEN AGE AND DESIRED CHANGES IN RELATIONSHIPS

Question	Age	
	Older than 35 (N=65)	Younger than 35 (N=88)
37. What changes do you want to see in your relationships?		
(1) improved communication	14.8%	27.7%
(2) greater confidence on my part	1.1%	6.2%
(3) more closeness	30.7%	18.5%
(4) more honesty	22.7%	10.8%
(5) more mutuality/equity	17.0%	18.5%
(6) more independence on my part	6.8%	3.1%
(7) greater attention to my sexuality	1.1%	3.1%
(8) more assertiveness on my part	1.1%	6.2%
(9) more relationships	4.5%	6.2%

$\chi^2 = 16.0$ with 8 df $\quad p < .05$

Omits = 47

TABLE 8

PERCENTAGE OF RESPONSES TO SEVERAL QUESTIONS ABOUT STRESS

Question	Percentage of Responses (N=200)
25. Please indicate the degree to which the situations below were concerns for you in the last year.	
A. Illness in your family	
(1) a major problem	14.2
(2) a moderate problem	13.2
(3) somewhat of a problem	14.2
(4) a minor problem	12.6
(5) not a problem	45.8
Omits = 11	
B. Illness on your part	
(1) a major problem	8.9
(2) a moderate problem	7.3
(3) somewhat of a problem	7.9
(4) a minor problem	18.3
(5) not a problem	57.6
Omits = 9	
C. Financial concerns	
(1) a major problem	26.0
(2) a moderate problem	17.2
(3) somewhat of a problem	19.3
(4) a minor problem	19.8
(5) not a problem	17.7
Omits = 8	
D. Unemployment or job uncertainty	
(1) a major problem	18.8
(2) a moderate problem	9.1
(3) somewhat of a problem	16.7
(4) a minor problem	6.5
(5) not a problem	48.9
Omits = 14	

TABLE 8 (Continued)

Question	Percentage of Responses (N=200)
E. Disharmony with husband/partner	
(1) a major problem	25.1
(2) a moderate problem	8.7
(3) somewhat of a problem	8.7
(4) a minor problem	16.5
(5) not a problem	41.0
Omits = 17	
F. Problems with children	
(1) a major problem	10.6
(2) a moderate problem	8.3
(3) somewhat of a problem	15.0
(4) a minor problem	21.1
(5) not a problem	45.0
Omits = 20	
G. Legal difficulties	
(1) a major problem	4.0
(2) a moderate problem	4.5
(3) somewhat of a problem	3.4
(4) a minor problem	4.0
(5) not a problem	84.1
Omits = 24	
H. Emotional discomfort for you	
(1) a major problem	29.8
(2) a moderate problem	20.2
(3) somewhat of a problem	15.4
(4) a minor problem	17.0
(5) not a problem	17.6
Omits = 12	

TABLE 9

RELATIONSHIP BETWEEN SELECTED STRESS QUESTIONS AND LEVEL OF SATISFACTION

Question	Level of Satisfaction	
	Satisfied (N=122)	Dissatisfied (N=77)
25. Please indicate the degree to which the situations below were concerns for you in the last year.		
A. Unemployment or job uncertainty		
(1) a major problem	13.3%	26.4%
(2) a moderate problem	6.2%	13.9%
(3) somewhat of a problem	15.0%	19.5%
(4) a minor problem	5.3%	8.3%
(5) not a problem	60.2%	31.9%
χ^2 = 15.20 with 4 df		p <.01
Omits = 15		
B. Disharmony with husband/partner		
(1) a major problem	15.5%	38.9%
(2) a moderate problem	5.4%	13.9%
(3) somewhat of a problem	9.1%	8.3%
(4) a minor problem	20.9%	9.7%
(5) not a problem	49.1%	29.2%
χ^2 = 20.71 with 4 df		p <.001
Omits = 18		
C. Problems with children		
(1) a major problem	6.4%	17.4%
(2) a moderate problem	4.5%	14.5%
(3) somewhat of a problem	10.9%	20.3%
(4) a minor problem	22.7%	18.8%
(5) not a problem	55.5%	29.0%
χ^2 = 19.30 with 4 df		p <.001
Omits = 21		

TABLE 9 (Continued)

Question	Level of Satisfaction	
	Satisfied (N=122)	Dissatisfied (N=77)
D. Legal difficulties		
(1) a major problem	1.9%	7.4%
(2) a moderate problem	1.9%	9.0%
(3) somewhat of a problem	1.9%	4.5%
(4) a minor problem	3.7%	4.5%
(5) not a problem	90.7%	74.6%
χ^2 = 10.14 with 4 df		p <.05
Omits = 24		
E. Emotional discomfort for you		
(1) a major problem	14.1%	54.1%
(2) a moderate problem	18.6%	23.0%
(3) somewhat of a problem	19.5%	8.1%
(4) a minor problem	20.4%	12.1%
(5) not a problem	27.4%	2.7%
χ^2 = 45.29 with 4 df		p <.0001
Omits = 13		

all but two of the life stresses. The response patterns are reported in Table 9.

With regard to participation in women's groups, individuals having such experiences reported significantly greater stresses on the dimensions of financial difficulty and marital disharmony than those not having such experiences. And almost twice as many women's group participants as non-participants reported that these two areas had been major problems in the past year.

A second measure of stress, the Social Readjustment Rating Scale (Holmes and Rahe, 1967), was also included in the survey questionnaire. This measure reflects the magnitude of an individual's stress over the course of the last year in Life Change Units (LCU). Table 10 includes the frequency distribution of LCU scores. The LCU mean for our sample of 200 women was 190, with a standard deviation of 125.

The association between LCU scores and many demographic variables was also calculated. In Table 11 we report those cross-tabulations which were statistically significant. LCU scores were significantly related to age, marital status, and employment. Of those women aged 35 or less, approximately 44 percent indicated LCU scores over 200, as compared with 29 percent of the sample who were over 35 years of age. Divorced and separated women indicated higher LCU scores than married, or single women. Employed women reported higher LCU scores than those unemployed.

TABLE 10

FREQUENCY DISTRIBUTION OF LIFE CHANGE UNITS (LCU) [N=200]

LCU	Frequency
1 - 50	19
51 - 100	34
101 - 150	37
151 - 200	30
201 - 250	26
251 - 300	12
301 - 350	17
351 - 400	11
401 - 450	6
451 - 500	2
over 500	6

TABLE 11

RELATIONSHIPS BETWEEN LIFE CHANGE UNIT (LCU) AND AGE, MARITAL STATUS, AND EMPLOYMENT

LCU	Age	
	35 Years or Less (N=107)	Over 35 (N=89)
0 - 100	21.5%	41.6%
101 - 200	33.6%	29.2%
201 - 300	21.5%	16.9%
301 - 400	17.8%	10.1%
401 - 500	5.6%	2.2%

χ^2 = 15.26 with 5 df p <.01

Omits = 4

LCU	Marital Status						
	Divorced (N=27)	Living With Opposite Sex (N=9)	Living With Same Sex (N=7)	Married (N=115)	Separated (N=13)	Single (N=21)	Widowed (N=4)
0 - 100	22.2	22.2	0	39.0	0	28.6	25.0
101 - 200	11.1	33.3	28.6	36.5	23.1	33.3	50.0
201 - 300	25.9	22.2	28.6	14.8	38.5	19.0	25.0
301 - 400	25.9	22.2	42.9	7.8	23.1	19.0	0
401 - 500	14.8	0	0	1.7	15.4	0	0

χ^2 = 48.97 with 30 df p <.05

Omits = 4

TABLE 11 (Continued)

LCU	Employment	
	Not Employed	Employed
0	5.3%	2.5%
1 - 100	38.7%	20.0%
101 - 200	30.7%	32.5%
201 - 300	10.7%	25.0%
301 - 400	10.7%	15.8%
401 - 500	4.0%	4.2%

χ^2 = 12.75 with 5 df $p < .05$

Omits = 5

Cross-tabulations of Life Change Units with other salient variables such as income, one's level of formal education, and the presence of small children at home, revealed no significant differences. A further analysis of the Life Change Unit data involved a consideration of the Holmes and Rahe Scale in relation to womens' reports of recent self-illness. The Holmes and Rahe Scale has been found to be a good predictor of illness onset. Rahe (1968), for example, demonstrated that respondents with higher life change scores were more likely to become physically ill in a subsequent period than respondents with lower life change units. He also found multiplicity of physical illnesses to be associated with Life Change Units.

In the present study, participants were asked to rate the degree to which their own illness was a problem in the past year. (See Table 12, sub-item B for a frequency distribution). We were particularly interested in how these ratings might associate with life stress. Several analyses were conducted with the rating data in an effort to find any variables with which Life Change Units (LCU) were related. A correlation between seriousness of self-illness and LCUs ($r = .17$, $p < .01$) is reported in Table 12. Thus, among our sample of women there is a low correlation between self-illness and life stress as measure by the Holmes and Rahe Scale.

Intercorrelations were calculated among various demographic and attitudinal variables, and the Life Change Units. The intercorrelations are reported in Table 13, and most of them were low to moderate in strength. Age was significantly correlated with a number of

TABLE 12

RELATIONSHIPS BETWEEN SELF-ILLNESS AND AGE, AND YOUNG CHILDREN AT HOME

Question	Demographic Variable	
To what degree was illness on your part a problem in the last year?		
	Age	
	45 and Under (N=156)	Over 45 (N=35)
(1) a major problem	10.3%	2.9%
(2) a moderate problem	3.8%	22.9%
(3) somewhat of a problem	8.3%	5.7%
(4) a minor problem	15.4%	31.4%
(5) not a problem	62.2%	37.1%
χ^2 = 23.23 with 4 df	p <.001	
Omits = 9		
	Young Children at Home	
	Yes	No
(1) a major problem	13.2%	6.1%
(2) a moderate problem	1.3%	11.3%
(3) somewhat of a problem	5.3%	9.6%
(4) a minor problem	15.8%	20.0%
(5) not a problem	64.4%	53.0%
χ^2 = 11.35 with 4 df	p <.05	
Omits = 9		

TABLE 13

INTERCORRELATIONS AMONG SELECTED DEMOGRAPHIC VARIABLES AND ATTITUDINAL, AND LIFE CHANGE UNITS (LCU) DATA (N=200)

	Variable						
	2	3	4	5	6	7	8
1. Age	.33**	.03	-.37**	.05	+.09	-.33**	-.32**
2. Income		.09	-.05	.19**	-.09	-.04	-.29**
3. Education of Self			.13	-.19**	+.07	.05	.05
4. Recency of Counseling/Therapy				-.38**	-.01	.20*	.36**
5. Life Satisfaction					-.25**	-.04	-.23**
6. Self-Illness						-.07	+.17**
7. Small Children at Home							.02
8. Life Change Units							

** $p < .01$
* $p < .05$

variables, including income ($r = .33$, $p < .01$), recency of counseling therapy ($r = -.37$, $p < .01$), the number of small children at home ($r = -.33$, $p < .01$), and Life Change Units ($r = -.32$, $p < .01$). Perhaps most interesting among these data is the negative correlation between age and the Life Change Units, suggesting that younger participants reported larger magnitudes of life stress. Not unexpectedly, income was positively correlated with life satisfaction, and negatively correlated with Life Change Units.

Continuing with the intercorrelations in Table 12, education of self and life satisfaction are negatively correlated ($r = -.19$, $p < .01$); thus, among our sample, as level of educational attainment increased, satisfaction with life decreased. The variable of recency of counseling/therapy is significantly related to life satisfaction ($r = -.38$, $p < .01$), meaning that the more recent a person's therapy experience the less they are satisfied with life; additionally, it is positively correlated to having young children at home ($r = .20$, $p < .05$) meaning the more recent the therapy, the greater the number of young children at home among our sample. Lastly, recency of therapy is significantly correlated with the magnitude of Life Change Units ($p < .001$), indicating that among our respondents the greater their LCU's, the more recently they were in a counseling, or therapy relationship.

One last correlation reported in Table 12 is of relevance to this study. Life Change Units were negatively correlated with life satisfaction ($r = -.23$, $p < .01$) indicating that, among our women, satisfaction with life decreased as life stresses, or LCUs, increased.

Though this correlation is moderate in strength, it does suggest an interesting relationship between these two variables.

Social Support

Several questionnaire items were written to assess significant aspects of social support in the lives of the women studied. From the results reported in Table 14, it is clear that 39 percent of the women found close friends "not difficult" to talk with. Parents and other relatives were reported to be the most difficult persons to talk with.

In Table 15 are reported two very interesting findings. About 54 percent of the women indicated that they shared most or all of their concerns or worries with others during the past year. On the other hand, about 14 percent of the women reported rarely sharing with others. Also, it is evident that 42 percent of the women talked over personal concerns with two or fewer persons. An overwhelming number of women (about 87 percent) indicated that they talked over personal matters with up to five others.

Several questionnaire items required women to reflect upon a recent life problem and a recently made decision. These life events were then related to support-seeking on the part of women. The results are summarized in Table 16. The key findings were that close friends were the most frequently designated as helpful (54 percent of the responses), with partner/husband ranking second (41 percent of the responses). Parents and other relatives were the most frequently rated as "not helpful" (about 22 percent of the responses). Further data

TABLE 14

PERCENTAGE OF WOMEN INDICATING VARIOUS DEGREES OF DIFFICULTY IN DISCUSSING PERSONAL MATTERS WITH OTHERS

Question	Number of Omits	Level of Difficulty					
		Very Difficult	Difficult	Somewhat Difficult	Rarely Difficult	Not Difficult	Not Applicable
34. How difficult is it for you to discuss personal matters with the person(s) listed below?							
(1) children	5	2	6	14	18	30	30
(2) partner/ husband	6	6	10	15	19	35	15
(3) parents	11	16	20	21	14	7	22
(4) other relatives	11	12	16	24	15	11	21
(5) doctor	8	9	15	14	13	21	28
(6) counselor	17	11	4	6	10	27	52
(7) minister	16	6	6	10	6	14	58
(8) close friends	4	3	5	22	31	39	1
(9) women's group	16	1	3	10	9	17	60

TABLE 15

PERCENTAGE OF RESPONSES TO QUESTIONS ABOUT SOCIAL SUPPORT SEEKING

Question	Percentage (N=200)
35. Of the concerns and worries you've had in the past year, how many have you shared with others?	
(1) all	17
(2) most	37
(3) some	32
(4) few	13
(5) none	1
38. When personal problems come up, how many people can you go to in order to talk over the concerns you're having?	
(1) no one	2
(2) 1 or 2	40
(3) 3 to 5	45
(4) 6 to 10	9
(5) over 10	4

TABLE 16

PERCENTAGE OF WOMEN RATING HELPFULNESS OF OTHERS REGARDING PROBLEMS AND DECISIONS

Question	Number of Omits	Level of Helpfulness (N=200)				
		Very Helpful	Helpful	Somewhat Helpful	Not Helpful	Not Applicable
24. With respect to the problem mentioned, how would you rate the helpfulness of each individual listed below?						
(1) children	14	13%	17%	12%	12%	46%
(2) partner/husband	14	25%	16%	21%	17%	21%
(3) parents	20	7%	10%	13%	22%	48%
(4) other relatives	20	6%	12%	11%	23%	48%
(5) doctor	27	9%	9%	8%	12%	63%
(6) counselor	26	17%	6%	8%	4%	65%
(7) minister	36	9%	4%	4%	10%	73%
(8) close friends	10	23%	31%	22%	8%	16%
(9) your women's group	29	6%	11%	6%	4%	73%
29. Please indicate the degree to which the people listed below were helpful to you in making the decision.						
(1) children	62	10%	9%	18%	9%	54%
(2) partner/husband	62	32%	17%	20%	11%	20%
(3) parents	64	7%	10%	18%	17%	47%
(4) other relatives	67	3%	7%	14%	20%	56%
(5) doctor	70	2%	7%	6%	8%	76%
(6) counselor	68	10%	11%	7%	4%	68%
(7) minister	69	2%	5%	5%	6%	82%
(8) close friends	59	19%	30%	23%	6%	22%
(9) women's group	71	5%	8%	4%	3%	80%

related to social support are reported in Table 16. Women were asked to rate the helpfulness of individuals in relation to a recently made decision. The results were quite similar to those concerning support in problem-solving.

The helpfulness of some support persons with problem-solving was related to age in our study. The results are shown in Table 17. Not surprisingly, more women over age 35 (47 percent) found their children to be helpful with a problem than women who were age 35 or younger (17 percent). This finding makes intuitive sense in that older women have older children whose problem-related helpfulness would be enhanced by their maturity and experience with life. Also, 24 percent of women over age 35 rated their friends' helpfulness as "not applicable" as compared with 10 percent of women 35 or younger. This finding is difficult to interpret, but perhaps it suggests a greater reluctance on the part of some older women to viewing their close friends as appropriate resource persons in problem times.

In the developing research on patterns of support-seeking, there has been evidence of sex and social class differences (Warren, 1975). In the present study of support-seeking in women, income and perceived-helpfulness of husband/partner were positively correlated ($r = .20$, $p < .01$). However, no strong income or education differences emerged relative to support-seeking. An analysis of self-education and perceived-helpfulness-of-ministers, however, yielded a positive correlation ($r = .18$, $p < .01$). Other correlations between income, education, and patterns of support-seeking were low.

TABLE 17

RELATIONSHIP BETWEEN AGE AND HELPFULNESS RATINGS

Question	Age	
	35 and Under (N=111)	Over 35 (N=89)
24. With respect to the problem mentioned, how would you rate the helpfulness of each individual listed below?		
(1) children		
(a) very helpful	6%	22%
(b) helpful	11%	25%
(c) somewhat helpful	10%	15%
(d) not helpful	10%	15%
(e) not applicable	63%	23%
χ^2 = 31.64 with 4 df	p <.01	
Omits = 14		
(8) close friends		
(a) very helpful	22%	25%
(b) helpful	33%	29%
(c) somewhat helpful	27%	15%
(d) not helpful	8%	7%
(e) not applicable	10%	24%
χ^2 = 9.16 with 4 df	p <.05	
Omits = 10		

Social Support Scores in Relation to Scores on Other Variables

A Social Support Score (SSS) was assigned to women in the study based upon their responses to relevant questionnaire items. The SSS reflects both the quality and quantity of an individual's support system. It was derived from a consideration of items 24, 29, 34, 35 and 38 (refer to Appendix B_2), all of which were intended to provide data on the support systems of women in our sample.

In Table 18 are reported correlations of the SSS with several variables. Three significant relationships emerged. The Social Support Scores were positively correlated with the recency of counseling/therapy ($r = .30$, $p < .001$). The correlation suggests that the more recent a person's therapy experience, the higher their SSS, or the better the quantity and quality of their support. The Social Support Scores were significantly correlated with life satisfaction, but the relationship was low ($r = .11$, $p < .05$). There was also a low correlation between the number of small children and Social Support Scores ($r = .11$, $p < .05$).

Correlations between age, general life satisfaction, social support and various attitudinal and satisfaction variables are reported in Table 19. Satisfaction with self understanding had a low positive correlation with age ($r = .11$, $p < .05$), as did satisfaction with one's relationships with male friends ($r = .11$, $p < .05$), suggesting that, within our sample, satisfaction on those two dimensions increased as age increased.

TABLE 18

CORRELATIONS OF THE SOCIAL SUPPORT SCORES (SSS) WITH RELEVANT DEMOGRAPHIC VARIABLES

Variable	Sample Size	Correlation
Age	200	-.05
Income	189	-.02
Education of Self	200	-.07
Recency of Counseling/Therapy	100	.30***
Satisfaction with Life	199	.11*
Number of Small Children	200	.11*
Life Change Units	193	.09

* $p < .05$
*** $p < .001$

TABLE 19

CORRELATIONS BETWEEN AGE, GENERAL LIFE SATISFACTION, THE SSS, AND ATTITUDINAL/SATISFACTION DATA

Attitudinal/Satisfaction Variables	Sample Size	Variables		
		Age	General Life Satisfaction	SSS
Relationships with female friends	200	.05	.24**	.05
Primary relationship	196	.06	.54**	.12*
Self-understanding	199	.11*	.44**	.11*
Career	176	.04	.41**	.02
Relationships with male friends	194	.11*	.48**	.00
Sex life	198	-.01	.48**	.05
Emotional support	197	.05	.42**	.27**
Relationships with one's children	187	.30**	.18**	.14*
Relationships with one's parents	191	-.36**	.06	.20**

** $p < .01$
* $p < .05$

Two variables were moderately correlated with age. Relational satisfaction with one's children was positively correlated with age ($r = .30$, $p < .001$), suggesting that as age increased in our sample so did the level of satisfaction with relations with one's children. A negative correlation existed between age and relational satisfaction with parents ($r = -.36$, $p < .001$), suggesting that as age increased, satisfaction with relationship with parents decreased.

All but one life satisfaction dimension (relationship with one's parents) were significantly correlated with general life satisfaction among our sample; reviewing this part of the table, general life satisfaction and satisfaction with one's primary relationship is the highest correlation ($r = .54$, $p < .001$).

General life satisfaction and sex life satisfaction, and relationships with male friends, are the next highest correlations (both $r = .48$, $p < .001$). Further, as general life satisfaction increases, so does satisfaction with: self-understanding ($r = .41$, $p < .001$), satisfaction with relationships with female friends ($r = .24$, $p < .001$), and satisfaction with relations with one's children ($r = .18$, $p < .01$).

Reported in Table 19 is a highly significant relationship between social support and emotional support satisfaction ($r = .27$, $p < .001$). Though it is a low to moderate correlation, this figure indicates that as SSS scores increased among our respondents, so did reports of their satisfaction with emotional support in their lives. The remaining correlations with the SSS are low and positive. Interestingly, relational satisfaction with parents is significantly correlated with the SSS ($r = .20$, $p < .01$).

Three out of the five life dimensions which are significantly correlated with the SSS are connected to "the family" while two (self-understanding and emotional support) are somewhat more existential in nature.

Personality Data

The Eysenck Personality Questionnaire (EPQ) has four sub-scales: Psychoticism (P), Extraversion (E), Neuroticism (N), and Lie (L). All sub-scales, with the exception of L are thought to represent major personality factors. P is a measure of psychoticism, and a high P scorer "may be described as being solitary, not caring for people: he is often troublesome, not fitting in anywhere" (Eysenck and Eysenck, 1975, p. 4). The E sub-scale is an introversion-extraversion measure. The N sub-scale, a measure of neuroticism, is considered by Eysenck and Eysenck to reflect emotionality or stability-instability. And L, the Lie sub-scale, is intended as a measure of respondents' attempts to produce socially desirable answers. Descriptive statistics for the four sets of scores are reported in Table 20.

Correlational results with the EPQ are reported in Table 21. Beginning with the Psychoticism sub-scale (P), three significant relationships emerged. P was negatively correlated with age ($r = -.17$, $p < .01$), with income ($r = -.15$, $p < .01$), and with education of self ($r = -.15$, $p < .01$). None of the remaining correlations with P were statistically significant.

TABLE 20

SUMMARY STATISTICS FOR THE EYSENCK PERSONALITY QULSTIONNAIRE (N=200)

Variable	Mean	Standard Deviation	No. of Items
Psychoticism	3.37	2.38	25
Extraversion	12.24	4.74	21
Neuroticism	11.69	5.48	23
Lie	6.84	3.96	21

TABLE 21

CORRELATIONS FOR EPQ SUB-SCALES WITH DEMOGRAPHIC DATA

Demographic Variables	EPQ Sub-scales			
	Psychoticism	Extraversion	Neuroticism	Lie
Age	-.17** (N=182)	-.12* (N=195)	-.14* (N=194)	.28** (N=191)
Income	-.18** (N=172)	.06 (N=184)	-.05 (N=183)	.00 (N=180)
Education of self	-.15** (N=182)	-.01 (N=195)	.17** (N=194)	.20** (N=191)
Recency of counseling/ therapy	.14 (N=94)	.22** (N=98)	.22** (N=98)	.00 (N=94)
Satisfaction with life	-.10 (N=181)	.17** (N=194)	-.44** (N=193)	.09 (N=190)
Self-illness	.01 (N=175)	.03 (N=186)	.22** (N=185)	-.11* (N=182)
Number of small children	.02 (N=182)	.11* (N=195)	.06 (N=194)	-.04 (N=191)

** $p < .01$
* $p < .05$

Turning to the E sub-scale, another group of statistically significant correlations are reported in Table 21. Extraversion was negatively correlated with age ($r = -.12$, $p < .05$), while positively correlated with recency of counseling/therapy ($r = .22$, $p < .01$) and satisfaction with life ($r = .17$, $p < .01$). These correlations indicate that in our sample, as Extraversion scores increased, age decreased. High Extraversion scores were significantly related to high life satisfaction. As for recency of counseling/therapy, high Extraversion scores were obtained by women with the more recent therapy experiences.

The Neuroticism sub-scale yielded the largest number of significant relationships. Neuroticism scores were negatively correlated with age ($r = -.14$, $p < .05$), self-illness ($r = .22$, $p < .001$), and with life satisfaction ($r = -.44$, $p < .001$). Positive correlations with N, reported in Table 21, revealed that N and education of self were significantly correlated ($r = .17$, $p < .01$), as were N and recency of counseling/therapy ($r = .22$, $p < .01$). These correlations indicate that Neuroticism scores increased as years of self-education increased; a slightly stronger correlation with therapy-recency indicates that as N scores increased among our sample, the likelihood of women with recent therapy experiences increased.

The L sub-scale is the last of the EPQ data contained in Table 21. Note that L was very strongly correlated with age ($r = .28$, $p < .001$);

thus, Lie scores were higher for older women than younger women. A slightly lower correlation existed between L and education of self ($r = .20$, $p < .01$), indicating that as L scores increased so did the educational level of respondents. Lastly, a low negative correlation existed between the Lie sub-scale and self-illness ($r = -.11$, $p < .05$); thus, as L scores increased, severity of illness for women increased (low illness values represent the more serious health problems).

The next level of data analysis involving the EPQ involved cross-tabulations; the reporting of these findings begins in Table 22 with the Eysenck Psychoticism (P) sub-scale. Variables considered in relation to all Eysenck sub-scales included: (1) Marital status; (2) Length of residency; (3) Employment; (4) Feminist identification; (5) Experience in, and recency of, Therapy; (6) A reported, spontaneous help-seeking conversation; and, (7) Attitude regarding desired relational changes. In the next four tables (22, 23, 24, and 25) are reported statistically significant cross-tabulations with each of the Eysenck sub-scales.

Two factors emerged as statistically significant in relation to the P sub-scale. Forty-four percent of the sample with P scores under the mean identified themselves as feminists, while 66 percent with scores over the mean claimed feminist identification. Thus, a larger number of respondents identifying themselves as feminists were found among women who scored above the mean on the P sub-scale.

TABLE 22

RELATIONSHIP BETWEEN PSYCHOTICISM SCORES AND SELECTED VARIABLES

Question	Psychoticism Scores	
	Under Mean	Over Mean
17. Do you consider yourself a feminist?		
(1) yes	44%	66%
(2) no	28%	13%
(3) unsure	28%	27%
χ^2 = 6.47 with 2 df	p <.05	
N = 179		
36. Is there anything about your relationships with others that you would like to change?		
(1) yes	65%	88%
(2) no	35%	12%
χ^2 = 12.92 with 1 df	p <.001	
N = 177		

TABLE 23

RELATIONSHIP BETWEEN EXTRAVERSION SCORES AND THERAPY/COUNSELING RECENCY (N=98)

Question	Extraversion Scores	
	Under Mean	Over Mean
19. When did your last formal counseling or therapy take place?		
(1) more than four years ago	30%	13%
(2) between two and four years ago	26%	14%
(3) between one and two years ago	11%	9%
(4) within the past year	33%	64%
$\chi^2 = 9.95$ with 3 df	$p < .01$	

TABLE 24

RELATIONSHIP BETWEEN NEUROTICISM SCORES, AND FEMINIST IDENTIFICATION AND THERAPY EXPERIENCE

Question	Neuroticism Scores	
	Under Mean (N=101)	Over Mean (N=90)
17. Do you consider yourself a feminist?		
(1) yes	60%	44%
(2) no	15%	23%
(3) unsure	25%	33%
χ^2 = 5.67 with 2 df	p <.05	
18. Have you ever been in formal counseling or therapy?		
(1) yes	41%	63%
(2) no	59%	37%
χ^2 = 8.02 with 1 df	p <.01	

TABLE 25

RELATIONSHIP BETWEEN LIE SCORES AND FEMINIST IDENTIFICATION AND DESIRE TO CHANGE RELATIONSHIPS

Question	Lie Scores	
	Under Mean	Over Mean
17. Do you consider yourself a feminist?	(N=103)	(N=85)
(1) yes	60%	42%
(2) no	10%	31%
(3) unsure	40%	27%
χ^2 = 13.59 with 2 df	p <.001	
36. Is there anything about your relationships with others that you would like to change?	(N=102)	(N=83)
(1) yes	85%	70%
(2) no	15%	30%
χ^2 = 5.53 with 1 df	p <.01	

TABLE 26

INTERCORRELATIONS BETWEEN EPQ, LIFE CHANGE UNITS (LCU), AND SOCIAL SUPPORT SCORES (SSS)

	Variable				
	2	3	4	5	6
1. EPQ - psychoticism	.01 (N=182)	.04 (N=181)	-.19** (N=178)	.25** (N=177)	.16** (N=182)
2. EPQ - extraversion		-.15** (N=194)	-.17** (N=191)	.19** (N=189)	.23** (N=195)
3. EPQ - neuroticism			.04 (N=190)	.21** (N=188)	-.09 (N=194)
4. EPQ - lie				-.07 (N=185)	-.09 (N=191)
5. LCU					.09 (N-193)
6. SSS					

** $p < .01$

Considering additional P relationships, Psychoticism was moderately correlated with Life Change Units (LCU) ($r = .25$, $p < .001$); in fact, this was the strongest correlation to be found in Table 26, indicating that as P scores increased, so did the LCU's reported by the women in the study. The last significant P correlation is with the Social Support Scores (SSS). This correlation ($r = .16$, $p < .01$) was positive, thus as Psychoticism scores increased, so did SSS (indicating higher social support).

Turning to the EPQ Extraversion (E) sub-scale, Table 26 reports several significant correlations. E was negatively correlated with Neuroticism ($r = -.15$, $p < .01$), a result that is very similar to data reported by Eysenck and Eysenck (1975). Thus, in our sample, as E scores increased, N scores decreased and vice versa. Considering the correlation between E and the Lie (L) sub-scale, it is low and negative ($r = -.17$, $p < .01$); it is similar to the E and L correlation reported by Eysenck and Eysenck (1975), and indicates that E and L have an inverse relationship.

Considered in relation to LCU scores, E was positively correlated as reported in Table 26 ($r = .19$, $p < .01$); thus, as E scores increased, so did the magnitude of LCU's as reported by study participants. Therefore, among women surveyed, as life stresses increased, so did their reports of extroverted behaviors and attitudes. Lastly, E was significantly related to the SSS measure ($r = .23$, $p < .001$); as E scores increased, respondents' SSS scores also increased; thus, an increase in extroversion scores was associated with better social support, both qualitatively and quantitatively.

The last significant correlation contained in Table 26 was between the EPQ Neuroticism sub-scale and the LCU magnitudes ($r = .21$, $p < .001$). Thus, in the present study, as participants' N responses increased so did the levels of life stresses they reported experiencing in the last year.

Social Support Interview Data

A small number of personal interviews with women randomly selected from those participating in the mail survey provided data of a rather informal nature. The interviews were conducted largely for the purpose of providing information and ideas which could open directions for future studies. Liem and Liem (1976), in their study of stress, social support and adjustment among undergraduates, suggested that interview data could clarify many of the relevant issues. The data reported in this section are an initial exploratory attempt at collecting information on social support in an interview format.

The interview results will be reported in several sections. Part One will deal with demographic data describing the sample of women interviewed. Part Two will consist of direct, quoted material taken from the interview recordings, and some brief quantified ratings. Lastly, Part Three will briefly elaborate on significant trends which, in the judgement of the author, appear to emerge from the interview data.

Part One

To begin with demographic data, the ages of women interviewed ranged from twenty-three to eighty. The median age was thirty-four.

With regard to marital status, fifteen of the interviewees were married, three divorced, two were widows, two single, and one woman was separated.

Twenty-one of the women participating in interviews had children. When asked about employment, sixteen of the twenty-three women indicated they were employed outside the home. We also inquired about the highest educational experience of our interviewees: ten had finished high school; four had completed an A.A. degree; seven women had completed the B.A., and two had gone beyond the undergraduate degree and had completed a Master's. Comparing the sub-sample with the original sample of two hundred, from which it was chosen, no major demographic differences emerged; the small group of interviewed women appears to be quite representative of the larger sample.

Part Two

Data gathering on social support began with questions related to friendship. Regarding the quantity of friends, for example, respondents varied considerably on this dimension. Most women indicated they had between six and seven friends, some of whom were close friends; the range, however, was from four to twenty friends.

A general trend was for women to list predominantly female friends. Only one-quarter of the interview participants identified male friends who were not family members. When queried about this, many women invoked a social taboo whereby they felt it was socially unacceptable to have male friends. Most respondents included one or more family

members among their friends, and these persons were often same-sex relatives, i.e., sisters, sisters-in-law. An unexpected finding was that seven of the fifteen married interviewees did not list their husbands as "friends." Thus, almost one-half of these women chose not to describe their husbands in this way. When asked about this apparent inconsistency, no consistent response emerged from the seven women in question.

Though there was variability, most respondents indicated at least one individual with whom they were in daily contact, often via the telephone.

Interviewees were asked about times of difficulty, times when they would potentially like to discuss matters with another person. We asked how interviewees would rate their abilities to choose/find helpful friends.

> Sometimes I think that I can go to the person who would be most helpful, but sometimes I feel as if I can't find anybody that would be helpful (No. 12).[1]

> I don't feel I always know how to solve every problem, I don't always feel that I'm going to get the answer from a friend, but I feel completely confident about coping with problems, or I feel confident that if I don't find an answer I will at least have a path to follow. To tell you the truth, I don't look for answers from my friends; friends are very important for support. Most of these friends are very supportive. I went to a psychologist a year ago, plus this discussion group I belong to--I have read a lot of books on support and I guess I'm just a very confident person now; confident that I can deal with a problem, but not that I have all the answers (No. 13).

Some respondents spoke to the issue of variability among their friends.

> 1 is very helpful. With 2 I can tell her what my problem is and she listens, and is afraid to make a suggestion for fear it'll be something I don't want to hear. And, 1 doesn't give a damn whether I want to hear it or not. If he thinks it's something I need to know...he will tell me (No. 4).

---

[1]Numbers refer to coding system employed by interviewers.

Other respondents touched on their intuitions of others.

> I think I can usually sense people that are willing to listen or willing to be helpful, but it's hard for me to ask favors from anybody and if I feel I am imposing I will avoid it (No. 11).

> Well, usually I can spot whether they are genuinely interested in what is going on and they really care.... Most of the people I'm closest to, they don't say anything if I'm telling them something is really wrong; and they listen, and they don't say anything until I'm completely through with what is going on, and then they think about it and try to help me (No. 004).

> I can't think of anytime I've made a friendship that was not helpful. I think I'm helpful as a friend, that like attracts like (No. 008).

Interviewees were asked to identify important qualities that they look for, that attract them in helpful, supportive others. Many women talked about listening skills, in addition to personality traits they considered important.

> I think somebody who listens well; some people like to listen... If you need somebody to talk to, you need somebody who can listen.... I think that sometimes when you have a problem if you just say it... you get the answer to your own question. You don't need anybody to give you the answer, you just need someone to be there (No. 007).

Many interviewees cited an ability on the part of friends or supporters to <u>understand how they felt</u> as an important quality.

> Compassion: like if you're sad about something--somebody who'll understand that, because they've been sad before--they understand why you're sad (No. 007).

> I think honesty, and someone I've had experience with... I don't particularly look for somebody who would agree with me, but someone who I feel would not put me on, who would not patronize me, who would perhaps give me an answer even if I didn't want to hear the answer (No. 006).

> I like to feel my friends accept me as I am, and I feel I accept them (No. 8).

Many respondents acknowledged the significance of trustworthiness and objectivity in the people they seek out.

In one section of the interviews, participants were asked to rate the importance of selected personal attributes found in others who are support persons. Table 27 reports these data, and several trends are apparent, even though our sub-sample was rather small.

To briefly highlight the results, we begin by noting that Responsiveness and Sensitivity were the two attributes most frequently rated as Very Important (N=16 and 18 respectively). However, not far behind was Objectivity (N=13). Among attributes rated as Important, Similarity of Experience was the most frequently selected; this finding is quite consistent with Gerald Caplan's conceptualization of an informal care-giver (1974) as one who is recognized by many community members as an "expert" because of her or his personal experience with certain discreet life events (i.e., divorce in the family, health problems, financial expertise).

Among the dimensions frequently rated as Not Important, Religion (N=18), Education (N=16), and Age (N=15) were the most frequently indicated. Interestingly, these three variables were three of the four "demographic" variables in the list (the other is sex). This finding would seem to indicate that the women felt personality attributes and degree-of-experience to be more important to them than demographic variables in selecting persons for support purposes.

Within the interview sessions, issues around the selection of support persons were pursued at greater length. We were interested

TABLE 27

FREQUENCIES RATING IMPORTANCE OF OTHER'S ATTRIBUTES IN SELECTION OF SUPPORT PERSONS (N=22)

Attributes	Ratings			
	Very Important	Important	Somewhat Important	Not Important
Responsiveness	16	5	1	0
Age	1	0	6	15
Religion	1	3	0	18
Intelligence	5	9	7	1
Sensitivity	18	4	0	0
Similarity of experience	4	11	6	1
General life experience	5	7	8	2
Sex	1	4	7	10
Education	0	2	4	16
Objectivity	13	9	0	0
Caring	12	9	1	0

in developing some information and explanation of this selection process; how is it that on some occasions we seek out one person, and on other occasions we seek out someone else?

> We had a death in the family, and it was something that was long and drawn out. And, I didn't talk to two particular people because I knew at the time that I would get a blatant "That's too bad," and that was the end of it, and I really didn't want to hear "That's too bad." I don't know that I wanted to hear anything, I just wanted them to listen (No. 006).

Some interviewees had very clear notions of just how they select persons for support purposes.

> If I want to talk about my children, I'd talk to my husband because he's more in tune with them than other friends are, and is probably more concerned about their welfare than any of my other friends. If I want to talk to someone about values, I would talk to someone who thinks within the same framework that I think. If I want to talk to someone about a school problem, I would talk to someone who's in that same situation, say another mother whose child was having, was experiencing something that my child might be experiencing (No. 11).

Several respondents mentioned that they specifically seek out male and female points of view on issues.

> Occasionally I want a male's point of view, or a female's point of view. I have done this occasionally with __1__ and __2__, who are both good friends. I'll ask them quite frankly: "What's your opinion and why, and what's your opinion and why?" (No. 8).

Access or availability of support persons was a major consideration for some women interviewed.

> The closeness of myself to the friend, what is involved, in other words if they have had any experience with the situation; sometimes timing comes into it: if this person is off having his own personal crisis, I'm certainly not going to rush up and add mine to his or hers. Availability would have something to do with it.... In this case, if something is stirring around, and I have to let it out, it may go to the person who is right there and then, or who I can get a hold of (No. 11).

Frequently, a concern with the similarity of others' experience emerged.

> If I was having trouble with my (menstrual) period every month, or something like that, I might go to __1__ (female friend) and say I'm not sure what I should do, go to the doctor, etc.... I could go to __2__, who's not really a close friend, but just a friend, because it is something she understands.
>
> Interviewer: But you might not go to __3__ (male friend) with that?
>
> No, I probably wouldn't. It would be an uncomfortable circumstance, he doesn't understand where that's at. If I needed some money, I might go to __3__ (male friend) because he would be in a position to loan it to me. Or, if I needed to buy my brother a birthday present and he and __3__ are the same type--outdoorsy--I might ask his advice as to what he'd consider appropriate (No. 007).

Our oldest interviewee was an 81 year old woman who was retired, yet was very active in community affairs, drove herself around the countryside in a car, and was generally a very interesting participant. She was the only person we interviewed who took the position that the age factor was an important one for her in selecting friends and support persons. When queried about the age concern, our interviewee indicated that age had only recently become extremely important to her; advancing age was a unique experience, one which she felt most younger people could not relate to. Also, she felt there was tremendous comfort to be found in sharing both the frustrations and joys of aging with one's contemporaries. This woman reported a wealth of younger support persons, friends who put in a garden for her, former students, and family members. Nonetheless, her relationships with contemporaries really provided the form of support she most needed, because of the similarity of experience.

In asking participants about the kinds of situations and concerns they took to others for the purpose of advice or information, or other support forms, we did receive expected responses. Interviewees mentioned health problems, family difficulties, problems of loneliness and related emotional discomfort, concerns over children, needs for advice on school, and a multitude of other issues.

> I have kind of a shaky marriage--a roller coaster--my husband is an alcoholic and it kind of depends on how he's doing. And, I guess basically for that I lean on...or tend to communicate with __1__ on the domestic end of it: things that come up domestically, she can relate to that.... I would lean on __2__ for suggestions about how she's handled a similar situation. And, __3__ would be the one I would just pour everything out to--how I feel about this, and maybe get a man's point of view on this, and when I really want to make a decision he seems to be the one that would help me...allow me to make a decision by offering suggestions....

> Like a situation that I have less experience, less knowledge, that I am less sure of myself: I'll use my friends a lot for that situation. Experiences that I feel I have good judgement in, that I have enough information, that I've made a good decision, then there's no need for me to use my friends.

"How is it for you to be in the role of supporter?", is a further question we asked of interviewees; we wanted to know what it was like when the support tables were reversed.

> As far as being considered a sensitive person, I really like that. The intelligence and creative things, sometimes I feel that I'm not qualified in those areas; that people think I'm a bit more intelligent and creative than I am. Also, a few of them consider me to be alot more experienced, a greater variety of things than I am. They feel that I've been through the same sort of problem that they have, which isn't always true, but they seem to think so. Sometimes I feel sort of uncomfortable about that because it's not always that I have had the same type of experience and I don't like giving advice and trying to help someone with a problem that I know nothing about; it makes me feel sort of uncomfortable (No. 004).

> I'm aware when people use me just to talk because some people--that's how they relieve their tensions--by talking alot. It doesn't have to be anybody in particular, it can be an acquaintance who's just handy as a sounding board (No. 003).

> It's kind of an honor to think that someone trusts you enough to bring their problems to you and to think that you might be able to have input in helping them deal with them (No. 4).

Many women we interviewed reported no difficulty functioning as supporters for friends, family or acquaintances. In fact, most women indicated they enjoyed the role, liked contributing to others, and considered it a meaningful activity.

Attitudes about professional caregivers also interested us. We asked interviewees how they felt about seeking out professional (i.e., from a minister, doctor, therapist) services at times of stress.

> Actually, if I really had a lot of stress I would, as I have in the past, go to get professional help. This I would do maybe in addition to talking with a friend (No. 13).

> I haven't (sought professional help) up until this point because I've done a good enough job thus far, but that doesn't mean that I never will. That's a source that I would always keep in mind, and would try other sources that I've had experience with and if I still don't feel right about whatever the issue is, then would go further to more professional people.

> I don't think I could handle that (seeking professional help). I have very strong feelings about that and I know that that's stupid, that there's nothing wrong with seeking professional help, but for me I would rather consult a friend.

> If you're at a point where you feel so insecure and so helpless that you don't have a friend that you could go to, someone that would really understand you and you're at a point where you're about to give up, then I would say you should probably seek someone that's a professional, but as long as I have someone that I think understands me as a person, and is reasonably intelligent, I would go to them instead.

The women we interviewed typically saw the seeking out of professional counsel as a "last step." While many were not opposed to

making such a decision, and were indeed almost relieved that professional caregivers were so readily available, nonetheless reliance on friends and informal sources of support was quite clear.

It became apparent both from interview data and from the survey data that women in our sample did not consider the family doctor to be a person they would normally seek out in times of personal stress; additionally, most expressed similar sentiments about ministers and priests, a finding similar to that of Warren (1975), though in her study there were related class differences, while in ours this finding is not in evidence.

Several of the women interviewed had been involved in either women's consciousness-raising or support groups. We asked people about these group experiences, and received generally favorable reports: they were meaningful, helpful, and a forum for learning about the self and others.

> It (participation in a women's group) made me feel better as a person because at the same time, when there were people that had the same type of problems I did, there were other people that had problems that were alot worse than mine. And, in a couple of instances I helped someone with a problem, and it made me feel really good. Because I always felt...that nobody can have any worse problems than I do, and just being able to see and realize that other people do have a great deal worse problems than I did, and being able to help other people, I think made me a stronger person (No. 004).

Generally, our respondents indicated that friendship, and what we called social support, are very important in their lives. Persons with a very limited number of relationships acknowledged their significance. For example, a divorced women whose children were not providing her with much support while they were attempting to form their own lives as young adults, said:

> Actually, except for the people I work with, my contacts with people are so limited. Possibly my relationship with ___1___ is blown all out of proportion because she is the only friend I have in the circumstances I find myself in (No. 6).

Other interviewees commented more generally, and yet discussed responsibilities:

> If you're really a friend...you're willing to help somebody no matter what it is, whether you need a ride to the store, or whether you need someone to listen to (sic) (No. 007).

Part Three

Clearly, our interview sample of twenty-two women was quite small. Nonetheless, consensus appeared on a number of issues; we did locate trends, some areas of distinct agreement. The more obvious of these are listed below:

1) A preponderance of same sex friendships, and clear taboos for married women about opposite sex friendships

2) A recognition that support-giving and receiving are not limited to family members or close friends

3) An awareness that personality generally plays a more important role in the selection of support persons than do demographic-type issues

4) An intuitive knowledge that people "need to talk things out," and that this contributes to coping and adaptation

5) A recognition that support-seeking takes different forms and as such is sometimes quite spontaneous, while at other times is very planned (i.e., seeking out the specific person who will understand a particular issue)

6) A willingness to acknowledge the importance of support persons, support-receiving, and support-giving.

The interviews were helpful, particularly in clarifying the above ideas. They also provided a discussion forum, where ideas could be elaborated upon, and from which new research questions can develop. In the

present study, interviews with a small sample did complement the quantitative data collected from the questionnaires, and provided several new directions for exploration.

Predictions of Outcome Measures

Several multiple regression analyses were completed in an attempt to explain the variance of six important outcome measures. The outcome measures were:

1) Life satisfaction,
2) Life stress,
3) Social support,
4) Psychoticism,
5) Extraversion,
6) Neuroticism.

The initial prediction considerations involved many exploratory analyses in which all possible variables were included as predictors of the criterion measures. These original analyses significantly reduced the sample size (from N=200 to N=80) because missing data were treated as missing cases which were then excluded from the procedure; the larger the number of predictors, the greater the chances of missing data.

Subsequent to the preliminary analyses, an attempt was made to selectively identify predictors in order to improve the sample size and the ultimate strength of the predictions. The final selection of predictors took into account results of the preliminary analyses, findings from previous related prediction studies, and the original research questions. Smaller subsets of variables were selected specifically in relation to the nature of the criterion measures.

equation was .45. The eight predictors were: marital disharmony, income, illness in the family, legal problems, age, problems with children, marital status, and extraversion. All of the predictors were externally/environmentally based, with the exception of the extraversion variable.

Social Support Scores

Four predictors were retained in the final solution for Social Support Scores. These data are reported in Table 30. The predictors included: satisfaction with one's emotional support, satisfaction in relationships with parents, recent counseling/therapy, and extraversion.

Eysenck Personality Questionnaire

Psychoticism. The proportion of variance accounted for in the prediction of Psychoticism was .21 and these data are reported in Table 31. Five predictors were retained in the final solution. The most important predictors were Life Change Units and satisfaction in relationships with female friends.

Extraversion. Five predictors were also retained in the final solution of Extraversion and are elaborated upon in Table 32. The two most important predictors were satisfaction with self-understanding and the general ratings of support persons' helpfulness. The proportion of variance accounted for was .20.

Neuroticism

The Neuroticism prediction yielded the highest R^2 of the personality variables: .30. Five predictors were retained in the equation, the most important of which was life satisfaction. These results are reported in Table 33.

In the following sub-sections, the results of the predictions are reported: these are supplemented by the data reported in Tables 28 through 33. Included in the tables are the predictor variables, the nature of their relationship with the criterion measure (a + indicates a positive association, a - indicates a negative association; a + with regard to marital status indicates "married" as compared with "not married").

Life Satisfaction

The proportion of variance accounted for in the prediction of life satisfaction, with the best combination of eight predictors, was .57. Adding more than eight predictors had only slight effects on the size of R^2. Data which were relevant to this analysis are reported in Table 28. Satisfaction with sex life accounted for the largest amount of the criterion variance.

Life Stress

In Table 29, the prediction analysis for life stress is reported. Again, eight predictors were retained in the final solution. The total amount of criterion variance accounted for by the prediction equation was .45. The eight predictors were: marital disharmony, income, illness in the family, legal problems, age, problems with children, marital status, and extraversion. All of the predictors were externally/environmentally based, with the exception of the extraversion variable.

Social Support Scores

Four predictors were retained in the final solution for Social Support Scores. These data are reported in Table 30. The predictors

included: satisfaction with one's emotional support, satisfaction in relationships with parents, recent counseling/therapy, and extraversion.

Eysenck Personality Questionnaire

Psychoticism. The proportion of variance accounted for in the prediction of Psychoticism was .21 and these data are reported in Table 31. Five predictors were retained in the final solution. The most important predictors were Life Change Units and satisfaction in relationships with female friends.

Extraversion. Five predictors were also retained in the final solution of Extraversion and are elaborated upon in Table 32. The two most important predictors were satisfaction with self-understanding and the general ratings of support persons' helpfulness. The proportion of variance accounted for was .20.

Neuroticism

The Neuroticism prediction yielded the highest R^2 of the personality variables: .30. Five predictors were retained in the equation, the most important of which was life satisfaction. These results are reported in Table 33.

TABLE 28

PREDICTORS OF LIFE SATISFACTION
(N=133)

Step Number	Variable Entered	Multiple R	R^2	Increase in R^2
1	Sex life satisfaction (+)	.56	.31	.31
2	Neuroticism (-)	.66	.43	.12
3	Emotional support satisfaction (+)	.69	.48	.05
4	Job problems (-)	.71	.51	.03
5	Psychoticism (-)	.73	.53	.02
6	Satisfaction in relationships with male friends (+)	.74	.55	.02
7	Satisfaction with self-understanding (+)	.75	.56	.01
8	Satisfaction in relationships with parents (+)	.75	.57	.01

TABLE 29

PREDICTORS OF LIFE CHANGE UNITS
(N=154)

Step Number	Variable Entered	Multiple R	R^2	Increase in R^2
1	Marital disharmony (+)	.39	.15	.15
2	Income (-)	.49	.24	.09
3	Illness in family (+)	.56	.31	.07
4	Legal difficulties (+)	.59	.35	.04
5	Age (-)	.63	.39	.04
6	Problems with children (+)	.64	.41	.02
7	Marital status (-)	.66	.43	.02
8	Extraversion (+)	.67	.45	.02

TABLE 30

PREDICTORS OF SOCIAL SUPPORT SCORES
(N=120)

Step Number	Variable Entered	Multiple R	R^2	Increase in R^2
1	Emotional support satisfaction (+)	.34	.12	.12
2	Satisfaction in relationships with parents (+)	.39	.16	.04
3	Recent counselling/therapy (-)	.44	.20	.04
4	Extraversion (-)	.47	.22	.02

TABLE 31

PREDICTORS OF PSYCHOTICISM
(N=191)

Step Number	Variable Entered	Multiple R	R^2	Increase in R^2
1	Life change units (+)	.27	.07	.07
2	Satisfaction in relationships with female friends (-)	.35	.12	.05
3	Proportion of worries shared with others (-)	.40	.16	.04
4	Marital status (-)	.44	.20	.04
5	Education of self (-)	.46	.21	.01

TABLE 32

PREDICTORS OF EXTRAVERSION
(N=171)

Step Number	Variable Entered	Multiple R	R^2	Increase in R^2
1	Satisfaction with self-understanding (+)	.31	.09	.09
2	General helpfulness ratings of support persons (+)	.37	.14	.04
3	Life change units (+)	.40	.16	.02
4	Satisfaction with life (+)	.43	.18	.02
5	Recent counseling or therapy (+)	.44	.20	.01

TABLE 33

PREDICTORS OF NEUROTICISM
(N=179)

Step Number	Variable Entered	Multiple R	R^2	Increase in R^2
1	Life satisfaction (-)	.44	.19	.19
2	Recent counseling/therapy (-)	.48	.23	.03
3	General helpfulness ratings of support persons (-)	.51	.26	.03
4	Age (-)	.53	.28	.02
5	Proportion of persons with whom concerns were shared (+)	.54	.30	.02

C H A P T E R V

DISCUSSION AND CONCLUSIONS

Introduction

In this final chapter, the results of the study are discussed and interpreted. Particular attention is directed toward the psychological and mental health service implications which can be drawn from the data. Lastly, an assessment of the study with recommendations for future research is presented. First, though, we will review the problem of interest, purposes of the study and method of investigation.

A Review of the Problem, Purposes and Method of Investigation

This study was undertaken in large part because of the author's interest in the accumulating evidence which connects life stress to significant physical and emotional illness (Caplan, Cobb, French, Harrison and Pinneau, 1975; Holmes and Rahe, 1967; Liem and Liem, 1976; and Myers, Lindenthal, and Pepper, 1975). Many of the relevant studies have focused on males. There seemed every reason to believe that females were also vulnerable to the effects of life stress; if anything, there is evidence which suggests that because of their lower status (Dohrenwend, 1973), and as a result of the effects of sexism (Guttentag, 1975), women may be more vulnerable than men to the deleterious effects of stress.

This exploratory study was intended to provide an initial look at the issues which are illustrated in Figure 1. The possibility that

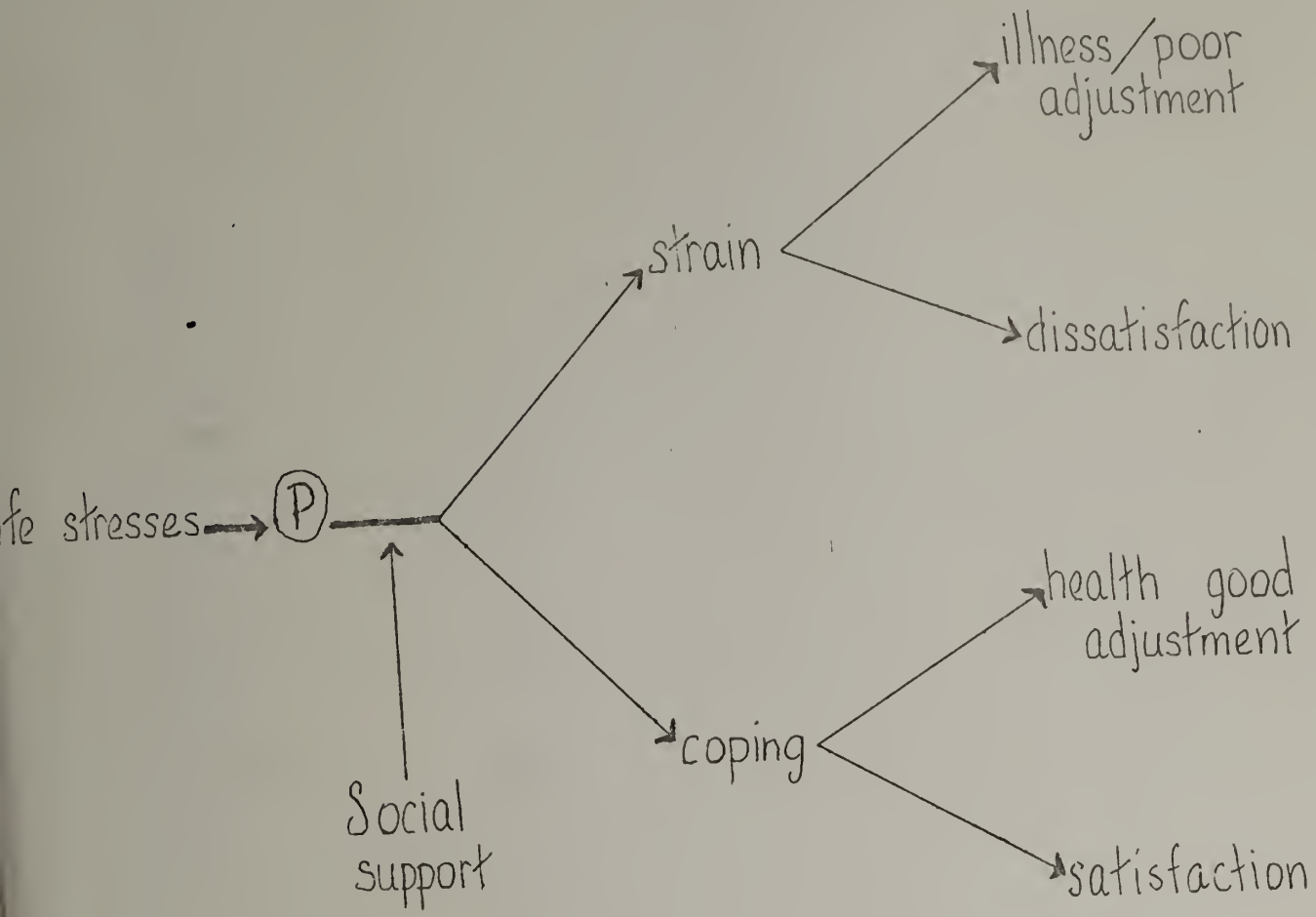
illness/poor adjustment
strain
dissatisfaction
fe stresses
P
health good adjustment
coping
Social support
satisfaction

Figure 1

social support functions both as a buffer between the individual and environmental stress, and as a facilitator of coping and adaptive behavior, has been suggested in the literature (Antonovsky, 1974; G. Caplan, 1974; R. Caplan, 1975). An improved understanding of these complex relationships could have meaning both for conceptualizations of emotional dysfunction and for treatment efforts of a psychotherapeutic nature.

There were several purposes toward which this study was directed. They centered on the interrelationships between three central variables: life stress, social support and adjustment behavior in women; a secondary variable, life satisfaction, was also studied. To briefly review, we were concerned with developing a better understanding of stress in women's lives both from the quantitative point of view (considering the magnitude of stresses) and the qualitative point of view (considering the kinds of stresses). Additionally, we investigated social support in an effort to understand both the kinds of support people have, and the variables which appear to influence high and low social support. Lastly, we investigated personality and adjustment in the sample of women; the intention was to provide information on any relationships which existed between stress, social support and personality/adjustment.

Reviewing the methodology employed in the study, two forms of data collection were involved, a mail questionnaire and a personal interview. The questionnaire was mailed to 350 women, 57 percent of whom completed and returned it. The interview was conducted with 24 women, randomly selected from volunteers who had participated in the questionnaire phase of the study.

The 200 study participants ranged in age from 18 through 81. All were residents of Northern New England, and had had informal, not-for-credit contact, through workshops and conferences, with Keene State College, Keene, New Hampshire.

Life Satisfaction

Introduction

For the purposes of this study, it was postulated that satisfaction is associated with stress, with the intervening nature of social support, with effective coping, and with adjustment. These proposed relationships are illustrated in Figure 1. Data from the present investigation identified many additional factors related to satisfaction. Specific support did develop for a relationship between stress and each of the following: stress, social support, and two adjustment factors (psychoticism and neuroticism). These findings and related results will now be discussed.

Interpretation of the Data

A primary task of this research was to generate data which would contribute to an understanding of emotional functioning in women. An indirect, though potentially relevant life dimension is that which reflects life satisfaction (LS). The sample of 200 women who participated in this study rated their life satisfaction; 122 were satisfied, 77 were dissatisfied (one women's ratings were not usable).

a. Demographic results. Social scientists are attempting to understand what factors are connected to and apparently influence satisfaction and well-being for women. Jessie Bernard (1973), for example, has been a strong critic of traditional housewife roles: "The housewife

syndrome might well be viewed as public health problem number one" (p. 48). Housewives are traditionally married women who do not work; as such, there exists an indirect comment in Bernard's statement about married life for women. Among those women sampled in the present study, more than twice as many married women as those in other marital categories were satisfied with their lives. Significantly, divorced and separated women were strongly represented among the dissatisfied (61 percent and 85 percent respectively). This finding is consistent with data from epidemiological studies (Radloff, 1975), and interpretations of data from county and state hospitals (Guttentag et al., 1975) which have suggested a higher incidence of emotional problems among divorced and separated women.

Another variable which social scientists have used in attempts to explain satisfaction among women is employment. Feree (1976), in a study of 135 working class women, found employment to be a major factor in life satisfaction. "Almost twice as many housewives as employed wives said they were dissatisfied with their lives [26 percent to 14 percent]" (p. 76). In the present study, a different result was obtained; there were no significant satisfaction differences between employed and unemployed women. (In a further analysis, level of employment was also unrelated to LS.) Of course, it is important to realize that participants in the present study were not predominantly working-class women, unlike Feree's sample. It may well be that represented among women in the current investigation were women who were perfectly pleased not to be employed, not to have to work outside of the home to bring in additional income, who enjoyed housework, and who were satisfied with this primary task.

A further variable considered in relation to life satisfaction was mobility, and some significant data developed. Of women living in the same area for three or more years, twice as many were satisfied with their lives as were dissatisfied (67 percent to 33 percent). One possible explanation for this result is that women who had a chance to establish meaningful social relationships with others were those who were less mobile, and subsequently more satisfied. Given the general significance of life satisfaction, further clarification of a relationship with mobility could be clinically useful.

Jessie Bernard, in a recent address at the annual American Psychological Association meeting (1976), commented that same sex friendships among women are on the decline. Bernard postulated that this was due to several factors, among them were: 1) increased technology; 2) a greater number of women in the working force who then had less contact with both members of their extended families, and other housewives with whom they might share a social network; and, 3) greater mobility, which affects the longevity and intimacy of interpersonal relationships. It may well be that the length of residency association with satisfaction in life involves many other factors, but there is little denying the impact of mobility on duration and intensity of interpersonal relationships; and, for the women surveyed, the association of dissatisfaction with mobility was strong.

b. Attitudinal variables and life satisfaction. Correlations between life satisfaction and selected life aspects were among the most consistent and powerful findings in the study. These data were reported

in Table 19. Not surprisingly, life satisfaction was positively correlated with levels of satisfaction in various relationships, including: 1) primary relationship; 2) relations with male friends; 3) relations with female friends; and 4) relations with one's children. Several other life dimensions were also related to LS. They included satisfaction with one's sex life, one's self-understanding, one's emotional support, and one's career.

For persons involved with the delivery of mental health services, the association of life satisfaction with these variables could be meaningful. It is occasionally difficult to gain a specific understanding of a client's difficulties if they are presented very generally, such as in the form of "I don't feel like myself." The strong relationship between levels of satisfaction with specific life dimensions and more general LS among the women who participated in the study could serve as prototypic relationships for the therapist whose client has rather vague presenting problems. The clinical worker could consider investigating client satisfaction with the several interpersonal relationships enumerated above, as well as with the more existential dimensions; satisfaction ratings of other dimensions could be sought by the therapist, leading to a clarified picture of a particular client's initially vague presenting problem.

What kind of inference can be made about the contribution of interpersonal relationships to LS? We know that social support comes from relationships with others. We know that among the women surveyed, satisfaction with life and satisfaction with several kinds of interpersonal relationships were strongly related. Lastly, we know that the women

who were satisfied with life were likely to be satisfied with the emotional support received from others.

In reviewing these data, it is inappropriate to draw cause and effect conclusions. What is helpful, however, is to review the results of the multiple regression analysis, reported in Table 28. These data enable us to account for a portion of the variance in Life Satisfaction among the women studied; the results will be considered next.

c. Predictions. A prediction study of Life Satisfaction was reported in Table 28. The best predictors (in order of importance) were as follows: 1) sex life satisfaction, 2) neuroticism, 3) emotional support satisfaction, 4) employment problems, 5) psychoticism, 6) satisfaction in relationships with female friends, 7) satisfaction with one's self-understanding, and 8) satisfaction in relationships with parents. The total amount of variance accounted for was .57. Several points deserve special mention.

1) The salience of sex life satisfaction was interesting because this variable is infrequently mentioned in the literature as an important factor in life satisfaction and well-being.

2) The fact that two Eysenck personality scales, N and P, emerged in the analysis suggests that personality factors play a part in life satisfaction.

3) The contribution of satisfaction-with-emotional-support received-from-others was undeniable.

4) Employment problems and satisfaction with one's self-understanding accounted for relatively low amounts of variance, as did satisfaction in relationships with male friends and parents.

In sum, the three best predictors of Life Satisfaction were sex life satisfaction, neuroticism, and emotional support satisfaction.

Nonetheless, all of the variable listed in the stepwise procedure might be areas which deserve attention from mental health workers who are concerned with female clients. For example, in recent years, family therapy advocates have suggested the importance of sex life satisfaction in healthy marital relationships (see Skynner, 1976). Results from the stepwise regression indicate that the role of sex life satisfaction in women's lives is indeed worthy of serious attention, and is deserving of further study. We could consider the results in relation to the woman vulnerable to life dissatisfaction: she would be dissatisfied with her sex life, predisposed to worry and anxiety, lacking in satisfaction with her emotional support from others, and experiencing employment problems.

Conclusions

Life satisfaction was one of the most important variables studied in this research. It was postulated that life satisfaction is affected by stress and by social support (refer to Figure 1).

We reviewed several areas of research on women's life satisfaction, and many of the findings are inconclusive. For example, it has been reported that some women are more satisfied when employed; yet, a simultaneous finding is that employed women have higher stresses than those who are not employed. Research on these issues must be continued in an effort to clarify results.

In the present study, generalizations to other women are not appropriate. However, comments can be made about the sample of women we investigated. Important aspects of the life satisfaction data are listed below.

1) A sizeable proportion of the women who participated in the study were less than satisfied with their lives (38 percent).

2) Low life satisfaction was more prevalent among separated and divorced women, and more mobile women; no relationship between employment and satisfaction was observed.

3) High satisfaction was related to satisfaction in relationships with partner/husband, with male and female friends, with one's children; all of these are interpersonal dimensions which could be investigated in therapy sessions.

4) Interestingly, for women who were employed, satisfaction with their careers was related to life satisfaction; mental health workers might consider this finding in relation to their responses to women who are unhappy with their work, realizing the possible significance this variable has for general life satisfaction and well-being.

5) The multiple regression analysis identified sex life satisfaction, emotional support satisfaction and neuroticism as the three best predictors of Life Satisfaction among the women studied. Quite clearly, the neuroticism variable is one toward which clinical assessments are generally sensitive on a diagnostic level. However, as mentioned earlier, sex life satisfaction is just becoming an area of concern for clinicians. The salience of social support satisfaction has been an area of clinical neglect for some time.

The relationships discussed above are still tentative. It is likely, however, that life satisfaction factors will be clarified through continued investigations by clinical workers and researchers of the variables listed above; and clearly the delivery of health services to women can be improved with the new knowledge.

Life Stress

Introduction

Data from the present investigation confirmed the postulated relationships between stress and each of the following: adjustment (specifically, extraversion), physical health, and life satisfaction. These proposed associations are illustrated in Figure 1. These and other stress

findings (related to demographic variables, among others) will now be reviewed. In the next sub-section of this Chapter, the proposed relationship between stress and social support will be considered.

As indicated in Figure 1, life stress was a variable of primary interest in this study. Because of the clinical significance of the postulated relationship between life stress and such variables as social support, emotional adjustment, and satisfaction, an effort was made to clarify our understanding of stress. The data confirmed a relationship between stress and both satisfaction and physical well-being. These and other stress findings will now be reported. In a later section, findings relevant to stress and adjustment will be discussed.

Interpretation of the Data

The Holmes and Rahe Schedule of Recent Events (1967), which was employed in this study as a measure of stress, is based on the premise that change, or readjustment, is the determining feature of stress. Thus, included in the scale are events generally considered to be positive (e.g., marriage, outstanding personal achievement) and events generally thought of as negative (e.g., troubles with the boss, major personal injury or illness).

Rahe (1972) demonstrated that high readjustment scores were associated with physical illness onset. "When subjects yearly LCU values ranged between 150 and 300 LCU, it was noted that an illness was reported during the following year in approximately half the instances" (p. 254); for those scoring over 300 LCU, illness was reported by 70 percent of the subjects in the subsequent year.

Additional research has documented the relationship between life stress and psychological difficulties (Dohrenwend, 1973; Liem and Liem, 1976; Myers, Lindenthal, and Pepper, 1975).

Of the 200 women who participated in the present study, 58 percent had LCU values over 150; 23 percent had LCU values over 300. The mean was 190, and the standard deviation was 125. Thus, in this sample of women, a large proportion had relatively high life stresses as reflected by the Holmes and Rahe scale.

a. Demographic variables. To improve our understanding of stress in women's lives, the relationships between stress scores and selected variables were considered. The following results (reported in Tables 11, 12, and 13) were observed:

1) younger women (35 years of age or less) had a greater incidence of high LCU values;

2) married and single women were underrepresented among those with high LCU values, while divorced and separated women had a much higher number of high LCU's'

3) employed women had a greater incidence of high LCU values than those unemployed;

4) income was inversely related to LCU values;

5) women with high LCU's were more likely to have been recent therapy or counseling recipients;

6) life satisfaction and LCU values were inversely related, thus among the women, life stress increased while life satisfaction decreased.

One context in which to consider some of the findings is related to the high risk woman. Guttentag et al., (1975) described the women vulnerable to depressive disorders and high life stress as one who is divorced or separated, under age 25, with a low income, and unsatisfying job, and young children at home. Next in order of vulnerability is the married mother, employed in the blue-collar labor force.

With regard to marital status in the present study, fewer divorced and separated women than those married, were included among study participants. Nonetheless, divorced and separated individuals were found to report a disproportionate number of Life Change Units (these data were reported in Table 10). The findings are consistent with data from two community-based studies by Radloff (1975) who found higher measures of depression among divorced and separated than married women. Additionally, Guttentag et al., noted that data from state and county mental hospitals suggest that divorced persons (both men and women) may be more vulnerable to depressive disorders than those in other marital categories.

Empirical data supporting the apparent connection between stress and depressive disorders in women are just beginning to accumulate. Results from the present study do not contradict the conclusions of Guttentag et al., who have considered the contributions of income, education, and marital status to stress and depression. However, criticism of the existing life events measures has developed. Guttentag et al., suggested that stress inventories have been insensitive to the day to day stresses generally connected with the housewife/mother role by underweighing these areas in scoring; as such, it is possible that the measures have contributed to a distorted picture of stress in women's lives.

The data on the effects of employment on women are interesting, but inconclusive. Bernard (1973) has documented the restrictedness of the traditional housewife role. Feree (1976) found that employed working-class women were more likely to be satisfied than their unemployed counterparts, yet there was strain involved in simultaneously filling several roles. Radloff (1975) reported working wives doing more housework than husbands. Other researchers have pointed out the more

general constrainst of the traditional female sex-role (Gove and Tudor, 1973; Guttentag, 1975; Seligman, 1974). The evidence has begun to accumulate which suggests the possible assets of labor force participation for women, yet there are potential problems in balancing participation in the world of work with more traditional female role behavior.

The association of LCU values with both recency of therapy and life satisfaction are results which do not have research precedents. Nonetheless, it is reasonable to consider these relationships. Women with high stresses had a greater likelihood of recent therapy; they were more inclined to seek out professional services than individuals not experiencing significant stress. On the other hand, it follows that high stress and life satisfaction would be negatively associated. Women experiencing satisfaction with their lives were less likely to have had high LCU scores.

b. Life change units and physical illness. In this study, data were collected concurrently on life stress/readjustment and physical illness; thus, the research design was different from that used by Holmes and Rahe, who considered illness in the year subsequent to the measurement of stress. Nonetheless, in the present study a positive correlation was found between the LCU values and the reported magnitude of self-illness ($r = .17$, $p < .01$) for the same twelve-month period.

c. Problem ratings and stress findings. Women who participated in this study also provided problem-ratings of various dimensions of their lives. (To review these items, refer to Question 25, Appendix B_3.) Three consistent areas of difficulty emerged in this data cluster: at least one-quarter of the participants indicated that financial concerns

(26 percent), disharmony with husband/partner (25 percent), and emotional discomfort (30 percent) were major problems for them over the past year. Though these life dimensions do not meet the "change" or "readjustment" criterion previously applied as a definition of stress (Holmes and Rahe, 1967), they are discrete, negative occurrences which would be stress producing for most people (Paykel, 1974). On two of the rating-dimensions, financial concerns and problems with partner/husband, the ratings were in part attributable to difficulties with external or environmental forces; emotional discomfort, however, is an internal state of affairs, the causes of which may not be immediately apparent.

One way in which these three variables can be construed as stresses is to realize the degree to which they require coping and adaptive responses; while the women wouldn't necessarily experience "change" relative to these stresses, they would be likely to manifest behavioral and emotional responses.

d. Stress and life satisfaction. In considering the problem ratings provided by the women, further clarification of these data was sought by analyzing their association with life satisfaction. These results, reported in Table 8, suggested that the problem ratings on many life dimensions were significantly related to general life satisfaction. That is, on problem ratings including, employment, primary relationships, disharmony, problems with children, legal difficulties, and emotional discomfort, a strong relationship existed between problem magnitudes and life satisfaction; generally, the greater the problem magnitude, the greater the chance that a woman was dissatisfied with life.

How does one explain the small percentage of women who had major problems as reflected by their own ratings yet who were not dissatisfied with life? Perhaps these were women whose coping abilities were well-developed, who were prepared to meet the stresses posed by various life problems without experiencing the strain that often accompanies deficiencies in coping skills (helplessness). Future research might well investigate the relationship between women's abilities to cope with life events and their levels of life satisfaction.

e. Predictions. A prediction study of life stress as measured by Life Change Units (LCU) was reported in Table 29. The proportion of variance accounted for was .45. The best predictors of life stress, as reflected by the prediction equation, were marital disharmony, income, and illness in the family. Additional variables were legal difficulties, age, problems with children, marital status, and Extraversion (as measured by the Eysenck scale).

Several of the predictors represented external/environmental stresses (e.g., marital disharmony, problems with children), and were very much in keeping with the Holmes and Rahe (1967) conceptualization of stress as an event which provokes change or readjustment. Other variables involved in the regression equation were quite "demographic" in nature (e.g., age and marital status).

Many of the predictors included in the LCU regression equation were quite consistent with factors identified by Guttentag et al. (1975) as significant in predicting the women who is a high risk for depressive disorders. Women vulnerable to depression included separated or

divorced persons, with low incomes, who were between the ages of 25-44. This profile is indeed consistent with the findings in the present study.

Implications which can be drawn from these data for mental health workers do not rest on cause and effect findings. However, assuming that clinical workers accept the possibility that stress is associated with dysfunction, particular attention to stress factors and coping processes could be employed in therapeutic efforts with women experiencing stresses which were identified in the LCU prediction. This sensitivity could take many forms, but one particular way in which it might be manifested would be on an attitudinal level. For example, rather than viewing marital disharmony as a discrete clinical symptom requiring psychodynamic consideration, it could be considered contextually, as in the "additive stress" model previously mentioned (Guttentag et al, 1975). That is, presenting problems could be viewed in relation to one another rather than as isolated symptoms. This contextual direction might be a particularly fruitful one to explore in relation to female clients, given the developing evidence of their considerable vulnerability to stress, whether as a result of their lower status (Dohrenwend, 1973), or the effects of sexism (Guttentag et al., 1975), or as a function of "helplessness" stemming from the differential effects of our socialization processes (Seligman, 1975).

Conclusions

A model which illustrates the initial relationships investigated in this study is presented in Figure 1. It is postulated that life

stress (both environmental events which prompt change or readjustment, and discrete occurrences which are negative in quality) has an impact on the person (P), whose abilities to cope with and accommodate the stress are related to adjustment, physical and emotional health, and life satisfaction. It remains to be seen however, just what P variables explain differential coping abilities. We have previously mentioned the additive stress model (Holmes and Rahe, 1967), and Seligman's theory of "learned helplessness" (1975) which postulates that women are socialized to lack effective coping skills. Consider, further, Dohrenwend's (1973) suggestion of a relationship between social status and stressful life events: she found that members of lower classes and females were exposed to relatively high rates of instability and life change. We suggest that younger, unmarried females with low incomes have less status than their same sex, more established counterparts; indeed, that these women are at the low end of the status hierarchy. It may well be that the "high risk" women, as proposed by Guttentag et al., is a person with significant coping deficits, who is indeed more vulnerable to illness and dissatisfaction with life.

Generalizing data from the current study to other women is not warranted. The sample size of 200 was relatively small, and the women were not randomly selected. Nonetheless, the results can be considered as an investigatory starting point. Several general comments are enumerated below:

1) A sizeable portion of the women studied had high LCU values, dispelling any myth that women have quiet, relaxed lives.

2) High stress was related to low income, age, marital status, and dissatisfaction with life, all of which could be considered as important variables during client assessment periods prior to therapeutic treatment.

3) Employed women were more likely to have high LCU scores, which suggests that mental health workers should carefully weigh the advisability of employment or career-seeking with their female clients and thoughtfully explore the currently popular notion that women need to "get out of the house."

4) Physical illness and LCU's were positively related, a connection that could be kept in mind on a preventive level by persons relating to clients who are experiencing high stresses.

5) There was consistent association between high LCU's and women's ratings of problems in their lives, which mental health workers could consider as support for the position that clients can be encouraged to be more specific about their presenting problems.

6) Stress and life satisfaction were associated, suggesting "complementary" dimensions that could illuminate one another in a clinical interview.

Social Support

Introduction

Social support was a central variable in the study. As indicated in Figure 1, social support was postulated as an intervening variable which buffers the effects of stress, facilitates coping, and encourages adjustment and satisfaction. Social support was the most difficult variable to measure in the investigation. While we were able to clarify several aspects of support, the proposed association between stress and social support as related to adjustment was not supported by the data, perhaps due to measurement problems. In the following section general findings related to social support are discussed, as are findings specifically related to the Social Support Scores (SSS).

Interpretation of General Data

a. Support persons in the social network. Women who participated in the study provided data on persons to whom they went for support purposes. Initially, they indicated the difficulty experienced in approaching specific persons (these ratings were reported in Table 13). The following individuals were most frequently rated as "not difficult--rarely difficult" persons with whom to discuss personal matters:

1) close friends - 70 percent
2) partner/husband - 54 percent
3) children - 48 percent

Two groups of persons emerged as consistently "difficult--very difficult" persons with whom to discuss personal matters:

1) parents - 36 percent
2) other relatives - 28 percent

Of professional caregivers, counselors and ministers received high "not applicable" ratings (by 52 percent and 58 percent of the women, respectively).

Primarily for the purposes of checking the reliability of the ratings, women were asked to identify a recent problem and a recent decision; they were then asked to rate the helpfulness of the same list of persons rated earlier for ease-in-discussing personal matters. These findings were reported in Table 14. Once again, partner/husband and close friends were the most frequently rated as "very helpful", while again parents and other relatives were most frequently "not helpful."

The three groups of professional caregivers (doctors, ministers, counselors/therapists) were most frequently rated "not applicable" as

helpers, though with regard to a problem and a decision, counselors/therapists were the most frequently rated "very helpful--helpful" of the professionals.

What did these data tell us about who the support persons were? Indeed, they confirmed the following for the women studied:

1) Close friends were the easiest persons to approach with concerns, and they were often experienced as helpful.

2) Partners/husbands were also relatively approachable and helpful.

3) Other family members were less approachable and less helpful, with the possible exception of children.

4) Professional caregivers were not easily approached, though counselors/therapists were the most helpful of the group.

5) Data on the support potential of women's groups were difficult to interpret because so many women rated them "not applicable."

b. Age as related to the helpfulness ratings. Age was not related to the helpfulness ratings generated by the women. In Table 15, cross tabulations were reported which divided the women into two groups: those age 35 and under, and those over 35. Helpfulness ratings of children and close friends were associated with age:

1) Women over 35 more frequently rated their children as "helpful", which certainly makes intuitive sense.

2) Surprisingly, more than twice as many women over 35 indicated that the helpfulness of a friend was "not applicable", as compared with the group of younger women, suggesting the possibility that older women rely more on the traditional family structure for support.

Age differences did not develop on any other helpfulness ratings. However, these data (especially number 2 above) are the first indications of significant age differences in support-seeking, which will be elaborated upon in a later section.

c. Help-seeking as related to demographic variables. As reported earlier, Warren (1975) found social class differences in the help-seeking behavior of men and women. Specifically, she found blue-collar women were most likely to seek out ministers/pastors during times of stress. Additionally, these working women were less likely than their white collar counterparts to turn to husbands, coworkers, informal neighborhood groups or professionals for help. In short, Warren's data suggest that employed, working-class women may well have social support deficits.

A traditional measure of social class was not possible in the present study. The classic Hollingshead Two Factor Index of Social Position (1957) was included in the questionnaire. The measure assesses levels of education and occupation, and these data are then used in a mathematical formula to compute social class. In studying women, however, a social class determination was difficult. First, many of the women participating in the study were not employed, thus eliminating one-half of the needed data. Second, one might argue that their social class could be computed with data on their husbands, however many of the women were not married. No social class (education and occupation) assessment could be consistently applied to all 200 women participating in the study, thus the relevant variables were reported and discussed separately.

Women who participated in the present study came from a fairly evenly distributed range of educational backgrounds and income brackets (see Table 1 for distribution). Several analyses were performed in an effort to clarify social class differences by looking at the relationships

between education, income and help-seeking patterns. Correlations revealed the following information:

1) Ratings of partner/husband helpfulness were positively correlated with income, both regarding problems ($r = .20$, $p < .01$) and decisions ($r = .12$, $p < .05$).

2) Education was positively correlated with the helpfulness of ministers ($r = .18$, $p < .01$).

3) With regard to general ease in approaching either partners/husbands or ministers as related to income and self-education, no clear trend emerged.

Warren's findings cannot be strictly compared to data from the present study because a true social class measure was lacking. Nonetheless, there was not evidence of a disporportionate number of working class women turning to ministers for assistance. If anything, general rating data on ministers indicated that few women actually called on their ministers for assistance during times of difficulty. This is consistent with findings in a study by Prescott and Letko (1976) on wife beatings; of forty women who were victims of physical violence by males with whom they were intimately associated, few reported contacting ministers for help or counsel.

d. Social support as a buffer. The epidemiological research of Cassel (1973), the investigations of Robert Caplan (1975) on occupational stress and worker health, the recent study of undergraduates by Liem and Liem (1976), and the work of Nuckolls, Cassel, and Kaplan (1972) on pregnant women, point to social support as an intervening variable which affects an individuals coping abilities, and which has an indirect bearing on physical and psychological well-being. From the previously reported data in this study, it is clear that women in the

sample did reach out to others in times of need, particularly to close friends and partners/husbands. Indeed, when the women were asked about the degree to which they did share concerns and worries with others, 86 percent indicated that they engaged in at least some sharing; when asked to estimate the number of persons with whom they talked over concerns, only 2 percent of the women indicated they had talked with "no one" (these two sets of data were included in Table 13).

An important age-related finding developed in the analysis of data related to the sharing of concerns with others. The data suggest that women over age 35 were less likely to engage others in discussions of concerns than younger women; 26 percent of the older women reported sharing "few" of their concerns of the past year as compared to 5 percent of the younger women. Further analysis of these data revealed that younger women did proportionately more sharing (64 percent reported sharing "all-most" of their concerns as compared with 41 percent of the women over age 35).

Conclusions

General social support data provided information in several relevant areas. We found rather clear indications of where women went for support and which sources were most helpful/effective:

1) Close friends were the most favorably rated as supporters.

2) Immediate family, partner/husband and children were also rated favorably as supporters.

3) Perhaps least favorably rated of family members were parents and other relatives.

4) Of professional caregivers, doctors were not favorably rated, while ministers were most frequently rated as "not applicable."

5) Counselors given helpfulness ratings (as compared to "not applicable" ratings) were the most often regarded as "easy to talk to" of professional caregivers.

Implications for mental health workers which can be drawn from the above findings could include consideration of the improvement of support functions within extended families. Among women surveyed, the extended family was an underutilized and poorly rated support resource. It is possible that this is true of other women's attitudes about and employment of relatives outside of the nuclear family for support purposes. Some clinical workers have emphasized the importance of kin and friendship networks, though not explicitly for their supportive functions. Family therapy is the clinical arena in which attention has been directed beyond the nuclear family for facilitating development and change (Rueveni, 1975; Speck and Attneave, 1973). Data from the present study would seem to indicate the need for continued clinical efforts to improve the usefulness of extended family members to one another for support giving and receiving.

Data from the study casts some doubt over the usefulness of professional caregivers as support persons. Doctors and ministers were particularly poorly rated. It may well be that supplementary counseling and mental health training for persons whose main concerns are in the spiritual and physical domains would improve their effectiveness and availability as support givers. A recent report in the American Psychological Association Monitor (1977) indicates that the National

Institute of Mental Health is considering a plan which would provide mental health training to physicians and other primary health care providers. This proposal would certainly direct itself to what appears to be, among women surveyed, an under-utilization of some professional caregivers and a possible over-utilization of the nuclear family in times of support-need. Indeed, by improving the effectiveness and mental health awareness of doctors and ministers, we might prevent the possibility of family dysfunction resulting from the strain of excessive support-giving in difficult, stressful times.

Of the support persons rated, close friends came out as helpful, easy to talk to, and as important resources. This finding was also confirmed by the data collected in the 24 personal interviews conducted as an adjunct to the survey procedure. This finding is certainly consistent with the developing interest in social networks. Additionally, the significance of friends in problem-times is somewhat of an affirmation of Gerald Caplan's (1974) notion of "informal caregivers."

Perhaps a future area of investigation could focus on successful, effective informal caregivers. Once again, the interview data we collected provided some information in this area, but systematic research could be undertaken for further clarification of effective, informal caregiving. On a preventive level, if components of good supporting and caregiving could be identified, there is no reason why interested persons couldn't be trained in these skills. Gerald Caplan and persons working with him have done some exploratory work in this area, but for the moment these ultimately preventive activities are rare, and are

certainly not the norm in such obviously appropriate settings as community mental health centers.

Of the women studied, 86 percent indicated they had shared at least some concerns with others in the past year, and only 2 percent indicated they had no one with whom to talk things over. Thus, for the most part, women included in the sample did not appear to have been socially isolated or totally lacking in social support.

Age was related to some of the ratings of others' helpfulness. Higher age (over 35) was associated with favorable helpfulness ratings of children and a high percentage of "not applicable" ratings with regard to friends. This latter finding raises the issue of whether support is age-related. That is, with a high percentage (25 percent) of women rating friends in this manner, is it possible that support deficits are more common among older women, and if so couldn't therapeutic attention be directed toward this problem?

One tool which is attracting clinical attention, and which addresses itself to support deficits in the Network Map (Bott, 1971; Tolsdorf, 1975, 1976). This procedure, if employed during client assessment periods, could provide information on both the quantity and quality of a person's social network. If there is a possibility that older women suffer from support deficits, network maps could provide information which would be clinically helpful and therapeutically relevant.

As previously mentioned, Warren (1975) found class differences relative to social support systems of women. No such differences developed in the present study (comparing education, employment, and income),

but further investigators could use network maps for the purpose of collecting additional data on the support systems of women, and continuing efforts to clarify their relationship to social class.

Interpretation of the Social Support Scores (SSS) Data

A mathematical figure which reflects quality and quantity of social support was determined for each woman participating in the study. The Social Support Scores (SSS) were then considered in relation to other variables.

a. Correlational results. In Table 18, several correlations were reported with the SSS. One moderate association was revealed, a correlation between the SSS and recency of counseling/therapy ($r = .30$, $p < .001$), indicating that the more recent a woman's therapy experience, the more likely she was to have a high SSS value. This finding may reflect some of the interpersonal skill-building that is thought to be a function of good therapy experiences; that is, women receiving the special support of the therapeutic relationship may find it easier to seek-out persons in the social environment for purposes of sharing and problem-solving. Of course, another possible interpretation of these data is that women recently in therapy/counseling relationships were having greater life difficulties, and persons in the social network responded with support-giving, thus inflating the SSS.

Two additional significant, but low correlations with the SSS were reported in Table 18, satisfaction with life and the number of small children (both $r = .11$, $p < .05$). Not unexpectedly, the higher a woman's SSS, the greater the chances of her being satisfied with

life. It may well be that some of the buffering effects of social support are related to the degree of life satisfaction; indeed, as Gerald Caplan suggests, social support often functions as a buffer, providing persons with some protection from stress through tangible means (e.g., loans of money) and intangible means (affection, nurturance). The relationship between social support and life satisfaction is one which warrants further investigation; some additional findings related to this study will be discussed in a later section in which SSS is analyzed.

Because some data does exist which suggests an association between depressive disorders in women and youthfulness of children at home (Radloff, 1975), we did several analyses related to the number of small children at home. Interestingly, this variable was positively correlated with the SSS (reported in Table 18), suggesting that the number of young children at home increased as did the Social Support Scores of the women. Whatever connection may exist between the stress of caring for young children and depressive disorders among women clearly needs further investigation, however having young children at home did not appear to be related to social support deficits in the women.

In an attempt to further explain the Social Support Scores, correlations were calculated using satisfaction ratings provided by the women on various life dimensions. These data were reported in Table 19. The correlations were all of modest strength, the largest being between satisfaction with one's emotional support and the SSS ($r = .27$, $p < .01$). This was not a surprising relationship.

The SSS was positively related to satisfaction with several interpersonal relationships: with parents ($r = .20$, $p < .01$), with one's children ($r = .14$, $p < .05$); and with one's primary relationship ($r = .12$, $p < .05$). Satisfaction with self-understanding was also significantly related to SSS.

Causative statements deriving from the SSS correlations are not appropriate given the nature of the data. Nonetheless, it is clear that among the 200 women, the SSS was related to some important life dimensions. Interestingly, the SSS was not strongly related to some major demographic variables (i.e., age, income, and education of self).

b. Predictions. Attempts to predict Social Support Scores (SSS) were not encouraging. The total amount of variance of SSS accounted for by the stepwise regression was only .22. The poor prediction results may be attributable to the rather elusive and complex nature of social support. Both defining and measuring this construct were difficult tasks, and clearly not perfected in the present investigation.

Conclusions

Social Support Score conclusions are difficult to draw perhaps because SSS was not measured very well. Nonetheless, for purposes of review, high SSS was related to:

1) Recent counseling/therapy,
2) High life satisfaction,
3) Small children at home,
4) Primary relationship satisfaction,

5) Self-understanding satisfaction,

6) Emotional support satisfaction,

7) Satisfaction in relationships with parents and children.

For clinical workers, data from the current study are compatible with other findings which have suggested the importance of social support. However, further conclusions about the Social Support Scores, per se, are unwarranted. What is clear, however, is the necessity for further clarification and investigation of the concept through additional research.

The Personality/Adjustment Findings

Introduction

In the current investigation, emotional adjustment was the primary dependent measure, as indicated in Figure 1. It was proposed that adjustment was related both to stress and to social support. Results from the study confirmed the association of adjustment and stress. However, the data did not support a conceptualization of social support as buffer between the effects of stress on emotional adjustment.

Interpretation of the Data

The Eysenck Personality Questionnaire (EPQ) was employed in the present study. The questionnaire has four scales: Psychoticism (P), Extraversion (E), Neuroticism (N), and Lie (L). Although investigations of life stress and psychological factors have been previously conducted, as far as can be determined no studies of life stress and personality adjustment have been reported.

As previously mentioned, research has been conducted on the psychological and physical effects of life stress. Cohler, Grunebaum, Weiss, Gallent, and Abernethy (1974) found that psychiatric hospitalization of women with small children was attributable to both deficits in social relationships and high life stress. Myers, Lindenthal, and Pepper (1975) studied life stress and psychiatric symptoms in a community setting. They found that persons with high stresses and fewer symptoms were more well-integrated into the social environment and less socially isolated, than those with greater symptoms and low stresses. Liem and Liem (1976), in an investigation of stress and social support among a sample of college undergraduates, found social and tangible support were strongly associated with physical and psychological well-being. The research employing social support as an intervening variable has begun to develop; in the current study, the focus, however, was on personality adjustment rather than psychiatric symptoms or physical health. In Figure 2, social support is graphically related to the variables investigated.

A review of the personality dimensions which are tapped by the EPQ is an important preliminary to further discussion of the results. Eysenck and Eysenck (1975) have indicated that the EPQ measures three major personality factors, P, E, and N. They have suggested terms which are synonymous with the scales for the purpose of further clarifying the three factors. Psychoticism (P) is synonymous with "tough-mindedness", and the high scorer as described by Eysenck and Eysenck resembles the classic description of the sociopathic personality: "He may be cruel

and inhumane, lacking in feeling and empathy, and altogether insensitive" (p. 5). The Extraversion-Introversion (E) scale is intended to tap a predisposition toward one end of a continuum ranging from excitability to inhibition. The Neuroticism (N) scale is intended to provide data on the lability or degree of emotionality present in a given personality. The high N person is described as a worrier, an anxious individual.

a. Personality correlates. In Table 21, correlations for the Eysenck scales with demographic variables were reported. Most of the correlations were low to moderate in strength. P was negatively correlated with socio-economic variables (income and self-education), suggesting that the high P scorer was likely to be an individual with lesser amounts of education and income. With regard to E, a correlation with recency of therapy ($r = .22$, $p < .01$) indicated that recent therapy recipients were more likely to be women with high E scores. Several variables were correlated with the N scale, most prominent, however, was life satisfaction ($r = -.44$, $p < .01$). The high N scorer, the person characterized by Eysenck and Eysenck as emotional, as a worrier, was associated with low life satisfaction. Further correlations with the N scale were of a lesser magnitude; for example, the correlation of counseling recency with self-illness ($r = .22$, $p < .01$). Again, none of the correlations provided cause and effect data. However, they did provide information about degrees of association.

The Eysenck Personality Questionnaire scales were correlated with significant variables in the study, but on the whole the correlations

were limited. Nonetheless, the associations could be considered as data which lend support to the viewing of women's behavior and emotional problems contextually (an argument put forth by Guttentag, et al.,) rather than in a more psychodynamic framework. This position will be further considered in the conclusion section.

b. Relationships between LCU, SSS, and the EPQ. The major considerations in this study involved an interest in stress as it occurred in women's lives, in personality adjustment as related to stress, and in the nature of social support as related to both stress and personality adjustment. In Table 26, intercorrelations were reported for the three major dependent measures employed in the study: the Holmes and Rahe Schedule of Recent Events, the Eysenck Personality Questionnaire, and the Social Support Scores.

Though the correlations were modest in size, they did provide information which may be useful in the planning of further related research, and in the delivery of mental health services. The Life Change Units (LCU) were associated with the three Eysenck scales, which were of primary interest in this study. The strongest of these correlations was between LCU and P ($r = .25$, $p < .01$); LCU and N were also positively correlated ($r = .21$, $p < .01$), as were LCU and E ($r = .19$, $p < .01$). Interestingly, these relationships suggest that among the sample of women studied, high stress was indeed associated with various personality predispositions, though most strongly with "tough-mindedness."

For persons concerned with delivery of mental health services, one might conclude that considerable sensitivity is needed in relating

to the means by which individuals manifest stress on a personality/ adjustment level. That high stress is related to high scores on P, E, and N, suggests an association between stress and adjustment; that individual clients manifesting personality disorganization through excessive: "toughmindedness", or extroverted behavior, or emotionality and anxiety, may also be experiencing the strain of attempts to cope with life stresses deserves clinical consideration. This relationship between life stresses and personality adjustment supports the value of a contextual interpretation of behavior (implied by Guttentag et al., 1975, and Liem and Liem, 1976) in which problems are assessed in relation to other salient factors.

The correlations with the Social Support Scores, also reported in Table 26, contained several interesting pieces of information. The strongest relationship was between SSS and E ($r = .23$, $p < .01$), suggesting that women with high Extraversion scores also tended toward high social support scores. This is another finding that makes intuitive sense; persons with a predisposition toward extraversion might well establish and maintain relationships with ease when compared to those who are more introverted.

The correlation between the SSS and the P scale was low ($r = .16$, $p < .01$), and that between N and SSS even lower (and not statistically different from zero).

It is interesting to consider the high N scorer in relation to what might be a social support deficit. The "worrier", the emotionally labile person who is moody and anxious, might well be the person Gerald

Caplan (1974) describes as lacking significant feedback from the social environment. Caplan mentions that the person with inadequate social support has difficulty negotiating the environment, and lacks cues for discriminating safe situations from those which might be hazardous.

Many of the relationships with adjustment in the study were low to moderate in strength, and as such were somewhat inconclusive though deserving of further study. Though not contradicting the model proposed in Figure 1, in which the interrelationships of stress, social support, and adjustment were sketched out, the findings do not lend conclusive support to the theory.

c. Predictions. Predictions of the Eysenck scales were reported in Tables 30-33. The variances accounted for on all three measures were low to moderate. Beginning the discussion with P, the Psychoticism scale, the total variance accounted for by the prediction equation was .21. Interestingly, the two factors accounting for the most variance were Life Change Units (LCU) and satisfaction in relationships with female friends.

In the multiple regression analysis on Extraversion reported in Table 31, a similar low total variance was accounted for ($R^2 = .20$).

Predictions of Neuroticism were the strongest of the three adjustment regressions. The data were reported in Table 31. In this analysis, the proportion of variance accounted for was .30. Variables entered as predictors included: life satisfaction, recent counseling or therapy, perceived helpfulness of others as helpers, age, and the number of individuals sought out as support persons when concerns

and worries developed. Once again, these findings were not incompatible with the relationships proposed in Figure 1. However, the low total amount of variance accounted for leaves much to be explained in the N scores.

Conclusions

The Eysenck Personality Questionnaire (EPQ) was employed in the present study as a method of assessing personality adjustment on three key factors: Psychoticism (P), Extraversion (E), and Neuroticism (N). The interest in adjustment focused on attempts to determine whether stress and social support were associated with personality in a way which might parallel the association of stress with physical illness.

In sum, the study generated some evidence affirming the role of stress in poor emotional adjustment of a Psychotic nature. However this relationship certainly warrants further investigation. Less certain, however, was the role of social support. While it appeared to have some relationships to Psychoticism, the association was not in the expected direction. Indeed, women with high P scores were more likely to have high SSS. Support also developed the postulated association between stress and adjustment as reflected on the Extraversion variable. However, social support was again positively associated with E, a relationship in the opposite direction to that proposed.

The Eysenck N scale was the most strongly associated to other variables.

1) High N scores were related to youth, high levels of education, recent counseling, dissatisfaction with life and self-illness.

2) High N was also associated with high stress (LCU).

3) There was, unlike with P and E, a low negative relationship between N and SSS; high N scores were somewhat likely to have low Social Support Scores.

What implications do these data hold for delivers of mental health services? Strong statements about the relationship between emotional adjustment and social support are not possible, given the low to moderate relationships that developed from the data. However, several general comments can be made.

1) Mental health workers could be encouraged to seriously consider the interrelationship of life stress and adjustment in the assessment and diagnosis of clients. Data from the present study do not contradict suggestions that environmental stresses and persons' attempts to cope with them are related to various forms of dysfunction.

2) The relationship of stress to adjustment in the current study was not strongly buffered by social support. If anything, persons high on two of the Eysenck scales, P and E, appeared to have high Social Support Scores. For clinical workers, the role of social support is less clear in data from this study. However, one possibility is that social support doesn't buffer people from the effects of stress on those two personality dimensions. As such, attempts to generate social support for clients should perhaps not be evaluated by their effects on personality functioning, but perhaps on some other variable such as symptomatology, or anxiety measures.

Limitations of the Study

The questionnaire and interview methods of this study requires a reliance on the good-will, memory, interpretation and honesty of the women involved. The data must be considered with these facts in mind.

The questionnaire, while an anonymous instrument validated through a pilot-testing procedure with both professionals in the field and

women similar to those in the sample survey, did require time and attention as well as responses to some very personal questions. There is the possibility that inaccuracies were reported by women in their questionnaire responses. Several questionnaire items required reflection to past events. Even with the best of intentions, there is the possibility that the selective nature of memory and recall processes would affect the response accuracy of the women.

The questionnaire return rate was 57 percent (N = 200). A possible limitation of the study is that the questionnaires which were not returned could have contained data collectively similar, though different from those returned and analyzed. There is the chance that the results would have been different had all questionnaires been returned.

This research study was exploratory in nature and was, by design, a field study; thus, it was not "controlled" in an experimental sense. An obvious weakness of such a design is that causal inferences and interpretations can not be drawn.

The women who participated in the study were residents of towns and small cities in Northern New England. Additionally, they had been in contact, though not specifically as students, with a state college. These two factors are sufficient reason for caution in generalizing the research' findings to other women who, for example, might live in other parts of the country or in urban areas, or who have had no contact with educational institutions.

An extremely important limitation of the study involved the difficulty of measuring two of the major variables, social support and social class. Quite clearly, the research would have benefited from better measures in these two areas.

Suggestions For Further Research

Liem and Liem (1976) and Guttentag et al., (1975) have pointed to methodological difficulties with the current life stress measures. Instruments need to be developed which more accurately reflect levels of stress.

There are justified criticisms of questionnaire data-collection methods. A research recommendation for those studying social support was proposed by Liem and Liem (1976). They suggested increased utilization of interview methods as a data gathering device because interviews control for the sizeable error variance found in questionnaire results. Interview methods would also make it easier to assess informal, non-systematic forms of social support which occur outside the traditional channels of family and friends (e.g., through co-workers).

In future studies, a larger, randomly selected sample of women from several populations (i.e., urban dwelling, black) might clarify the many low to moderate correlations observed in this investigation.

As mentioned earlier, continued attention must be directed toward the assessment of social support, on both qualitative and quantitative dimensions.

A final recommendation would be to create a data collection system which allowed for greater experimental control. This might involve,

for example, individuals reporting and rating their support contacts on a daily basis over time, as a means of gathering data which were not retrospective, and possibly distorted.

Psychological Implication of the Findings

The relationships which were investigated in this study involved stress, social support, and personality adjustment among a sample of 200 women; a secondary area of interest was life satisfaction. Figure 1 sketched out the proposed interrelationships.

Consideration in this study was focused on the psychological implications of the findings, particularly those relevant to the delivery of therapeutic services.

Some of the relationships proposed in Figure 1 were confirmed by the findings:

1) Life stress was related to personality adjustment.

2) Life stress was also related to satisfaction.

3) No clear empirical data developed which demonstrated the proposed buffering effects of social support.

We have reviewed at length the implications of the findings for mental health workers. However, a restatement of major implications to be drawn for clinical workers is important.

Women in the study were exposed to considerable stress magnitudes. From this, we would conclude that this may be true of other women, and greater clinical sensitivity could be directed toward the environmental, change-related events with which women must cope.

The clear relationship between stress and poor adjustment suggests that mental health workers could bear such a connection in mind when evaluating and assessing the problems of female clients. Prior evidence exists which connects stress to physical illness and psychiatric symptoms. In this study stress has been related to personality adjustment. This suggests a focus for therapeutic investigation and treatment of women with adjustment-type presenting problems. That is, consideration could be given to the magnitudes of their stresses. If the stress is determined to be a contributing factor to adjustment difficulties, therapeutic treatment could, in part, be directed toward assisting with the coping responses that are so important in dealing with stress, particularly given the proposed "learned helplessness" that may render many women ineffective copers.

We have mentioned the criticism of current stress inventories which has charged that the measures are insensitive to the stresses involved in the day-to-day functioning of housewives. Clinical workers could bear this possibility in mind, particularly if their intention is to consider the effects of additive stress.

A final general consideration related to the treatment of women has been mentioned several times in this section. That is, therapeutic attention could be directed toward an acknowledgement of the "real" stresses women clients experience and toward the development of effective coping responses. Therapeutic explorations in this direction would de-emphasize the intra-psychic aspects of women's problems in an attempt to help them acquire the needed coping skills.

With regard to the social support data, results did not develop which would confirm its role as an intervening variable. It is possible that the difficulty of measuring the variable was the reason the proposed relationship did not develop. Nonetheless, clinical workers could continue their attention to the quality and quantity of social support and network belongingness of their clients without doing them a disservice. There is certainly strong evidence from other research which has confirmed the important buffering function of social support as related to physical illness and emotional well-being. However, continued research attention will have to be directed toward the relationship between adjustment and social support to further clarify the association.

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APPENDIX A

Introductory Letter to Study Participants

keene state college
keene, new hampshire 03431 603-352-1909

2/1/76

Dear Ms

This letter is being sent to all registrants of 1974-76 courses and workshops sponsored by WERC at Keene State College and the Keene WISE office. The purpose of the letter is to introduce you to a study I am conducting on women's uses of social relationships in times of stress, and to ask for your participation.

As you may know, psychological research on women has been rather scanty and what work has been done has typically been limited to female college students and women living in either predominantly academic communities or urban areas. Rarely have mature women living outside those environments been studied. The research I am planning and in which I'm asking you to participate will provide much needed information. It will add to the development of our knowledge about the emotional and tangible stresses contemporary women are experiencing and may well suggest some methods for providing improved assistance and support to women.

Eleanor vander Haegen, Director of WERC, and Judy Huntley of WISE, have both been involved with me in discussions of this study. This letter is sent to you with their permission. It is our hope that the information provided by the study will be helpful to members of Keene State College's women's offices, and to community organizations in identifying some of the needs experienced by women who receive their services. Further, we expect the results of my study to aid in the development of programs and services you will find useful.

In one week you will receive additional details on the research project, and a questionnaire. Your cooperation in completing the questionnaire will be greatly appreciated. It will take about twenty-five minutes. The success of this study depends on the return of every questionnaire so that the results will accurately reflect the diverse experiences of women. All returned questionnaires will be completely anonymous.

Research studies such as the one in which I'm asking you to participate will lend themselves to an improved understanding of women, a goal which should contribute to fuller lives for all of us. Thanks in advance for your contribution. Should you have any questions, you may reach me at 603-756-3782.

Sincerely,

Elizabeth Dickey

Elizabeth Dickey

APPENDIX B

Mail Survey Cover Letter

keene state college

keene, new hampshire 03431 603-352-1909

2/1/76

Dear Ms

The questionnaire enclosed is being distributed to women who participated in courses and conferences sponsored by WERC at Keene State College and by the Keene office of WISE over the past two years. Your response will be anonymous, so please do not indicate your name.

There are a couple of issues to be clarified before you respond to the questionnaire. First, I must acknowledge that many of the questions posed are quite personal. I feel, however, that the information they will provide is of considerable significance to the study and my efforts to understand some of the problems contemporary women are experiencing. (And, I would remind you that your responses are anonymous.) Second, the questionnaire will take a little time, probably between 20-30 minutes, but the details will help complete a picture of over 300 women. Third, the questions require some privacy and freedom from interruption to answer fully. And fourth, should any publication develop from this study all data and conclusions, because of the anonymity of the questionnaire, will be reported as representing groups of women rather than specific individuals.

You will find a stamped, addressed post card attached to this package. It asks for your name and address, and poses two questions. Please complete the card as you complete the questionnaire, but mail them separately. This procedure will make it possible for me to know who has answered the questionnaire, without individual identities being related to anything but the card. Both the post card and questionnaire mailing envelope have been addressed and stamped for your convenience.

You could increase the value of this research by helping to locate other women willing to participate in the study. Perhaps you have friends or neighbors who would be interested. Would you contact any possible volunteers for the study and ask them to write or call me for a questionnaire? Please do not send me women's names, as suggested participants, without first checking with them.

As I pointed out in my earlier letter to you, social science research on women has been lacking. The information gathered in this study will be used as the basis of a report which will be available to social scientists, therapists, and others interested in the area of women and mental health in America. I would like to express in advance my appreciation for your participation and interest in this research study. Should you have any questions, do call me at: 603-756-3782.

Sincerely,

Elizabeth Dickey

Elizabeth Dickey

APPENDIX B

Questionnaire: A Survey of Women and their Environments

A Survey of Women and Their Environments

Part A

1. What is your present age? (in years) _____

2. What is your present marital status? (circle one)
   1. divorced
   2. living with opposite sex person
   3. living with same sex person
   4. married
   5. separated
   6. single
   7. widowed

3. Do you have children? (circle one)
   1. yes, 1
   2. yes, 2
   3. yes, 3
   4. yes, 4
   5. yes, 5 or more
   6. no

   If you answered "no" to question 3, please go on to question 6.

4. How many children are living at home with you? (circle one)
   1. one
   2. two
   3. three
   4. four
   5. five or more
   6. none

5. What are the ages of the children living at home? (Please list the ages on the line below.)

   _____

6. How long have you lived in the area in which you are currently a resident? (circle one)
   1. less than one year
   2. between one and three years
   3. more than three years

7. Are you presently employed outside the home? (circle one)
   1. yes
   2. no

   If you answered "no" to question 7, please go on to question 9.

8. Seven types of occupations are listed below. Which one describes your job? (Place a "√" in the appropriate space.)

____1. executives and proprietors of large concerns (e.g., banks, large industries), and major professionals (e.g., accountants (CPA), dentists, lawyers, physicians, teachers at the university or college level)

____2. managers and proprietors of medium-sized businesses (e.g., large stores,) and medium level professionals (e.g., personnel managers, nurses, social workers, advertising directors, teachers at all levels except college)

____3. administrative personnel of large concerns, owners of small independent businesses (e.g., gas station, grocery store), and semiprofessionals (e.g., sales representatives, public relations and publicity, advertising agents)

____4. owners of little business (e.g., newstand, day care service), clerical and sales workers, and technicians (e.g., bookkeepers, sales clerks, draftspersons, technical assistants)

____5. skilled workers (e.g., carpenters, potters)

____6. semiskilled workers (e.g., factory machine operators, housekeepers)

____7. unskilled workers (e.g., unskilled factory workers, cafeteria workers, dishwashers)

9. What was the gross income reported on your (joint, if married) 1975 income tax return? (circle one)

1. $0- 4,000
2. $4,001- 8,000
3. $8,001-12,000
4. $12,001-16,000
5. $16,001-20,000
6. over $20,000

10. What is the highest educational level reached by you, your husband/partner, your father and your mother? (Please place a check "√" in each column beside the appropriate choice.)

	self	husband/ partner	father	mother
1. some elementary school	____	____	____	____
2. completion of elementary school	____	____	____	____
3. some high school	____	____	____	____
4. completion of high school	____	____	____	____
5. partial college or professional training (e.g., A.A.)	____	____	____	____
6. completion of college or professional degree	____	____	____	____
7. completion of a graduate degree	____	____	____	____
8. unknown	____	____	____	____
9. not applicable	____	____	____	____

11. Below are listed 43 life events. Which of these have you experienced in the last year? (Please indicate your response by placing a "✓" on the appropriate lines.)

1. Marriage
2. Troubles with the boss ____
3. Detention in jail or other institution ____
4. Death of partner/husband ____
5. Major change in sleeping habits (a lot more or a lot less sleep or change in part of day when asleep) ____
6. Death of a close family member ____
7. Major change in eating habits (a lot more or a lot less food intake, or very different meal hours or surroundings) ____
8. Foreclosure on a mortgage or loan ____
9. Revision of personal habits (dress, manners, associations, etc.) ____
10. Death of a close friend ____
11. Minor violations of the law (e.g., traffic tickets, jaywalking, disturbing the peace) ____
12. Outstanding personal achievement ____
13. Pregnancy ____
14. Major change in the health or behavior of a family member ____
15. Sexual difficulties ____
16. In-law troubles ____
17. Major change in number of family get-togethers (e.g., a lot more or a lot less than usual) ____
18. Major change in financial state (e.g., a lot worse off or a lot better off than usual) ____
19. Gaining a new family member (e.g., through birth, adoption, oldster moving in) ____
20. Change in residence ____
21. Son or daughter leaving home (e.g., marriage, attending college) ____
22. Marital separation from mate ____
23. Major change in church activities (e.g., a lot more or a lot less than usual) ____
24. Marital reconciliation with mate ____
25. Being fired from work ____
26. Divorce ____
27. Changing to a different line of work ____
28. Major change in the number of arguments with partner/husband (e.g., either a lot more or a lot less than usual regarding child-rearing, personal habits) ____
29. Major change in responsibilities at work (e.g., promotion, demotion, lateral transfer) ____
30. Partner/husband beginning or ceasing work outside the home ____
31. Major change in working hours or conditions ____
32. Major change in usual type and/or amount of recreation ____
33. Taking on a mortgage greater than $10,000 (e.g., purchasing a home, business) ____
34. Taking on a mortgage or loan less than $10,000 (e.g., purchasing a car, TV, freezer) ____
35. Major personal injury or illness ____
36. Major business readjustment (e.g., merger, reorganization, bankruptcy) ____
37. Major change in social activities (e.g., clubs, dancing, movies, visiting) ____

38. Major change in living conditions (e.g., building a new home, remodeling, deterioration of home or neighborhood) ____
39. Retirement from work ____
40. Vacation ____
41. Christmas ____
42. Changing to a new school ____
43. Beginning or ceasing formal schooling ____

Part C

The next four questions are to be answered only by women who have had women's support or consciousness-raising group experiences. If you have not had such an experience, please go to question 16.

12. In what year did you have your first women's group experience? 19 ____

13. In how many women's groups have you participated? _____

14. Was your first women's group experience sponsored by an institution (i.e., a college, women's center, church or mental health center)?
    1. yes
    2. no
    3. unsure

15. Below are listed some common reasons given by women for joining support and consciousness-raising groups. Indicate how important each reason used below was in your decision to join a group(s) by placing a "✓" beside each reason under the appropriate column.

	very important	important	somewhat important	not important
1. to do something different	____	____	____	____
2. to make new friends	____	____	____	____
3. to learn about other women and their lives	____	____	____	____
4. to increase self-knowledge	____	____	____	____
5. to have a new social activity	____	____	____	____
6. to put more meaning in life	____	____	____	____
7. to consider some problems I was having	____	____	____	____
8. to satisfy my curiosity	____	____	____	____
9. to get help making some important decisions	____	____	____	____
10. to deal with my loneliness	____	____	____	____

16. Below are listed several situations in which women have reported discrimination. Please circle any of these situations in which you have experienced discrimination.
    1. career counseling (high school or college)
    2. college/graduate school (admission, fellowships)
    3. employment seeking
    4. job promotion
    5. salary
    6. credit applications (loans, credit cards, and charge accounts)
    7. housing
    8. I have never experienced discrimination

17. Do you consider yourself a feminist?
    1. yes
    2. no
    3. unsure

18. Have you ever been in formal counseling or therapy? (family, group, or individual)
    1. yes
    2. no

If you answered "no" to question 18, please go on to question 20.

19. When did your last formal counseling or therapy take place? (circle one)
    1. more than four years ago
    2. between two and four years ago
    3. between one and two years ago
    4. within the past year

20. Below are listed several aspects of women's lives. At the present time, how satisfied are you in each of the areas listed below? Indicate your answer by placing a "✓" beside each aspect, under the appropriate column.

	very satisfied	satisfied	somewhat satisfied	not satisfied	not applicable
1. relationships with female friends	____	____	____	____	____
2. your marriage or primary relationship	____	____	____	____	____
3. understanding of yourself	____	____	____	____	____
4. your career	____	____	____	____	____
5. relationships with male friends	____	____	____	____	____
6. your sex life	____	____	____	____	____
7. emotional support you receive from others	____	____	____	____	____
8. relationships with your children	____	____	____	____	____
9. relationships with your parents	____	____	____	____	____

21. Overall, how satisfied are you with your life? (circle one)
    1. extremely satisfied
    2. very satisfied
    3. satisfied
    4. somewhat satisfied
    5. not at all satisfied

22. When was your most recent, upsetting personal problem or experience?

    _____ month _____ year

23. Below, briefly describe the nature of the problem.

_____

_____

_____

_____

24. With respect to the problem mentioned in question 23, how would you rate the helpfulness of each individual listed below? Please indicate your answer by placing a "✓" beside each person under the appropriate column.

	very helpful	helpful	somewhat helpful	not helpful	not applicable
1. children	____	____	____	____	____
2. partner/husband	____	____	____	____	____
3. parents	____	____	____	____	____
4. other relatives	____	____	____	____	____
5. doctor	____	____	____	____	____
6. counselor/therapist	____	____	____	____	____
7. minister	____	____	____	____	____
8. close friends	____	____	____	____	____
9. your women's group	____	____	____	____	____

25. We are interested in the quality and quantity of problems and life experiences women are currently undergoing. Please indicate (by checking the appropriate column) the degree to which the situations below were concerns for you in the last year.

	a major problem	a moderate problem	somewhat of a problem	a minor problem	not a problem
1. illness in your family	____	____	____	____	____
2. illness on your part	____	____	____	____	____
3. financial concerns	____	____	____	____	____
4. unemployment or job uncertainty	____	____	____	____	____
5. disharmony with your husband/partner	____	____	____	____	____
6. problems with child(ren)	____	____	____	____	____
7. legal difficulties	____	____	____	____	____
8. general emotional discomfort for you	____	____	____	____	____

Please list any other problems below and rate them.

9. _____						
_____	____	____	____	____	____	
10. _____						
_____	____	____	____	____	____	

26. Please describe below a decision made in the past year that was important to you (i.e., to quit smoking, to end a career, to move, to begin a relationship).

_____

_____

27. When did you make this decision? _____ month _____ year

28. Did you consult with others in making the decision? (circle one)
    1. yes
    2. no

If you answered "no" to question 28, please go on to question 30.

29. Please indicate (by checking the appropriate column) the degree to which the people listed below were helpful to you in making the decision identified in Question 26.

	very helpful	helpful	somewhat helpful	not helpful	not applicable
1. children	____	____	____	____	____
2. partner/husband	____	____	____	____	____
3. parents	____	____	____	____	____
4. other relatives	____	____	____	____	____
5. doctor	____	____	____	____	____
6. counselor/therapist	____	____	____	____	____
7. minister	____	____	____	____	____
8. close friends	____	____	____	____	____
9. your women's group	____	____	____	____	____

30. Sometimes we quite unexpectedly discuss a personal concern with someone. Has this happened to you recently? (circle one)
    1. yes
    2. no

If you answered "no" to question 30, please go on to question 34.

31. When did this happen? _____ month _____ year

32. With whom did you have the discussion? (please identify the relationship, i.e., friends, a co-worker)

_____

33. Please describe briefly the concern. _____

_____

_____

34. Generally, how difficult is it for you to discuss personal matters with the person(s) listed below? Indicate your response by placing a "√" beside each person(s) and under the column corresponding to your answer.

	very difficult	difficult	somewhat difficult	rarely difficult	not difficult	not applicable
1. children	____	____	____	____	____	____
2. partner/husband	____	____	____	____	____	____
3. parents	____	____	____	____	____	____
4. other relatives	____	____	____	____	____	____
5. doctor	____	____	____	____	____	____
6. counselor/therapist	____	____	____	____	____	____
7. minister	____	____	____	____	____	____
8. close friends	____	____	____	____	____	____
9. your women's group	____	____	____	____	____	____

35. Of the concerns and worries you've had in the last year, how many have you shared with others? (circle one)
    1. all
    2. most
    3. some
    4. few
    5. none

36. Is there anything about your relationships with others that you would like to change? (circle one)
    1. yes
    2. no

If you answered "no" to question 36, please go on to question 38.

37. What changes do you want to see in your relationships?

_____

_____

_____

38. When personal problems come up, how many people can you go to in order to talk over the concerns you're having? (circle one)
    1. no one
    2. 1 or 2
    3. 3 to 5
    4. 6 to 10
    5. over 10

39. Below are listed services that are sometimes available to women. Which of these services do you feel are most needed by women like yourself? Indicate your answer by placing a "√" in the column which corresponds to your feeling.

	very much needed	needed	not needed	uncertain
1. assertiveness training	____	____	____	____
2. career counseling	____	____	____	____
3. confidence building	____	____	____	____
4. divorced women's group	____	____	____	____
5. educational skills	____	____	____	____
6. feminist study group	____	____	____	____
7. financial planning	____	____	____	____
8. health information	____	____	____	____
9. older women's group	____	____	____	____
10. personal growth group	____	____	____	____
11. self-defense training	____	____	____	____
12. workshops on conflict resolution	____	____	____	____

APPENDIX B.

Post Card

Post Card

NAME: _____

ADDRESS: _____

Home Phone: _____

1. Have you ever participated in a women's consciousness-raising or support group? (circle one)

   a. yes
   b. no

2. Would you be willing to be personally interviewed on matters related to social problems facing women today? (circle one)

   a. yes
   b. no

APPENDIX C

Interview Cover Letter

ANTIOCH — NEW ENGLAND
ANTIOCH GRADUATE SCHOOL OF EDUCATION
One Elm Street Keene, New Hampshire 03431 Area Code 603 357-3122

23 August, 1976

Dear

Thank you for participating in the Questionnaire phase of my study on Women and Their Environments, last May. We are now moving into the second, or Interview phase, of the study. You are one of thirty randomly selected volunteers for this second phase, and I am writing as an initial step in the arranging of the interview appointments.

In the next several weeks, my colleague Harriet Samuelson or I will contact you by telephone to make an appointment. We will hope to see you at a time convenient for you, and we will either travel to your home of meet you at our Keene office.

I expect the interviews to take approximately one hour. All information collected during that time will be completely confidential, with no one other than Harriet and myself knowing the identities of the participants.

To date, the questionnaire has produced some very valuable information; the personal interviews will provide complementary information which will assist us in interpreting our findings. Thank you in advance for your cooperation. Should you have any questions, please feel free to call me (603-256-6517).

With best wishes,

Elizabeth Dickey

Elizabeth Dickey

APPENDIX D

The Interview Schedule

Interview Schedule

Introductory Remarks

As you know, we began our study with a questionnaire which examined some general issues related to women and their environments. In the interview phase of the study, we are trying to take a closer look at friendship, and some of its elements. So, let me move to my first question.

Coping Questions

1. Would you tell me the first names of the people who are your friends at this point in your life? If you'll list them for me by first names, I'll write them down. Probe: this could include family members, relatives, and people who are close as well as casual friends.

2. I'd like to suggest that it's possible to organize friends into three distinct descriptive groups: close friends, friends, and acquaintances. Could your friends, mentioned on this page, fall into such a system? (show sheet from Q 1)
   1) yes
   2) no

3. Staying with this list for a minute, would you arrange these people into the descriptions: close friend, friend, acquaintance? We can go down the list together, and I'll note your descriptions.

4. I'd be interested in the frequency of your contact with these people. Could you give me a rough idea of how often you're in touch with each of these persons? Let's just go down the page, person by person.

5. As you consider the list of friends, I'd like to know which, if any, of these people you seek out when you need to talk something over? (Go through list and note)

6. A further question I have deals with the helpfulness of these people. What's your impression of your own ability to pick out helpful people to talk with during these times?

7. Now I'd like to move in on the qualities you find or look for in helpful and supportive people. Can you identify the qualities that attract you, that are important when you need someone to talk to?

8. This next question involves a bit of fantasy. Let's imagine you are running a school to train people to be supportive and helpful. What kinds of skills and qualities would you want to develop in your trainees?

9. In a somewhat more general vein, on some occasions you may chose one friend to talk with, and on other occasions you might chose a completely different friend. How do you explain this?

10. I've asked you to tell me of qualities that are particularly important to you in other people at times when you need a person to talk with. Now, I'm going to list a specific group of qualities and I would ask you to rate these as to their importance to you when seeking out a person to talk with.

	not important	somewhat important	important	very important
1) their responsiveness				
2) their age				
3) their religion				
4) their intelligence				
5) their sensitivity				
6) their experience with a situation similar to the one you need to talk over				
7) their general life experience: a friend who has or hasn't been around				
8) their sex				
9) their level of formal educational completion				
10) their objectivity or fairmindedness				
11) their caring for you				

11. One of the issues our study is attempting to understand is how friends provide each other with considerable assistance and support on a very informal basis. Are you aware of either close friends or acquaintances making use of you in such a way?
   1) yes
   2) no

12. When you are in the role of supporter and friend, which of your skills do friends seem to tap into? (Probe: what are they looking for from you?)

13. How do you feel about being placed in such a role?

14. Could you describe to me a couple of instances from your own recent experience in which you found yourself employing friends as sounding boards?

15. How typical is it for you to consult friends on matters of personal importance to you?
   1) very typical
   2) typical
   3) somewhat typical
   4) not typical

16. What distinguishes issues/feelings which you talk over with others from those you end up keeping to yourself?

17. Some people typically seek out professional counsel from doctors, ministers, and counselors during more difficult periods. What's your feeling about doing this yourself?

18. What do you think distinguishes situations in which one seeks out professional counsel from those in which one does not?

FOR PARTICIPANTS WITH WOMEN'S GROUP EXPERIENCE ONLY

I've asked you many questions about how individuals help each other and provide support. My last question in this area deals with your experience in women's groups. As you may remember, on the post card you returned indicating your availability for this interview, there was a question about women's group participation--you responded that you had had such an experience.

19. My question is, did your women's group provide you with personal support and if so, in what way(s)?

Demographic Questions

20. Are you employed?
1) yes
2) no

21. Would you describe the work you do?

22. How old are you?
1) 16-25
2) 26-35
3) 36-45
4) 46-55
5) 56-65
6) over 65

23. Now I'd like to ask about your marital status. Are you:
1) divorced
2) living with someone
3) married
4) separated
5) single
6) widowed

24. What is the highest level in school you have completed

25. What is the highest level in school completed by your husband or partner?

26. Does your husband work?
1) yes
2) no

27. Would you describe his work to me?

28. Do you have children?
1) yes
2) no

29. What are their ages?