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Social Roles, Psychosocial Factors and Health in Venezuelan Working Women

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ABSTRACT

FACULTY OF MEDICINE, HEALTH AND BIOLOGICAL SCIENCES

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SOCIAL ROLES, PSYCHOSOCIAL FACTORS AND HEALTH IN VENEZUELAN WORKING WOMEN

by Lya Feldman-Chaberman

Increases in women's labour force-participation, including that of women with children, have led researchers to study the health effects of women's multiple roles. Recent investigations have shown that the specific qualities of women's social roles as well as other psychosocial variables such as social support, distribution of household responsibilities and work-family relationship can affect women's health.

The present study aims to explore the relationships between sociodemographic and psychosocial variables on self-perception of physical and mental health in Venezuelan working women at different occupational levels.

Four studies were carried out using different methodologies, designs and testing additive and interactive models. Study 1 considered only secretaries (n= 122), Study 2 included working women from different occupational levels and a group of housewives (n=417). Both studies were cross-sectional. In order to test the potential causal influence of psychosocial variables on self-reported physical and mental health, a longitudinal study was carried out (n= 130). To enrich the results obtained from the three quantitative studies, the final study was qualitative (n=32).

Only the level of education and having pre-school children turned out to be health predictors. In general, women with partners reported better health than women without partners. The characteristics of women's social roles were the most important psychosocial variables considering the main and interactive effects that either put a strain on, or enhance women's health and well-being. Supervisor and co-workers support as well as the perception of job control were the most important protective aspects. Social relations at work played a fundamental role on mental health, moderating important work-related stressing conditions such as dissatisfaction with the salary/lack of recognition and promotion. Marital satisfaction was directly related to women´s perception of health. Job control and social integration protected working women from stress related to marital conflict. None of the psychosocial factors studied for the mother role acted as protectors against the effects of this role on women's health. The results showed that integral approaches, which simultaneously consider work and family spheres, are required for the comprehension of working women's health.

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CHAPTER 1

INTRODUCTION, RATIONALE AND PLAN OF THESIS

1.1. - Introduction and rationale

During the last three decades women's lives have changed dramatically in most Western countries. As increasing numbers of women enter the workforce, a process of change began at the family, social, cultural, political and economic levels (Le Feuvre, 1998).

According to the International Labour Organization (ILO), two thirds of working hours around the world are filled by women because of the various roles they play in the workplace, the family and society. The pattern of women's employment is very different throughout countries; however, there is evidence of an increase of women in the labour market, and especially women with dependent children (Mattheus & Rodin, 1989; Ford Arkin, 1995; Hewlett, 1998).

Researchers from a variety of perspectives have followed this dramatic social change to investigate its impact on the well-being of the contemporary family as well as work-stress in women (Glezer & Wolcott, 1998; Milkie & Peltola, 1999; Barnett & Baruch, 1985). However, since most of the research in the workplace has focused on men, several aspects need to be taken into account when considering work-related stress in women. First, findings from studies of men have been often and incorrectly generalized to women. Second, most models, concepts, and instruments in this area have been standardised on men and may therefore not be appropriate for women. Third, the focus of research differs for men and women. Whilst for men the emphasis is on the relationship between psychosocial working conditions and health, for women the focus is on the impact of women's multiple roles on their own mental and physical health (Hibbard & Pope, 1991; Ford Arkin, 1995; Waldron, Weiss & Hughes, 1998). Fourth, women and men continue to inhabit relatively different occupational roles and thus the relationship between occupations, stress and health is not likely to be the same (Feldman, Bagés, Chacón & Pérez, 2000).

Regardless of their positions in the workplace, women are still primarily responsible for the traditional roles of caring for the children and the home. Such responsibilities have been considered as sources of conflict and stress within the family, especially as they relate to the relationship between the spouses. They have been a source of overload, depression, anxiety and lower quality of life for women (Scarr, Phillips & McCartney, 1989; Lennon & Rosenfield, 1992; Almeida, Maggs & Galambos, 1993; Mayor, 1993). Bird (1999) found that inequity in the division of household labour has a greater impact on distress than does the amount of work.

Nowadays a rapidly growing literature has examined the impact of women's multiple roles on their mental and physical health (Hibbard & Pope, 1991; Barnett & Baruch, 1985; Baruch & Barnett, 1986). The underlying paradigm of the research on work, family and health has focused on the study of labour stressors, the characteristics of work, as well as the impact of family roles in the relationship between work concerns and rewards, physical, mental health and well-being (Barnet & Marshall, 1991; Voydanoff, 1988). The results of the research studies on the relationship between women's multiple roles, well-being and health have been contradictory. For some researchers, the fulfilment of multiple roles by women has been seen as a source of stress and conflict. This has resulted in negative effects on their physical and mental health, marital adjustment, family relationship, well-being and productivity. Multiple roles have been a greater burden for women with small children regardless of employment status (Ladwing & Napholtz, 1996; Campbell & Moen, 1992).

A different position claims that as women perform more roles, the benefits to their health and well-being will be greater. Employment provides women with several advantages, such as social support, financial resources and opportunities for challenge and for enhancing self-esteem (Barnett & Marshall, 1991; Rodin & Ickovics, 1990). More recent studies, however, report mixed results (Lennon, 1994; Weatherall, Joshi & Macran, 1994). Other studies have turned to questions about whether those effects depend on the context in which those roles are embedded (Bartley, Sacker, Firth & Fitzpatrick, 1999). The effects on women of combining paid employment and family roles clearly depend on the individual and family characteristics, job conditions, children's age, partner support, education and occupational status. In addition, this

accumulating research has focussed on role occupancy with little attention on the quality of the individual roles. A clear assessment of the effect of multiple roles in health and well-being must investigate the inherent characteristics of roles and how those roles are experienced. The satisfactions as well as the stresses must be addressed. Role quality depends on both the subjective experience and the objective characteristics of the role (Hibbard & Pope, 1993; Barnett, Raudenbysh, Brennan, Pleck & Marshall, 1995; Noor, 1995a).

Most of the empirical research on women's multiple roles and health has been done in the United States (U.S.). On the whole, these studies (Chapter 2) would seem to show more evidence of role enhancement than role overload, especially with regards to mental health and well-being. As in the U.S., evidence from U.K. studies would seem to indicate a role enhancement effect for mental health, whilst studies that have looked at the effects of combining motherhood and employment do not present such a consistent picture (Macram, 1993; Weatherall, Joshi & Macran, 1994). Despite a rising interest in this area, in Latin America little research in this area has been reported in the English international literature.

In the present thesis social roles, psychosocial factors and health in working women will be addressed focusing, in particular, on the evaluation of these aspects in a Latin American context, and specifically in Venezuela.

The final objective of this research is to obtain a deeper understanding of the relationship between multiple roles, psychosocial factors and mental and physical health of Venezuelan working women. Four studies were carried out: two cross-sectional, one longitudinal and a qualitative one. It is expected that the present thesis also contribute to the understanding of Latin America women's health from the perspective of women's social roles.

1.2. - Plan of Thesis

Chapter 2 reviews the literature on the effects of multiple roles, psychosocial factors and health. It includes theoretical positions and models as well as an exhaustive revision of the empirical support and methodological issues, especially in the last decade, related to this area.

Chapter 3 presents the different research methods and assessment procedures used in the research. It includes an overview of the combination of quantitative and qualitative methods and the reasons for their use as well as the selection of cross-sectional and longitudinal designs. This chapter also justifies the use of self-report measures as a method of data collection for both quantitative and qualitative studies. Finally, the different instruments used in the present thesis are included with their background, design, psychometric validation and/or adaptation and translation into Spanish. It was considered very important for the development of the area in Venezuela and in general in Latin America, to have valid instruments in Spanish that could be used in future studies and the possibility to compare and generalise the findings not only within the country but also among other Latin American countries.

Chapter 4 describes the first of three quantitative studies presented in this thesis. Study 1 examined the impact of multiple roles, role quality and social support in their relation to mental and physical health in a sample of 122 female clerical university employees.

As Study 1 only considered clerical workers, Study 2 (Chapter 5) was carried out on four groups of working women and a group of housewives in order to increase the generalisation of results. The four groups of working women were selected on the basis of different occupational positions: blue-collar workers (mainly cleaning and maintenance), clerical, school teachers and professionals (the majority of whom were academics). Additional to the variables measured in Study 1, Study 2 looked at the distribution of household chores and child rearing as well as work-family relationship. This study included not only the measurement of indicators of mental health problems (e.g. anxiety and depression) but also positive dimensions of mental health such as self-esteem and self-perception of well-being. The data were collected in different

educational organisations with a total of 417 participants. Studies 1 and 2 were cross-sectional.

Chapter 6 describes a study which used a longitudinal design in order to test the potential causal effects of the role characteristics on self-reported physical and mental health. Employed women in Study 2 who worked as blue-collar workers, clerical and professionals participated in the present study. Data were collected at two different points in time, over a period of 16 months. Pre-existing levels of health and well-being were controlled in the analysis in order to control for *the healthy worker effect.*

A Qualitative Study was carried out and is described in Chapter *7.* The objective of this study was to gain a deeper understanding of the findings obtained in the previous quantitative studies and to explore new aspects that could give insight and enrich the data. Thirty-two working women from different occupational status were interviewed using a semi-structured interview; content analysis was the chosen method of data analysis. Finally, the main findings and recommendations for future investigations are presented in Chapter 8.

CHAPTER 2

LITERATURE REVIEW

2.1. - Introduction

Work and family roles represent important social contexts for interacting with others, engaging in health-relevant behaviour and coping with stress. Stress and coping processes, mental health, the social environment and health behaviours are critical aspects for a comprehensive model of women's health. The multiple roles literature anchors these psychosocial variables in a real and relevant social context (Repetti, 1998b).

According to Greenhaus (1988) there are several advantages to viewing work and family issues within a stress perspective. First, the stress literature has historically emphasized the role of personal appraisal in the interpretation of a stimulus situation to explain individual differences in felt stress across similar objective environments. Second, a great deal is known about behavioral, emotional and physiological consequences of extensive stress (Lazarus & Folkman, 1986; Ivancevish & Mattenson, 1992). This knowledge can be incorporated into models of work and family relationships. Third, the stress literature has focused on the roles of personal resources such as self-esteem and personal hardiness, social support and coping responses as buffers against extensive stress. Many of the models regarding these resources in the literature can be applied to work-family dynamics.

The performance of work and family roles could be a source of stress, depending upon individual appraisals, his/her personal resources and social contexts. This position is in agreement with the Interactionist Model of Stress (Lazarus & Folkman, 1986) and is considered to be most useful for the study of the impact of work and family on women's health.

2.2. - Role Theory and Multiple Roles

According to social role theory, roles are patterns of expectations which apply to a particular position and normally exist independently of the people occupying the position (Sieber, 1974; Marks, 1977).

The general assumption underlying most of the recent research on social role theory has been that to be involved in multiple role relationships is harmful for individual mental health and also for his/her social relationships. Goode (1960) introduced the term "role strain" which described the difficulty in fulfilling all the role obligations. Role strain generates tension, anxiety and in general psychological distress and it is associated with lack of time and energy. According to this position different mechanisms for reducing role strain are suggested: first, the individual has to enter or leave the role relationship; second, the individual has to delegate his/her responsibilities or third, the individual might try to select which role (s) is (are) less demanding or mutually supportive. However, these alternatives are not always possible because sometimes some roles are linked or there are responsibilities, which are impossible to delegate (e.g. parental role especially with small children).

These ideas have been criticised and theorists like Sieber (1974) proposed that multiple roles could bring support, social contacts and self-esteem, which might balance the feelings of strain. Likewise, a person might compensate when there are problems in one role by being more involved in another. Thoits (1983) argues that accumulating many roles may be beneficial for good mental health because they provide meaning, structure and order to life.

2.2.1. - Theoretical Models

Women's health research is a rapidly expanding field. In the 1970s, the main focus of most women's health research was around issues such as pregnancy, childbirth, and women's reproductive health (Verbrugge, 1982 c.b. Messias, Im, Page, Reger, Spiers, Yoder & Meleis, 1997). However, with the increased participation of women in paid work, research on women's health expanded to include women's health experiences across different roles, different social groups and across the life span (Bernal & Meleis, 1995).

The results of studies on the relationship between women's multiple roles, well-being and health have been contradictory. For some researchers, the fulfilment of multiple roles by women has been seen as a source of stress and conflict with negative effects over their physical and mental health, marital adjustment, family relationship, well-being and productivity (Anderson-Kulman & Paludi, 1986; Duxbury & Higgins, 1991; Gutek, Searle & Klepa, 1991). Others claim that as women perform more roles, the advantages to their health and well-being, (Thoits, 1983; Barnett & Marshall, 1991; Rodin & Ickovics, 1990; Barling, 1990) as well as their physical health will be greater (Verbrugge, 1983; Waldron & Herold, 1986). Still others argue that employment has no effect on mothers' mental health, except under special circumstances (Aneshensel , Frerichs & Clark, 1981).

The first position is based upon the **Scarcity and Strain Hypothesis** (Goode, 1960; Marks, 1977; Coser, 1974). This formulation relies on two premises: a) that individuals have a limited amount of energy; and b) that social organisations demand loyalty from their members. According to this hypothesis, the individual lacks energy and time to meet the demands, obligations and commitments necessary to play each of the roles. The desire to cover all of them generates conflicts, anxiety, overload and tension between the roles, leading to psychological discomfort and physical problems. For this model, the family/work conflict is a major source of concern for both individuals and organisations because it constitutes a source of stress associated with negative consequences such as the increase in health risk factors, poor performance of the parents' role, decrease in productivity, absenteeism and tardiness for work, poor morale, low satisfaction with life and a perception of deterioration in mental health

(Duxbury & Higgins, 1991; Gutek, Searle & Klepa, 1991). This conflict increases when women perceive inequality with respect to childcare and household tasks (Biernat & Wortman, 1991). Moreover, due to role overload, married working mothers have usually been considered more vulnerable to stress (Fox & Hesse-Biber, 1984, c.b. Malley & Steward, 1988), especially if they have pre-school children (Campbell & Moen, 1992). The influence of this position is evident in studies comparing stress, coping strategies and health among housewives and employed women (Nathanson, 1980)

In contrast to the role overload hypothesis, the **Enhancement Hypothesis** suggests that physical activity can increase the energy reservoir. Consequently, the performance of multiple roles can also increase this potential, offering better sources of status and social support, stimulation, privileges, rewards and thus higher self-esteem. This view is supported by the **Role Expansion Model**, which focuses on the rewards associated with multiple roles (Barnett, Marshal & Pleck, 1992). Studies have consistently shown that the more roles a woman perform, the better her physical and mental health (Barnett & Marshall, 1991; Meleis, Norbeck, Laffrey, Solomon & Miller, 1989; Nelson & Hitt, 1992; Thoits, 1983). Women who perceive rewards from their employment may experience positive spillover effects to their parenting work (Barnett & Marshall, 1992); more satisfactory health, feelings of autonomy, a better relationship with their partner (Barron, 1990) and life satisfaction (Malley & Stewart, 1988). Furthermore, women's economic contribution to the household reduces financial strains, which improves marital quality (Barnett & Rivers, 1996).

Attempts to confirm either of these models have yielded contradictory results. This is because the two models are not mutually exclusive (Macran, 1993). For instance, depending on a woman's social circumstances (e.g. number and age of children, social class, type of employment, quality of marriage) it is possible to envisage employment as creating strain in some cases and being protective in others (Macran, 1993). It means that the number of roles *per se* is not sufficient to explain the relationship between multiple social roles and health. Tiedje, Wortman, Dowly, Emmons, Biernat and Lang (1990) found that, contrary to the expansion hypothesis, multiple roles do not always lead to perceptions of enhancement and that women may

derive both conflict and enhancement from their multiple roles. The results on women's mental health depend on the combination of these two aspects.

An alternative conceptualisation is the **Role Integration Hypothesis** (Baruch & Barnett, 1986; Meleis et al, 1989) which differs from the overload and enhancement models in that it does not predict the direction of the effect of work on health *per se* but rather considers that the effect on health depends more on the "balance between role satisfaction and role stress within and between key roles" (Meleis et.al, 1989). This hypothesis also suggests that the quality of women's experience within roles and not merely role occupancy is more important in understanding the process that affects women's health (Barnett & Baruch, 1985; Barnett, Davidson & Marshall, 1991). A positive balance between role satisfactions and role stress indicates a sense of coherence and balance and will tend to increase well-being. On the other hand, a negative balance between role stress and satisfactions will tend to decrease well-being (Hilfinger et al., 1997). Hibbard and Pope (1993), using a longitudinal design to analyse the effects of the quality of social roles on health in a representative sample of American men and women, concluded that the quality of family and labour roles is a predictor of women's morbidity and mortality.

In line with this perspective, the performance of a particular role per se would not generate any stress, but rather both work roles and family roles could be sources of strength or stress, depending on the cognitive evaluation of that experience and on the individual differences (Verbrugge, 1987; Lazarus & Folkman, 1986). The present study will follow the Role Integration Hypothesis.

2.2.2. - Work and Family Relationship

Work and family represent two of the most central arenas of human beings. However, these two domains have traditionally been studied independently. While occupational stress research has tended to neglect the impact of non-work influences, researching within the area of women's work and family has been primarily concerned with family dynamics. The recognition that women are increasingly being forced to deal with job-related demands that limit their performance of family roles, together with

the awareness that men are becoming more involved with their families (Pleck & Staines, 1985), have resulted in a convergence of these two lines of research.

Theoretical Models

The literature shows five main models of the relationship between life at work and life at home. The models all focus on the individual rather than on the family unit (Zedeck & Mosier, 1990).

Segmentation: This model postulates that work and family domains are not connected. An individual can function successfully in one without any influence on the other. The separation in time, space and function allows the individual to compartmentalize his or her life (Piotrkowski, 1984).

Compensation: It postulates that there is an inverse relationship between work and family. Individuals who are dissatisfied with their jobs compensate by seeking other network activities or experiences (Staines, 1980).

Spillover: This is the most popular model for studying the relationship between work and non-work spheres. It asserts that there is a similarity between what occurs at work and what occurs in the family (Staines, 1980). Spillover can be positive or negative. Job stressors can displace the potential for positive family interactions, while requiring family members to expend their personal resources in assisting the worker to manage stress. Alternatively, the spillover in situations in which work is monotonous can result in an "energy deficit" making him/her "lazy", which in turns leads to the worker not doing things at home or with family members (Piotrkowski, 1984).

While the spillover model is the most widely accepted, there is some evidence supporting the segmentation and compensation models. Moreover, Lambert (1990) showed that these three processes are overlapping, rather than competing and can occur simultaneously. This author also considered a new process, that of **Accommodation**. In accommodation, high involvement in one domain leads to low involvement in the other. The outcome of accommodation is the same as that of compensation: unequal involvement in work and family. The process of compensation and accommodation can also be viewed as cases of spillover. For instance, women may become more involved in their work when experiencing family problems.

Recent studies have suggested the need to expand these models to include mediating and moderating influences. Eckenrode and Gore (1990) propose a model focused on stress **across social roles**. Family and work affect each other. The extent of this influence depends on the family and workplace structures; the nature of the stressors and those situational factors that moderate the stress-transmission process. This model considers four major sets of variables: (1) The stressors which are occurring or are going to occur, (2) Coping resources or strategies, (3) The health-related outcomes and (4) The characteristics of the participants, the family and work structure which could modify the stress processes.

Stress may flow across the work-family boundary in both directions and have a net positive as well as negative influence in terms of the worker and his/her family's well being. The stress process involves both stressors and negative outcomes (physical and psychological well-being) but also positive resources and experiences that may buffer the adverse effects of stressful situations. This part of the model is supported by studies on the additive effect of women's roles and health (Barnett & Baruch, 1985; Baruch & Barnett, 1986).

The Eckenrode and Gore (1990) model also incorporates both moderators and mediators in the relationship between stress and psychological and physical well-being. According to Baron and Kenny (1986) a moderator variable specifies when certain responses to stress will occur. In the link between stress and health, it means that the presence of a particular moderator variable alters the nature of the relationship (in strength or in direction). A mediator is an intervening variable between the stressor and the outcome, and represents the mechanism through which the stressor is able to influence the outcome. Prior to the Baron and Kenny report (1986), the terms moderator and mediator were often used interchangeably.

Studies carried out by Barnett and Marshall (1992) and Barnett, Marshall and Sayer (1992) showed how moderator variables could also move across work and family boundaries both in positive and negative directions. Barnett, Marshall and Sayer (1992) found that for employed mothers, challenge was the job-reward that moderated the relationship between children's disaffection and distress. Barnett (1994) also

found that for full-time employed men and women in dual earning couples, positive experiences in the role of partner or parent buffered the effects of job experiences in psychological distress.

In relation to mediator variables, Matthews, Conger and Wickrama (1996) showed that work-family conflict resulting from husbands' and wives' employment was positively related to the psychological distress of each one, and that psychological distress affects marital outcomes both directly and indirectly through its association with greater marital hostility and less marital warmth and supportiveness.

Eckenrode and Gore (1990) added that the stress transmission and stress-buffering processes in work-family relationships are also sensitive to the characteristics of the people involved (e.g. personality characteristics), the characteristics of the relationships (e.g. pre-existing conflicts or support in the marital relationship), the combination of work and family roles assumed by individuals (e.g. whether the wife or mother is working or whether children are present) and the nature of the stresses involved. The considerations of all these factors, either by themselves or in combination, are very useful to understand why some individuals are more resistant than others to stressors.

Finally, Eckenrode and Gore's model offered important elements to the further study of work and family relationships. It has the advantage that it incorporates both work and non-work domains simultaneously, which has proved to be very useful in the studies on women's multiple roles and well-being. However, its empirical data are derived *post hoc* rather than from controlled previous studies. This model requires more empirical support in order to test each of its elements.

The models presented above have progressed in complexity and empirical support. However, little has been done to link these findings into a conceptual framework (Piechowski, 1992).

An example of a complex interdisciplinary stress model that has been useful in understanding how work-related variables affect mental and physical health, advanced

by Karasek and colleagues (Karasek & Theorell, 1990), might be expanded and extrapolated to provide a conceptual framework for understanding how women's experiences in multiple roles could influence their mental and physical health.

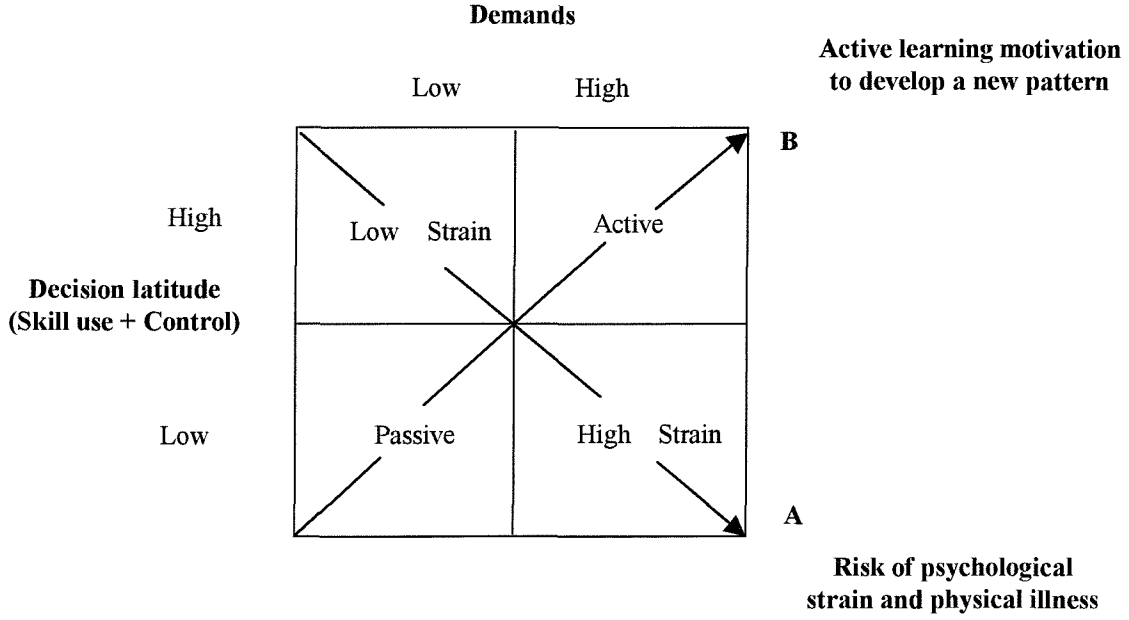
2.2.3. - The Demand-Control-Support Model

The demand-control model developed by Karasek (1979), best known as the job-strain model, predicts that job stress is a function of two structural characteristics: demands (which refers to responsibilities) and control (or decision latitude). In the eighties the model was to expanded to include social support as another variable that can buffer the potential negative effects of high demands on physical health. According to this model, the presence of both high psychological work demands, like overload, conflicting demands, insufficient time, combined with low levels of control over the work process (low skill discretion and decision authority) has been shown to be predictive of all-cause mortality, cardiovascular disease (CVD) and psychological symptoms (Schnall, Landsbergis & Baker, 1994; van der Doef & Maes, 1998).

The model distinguishes between four main types of jobs: high strain jobs (high demands and low decision latitude), low strain jobs (low demands-high decision latitude), active jobs (high demands-high decision latitude) and passive jobs (low demands-low decision latitude). The main hypothesis is that the lowest levels of psychological well-being and the highest levels of symptoms and diseases (mainly CVD) are to be found in the high strain group. Another hypothesis is that active jobs, compared to passive ones, provide higher learning and personal development as well as active participation in social life. As is presented in Figure 2.1, the model has two diagonals: the strain diagonal, from relaxed to high strain jobs and the learning diagonal from passive to active jobs. If one looks for personal development and learning one should find an active job, if psychological well-being is one's goal, a relaxed job is the best. The new third dimension of the model has been the job social support. According to the extended model, the demand-control-support model, the highest risk of ill-health is to be expected in the iso-strain group with high demands, low decision latitude and low social support (Kristensen, 1995).

Figure 2.1

The Karasek Demand-Control Model



The Demand-Control-Support model provides a large body of literature, both theoretical and empirical findings that strongly suggest a causal association between job strain and health, especially job strain and CVD (Karasek & Theorell, 1990). However, this model receives theoretical and methodological criticism (for a review see Kristensen, 1995; van der Doef & Maes, 1998) that points out the need for more research and empirical studies.

In relation to research on multiple roles and health in women, Baruch, Biener and Barnett (1987) as well as Piechowski (1992), pointed out that even though Karasek's model has rarely been tested among women, it could be useful because it has been noted that women are more vulnerable than men to experience strain not only in the workplace but also in family roles. Although Karasek (1979) defined the variables of this model as features of the environment, this model might be extrapolated further to encompass individual responses and perceptions. Specifically, this model would predict that among multiple-role women, negative mental health outcomes would be associated with a combination of both high levels of demanding roles and an inability or unwillingness, due to environmental or individual factors, to exert control over those demands (Piechowski, 1992). It is well known that controllability or predictability of an event affects the degree to which it is stressful. Also there is a large body of evidence in relation to social support and health (Cohen, 1990; Callaghan & Morrisey, 1993; Sarason, Sarason & Pierce, 1990). As Bjornberg (1998) pointed out in her study with employed mothers with pre-school children, Karasek's model could be applied to the psychosocial analysis of labour in the household. Also, women's jobs (e.g. clerical workers or nurses) are often characterised by low levels of autonomy and control as well as heavy workloads relative to task accomplishments (Karasek & Theorell, 1990).

The objective of the present thesis was not to evaluate this model but, as Baruch, Biener and Barnett (1987) and Piechowski, (1992) suggested, the stress model associated with women's multiple roles and health to determine how it might be expanded by applying the demand-control model.

2.3. - Women and Employment Patterns

In industrialized countries like the U.S., between the years 1948 and 1988, the number of women in the civilian workforce more than tripled. During this period female workers comprised 45% of the employed workforce in the U.S. The number of employed women with young children is also steadily increasing. In 1992, married women with children between the ages of 6 to 13 participated in the labour force at a rate of 74.9 percent. Overall, 57.8 percent of women in the U.S. are employed and this rate is projected to be higher by the year 2005 (Clevelan, Stockdale & Murphy, 2000).

In the United Kingdom (UK), much of the growth in female employment is taken up by mothers with dependent children. Their employment has risen from 49 percent in 1981 to 59 percent in 1989, after which the rate stabilised until 1992. In 1996, 60.4% of women in the U.K. participated in the labour force (Rubery, 1996). Also, half of the increase for mothers with dependent children has been in full-time work, whereas 100% of the increase among non-dependent women with children was in part-time jobs (Bridgwood & Savage, 1993; Thomas et. al. 1994 c.b. Brannen, 1998). Nevertheless, fewer women than men work full-time in Britain. In 1996 only 37% of women between the ages 16 and 59 were employed full-time compared to 70% of men (Emslie, Hunt, & Macintyre, 1999). In Sweden, in 1963, 53 percent of Swedish women were active in the work force, compared to 93 percent of men. Thirty years later, 77% of women and 81% of men between 16 and 64 years of age were in the labour force (Lundberg & Gonäs, 1998). In spite of the general upward tendency to hire more females in assembly lines in the European market, large disparities continue to exist among countries (e.g. Spain, Greece, Ireland and Italy with rates of 32.3%-38%; Belgium, Luxembourg, France and Austria, 45%- 57%, compared to countries like Denmark and Sweden with rates of 68%-76%) (Rubery, 1996).

Hollinger (1991 c.b Lee, 1998) carried out an international comparison of attitudes and work practices in employed women and found that the primary motivating force behind women's entry into the paid labour market was not an ideology of egalitarianism, but changing economic pressures. However, many women may

appreciate their increasing independence and many may gain both financially and personally as a result of having paid employment (Lee, 1998).

The participation of Latin American women in the work force has been conditioned by the characteristics of the socioeconomic development of the countries in the region rather than by the desire for personal improvement (Garbi & Palumbo, 1993). Just like in the rest of the world, in the last three decades Latin American women have been actively incorporated into the work force. Despite the current available data noting under-registration of female participation in economic activities, data taken from population census in Latin American countries indicate that between 1960 and 1990 the number of economically active women tripled, from 18 to 57 million persons, representing a growth in female employment of 18.1% to 28.1% (Valdes & Gomariz, 1995). Although these figures reflect the general trend in the region, important differences exist among countries. For example, in Guatemala the rate of activity barely reaches 20%, whereas in Uruguay it is around 40%. As in developed countries, around 78% of these working women have small children under their care and 22% to 30% are breadwinners (Buvinic, 1994).

Despite of this progress, women still have the responsibility of household tasks and childcare. The maintenance of traditional gender-based division of household labour explains why an important percentage of women in the entire world look for part-time positions with few opportunities for career advancement.

The concentration of women in a certain type of occupation is another trend pointed out by the ILO (International Labour Organization). This trend is observed in the majority of countries independent of their level of development. Services and assembly lines are the two economic areas that report the highest proportion of women in most of the countries (For the EU it is between 48.4% and 39.2%; for Latin America between 60% and 80%) while their proportion is lower among managers and higher-level officers. Nonetheless, an increase in the number of women occupying these positions has been observed in the last decade (Valdes & Gomariz, 1995; Le Feuvre, 1998).

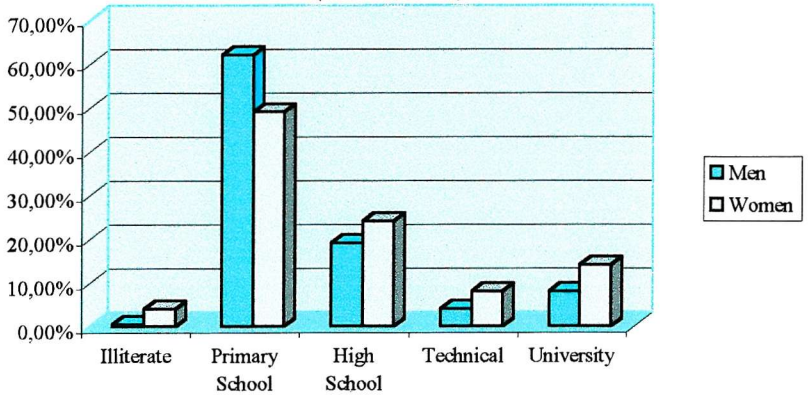
2.3.1. - Working Women in Venezuela

It is estimated that nearly one third of the work force in Venezuela are women. According to OCEI (the Central Office of Statistics and Information) during the first trimester of 1999, 37.3% of women were incorporated into the labour market. In proportion to men, between the second trimester of 1998 and the first trimester of 1999, the women's labour force increased 61% (OCEI, 1999).

During the period between 1988 and 1999, a change took place in the civil status of women 15 years and older. The proportion of single women dropped, and there was a slight increase in the number of women with partners, both married and unmarried, widows and divorcees. However, the OCEI data also point out that the role of women as heads of family has also increased in all socio-economic levels (Household Survey, 2nd. semester, OCEI, 1990). According to this survey, women are the heads of almost 30% of family units.

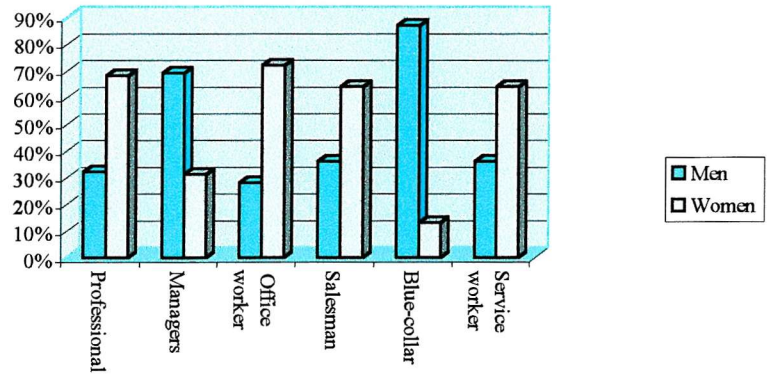
On the other hand, the educational level of women has improved noticeably in the last 40 years, and its increase was particularly important in the 70's. According to recent statistics, an increasing number of women are graduating from higher education centers, even though the number of male students in basic education is higher. This is because the dropout rate is greater for men than women. The percentage of women with lower educational levels looking for remunerated jobs is lower and their formal preparation is thus of a higher standard than that of men (Figure 2.2).

Figure 2.2
Work Force: Educational Level According to Gender
(OCEI, 1998)



The majority of Venezuelan employed women are between 25 to 44 years old. If their education level is lower they tend to be wage earners as opposed to being self-employed, both in the public and private sectors. Most of those with higher education levels belong to the categories of professionals or technicians. They can hold positions with high economic-labour status in managerial fields where they are even involved in decision-making processes. Nevertheless, their numbers are low compared to men and their remuneration is an estimated 30% lower than men in the same job position (COPRE, 1989; Marquez & Lejter, 2000). Figure 2.3 shows the difference between men and women with respect to the occupational groups established by the OCEI.

Figure 2.3
Differences Between Men and Women According to Occupational Status (OCEI, 1998)



In summary, based on the above information, the likelihood of an increased percentage of women in the labour force worldwide can be inferred. Women's preference for certain types of occupations may be due to a twofold process of minimization of conflict among roles: one, that certain women look for occupations that they perceive as a continuation of their traditional roles; or two, that they opt for positions that allow them to comfortably fulfill a double duty, that of employee, on the one hand, and housewife and mother, on the other. This is the reason a high percentage of women look for part-time jobs and a higher percentage of women look for jobs as teachers, secretaries or nurses (Garbi & Palumbo, 1993; Lee, 1998).

Since the beginning of the 70's, this has been a topic that has been approached from different theoretical perspectives with emphasis on varying aspects such as the impact of juggling multiple roles on the well-being of the family, on child rising and on the mental and physical health of women.

2.4. - Multiple Roles and Women's Health: Empirical Support

Some of the more general questions concerning the relationship between women's multiple roles and health and well-being during the 70's and 80's will now be addressed.

1. Do Working Women Enjoy Better Health Than Non-Working Women?

An implicit assumption underlying studies of employed women and housewives is that employed women have an additional role and not a substitute one. Employed women are assumed to retain a large proportion of their household responsibilities despite their involvement in work outside home. However, evidence has demonstrated that holding a remunerated job -directly and indirectly- is a source of well-being (Coleman, Antonucci, Adelman & Crohan, 1987; Verbrugge, 1983; Baruch & Barnett, 1986). Several studies suggest that employment per se has positive psychological consequences for women, either as a primary source of well-being and self-esteem (Pietromonaco, Manis & Frohardt-Lane, 1986) or as a buffer against stress experienced in other roles. Moreover, to be employed was beneficial even to women with low-level jobs (Baruch, Barnett & Rivers, 1983; Verbrugge, 1982).

A study of British women showed that for those in stressful life circumstances who did not have confidantes, being employed seemed to protect against the occurrence of psychiatric symptoms. The presence of psychiatric symptoms in employed women was 14% against 79% in non-employed women (Brown & Harris, 1978). Arber, Gibert and Dale (1985) found high rates of restricted activity days in housewives with no children, particularly those under 40 years.

Nathanson (1980), based on a survey of over 12,797 women between 45 and 64 years of age, found that working women report fewer symptoms of, or are less concerned about illness behaviour, and that, when concerned about a health problem, they tend to go to a specialist. Also, employed women report lower number of days of restricted activity and fewer visits to the doctor compared to housewives. However, other studies did not find significant differences (Radloff, 1975). Longitudinal data from the Framingham Heart Study indicated that among middle age and older women there were no significant differences between employed and nonemployed women in incidence rates of coronary heart disease (Haynes & Feinleib, 1980).

The benefits of employment may not apply to all women. Waldron and Jacobs (1989) using longitudinal data from a national sample, found that labour force participation has beneficial effects on health for unmarried women and black married women, and no significant effects on health for white married women. These authors also found that employment may have particularly beneficial effects on health for unmarried women and for married women whose husbands are not emotionally supportive. Pietromonaco, Manis and Markus (1985) reported that full-time employment does not enhance self-esteem and well-being for women who are not career- oriented but does for career-oriented people.

Rosenfield (1989) argued that one explanation for the inconsistencies in relation to women's employment and health is related to the role overload or the greater demands women experience when they are employed. According to this author, personal control underlies the effects of both high demands and low power in relation to anxious and depressive symptoms in women and this also helps explain the differences between men and women in psychological distress.

These inconsistencies in findings may also be due to the lack of control of the *healthy worker effect* (Nathanson, 1980). Therefore, healthier women are more likely to become employed and stay employed, and that is why employed women are healthier.

2. *Are Mothers More Stressed Than Childless Women?*

The mother role seems to be the major source of stress among women (Barnett & Baruch, 1985). Mothers and wives consider themselves and are considered to be responsible for the well-being of their children and their husbands. Despite the fact that there is little control over the misfortunes and happiness of others, mothers are likely to blame themselves when one of their children shows problems or distress. The combination of little control, high demands and huge responsibility to which mothers and wives are exposed, produce frustration and distress.

Baruch and Barnett (1986) demonstrated that the mother role does not predict any of the three indicators of well-being (i.e. self-esteem, pleasure, or low levels of depressive symptoms.). As for physical health, Verbrugge (1983) found that women with children have a slight advantage over those who have no children. However, this advantage depends on the age and the number of children. Additionally, women with small children report more health problems.

Other researchers have studied the role of work as a moderator of the effects of family stress. A lack of satisfaction with the mother role may be attenuated, for example, with a positive experience in the labour role. Barnett and Baruch (1985) revealed that among working women the more positive their experience with their labour role, the less they worried about overload in their role as mothers. Because employed mothers have a greater sense of control, they seem less harmed by the stress caused by raising children in comparison with non-working mothers. According to these authors, whether or not motherhood has a positive effect over physical health depends upon the characteristics of the children and marital status of the woman.

The results of the Framingham Heart Study (Haynes & Feinleib, 1982) demonstrated the interactive effects of parental, marital and labour roles on the risk of cardiovascular diseases. Analysing the family role of working women in this longitudinal study, the authors found that the only group at risk were clerical women married to blue-collar men, and those who had more than two children. Women who

have children, a remunerated job in high demand and little control married to a traditional husband are at higher risk of cardiovascular diseases.

A study conducted by Kessler and McRae (1981), using data from a national survey in the United States in 1976, found that the positive effects on mental health produced by work were fewer for working women than for working women with children. In contrast, Waldron and Jacobs (1989) found that for white middle-aged women, the effects of labour force participation on self-reported general health did not differ according to the parental status. Mixed results have been obtained in other studies that used cross-sectional data to test the interaction between employment status and maternal status in relation to depression (Aneshensel, 1986; Kessler & McRae, 1982).

Other reviews on mothers' employment showed that mediating factors such as husband support, which includes co-operation with household and child care as well as a positive attitude toward maternal employment, are fundamental to interpreting any effect of maternal employment on family relationships (Bernardo, Shehan & Leslie, 1987; Baruch, Biener & Barnett, 1987). Likewise, when family income has been controlled no significant differences were found between working women and housewives with young children (Cleary & Mechanic, 1983).

3. Who Reports More Benefits in relation to Health, Employed Women with a Partner or Employed Single Women?

The results in relation to partner are contradictory. Some studies have demonstrated that married women have advantages over non-married only if they are happy with their marriage (Nathanson, 1975). Barnett & Baruch (1986) found that single and divorced women showed higher indices of well-being, e.g. self-esteem, compared to married women.

Other researchers have shown that factors such as the educational level, the choice of and satisfaction with work, salary and husband support influence the effect of women's work over their marital relationship. Marital satisfaction is higher among working women who have a high educational level, have been able to choose the type

of work, work part-time or are supported by their partners. On the other hand, women's work is associated with marital dissatisfaction when the level of revenue is low and they are not satisfied with their work (Rallings & Nye, 1979; Szinovacz, 1984 c.b. Voydanoff, 1988). Being married to a traditional husband has been associated with depressive symptoms in working women (Roberts & O'Keefe, 1981).

Employment does not make much difference for the subjective perception of health among married women. Among married women and women with children, there is no difference between those who work and housewives. Only married housewives without children perceive their health as not being too good. Nevertheless, in terms of labour conditions, a difference is seen in the group of divorced women and widows. Divorced, separated or widowed women who do not work perceive their health as being worse than working women (Nathanson, 1980).

Repetti (1987) concluded that experiences in work and family roles contribute to mental health in additive, linear fashion. Her results also indicated that the effects of experiences at work are magnified for women who perceived greater inequity in their marriages and who are highly involved in their job.

In relation to mortality, the empirical evidence of multiple roles from the 70's and the 80's is scarce. Macran (1993) reported that a very small number of studies of multiple roles have used mortality as their outcome measure. Passanante and Nathanson (1985) reported that between 1974-1978 death rates in the USA for women in nearly all kinds of paid employment were lower than for housewives. Kotler and Wingard (1989) investigated the impact of combining occupational, marital and parental roles upon 18-years risk of mortality from all causes. They found that employment status and type of employment did not predict mortality risk among women. Contrary to the multiple roles hypothesis, an increasing numbers of children among working women had no impact upon mortality, except among single working mothers. The major impact of children was for housewives, who had a higher risk when there was a child at home or when they had four or more children. Controlling for a variety of other factors (e.g. education, alcohol consumption and smoking) did not change the forgoing relationships.

In summary, empirical evidence between the 70-80s, for an impact of multiple roles on health is mixed and also yields inconsistent results. Some studies emphasised either the positive or negative side of combining multiple roles. Other researchers showed that the perceptions of conflict and enhancement are not mutually exclusive. Women may derive both conflict and enhancement from their multiple roles (Tiedje et al. 1990). These studies place an emphasis only on the role occupancy. Studies such as those of Barnett and Baruch, 1985; Baruch and Barnett, 1986; Froberg, Gjerding and Preston, 1986, suggested that the quality of women's experience and not merely the number of roles is more important in the understanding of the process that affects women's multiple roles and health. The inclusion of experience or quality in each role rather than the role occupancy contributes to a better understanding of the phenomena and explains some of the inconsistencies. Another conclusion is that working women are not a homogeneous group. In certain circumstances psychological well-being is significantly associated with having paid employment but this association is not a general one. Physical health outcome is a more complicated variable that needs to be considered carefully. Variables such as children's age, husband and other types of support, job conditions, and attitudes toward employment need to be considered. Also, more sophisticated longitudinal research studies that control for previous mental and physical conditions in order to avoid the healthy worker effect are needed (Warr & Perry, 1982).

The studies reviewed seem to show more evidence of role enhancement than role overload, especially in regards to psychological well-being. The picture becomes more confused when physical aspects are included as an outcome and mortality is still relatively unexplored. Limitations such as different samples and instruments used to measure both mental and physical health and sociodemographic variables (e.g. marital status, employment status) make it difficult to compare studies in relation to women's social roles and health.

2.4.1.-What Happened in the 90's about Multiple Roles and Women's Mental and Physical Health?

During the last decade the interest in this area has increased. Considerable progress has been made between the 70's and 80's in understanding the important characteristics of women's social roles and their effect on mental and physical health, along with the impact on family and organisations. But, as was mentioned before, the complex and contradictory findings as well as significant methodological problems have stimulated researchers to improve and test conceptual models of women's multiple roles (Repetti, 1998b).

In the present section a systematic review of the studies published in the last decade is presented. A literature search was conducted, using the following databases: MEDLINE, EMBASE, SSCI and PSYCLIT. Different combinations of keywords were used: multiple roles, women's roles, social roles, women's health, work, working women, employment, family, marriage, stress, role-quality, role experiences, role enhancement, role conflict, well-being, mental health, morbidity and mortality.

The articles selected for the present review meet the following criteria:

1. Empirical studies published in journals or books between 1990 to 2000
2. Evaluation of theoretical models
3. Papers considering different variables (e.g. social support and household responsibilities) that have proved to be associated to work, family and health
4. Papers incorporating different methodologies
5. Reviews or intervention programs were not considered

After a comprehensive review and strict application of the aforementioned criteria, 89 papers were selected.

Table 2.1 (Appendix 1) presents chronologically each of the selected articles including authors, the country were the research took place, aspects related to methodology (sample, design, etc) and the main findings.

Most of the studies mentioned in Table 2.1 were carried out in the United States of America (n=53; 60%) followed by a much lesser percentage in the United Kingdom (n=14; 16%) and Canada (n=7; 8%). The rest of the studies were carried out in Australia (n=3), Finland (n=3), Sweden (n=2), Poland (n=1), France (n=1), Germany (n=1), Malaysia (n=1) and The Netherlands (n=1). Only 2 studies were found in Latin America. This confirms the tendency observed in the past, that most of the empirical research in this area has been done in the U.S. It is important to highlight that other countries from the Western world also are showing increasing interest in this area.

2.4.1.1.-Methodological Critique

The majority of the studies were quantitative and most of them used multivariate statistics, specifically multiple regression analysis. Some qualitative studies (e.g. Simon, 1995; 1997) began to appear and also some with combined methodologies (Shipley & Coats, 1992; Meleis, Douglas, Eribes, Shih & Messias, 1996).
Volunteers or intentional samples (n= 39; 44%) were the most common method of participant selection. Thirty eight percent (n=34) of the studies used nationally representative samples, household interviews, surveys, census records or probability samples. In some cases, the same database was used by different researchers according to the purpose of their paper (e.g. Macran, Clarke & Joshi, 1996; Bartley, Popay & Plewis, 1992, used the British Health and Lifestyle Survey). Random samples (stratified or not) were used in 21% of the studies.

Sixty one percent of the studies were cross-sectional followed by longitudinal studies (29%) with varying follow-up periods (1 month to 30 years). Three of the research papers combined cross-sectional and longitudinal designs. Likewise, four studies used a repeated measurements design (e.g. blood pressure or cortisol levels), a case-control design and a comparative design. Even though cross-sectional studies were more frequent in this review, it seems like there was an increase in longitudinal studies in comparison with previous periods. It is also stimulating to find different types of designs for studying this area (e.g. the study carried out by Collijn, Appels & Nijhuis, 1996, who used a case-control design for studying multiple roles as a high risk factor for MI in women).

Questionnaires constitute the most frequently used evaluation method (44.4%), followed by face-to-face interviews (31%). Five studies used telephone interviews and 13 (14.4%) combined the use of interviews with questionnaires. Twelve percent (n=11) used physiological measures, four studies included physical exams, one reviewed medical histories and two included diary data.

There was an enormous variety of variables ranging from the inclusion of sociodemographic and psychosocial variables as well as different indicators of mental health and physical health, with a large degree of variability among each of these. To this must be added - specifically in the case of psychosocial and health variables - the different types of instruments used to measure each of these variables (e.g., psychological distress, work stress, anxiety, role-quality).

As for sociodemographic variables, more than 28 different variables were mentioned, being the most frequent age, education and to a lesser degree, employment status, marital status, number of children and the children's age. Sometimes the variable had the same name in different studies such as social position, social class, and/or SES but each study used different indicators or classifications depending on decisions made by each country's official statistics-collecting organisations or according to researchers'theoretical concepts.

Regarding psychosocial variables, there was even a greater variety (more than 35 different variables). In some studies, researchers designed their own instruments or questionnaires for measuring the same variable (e.g. stress, marital satisfaction) or combined or selected specific items from standardised questionnaires. To a great extent, these variables refer to stress indicators, followed by measurements of social support and networks, a sense or perception of control, locus of control and psychosocial work characteristics.

The mental health indicators also varied. The most frequently used indicator was depression (24%) and this was measured with the same instrument in most of the studies (Centre for Epidemiological Studies Depression -CES-D- Scale). This indicator was followed by the measurement of psychological distress, mostly

measured through the General Health Questionnaire (GHQ). But it was also found that in some studies such as those of Barnett et al. (1991,1993) and Ross and Bird (1994) for example, psychological distress is conceptualised as a combination of anxiety and depression. Measurements on anxiety, well-being, self-esteem and life satisfaction followed in frequency.

With respect to physical health measurements, these followed the same characteristics as psychosocial and sociodemographic variables. The most frequent measure was symptom report; followed by self-perception of physical health in the last six months, physical health condition, risk habits (smoking, overweight, alcohol) and physiological measures.

2.4.1.2.-Main Findings

1. - Multiple Roles Occupancy and Women's Mental and Physical Health

The majority of the studies included in this review considered specifically role occupancy in relation to mental and physical health. The most important factor for women's mental health was having young children, particularly if they worked full-time, as they perceived more distress and less psychological well-being and had unhealthy lifestyles (Elliot & Huppert ,1990; Walker & Best, 1991). This finding refers particularly to for unmarried women and housewives who reported psychological problems such as disaffection with life, depression and coping difficulties. Macran et al. (1996) found that full-time lone mothers with dependent children had poor psychological health, after controlling for household income, employment status and occupation.

Khlat, Sermet and Le Pape (2000), using a French national health survey, found that women with a husband/cohabitant were definitely in a better position than women without a partner in terms of perceived health, mental health conditions and malaise symptoms. They also found that having children at home was associated with a better perception of health and health-related behaviours only for women with

husband/cohabitant. The findings show that the balance between the harms and the benefits of role involvement depends on the amount of resources available to the household. These authors found appreciable diversity across roles in the middle-income stratum. Lone mothers were the most disadvantaged group in terms of mental health conditions (health state, malaise symptoms, drug consumption and smoking), and housewives in terms of physical health conditions. Higher household income was clearly associated with better health. In the top and in the bottom income no differences were found between working women and housewives. These results clearly show that social roles and health are closely related to social position.

Bartley et al. (1992), using also a British sample, confirmed that women with full-time and part-time employment were more likely to experience lower levels of physical and psychological symptoms than housewives. Part-time work appears to be more advantageous than full-time and the benefits more psychological than physical well-being. Women working full-time in professional and managerial occupations did not show any advantage after controlling for domestic conditions (e.g. number of children and children's age, housing conditions and underlying health status). This group of women had 11% higher risk of reported physical symptoms than housewives. Results in this study are consistent with Arber's (1989) who found that women employees and managers reported considerably more long-term illnesses than any other non-manual group, regardless of marital status or number/age of children. Both results suggest that the higher levels of physical illness reported by women professionals or managers were not due to their multiple role responsibilities, but might be better explained by particular stresses involved when participating in high status occupations.

Other studies in this review that include managerial and professional women's samples, such as Beatty (1996), Burk and McKeen (1995) and Lagan-Fox and Poole (1995), can not be compared with the studies described above because they do not make comparisons with other occupational groups. However, their findings are also contradictory; i.e. Beatty (1996) found lower levels of depression, anxiety and hostility and no interactions for parental status, work stress and work-family conflict in her sample, while Lagan-Fox and Poole (1995) found that professional single women reported poorer mental health and scored higher for Type A behaviour, and

women with three or more children reported poorer physical health. Additionally, having parental status was associated with headaches, exhaustion, overeating, smoking and drinking.

According to Arber and Lahelma (1993) occupational level was associated with ill health amongst British and Finish working women. But housing tenure and family roles were additional factors only among British women. Arber (1991) also found that health disadvantage for women was associated with non-employment (either being a housewife or unemployed), being in a manual class, being divorced, separated or widowed, living in local authority housing, and not having dependent children. Women with dependent children reported better health irrespective of their employment status. Employed women reported better health irrespective of marital and parental status.

In relation to morbidity indicators, especial attention had to be given to the work carried out by Waldron, Weiss and Hughes (1998) who tested several hypotheses using interactive models concerning the effects of employment, marriage and motherhood on women's general physical health using longitudinal panel data from two follow-up intervals (1978-83 and 1983-88). Employment and marriage generally have beneficial effects on women's health, probably because both employment and marriage can provide benefits such as increased income and social support. This result agrees with other studies reported in this review (Hibbard & Pope, 1991; Moen, 1992; Ross & Mirowsky, 1995) as well as others reported previously (Waldron & Jacobs, 1989; Repetti, Matthews & Waldron, 1989). Current evidence suggests that these roles do not have additive effects on health; rather employment and marriage appear to have interacting effects. Employment has more beneficial health effects for unmarried women (Ali & Avison, 1997) and marriage has more beneficial effects for women who are not employed.

With respect to the parental role, Waldron, Weiss and Hughes (1998) found no interaction effect between employment and parental status. However, analysis of the first follow-up interval suggested that employment had less beneficial effects for mothers of preschoolers. These authors did not observe particularly harmful health

effects for employed women with many children or for mothers who were employed full-time. Full-time employment had more beneficial effects on physical health than part-time employment. These results were also supported by Ross and Bird (1994) but contrast with Bartley's findings (1992) that were mentioned above.

Considering differences in health according to racial/ethnic variation is a very important issue that needs to be taken into consideration in these studies (Braboy Jackson, 1997).

Bartley, Sacker, Firth and Fitzpatrick (1999) investigated the relationship between social roles, social position and health in English women using theoretical measures of social position. According to these authors women's combinations of social roles have changed considerably between the 1980's and the 1990's reflecting these changes in health. They found that the group at higher risk of ill-health in relation to others of their own age has changed, from never-married lone mothers in the mid-1980's to older women living alone with no paid employment in the mid-1990's. This is a very important finding because it shows how women's lives have changed in the last years.

2. -Women's Multiple Roles and Cardiovascular Disease

Cardiovascular diseases have traditionally been associated with work variables, especially in men. They are also the most important cause of death among women in the West (Collijn et al, 1996). This is an area that has not attracted much attention until very recently. In the present review, directly or indirectly eleven studies look at cardiovascular disease, and especially MI, stroke, and other risk factors associated with working women and their family roles (Ebi-Kryston, Higgings, & Keller, 1990; Theorell, 1991; Dixon, Dixon & Spinner, 1991; Hibbard & Pope, 1991; Eaker, Pinsky & Castelli, 1992; Haertel, Heiss, Filipiak & Doering, 1992; Hibbard & Pope, 1993; James, Schulussel & Pickering, 1993; Collijn et al, 1996; Luecken, Suarez, Kuhn, Barefoot, Blumenthal, Siegler & Williams, 1997; Steptoe, Lundwall & Cropley, 2000).

Studies such as Theorell (1991) using Karasek's Demand-Control model, found that women in occupations that included a high proportion of overtime work reported subjective symptoms such as fatigue and headache and had higher risk of MI. Also MI was a risk factor for married women in lower status occupations (Hibbard & Pope, 1991) and work support was a protective factor against stroke and work stress (Hibbard & Pope, 1993).

Eaker et al. (1992) using a sample of women from the Framingham study, found that after controlling for age, systolic blood pressure, HDL, diabetes and body mass index, the predictors of the 20-year incidence of MI or coronary death were, among all women tension and infrequent vacations; among employed women perceived financial worries and among housewives, symptoms of tension and anxiety, being lonely during the day, lack of opportunity or desire to get away and relax. Occupational level was not significantly associated with MI or coronary death. These findings are different from those by Haynes et. al. (1980). Haertel et al. (1992), using a sample of women from the MONICA project, found both in cross-sectional and longitudinal data that employment may have a protective influence on coronary risk in women. Employed women had higher levels of HDL cholesterol compared to housewives.

Collijn et al (1996), using a case-control design, found that multiple roles do not constitute a risk factor for a first MI in women, although the findings do support the enhancement hypothesis with regard to general health.

James et al. (1993) and Luecken et al. (1997) showed how work and family life interact and how it affects women's health, especially when they have children at home. Using repeated measures such as ambulatory blood pressure or daily excretion of urinary catecholamines and cortisol as well as stress and social support, both studies conclude that working women who were exposed to a stress increased their levels of blood pressure and excreted greater amounts of cortisol. Steptoe et al. (2000) measuring blood pressure over a working day and evening, did not find any indication of multiple role strain for full-time working mothers.

These results are a demonstration of the importance of studying psychosocial and physiological risk factors associated with health in working women using different methodological approaches which complement epidemiological and sociological investigations on social roles and health.

3. - Women's Multiple Roles and Mortality

A review of the last decade presents four studies, which attempted to test the multiple roles and multiple accumulation hypothesis and mortality (Hibbard & Pope, 1991, 1993; Weatherall, Joshi & Macran, 1994; Martikainen, 1995). These studies are very important because mortality, with few exceptions, was relatively unexplored in the past in relation to the impact of multiple roles on health (Macran, 1993; Weatherall et al., 1994). It is also important to highlight that these studies have been carried out in other countries (U.K. and Finland) other than the U.S. where most of the empirical research had been done in relation to mortality and women's roles (Haynes & Feinleib, 1980).

Hibbard and Pope (1991) found that women with more roles had lower risk of death and morbidity than women with few roles. The only exception to this were married women who were in lower status occupations (it includes clerical positions); they were at greater risk of death. This effect was not similar for the unmarried in similar occupations. These results not only highlight the importance of considering the presence or absence of each role but also its characteristics.

Markainen (1995), in a study carried out in Finland, found that women with multiple roles had low mortality. Only lone mothers with more than one child had higher mortality. Hibbard and Pope (1991) in the U.S. also found that parental status affected employed and nonemployed women differentially. Having at least one child at home increased the risk for ischemic heart disease among employed women and a risk of stroke among nonemployed women. The study reported by Weatherall et al. (1994) within the OPCS Longitudinal study, showed poorer health among those with neither employment nor children, but there was no evidence of harmful or beneficial effect of combining these roles on mortality.

The conclusions derived from the majority of these studies on multiple roles and women's health, in general support the Enhancement hypothesis. Multiple roles confer benefits to women's mental and physical health.

These studies based their findings defining social roles in terms of role occupancy (marital, parental and employment status) and testing their hypothesis using both additive as well as interactive models. Many of these investigations considered structural factors such as occupational class and/or social position, because of their important role in the study and understanding of health inequalities However, the complex and sometimes contradictory results on mere role occupancy have prompted researchers to focus on specific qualities or characteristics of women's social roles (Barnett et al. (1991, 1992, 1995); Shipley & Coats, 1992; Houston, Cates & Kelly,1992; Luchetta, 1995; De Salvo Rankin, 1993; Geller & Hobfoll, 1994; Greenberg & O'Neill, 1993; Miller, Wilburg, Montgomery & Chandler, 1998; Reid & Hardy, 1999, among others). This last aspect will be presented in the next section.

4. - Role Quality versus Role Occupancy

Barnett and Baruch (1985) and Baruch and Barnett (1986) introduce the quality of the experiences of each one of these roles as a new element which stresses the importance of the occupational role in relation to health and well-being. According to these authors, **Role Quality** is defined as "the demands, conflicts, benefits and rewards of each role, rather than trying to infer them from occupational roles..." (Kotler & Wingard, 1989, p. 611). The performance of a particular role per se would not generate any stress, but rather both work roles and family roles could be sources of strength or stress, depending on the cognitive evaluation of that experience and on the individual differences (Lazarus & Folkman, 1986).

Recent investigations have shown that the quality of social roles is related to anxiety, depression, morbidity indicators and also mortality (Barnett & Baruch, 1985; Baruch & Barnett, 1986; Hibbard & Pope, 1993; Miller et al. 1998) not only in women but also in men and among dual-earning couples (Marshall & Barnett, 1993; Barnett,

Brennan, Raudenbush & Marshall, 1994). The findings show that for married women, equality in decision-making and companionship in marriage are protective against death. Work support is protective against death, malignancy and stroke among employed women. None of the parental role characteristics were significant predictors of health outcomes for men and women. No interactions were found among roles (Hibbard & Pope, 1993).

Another study indicated that declines in job quality were associated with increased psychological distress for single women and women without children; however, changes in job quality were unrelated to psychological distress for partnered women and women with children (Barnett, Marshall & Singer, 1992). Findings like this suggest that women who encounter problems in their jobs are more likely to feel depressed and anxious if they are single than if they are married or have children.

Barnett and Marshall (1991, 1992) state that mental health is affected by both the presence of concerns and the absence of rewards. Reducing concerns or increasing rewards can achieve improvements in mental health and well-being. Also some role-concerns could be buffered by other role-rewards. Women's mental health reflects a combination of their experiences in their multiple roles.

Epidemiological and survey studies have shown a relationship between being married and positive mental health, physical health and mortality. Marriage is assumed to protect both men and women because of social support, intimacy, and material resources. However, having a spouse is not a guarantee of health and well-being. Unsatisfactory marriages are a risk factor for health and problematic relationships with spouses have considerably stronger impact on depression compared to supportive relationships (Fincham, 1998; Horwitz, MCLaughlin & Raskin, 1997).

As well as Barnett et al. (1991, 1992, 1995), Simon (1995, 1997), Burton (1998) consider that the differences observed between men and women with respect to multiple roles and health cannot be explained solely by structural factors (number of roles, occupation, income, division of household labour, labour market inequality, etc.). According to these authors, the meanings individuals themselves attach to role

identities are crucial for explaining differential vulnerability to stress. This approach is rooted in a symbolic interactionism viewpoint. Based on data from in-depth interviews, Simon (1995) found that gender differences in the perceived relationship between work and family roles may help account " for gender differences in distress by contributing to male-female differences in the *extent* and *nature* of work-parent conflicts, attributions of *responsibility* for marital problems, feelings of guilt, and *self-evaluations* as parents and spouses" (page. 191). Likewise, social roles have a salutary relationship on distress and integrative meaning mediates these effects (Burton, 1998). Cade Harber (1991) found that the meaning that an individual attaches to a role would influence its importance for self-esteem. This author found that full-time working women with modern gender-role preferences have higher self-esteem.

Moen et al. (1992, 1995) specifically studied the effect of multiple roles during the course of a lifetime and their effects on health in general. This author proposes a very interesting approach by underlining the notion of multiple roles as promoting resilience by means of greater social integration, which results in successful aging. This author also coincides with the proposals by Barnett et al. (1991, 1992, 1995) and Simon (1995, 1997) in the sense that satisfactions and stressors associated with each role turn out to be much more important than merely role occupancy but adds that social roles are dynamic in that they vary during a life-span both in quantity and in quality.

Another related concept incorporated to the literature on this subject is that of Role Centrality (Martire, Parris Stephens & Townsend, 2000). Theorists have proposed that greater centrality (personal importance) of a social role is associated with better psychological wellbeing but role centrality can also be a condition for stress when the role is of great importance to the individual. All the foregoing positions coincide in assuming the importance of the perception experienced or the meaning of each role for men/women, taking into account the positive as well as the negative dimensions and interactions thereof.

These results demonstrated that social roles are very complex and multidimensional. The experiences or qualities of social roles need to be taken into account for a deeper

understanding of the relationships between women's roles and health. The present thesis used the concept of Role Quality introduced by Barnett and Baruch, (1985), Barnett and Marshall (1991) as a crucial psychosocial variable for understanding the relationship between women's roles and health.

5. - Social Support and Women's Health

The present review incorporated other psychosocial variables that could behave as risk or protective factors in the study of multiple roles and women's health. Social support is the protective factor that has generated more studies and interest in the last 20 years because of its link with stress and psychological well-being and physical health (Ganster & Victor, 1988; Cohen, 1988; Cohen, 1990; Callaghan & Morrisey, 1993; Chesney & Darbes, 1998).

Social support has been used in the literature to represent many different concepts. Dunkel-Schetter and Bennett (1990) categorised three levels of social relationships: First, social integration which acknowledges the existence of social relationships. Second, social networks which describes the structure of a social relationship and the interrelationships between individuals (e.g. density and size) and third, social support, which explores the functionality of social relationships in two aspects: cognitive, which refers to the perceived availability of support (it may exist or not) and behavioural. The support is given or received in response to particular needs and comes in three forms: emotional, informational or instrumental support (House, 1981). More recently, in relation to the difference between available support and received support, Komproe, Rijken, Ros, Winnubst and Hart (1997) found that available support had direct beneficial effects on depression and received support has indirect effects via appraisal and coping. Other researchers refer to helpful sources of support such as family, friends, co-workers, supervisors, institutions (Sarason, Sarason & Pierce, 1990). An individual's satisfaction with the perceived social support can also influence the effectiveness of support (Gottlieb, 1992).

Henderson, Duncan-Jones and Byrne (1980) developed a conceptual definition of support based on attachment, social integration, nurturance and reassurance of personal worth and sense of reliability. Support is provided by membership of a

network of persons having shared interests and values, the opportunity of nurturing others, reassurance of personal worth, a sense of reliable alliance and obtaining help and guidance from informal advisers in times of difficulty. Henderson et al. (1980) developed an instrument called the Interview Schedule for Social Interactions (ISSI). This instrument was reported to be acceptable to both healthy and psychiatrically disturbed respondents (Bowling, 1997a). It has been used in epidemiological studies and proved its capacity for predicting ischaemic heart disease in men and women (Unden & Orth-Gomer, 1989; Orth-Gomer, Rosengreen & Wilhelmsen, 1993; Horsten, Wamala, Vingerhoests, & Orth-Gomer, 1997).

As can be seen, there are several different conceptualizations and/or levels of social support, which come from an established body of knowledge and all raise questions. The main problem has been that although measures have multiplied, relatively little work has been done to establish their comparability. All types of social support provide us with relevant information but they refer to different aspects of social support, giving also different relationships with the predictor variables (Sarason, Sarason & Pierce, 1990; Hupcey, 1998). Given such complexities and the variety of operational definitions of social support employed, a number of recurrent findings emerge from the different investigations into social support and health: individuals evidencing relatively lower levels of social support would seem to suffer from increased mortality from different causes, increased morbidity and poor prognoses (Carroll, Niven & Sheffield, 1993).

The papers selected for the present review reconfirmed the view that social support at work is one of the most important variables in relation to health and well-being of employed women as employment offers the opportunity to increase social networks and receive emotional and practical support (Lee & Duxbury, 1998). Working women under stress and specially unmarried women and women with pre-school children are the ones who benefit most from the protection offered by job-related social support, according to recent results (Warren & Johnson, 1995).

Reifman, Biernat and Lang (1991) found that social support yielded no stress-buffering effects in a study with married professional women with children. However,

Houston et al. (1992) found that for employed women, support from supervisor and co-workers moderated the relationship between job stress and psychological strain. Gómez et al. (2000), in a study carried out in Colombia with working women from different occupational levels, found that job-role quality was related to a higher perception of social support and higher decision latitude. Also Noor (1995a) reported that locus of control and work support combined interactively to moderate the impact of job challenge on happiness. Co-worker's support is also very important and has been related to lower levels of depression and frustration (Beehr, Jex, Stacy & Murray, 2000).

Special importance has been attached to the co-operation of husbands at home. Smith, Smith, Kearns and Abbott (1993) reported that the presence of partner's support mitigates the adverse effect of housing stressors and is associated with reduced psychological distress.

The importance of social support has also been pointed out in the literature on Latino families. A study carried out in Venezuela with working women with a partner and children, showed that religious support was one of the most important sources of support and clearly associated with mental health (Meneses, Feldman & Chacon, 1999). This result reflects socio-cultural characteristics of Latin American families, especially women, who are more often responsible for the education, moral and spiritual welfare of their children.

In relation to physical health, Orth-Gomer, Horsten, Wamala, Schenck-Gustafsson et al. (2000) found that lack of social integration and support contributes to the prediction of coronary artery disease (CAD) in women, independently of standard coronary risk factors.

6. - Distribution of Household Responsibilities

It was expected that women's employment would bring about multiple changes in the family, one of them being the participation of husbands in home-related tasks and the

care of children. This expectation has not been fully met inpractice (Sheldon & John, 1996; Noor, 1997).

Distributions of household tasks and child caring have been considered as sources of overload for women and conflict and stress between the spouses (Mayor, 1993). Household labour allocation is part of the micro interaction in the family and implies connections with the macro structure of gender inequality. Household chores become progressively routine and boring and represent a heavy load for women, compounded by the fact that they are usually carried out in social isolation. The conflict of interests between outside work and work at home can bring exhaustion, tension, and influence women's marital satisfaction and mental health, especially if the woman does not receive any support from her husband in duties and child care (Peterson & Gerson, 1992; Piña & Bengtson, 1993).

Mederer (1993) points out that recent studies of household labour reveal two current research issues: how family work is measured and how the division of household labour is perceived by husbands and wives. This author discussed the conception and measurement of household labour categorising housework into types of caring: for home, for family members and for transactional matters, the distinction between household management and task accomplishment is incorporated

Home responsibilities have been basically defined in two ways: some authors (Almeida, Magos & Galambos, 1993; Noor, 1997) consider household chores as the participation in tasks inherent to the home - preparing meals, cleaning the house, minor home repairs, among others. Other authors include the care of children as part of these home responsibilities (Baruch & Barnett, 1986; Peterson & Gerson, 1992).

This distinct difference relates largely to the tendency to consider the care of children as an extension of the responsibilities inherent for females and to the tendency not to include them within the routine of household duties (Mederer, 1993). Including the care of children as one more household responsibility and not as a solely feminine chore has allowed the spouses of working women to be included in this activity. Wiersma and Van Den Berg (1991) reported a minimal association between the

number of hours the woman works outside her home and the amount of time her husband dedicates to home responsibilities; but when the hours dedicated to child care are included, a considerable increase in male participation is appreciated. Rosenfield (1992) affirmed that more than 50% of household chores refer to the care of children.

This study will use the definition given by Baruch and Barnett (1986) which includes the care of children within the household responsibilities, taking into account that not only is the participation by each spouse in household chores or activities to be evaluated, but also the differentiation suggested by Mederer (1993) regarding the separate evaluation of organization or planning of tasks and execution thereof.

According to the review of the latest decade (Table 2.1), role overload and conflicts over the division of household labour was related to unhappiness and cleanliness in women (Robinson & Milkie, 1998). Bird (1999) found that men's lower contributions to household labour explain part of the gender differences in depression. Men reported performing 42.3% of the housework compared to 68.1% reported by women. This author also reported that for women, equity in the division of household labour was more important to psychological well-being than the amount of time spent in household labour. She also found that social support mediates the effect of the division of household labour on distress. Also the perception of equity in the division of labour (paid or unpaid) was significantly associated with lower levels of depression (Glass & Fujimoto, 1994). Noor (1997) found in a sample of employed married women that their estimate of their husbands' time spent doing housework was a better predictor of their distress symptoms than their estimates of their own time. Further, this relationship between wives' estimates of husbands' time spent on housework and distress was mediated by their perceptions of support.

In relation to physical health, Luecken et al. (1997) found that working women with children at home, independent of marital status or social support, excrete greater amounts of cortisol and experience higher levels of home strain than those without children at home. It means that working women, especially those with small children, were less able to relax and unwind at home, due in part to the stress of household labour.

Although housework can be burdensome, some authors suggested that little attention had been given to the satisfaction with or qualities of housework. Bird and Ross (1993) found that compared to employers, housewives reported more autonomy which increased their sense of control. In addition, household labour is productive work, involves physical activity and yields a clean and pleasing living environment, and could have beneficial effects on well-being. Pittman, Teng, Kerpelman and Solheim (1999) found that satisfaction with housework was partially mediated by qualities of outcomes and also moderated by time spent.

As can be observed there has been a proliferation of research on the organisation, structure and social meaning of housework. Research has concentrated on the division of household labour, perceptions of its fairness and marital satisfaction and well-being. This has contributed to an understanding of the gendered aspects of housework and some findings have been quite inconsistent. Although the gender division of household labour is associated with distress in women, few studies have controlled for prior psychological distress (Glass & Fujimoto, 1994; Ross & Bird, 1994; Bird, 1999).

The performance of multiple roles has brought about higher demands for women, thus creating greater tension and dissatisfaction when faced with fulfilling a full-time job at work as well as at home. These consequences have been moderated by variables such as their age, the number of hours worked outside the home (part or full-time), marital status, participation of spouses in household tasks, employment status, number of and children's age and social support.

2.5. – What Have We Learned About Multiple Roles and Women's Health in the Last Thirty Years? Main Conclusions.

2.5.1. - Empirical Evidence

1. – Multiple roles are a very complex and multidimensional phenomenon in which sociodemographic and psychosocial factors have differential effects on women's

mental and physical health. Both cross-sectional and longitudinal studies tend to support the enhancement model of multiple-role involvement. The benefits include financial gain, a wider social network and social support, job satisfaction and an increased sense of autonomy and self-esteem. Also women who enacted more roles were mentally and physically healthier than women who enacted fewer roles. This advantage includes lower mortality. However, some studies found that the effects of role accumulation on physical and mental health depends not simply on the total number of roles, but also on the particular types of social roles that a woman occupied. Many authors point out the importance of studying the interaction between roles for understanding their effects on women's health. Being employed, married or having children could have beneficial, neutral or harmful effects on health for different subgroups of women because it depends on the interaction between and within the roles.

2. - In relation to employment, many studies have reported specific advantages for employed women compared to non-employed or housewives. However, the net effect of employment on women's health depends on several factors, including the characteristics of their other roles, job conditions and employment status. For example, employment had beneficial effects on health for unmarried women, but little or no effects for married women. In relation to these findings, the *healthy worker effects,* that refers to the fact that healthier women are more likely to enter and remain employed, does not necessarily imply that employment has beneficial effects on women's health. However, in the last decade, longitudinal studies increasingly control for initial health status. In this manner, the impact that employment has on health can be separated from the effect that health has on employment status. None of these studies have found negative effects of employment per se on women's mental or physical health.

3. - Marriage has been also associated with better mental and physical health both for men and women. However, the effect of marriage on women's health does not always depend on the fact that the woman has a spouse. Many studies have found that marital quality and husband's support are more important determinants of women's health

and well-being. Also, marriage has more beneficial effects on health for women who are not employed.

4. - In relation to parenthood, being a mother could have beneficial, neutral or harmful effects on health for different groups of women. As some studies find that this role has negative mental health consequences for women, others suggest that the impact of one social role may depend on the other roles that a woman occupies. Having small children at home was associated with higher rates of depression, especially for women who were unemployed and did not have a partner. Lone unemployed women with children seem to be the group of women with a higher risk of both mental and physical health problems. Also, employment had less beneficial effects for mothers of pre-schoolers.

5. - The complex and sometimes contradictory findings on mere role occupancy have prompted researchers to include the qualities of women's experiences in their social roles. The number of roles and role occupancy per se do not explain the complexity of the whole phenomenon. The health effects on women of combining paid employment and family roles clearly depend on structural variables as well as on the perception of the rewards and concerns associated with each role and the interaction between roles. Role characteristics (quality) act directly or moderate the effects of role occupancy by either straining or enhancing women's health.

6. - The effect of multiple roles on health also needs to be studied using a life-course perspective as is proposed by Moen et al. (1992, 1995). Roles in terms of quantity and quality change during the course of life and affect health and aging. As pointed out by several authors in this review, role occupancy tells us only a limited amount about women's experiences of role strain or role enhancement and this is in itself likely to change over time.

7. - Psychosocial variables such as social support and household responsibilities also contribute directly or indirectly to a much better understanding of the relationship between women's social roles and their mental and physical health. Personal variables such as perception of control, locus of control and hardiness also are very important to

consider. As some studies produced mixed results, much more research is needed which considers these variables and their relationships between social roles and women's mental and physical health.

8. - The studies presented confirmed that social inequality is a powerful predictor of health problems. Social position defined in terms of employment status and conditions or as social status (prestige) and material resources (household income) needs to be considered in these types of studies. Many studies in the literature confirmed the role of social gradient and its relationship with health (e.g. Marmot, Smith, Stansfield, Patel, North, Head, White, Brunner & Feeney, 1991).

9.- The performance of multiple roles has brought about higher demands for women, thus creating greater tension and dissatisfaction when faced with fulfilling a full-time job at work as well as at home. These consequences have been moderated by variables such as their age, the number of hours worked outside the home (part or full-time), marital status, participation of spouses in household tasks, employment status, number of and children's age and social support.

2.5.2. - Methodological Issues

Cross-sectional versus Longitudinal Studies

Most studies concerning multiple roles and women's health are still based on cross-sectional data. This type of design does not provide meaningful evidence of the effects of multiple roles on women's health. Nevertheless, the number of previous research studies which have attempted to estimate the importance of multiple roles protection (especially employment and/or marriage) or multiple roles selection based on analyses of cross-sectional data are very high. These analyses are not persuasive due to a variety of methodological flaws (Waldron, 1980; Repetti, Matthews & Waldron, 1989). That is why there has been increasing interest in analyses on prospective data. Longitudinal data have significantly improved research methods on multiple roles by allowing investigators to control for initial health status when estimating the impact of

occupying a particular role or accounting for particular role characteristics on women's health. Unfortunately, there are not many published longitudinal studies compared to the cross-sectional studies of role characteristics and women's health. More longitudinal studies are needed (Repetti, 1998a,b).

Sampling, Definition of Variables and Instruments

Though research in this area is fast expanding, many studies still suffer from problems of inadequate sampling. The majority of the studies in this review used intentional samples or volunteers. However, an important progress is the increase of studies using nationally representative samples as was shown in the review of the last decade (Table 2.1). The majority of the studies were carried out in the U.S. the population most intensively studied in this literature has been American middle-class, urban and suburban, white, married women with children.

Another methodological problem that makes the interpretation of the findings difficult is related to the definition of certain variables. For example, different studies use different definitions of employment status. Also, much of the literature makes no distinction between full-time and part-time paid work. Some studies, especially those that have been carried out in the U.K seem to show that this is crucial, according to some researchers like Bartley et al. (1992). The definition of married is also a problem and several investigators have grouped together women who were legally married whether they were currently living or not with their husbands. This makes it difficult to compare results because some studies failed to specify which definition they were using.

There are important inconsistencies in the way in which social position is dealt with. To some extent this is inevitable given the different ways in which such information is collected in the different countries. Even within the same country, these differences represent different concepts in relation to this variable.

The different psychosocial variables included in the studies are measured in many different ways. The multiplicity and variability of the measures used in the literature review (See Table 2.1) make the comparison of the findings difficult.

In relation to the health outcomes, researchers used different definitions of "health". Note for example, the distinction between "health state" (current health or acute illness, e.g. restricted activity due to illness) and "health status" (person's stock of health, e.g. limiting long-standing illness). Also different indicators, which refer to mental and physical health, are used. They include self-assessment, medical examinations, physiological measures, somatic symptoms and several measures of psychological states or personality characteristics.

Progress in relation to methodological aspects is related to the inclusion of more objective and innovative measures of both mental and physical health and not only those based on self-report. The use of independent sources of information such as co-workers or spouses, blood tests, repeated physiological measures (blood pressure monitoring or cortisol) and daily-report studies are examples of alternatives that some researchers have implemented to overcome methodological limitations resulting from biased inflated correlations between description of role characteristics and self-reported health outcomes.

Additive versus Interactive Models

The majority of the studies on multiple role involvement and health used additive models. This model predicts that work and family roles have direct and independent effects on health. The findings showed additive models provide very important results but interactions between roles also need to be considered. That is why in recent years interactive models have been used, contributing to strengthen research in this area.

Combination of Methodologies

Another contribution to research in multiple roles and health is the use of combined methodologies and the introduction of qualitative methodology as a useful tool for an in-depth study of this topic.

Cultural Differences?

The majority of the studies have been carried out in the U.S. and the U.K, thus the research conclusions are based on women belonging to Anglo-Saxon culture. As it is a world tendency that women have invaded the labour market, it will be very important to begin studies that include working women from different countries and cultures. In the present review we found few, but very important, published studies from South America and Malaysia.

In sum, there has been great progress concerning an area of such importance for different disciplines related to health. However, it requires consolidation of aspects that are still contradictory or confusing and needs to overcome methodological limitations. It has been widely studied in highly developed countries such as the U.S., the UK, Canada and Europe, and it is a priority within the social and health policies in those countries. In Latin America the study of women's roles and health is still in an incipient stage although it is considered relevant for social and medical researchers as well as for governments. Therefore, one of the objectives of the present investigation aims at addressing this issue.

CHAPTER 3

RESEARCH METHODS AND ASSESSMENT PROCEDURES

The main objective of this chapter is to present a description and rationale of the different methods, research designs and instruments used in the present thesis.

3.1. - Combining Qualitative and Quantitative Methods

Qualitative and quantitative methods of research make different but important contributions to the development of social and health sciences (Hammersley, 1996; Mason, 1996; Morse, 1997; Guba & Lincoln, 1994). Some philosophers of social science and social scientists have argued that the purpose of quantitative and qualitative paradigms are so different that using them together is not possible or desirable (Rosemberg, 1988). Nevertheless, both the qualitative and quantitative paradigms have strengths and weaknesses and sometimes the weakness of one is compensated by the strengths of the other (Steckler, Mcleroy, Goodman, Bird, & McCornick, L., 1992).

Some authors argue that a false dichotomy exists between qualitative and quantitative methods and that both approaches may share similar methods of data collection (Clark, 1998, Chamberlain, Stephens & Lyons, 1997). The difference lies in the way the data are transformed and interpreted. In qualitative research, the results tend to be expressed in words compared to quantitative research where the results are usually expressed in numbers. According to some authors qualitative assessment methods are considered appropriate for exploring new topics and obtaining insightful and rich data on complex issues (Bowling, 1997b; Brannen, 1992). What is really important is choosing the right method to appropriately answer the research questions (Holloway & Wheeler, 1996; Clark, 1998).

Much of today's research in social sciences combines both types of methods including statistical analysis, with analysis of documents or interviews (Hammersley, 1996). Also, health researchers have been especially interested in combining qualitative and

quantitative methods due to the complexity of the many factors that influence health (Morgan, 1998). Health Education Quarterly dedicated an edition to the integration of quantitative and qualitative methods in health education research and evaluation (Health Education Quarterly, Volume 19, Number 1,1992).

The idea of combining quantitative and qualitative approaches owes much to past discussions about mixing methods, linking paradigms to methods, and combining research designs in all or different phases of a study (Creswell, 1993; Mason, 1996). Denzin (1978) used the term *triangulation* to argue for the combination of methodologies, data sources, researchers and theories in the study of the same phenomena. Sometimes researchers employ different methodologies which have their roots in distinctively different views of the world, not for validating the results but to gain a variety of information, to illuminate a particular problem from different angles, or to look at different aspects of a phenomenon (Holloway & Wheeler, 1996).

Mason (1996) states that researchers need to think about the purpose of integrating methods (which research questions might be addressed by different methods and how that might be done); the mode of integration of methods (it involves whether the ontologies and epistemologies expressed in the different methods are complementary, as well as whether they can be made to be consistent in a technical sense) and the basis on which generalisations can be made.

Despite the fruitful discussion, there are very few guidelines regarding when the two paradigms could and should be combined (Bryman, 1992). Hammersley (1996) argues that the selection among these approaches requires criteria according to the situation and purpose, rather than a judgement based on a commitment to a particular philosophical view of the world. He emphasises the practical character of research, where the goals of the research, the resources available, the obstacles faced are considered, but warns against ignoring the methodological problems and debates involved. Steckler et al. (1992) point out four ways of integrating quantitative and qualitative methods:

1. - Qualitative methods that help to develop quantitative measures and instruments.
2. - Qualitative methods that help explain quantitative findings.
3. - Quantitative methods that help interpret qualitative findings.
4. - Quantitative and qualitative methods used equally and in parallel. In this latest way of combining quantitative and qualitative methods, the results from each approach are used to cross-validate the study findings. Researchers analyse the results of each method separately and then decide if the results from each method suggest the same conclusions. If they do, the confidence in the results is strengthened. If they do not, the researcher tries to understand why and tries to determine which results are more valid.

Creswell (1993) describes three models of combined designs. The first model is called the two-phase design approach, in which the researcher proposes to conduct a qualitative phase and a separate quantitative one. The second model is called the dominant/less dominant design. In this design the researcher undertakes the study within a single, dominant paradigm with one small component of the overall study drawn from the alternative paradigm. The third model is the mixed-methodology design. This design represents the highest degree of mixing paradigms because the researcher would mix many methodological steps in the design of both methodologies. According to Creswell (1993) this design adds complexity and uses the advantages of both quantitative and qualitative paradigms.

The present thesis followed the second model of combined designs according to Creswell's (1993) classification. The main paradigm used was the positivist (three quantitative studies). Additionally a qualitative study was carried out in order to enrich the overall findings of the research and gain a deeper understanding of the results obtained.

3.2. - Cross-sectional and Longitudinal Research

Cross sectional research involves the measurement of current behaviours, attitudes or events of a group or population at one particular point in time. Cross-sectional surveys

are popularly used in the social sciences to investigate phenomena, and in epidemiology to investigate the prevalence of disease (Bowling, 1997b).

Most cross-sectional studies are retrospective. This means that they involve questioning respondents about past as well as current behaviours. The advantage of this type of research is that it is relatively economical in relation to time and resources, a large number of people can be surveyed relatively quickly, and standardised data are easily coded. This type of research provides useful indications for future studies. However, cross-sectional studies can only point to statistical associations between variables and cannot, alone establish causality. Also they have been criticised because they involve retrospective questioning and the potential for selectivity in recall and hence recall bias (Bowling, 1997b). To minimise these effects great care should be taken in the design of the questionnaires and in their psychometric validity. In the present thesis two cross-sectional studies were conducted.

Longitudinal research involves measuring of behaviours, attitudes, beliefs or events at more than one period of time. It tends to be either panel (follow-up of the same population) or trend (different samples at each data collection period). The most important advantage of this type of study is the opportunity to follow individuals and to assess the impact of events on the indicators used. Unlike cross-sectional studies a well-conducted longitudinal study could suggest a causal relationship between the different variables. This method is also of value for studying the effects of new interventions. It is also useful for studying trends in behaviours and attitudes, as greater precision will be obtained when measuring changes than with a series of cross-sectional surveys (Bowling, 1997b).

However, longitudinal studies have also several disadvantages. They require careful definitions of the groups to be studied and careful selection of measured variables. Also, they are very expensive, take a long time and require a great deal of administration, computing and efforts in order to minimise sample attrition (Bowling, 1997b). In relation to this last aspect, people may drop out of the study as time goes by mainly because of inaccessibility due to geographical moves or unwillingness to continue co-operating with the study (Coolican, 1990; Robson, 1993). It is necessary

to control those who remain in the study because they could turn into a biased sample. Statistical comparisons are needed between those who remain in the study and those who drop out in order to decide if they are different in relation to the variables studied or are more complaint or more interested in the topic. As the data need to be collected at more than one time interval, it is necessary to consider strategies for re-contacting people and ways to motivate them to continue participating. Additionally, anonymity cannot be claimed because the researcher will need to identify respondents' questionnaires/interviews (Fife-Schaw, 1995).

This thesis conducted a longitudinal study with follow-up measures sixteen months after the first measure, in order to evaluate the predictive value of sociodemographic and psychosocial variables at Time-1 in relation to health indicators at Time-2 in a group of working women. It considered the methodological requirements mentioned above.

3.3. - Self-report Measures

Most of the information used in social sciences is based on self-report of feelings, attitudes, beliefs and behaviours by people in an interview situation or in response to self-administered questionnaires. Health psychology has relied most heavily on self-report procedures both in quantitative or qualitative approaches (Branon & Feist, 1992).

One of the strengths of self-report measures is that they provide factual statements of subjective assessments of the person's experiences (e.g. feelings, thoughts, attitudes, beliefs, self-perception of health).

The use of self-report measures has been reinforced with the conceptual advances of personality theories and the influence of social cognitive theory (Bandura, 1987, 1997), which highlight the role of cognitions in the explanation of psychological functioning and therapeutic intervention (Mahoney, 1983; Meichenbaum, 1977).

Self-reports can be used not only for exploring the cognitive component but also for measurement of the physiological or behavioural response components (Lang, 1978). According to Cone (1979) the modality of response depends on its referents. For example, when someone says, "I avoid social situations", his/her statement gives information about his/her behavioural response while "I tremble when I have to speak in public" refers to the physiological response. It means that through the cognitive-behavioural assessment method and using self-report as the tool one can assess either the physiological or behavioural component when external objective information like direct observation or physiological measures are not possible (Fernández-Ballesteros, 1994).

The disadvantages of self-report measures are mainly related to establishing the reliability and validity of the measures due to problems such as social desirability and faking of the information. These issues are widely described in the psychometric literature (Fernández-Ballesteros, 1994).

Research studies that investigate health self-report have received special interest in the last decade. Moun (1992) provided four reasons why such research has been and is necessary:

a) Due to its subjective nature, self-reports can be compared to other more objective health measurements such as medical examination or physiological measurements, which make it possible to expand population morbidity studies.
b) Self-assessment of health may be used to monitor health seeking activities such as health promotion and prevention, as well as the adequate use of the health service system, correct use of medication and other care and prevention measures.
c) Self-assessment works as a variable that intervenes in the presence of diseases; it is a subjective measurement of life quality and well-being.
d) Self-report has become a predictive indicator of mortality.

Idler and Angel (1990) conducted a study with 6,440 individuals between 25 and 74 years of age, who were part of a national epidemiological study. Participants had a complete medical examination which included a detailed clinical evaluation,

laboratory tests and special tests such as audiometer, spirometry and electrocardiograph, among others. The study also took into account socio-demographic variables (age, sex, educational level, married status, employment and income). Results showed that older individuals, smokers, consumers of excess alcohol, divorced people or individuals without a partner and the unemployed had a negative perception of their health and higher mortality.

Segovia, Bartlett and Edwards (1989) in a study of 3.300 participants, found an association of health self-report with healthy habits such as sleeping hours, smoking, physical exercise and consumption of alcohol. These results show that health self-reports expressed in categories of excellent, good, fair and poor are, in general, valid and reliable health indicators and good predictors of practices associated with health habits, specifically physical exercise and cigarette consumption. Both aspects can be verified biologically and clinically, and constitute factors of cardiovascular and respiratory risk.

The present research used different indicators for the measurement of self-perception of physical health. The first indicator is self-perception of health in terms of excellent, very good, good, poor and very poor. Other indicators were: alcohol and cigarette consumption, sports, sleeping. Morbidity indicators are explored: medical and psychological appointments, work absenteeism, staying in bed because of health problems.

In relation to the measurement of mental health (Barnett & Marshall, 1991), the lack of symptoms does not necessarily indicate the presence of a state of well being. There is enough support, both theoretical and empirical, in the field of personality psychology to support the notion that the "mental health" construct is made up of two dimensions, the subjective state of well-being and psychological distress (Barnett & Marshall, 1991). In the present research measures of psychological distress as well as self-esteem and well-being were included.

Two methods of data collection based on self-report were used: structured questionnaires and a semi-structured interview.

3.3.1. - Structured Questionnaire

Questionnaires are probably the most common research tool in social sciences (Fife-Schaw, 1995). One of the advantages of structured questionnaires is the ability to collect unambiguous and easy to count answers, leading to quantitative data for analysis. It is also relatively economical in time, effort and money, and applicable to large samples of people (Robson, 1993; Bowling, 1997b). Their main disadvantages could be that the pre-coded response choices may not be sufficiently comprehensive and not all answers of the questionnaires may be easily accommodated. It means that some respondents may be forced to choose inappropriate answers or will not answer the item. Another disadvantage is that there is little or no check on the honesty or seriousness of responses (Fife-Schaw, 1995). Robson (1993) presents in his book useful guides for the design and construction of a questionnaire. In section 3.5 the different questionnaires used in the quantitative studies will be described.

3.3.2. - Semi-structured Interview

Semi-structured interviews or focused interviews are often used in qualitative research. The questions are contained in an interview guide with a focus on the issues to be covered (Kvale, 1996; Mason, 1996; Barribal & While, 1994). The sequence of questions is not the same for every participant as it depends on the process of the interview and the answers of each individual. The interview guide, however, ensures that the researcher collects similar types of data from all informants (Holloway & Wheeler, 1996). The interview guide focuses on particular aspects of the subject area to be examined, but it can be revised after interviewing because of the new issues that arise (Holloway & Wheeler, 1996; Mason, 1996). Researchers use semi-structured interviews in order to gain a detailed picture of respondents´ beliefs or accounts of a particular topic (Smith, 1995).

According to Smith (1995) the advantages of using semi-structured interviews are: They facilitate rapport/empathy, allow a greater flexibility of coverage and enable the interview to enter novel areas, and tend to produce richer data. Also, the semi-

structured interview has the potential to overcome the poor response rates associated with questionnaire surveys (Bowling, 1997b; Barribal & While, 1994).

Semi-structured interviews also have disadvantages that should be considered before deciding to use them as a method for data collection. For instance, this form of interviewing reduces the control the investigator has over the situation, is harder to analyse, has higher costs in term of time consumed and requires trained interviewers in order to avoid biased responses that affect the quality and accuracy of the information obtained (Smith, 1995; Coffey & Atkinson, 1996; Mason, 1996; Creswell, 1993). Nevertheless, these disadvantages are overcome by its many advantages.

The assessment procedure used in the Qualitative Study was a semi-structured interview. It aimed at exploring more in-depth the psychosocial and health variables in working women with multiple roles. It was designed to elicit the feelings, beliefs, attitudes and life experiences of working women by evaluating a series of psychosocial variables (quality of the role, work-family relationship, distribution of household responsibilities and the relationship to their physical and mental health, including the subjective perception of the individuals and the meanings attributed to their experiences). The interview was planned as a face-to-face encounter between two people who were going to have a flexible, dynamic, non-directive and open conversation (Taylor & Bodgan, 1984; Mason, 1996; Smith, 1995).

The protocol was based on a review of the literature as well as on questionnaires that had already been used. The following subjects were covered:

- The perception of quality in the roles as a partner, mother and working woman.
- The perception of the work-family relationship.
- The distribution of responsibilities at home (perception of equity).
- The perception of the physical and mental health.

A first version of an interview schedule was designed and discussed with experts in qualitative research. This was piloted with 3 volunteers who offered to co-operate at this stage of the study. Some of the changes refer to wording, ways of presenting the sensitive

issues and shortening some questions. These were necessary in order to make the questions as clear as possible for the interviewees.

At the end of the interview, the interviewees had the opportunity to raise any other issues that were not covered by the interview schedule. The average length of time for the interview was approximately one (1) hour and a maximum time of two (2) hours. The semi-structured interview schedule is in Appendix 2.

3.4. Instruments

The different instruments used for measuring of psychosocial and health variables in the quantitative studies will be described. Relevant information is presented as well as details about translation, cultural adaptation and content. In relation to psychometric procedures, reliability was calculated for each questionnaire using Cronbach's alpha for internal consistency. Factor Analysis using Principal Component Analysis was also conducted with varimax rotation and eigenvalues higher than 1. Predictive validity using different health measures was also calculated.

3.4.1. - Psychosocial Measures

Role Quality Scales

- **Background and Purpose**

The quality of experience within each of the worker, partner and parent role was assessed by modified versions of scales by Baruch and Barnett (1986) and Barnett and Marshall (1989). The role as a worker, partner and mother /father measures both, positive (rewarding) and negative (distressing) aspects of each role. A balance score (the difference between the mean reward score and the mean concern score) that constitutes an index of the quality of experience in each role was also calculated.

The method for the development of the second version of the original scale is described in the Manual for the Role-Quality Scales (Barnett & Marshall, 1989). This

original scale includes 157 items and the respondents are asked to rate their current experience in each role on a four-point scale (1= not at all rewarding or concerning, to 4= extremely rewarding or concerning). The authors reported appropriate alpha coefficients using Cronbach's Alpha and test-retest methods in each role ranging from 0.70 to 0.93. Concurrent validity showed that reward and concern scales were moderately but significantly correlated in the expected direction with mental and physical health indicators. Confirmatory Factor Analysis was also carried out (Barnett & Marshall, 1989).

- **Content**

For the present thesis, two versions of the scales published by Baruch and Barnett (1986) and Barnett and Marshall (1989) were used. Both versions were translated, back translated and adapted to Spanish by Feldman, Chacón and Payne (1995).

The first version of the scale contained 96 items divided according to the quality (rewards and concerns) of women as workers (38 items), partners (30 items) and mothers (28 items) and answered on a four point Likert scale (1= not at all rewarding or concerning to 4= of extremely rewarding or concerning) as in the original Baruch and Barnett (1986) published scales. This version was used in Study 1 (Appendix 3).

Studies 2 and 3 used the second version of the questionnaire described in the Manual for the Role-Quality Scales by Barnett and Marshall, (1989). This version was sent and suggested by the authors after a personal meeting with Dr. R. Barnett. Several items within the job, partner and mother roles were modified and/or eliminated to adapt the questionnaire to the Venezuelan and Latin American cultural characteristics. As in Study 1 it was found that religious support was an important variable related to health, 7 items related to this were included in relation to the partner (n=6) and mother roles (n=1). The questionnaire contained a total of 146 items (Job role, 57 items; partner role, 56 items; mother role, 33 items) (Appendix 4).

- **Reliability and Predictive Validity**

In the 96-item version, Cronbach's alpha ranged from 0.88 to 0.98. For the 146-item version, Cronbach's alpha ranged from 0.83 to 0.96. Both versions of the Role Quality Questionnaire showed appropriate predictive validity with the different health measures used. (Appendix 5).

- **Factor Analysis**

A Principal Component Analysis was conducted only for the second version of the questionnaire because of the sample size (n= 417). A Four-factor solution was found for both the rewards and the concerns associated with the Job Role, which explained 47.1% of the variance for the rewards and 44.2% for the concerns (Table 3.1). As for the Partner Role, 3 factors were found that explained 57.2% of the variance for rewards and 48.4% for concerns (Table 3.1). In relation to the Mother Role, 3 factors explained 53.4%.

Table 3.1: Role-Quality Factors

Factors	Eigenvalue	% Explained Variance	% Accumulated variance
Job Reward Factors			
Factor 1 Supervisor support	9.22356	30.7	30.7
Factor 2 Decision authority/Skill discretion	1.78771	6.0	36.7
Factor 3 Satisfaction with the salary / promotion and recognition	1.60146	5.3	42.0
Factor 4 Co-workers support and helping others	1.50755	5.0	47.1
Job Concerns Factors			
Factor 1 Overload	6.011055	22.3	22.3
Factor 2 Monotony	2.84066	1.5	32.8
Factor 3 Dissatisfaction with the salary / lack of recognition and promotion.	1.76600	6.5	39.3
Factor 4 Job conditions	1.31564	4.9	44.2
Partner Reward Factors			
Factor 1 Marital satisfaction and compatibility	14.82132	47.8	47.8
Factor 2 Partner support	1.59032	5.1	52.9
Factor 3 Religious beliefs	1.32153	4.3	57.2
Partner Concern Factors			
Factor 1 Marital dissatisfaction, lack of support and communications	8.28990	33.2	33.2
Factor 2 Partner job	1.98472	7.9	41.1
Factor 3 Religious beliefs	1.83562	7.3	48.4
Mother Reward Factors			
Factor 1 Satisfaction	5.90651	36.9	36.9
Factor 2 Support and communication	1.51923	9.5	46.4
Factor 3 Interaction	1.11337	7.0	53.4
Mother Concern Factors			
Factor 1 Conflicts, dissatisfactions	4.868	28.63	28.63
Factor 2 Demands and interferences	1.905	11.20	39.84
Factor3 Economical strain, adolescent period	1.288	7.57	47.41

The tables with the factor structure and loadings for job, partner and mother role quality analysis factor are included in Appendix 6.

Social Support Questionnaire

- **Background and Purpose**

This scale measures the perception of availability of different sources of social support. It was originally developed by Fleming, Baum, Gisriel and Gatchel (1982) who developed a six-items short version to assess perceived general social support. A longer version was created by Dunn, Putallaz, Sheppard and Lindstrom (1987) with the purpose of assessing the relative importance of various sources of support in adolescent adjustment. This extended version consists of 25 items making up five subscales: general support, support from family, friends, neighbors and opinions

regarding the importance of social support. The Dunn et al. (1987) version was translated to Spanish and adapted by Bagés, Feldman, Chacón, Pérez and Guarino (1990) for working adults in the Venezuelan population (Appendix 3). This scale was used in Study 1.

- **Content**

It includes 18-items to be responded on a 4 point Likert scale (1= No, never to 4= Yes, always). For each item respondents are asked how often each kind of support is available to them. It includes different subscales that measure the perception of availability of different sources of social support.

- **Reliability and Predictive Validity**

Cronbach's alpha coefficient was calculated in different studies carried out in Venezuela (Bagés, Feldman, Chacón, Pérez & Guarino, 1990; Calvanesse, 1992; Guarino & Feldman, 1995) ranging from 0.73 to 0.78. For the present study the Cronbach's alpha coefficient was 0.74.

Significant and negative correlations between total social support with total General Health Questionnaire (GHQ) as well as with the dimensions of GHQ were found. Social support was also positively related to a better perception of physical health. No significant associations were found with the morbidity indicators (Appendix 5).

- **Factor Analysis**

In a sample of 246 working people a 6-factors solution was found explaining 61.1% of the total variance. These six factors were related to family support (21%), partner support (10.1%), availability of general support (9.4%), support coming from groups and religion (7.3%), job support (7.1%) and the perception of lack of social support (6.3%) (Table 3.2).

Table 3.2: Social Support Factors

Factors	Eigenvalue	% Explained Variance	% Accumulated variance
Factor 1: Family support	3.77	21.0	21.0
Factor 2: Partner support	1.81	10.1	31.1
Factor 3: Perception of general support	1.68	9.4	40.4
Factor 4: Religious and groups support	1.31	7.3	47.7
Factor 5: Job support	1.26	7.1	54.8
Factor 6: Lack of social support	1.12	6.3	61.1

The table with the factor structure and loadings for social support analysis factor is in Appendix 6.

Interview Schedule for Social Interaction

- **Background and Purpose**

It was developed by Henderson et al. (1980). The conceptual definition of support was based on the theory that social relations are based on attachment, social integration, nurturance, reassurance of personal worth and sense of reliability. The scale was used in a sample of 130 people in health centers, outpatient departments, in a club for the elderly and in a general population sample. It was reported to be acceptable to both healthy and psychiatrically disturbed respondents (Bowling, 1997a). The original scale comprises 52-items which measure availability and perceived adequacy of a wide variety of social contacts (networks) and emotional support (attachment), provided by close relationships.

A short 12-items version of the scale has been developed by Unden and Orth-Gomer (1989) for use in population surveys and to prove its capacity for predicting differences in risk factor levels for ischaemic heart disease. This version has similar levels of reliability, validity and discriminative ability as the full scale and has been used in several studies (Unden & Orth-Gomer, 1989; Horsten, Wamala, Vingerhoets & Orth-Gomer, 1997; Orth-Gomer, Rosengren & Wilhelmsen, 1993). This short version yielded two scales, one describing availability of deep emotional support or "attachment" (6 items) and another describing availability of the more peripheral contacts of social networks or "social integration" (6 items). Both consist of six-items continuous scales with ranges in scores from 0 to 6 and 6 to 36, respectively. Orth-

Gomer and Wamala (1994) developed a more condensed version (9 items) for the Project "Multiple Roles and Health in Working Women: Cross Cultural Comparisons" (4 items for Emotional Support; 5 items for Social Integration). The Scales were translated and back translated by Feldman et al. (1995) for use with the Venezuelan population. This last version was used in studies 2 and 3 of the present thesis (Appendix 4).

- **Content**

The sub-scale for emotional support has 4 items with a minimum score of one and a maximum score of 4. The sub-scale of Social Integration has 5 items with a total score ranging from 5 to 30.

- **Reliability and Predictive Validity**

Cronbach's Alpha coefficient is the same (0.76) for social integration and social attachment as they are two dimensions of the same questionnaire.

Significant positive correlations were found for Social integration with health perception of physical health, self-esteem and well-being. Also, Social integration associated negatively with depression and symptoms. Significant but lower and positive correlations ($p < .05$) were found for Emotional support with anxiety, depression and symptoms report (Appendix 5).

Work-Family Relationship Questionnaire

- **Background and Purpose**

Small and Riley (1990) proposed that the work-family relationship could be evaluated through a questionnaire that would refer to the possible relationship between the activities of the work and family roles. For this purpose, the authors stated that it is necessary first to evaluate those activities bearing in mind three elements: the time, the energy and the psychological dedication generated by each of these activities.

Secondly, these elements should be evaluated in each of the following contexts: the marital relationship, relationships with the parents, responsibilities at home and recreational activities.

The authors developed a 20-items questionnaire. Five items evaluate the possible interference of the family role and the work role, 5 refer to the relationship with parents, 5 to the distribution of responsibilities at home and 5 to recreational activities. Strong support was found for the construct validity and internal consistency of the global measure of work-family relationship (Small & Riley, 1990).

The questionnaire developed by Small and Riley (1990) only considered the interferences or negative aspects that could be generated when relating activities carried out in the work role with those performed in family roles. This is a great limitation in evaluating the variable inasmuch as it does not include the positive aspects or satisfactions of this relationship.

Faced with this limitation, for the present research a modified version was developed. It incorporates the satisfactions or positive aspects that could be generated upon relating family and work. The instrument has 12-items, 4 of which evaluate the possible satisfactions generated in relating work and family while 8 items measure possible interferences. This questionnaire was used for studies 2 and 3 (Appendix 4).

- **Content**

The scale consisted of 12- items to be answered on a 4-points scale.

- **Reliability and Predictive Validity**

The resulting internal consistency of the questionnaire was appropriate (0.73) using Cronbach's Alpha.

Satisfactions from work and family were negatively associated with anxiety. Interferences between work and family were associated with higher level of depression

and negatively related to self-perception of physical health, well being and self-esteem (Appendix 5).

- **Factor Analysis**

A factor analysis was performed, resulting in two factors (Interference of work, home, partner and children, and job rewards with other roles), which explain 44.5% of the variance (Table 3.3).

Table 3.3: Work -Family Relationship factors

Factors	Eigenvalue	% Explained variance	% Accumulated variance
Factor 1 Interferences	3.77979	31.5	31.5
Factor 2 Satisfactions	1.55433	13.0	44.5

The tables with the factor structure and loadings for Spillover analysis factor are in Appendix 6 .

Distribution of Household Responsibilities Questionnaire

- **Background and Purpose**

The distributions of household tasks and child rearing have been considered as sources of overload for women and conflict and stress between the spouses (Mayor, 1993). It was considered in the present study because of its close relationship with health and well-being (Peterson & Gerson, 1992; Almeida et al., 1993).

Household labour allocation has been measured in different ways. Some measures consist of creating lists of household tasks and asking how often various household members accomplish each task (Coleman, 1987; Thompson & Walker, 1989). Other measures have been created to indicate the balance of "feminine" and "masculine" tasks (cf. Blumstein & Schwartz, 1983), to measure men's participation in traditional female tasks (cf. Brayfied, 1992) or to assess the estimated number of hours per week women and their husbands spend on household chores (Piña & Bengtson, 1993).

Mederer (1993) developed a questionnaire, which included a 19-items list of

household activities representing three dimensions of family work: caring for the home, caring for family members, and dealing with transactional matters. Many of the 19 items were derived from the extensive list that Berk and Berk (1979) generated from time diaries. The items chosen represent corresponding household management and tasks (e.g., making a grocery list, doing grocery shopping). Child care items were not included in this questionnaire

Mederer's questionnaire was translated, back translated and adapted to the Spanish population. The adapted version of the questionnaire was used for studies 2 and 3 (Appendix 4).

- **Content**

The questionnaire assesses the management of the tasks, which consists of 7 items, and the performance of the tasks (23 items). The present scale included items related to childcare, which are not in Mederer´s scale. The items were responded on a 6-points scale (1= other persons like maid; 2= your partner usually; 3= your partner always; 4= sharing with your partner or others; 5= you usually and 6= you always). The category of "Others" was added since a significant proportion of Latin American families have live-in domestic help or extended family members.

- **Reliability and Predictive Validity**

Cronbach´s alpha coefficient was calculated for the present research and it revealed adequate internal consistency values that ranged from 0.72 for the management factor and 0.86 for the tasks performance.

Both management and tasks were associated with anxiety and depression (Appendix 5).

- **Factor Analysis**

A Principal Component Analysis was conducted in a sample of 417 women for the Management and Tasks dimensions separately. For the Management dimension, a 2 factors solution emerged which explained 63.8% of the variance; for the Tasks performance dimension 4 factors were found which explained 57.7% of the variance (Table 3.4).

Table 3.4: Distribution of household responsibilities for the Management and Tasks dimensions Questionnaire

Management Dimension	Eigenvalue	% of the variance	% Accumulated variance
Factor 1 General management and decisions	2.97647	42.5	42.5
Factor 2 Management of the meals	1.48871	21.3	63.8
Tasks Dimension			
Factor 1 Tasks related with home	5.59652	25.4	25.4
Factor 2 Children care	4.33408	19.7	45.1
Factor 3 Others tasks	1.52460	6.9	52.1
Factor 4 Home maintenance	1.26101	5.7	57.8

The tables with the factor structure and loadings for the Management and Task dimensions analysis factor are in Appendix 6.

3.4.2. - Physical and Mental Health Measures

General Health Questionnaire (GHQ)

- **Background and Purpose**

The GHQ is a widely used scale of psychological morbidity. This measure assesses symptoms of emotional distress in four areas: anxiety/insomnia; somatic symptoms; social and cognitive dysfunction and depression. The GHQ was developed in London in the 1960s and 1970s for use in general practice settings. It is one of the most widely applied self-completion measures of psychiatric disturbance in the UK and has numerous worldwide applications (Goldberg, 1972). It is the most extensively tested scale for reliability, validity and sensitivity to change across the world, and the results are good. The original version consists of 60 items, although shorter versions with 30, 28, 20, and 12 items exist (Bowling, 1995; 1997a).

The GHQ was designed to be self-administered and has been administered by postal survey and by interview (Bowling, 1995; 1997a). It is sensitive to transient disorders and detects symptoms of at least two weeks' duration. It is also as sensitive to depression disorders as any of the specifically designed depression scales (e.g. Hospital Anxiety and Depression Scale) and also detects anxiety disorders (Bowling, 1997a).

It consists of a series of statements and respondents were asked to compare their recent experience with their usual state on a four-point scale of severity. The scoring scale consists of 0 or 1 and the overall GHQ is the sum of the item scores. Threshold scores are defined as equivalent to the concept of caseness, which is the average patient referred to psychiatrists. There is a need for manipulating the threshold score to enhance discrimination in different populations as, for example, physically ill people score highly and are over-represented among false positives (Bowling, 1995, 1997a).

Although the GHQ is culture specific in development, it works well in other settings, e.g. among both white and black people in Philadelphia, in Calcutta, China, Brazil and Australia (for a review see Goldberg and William, 1988; Bowling, 1997a). The GHQ-60, GHQ-30 and 28 versions were also adapted into Spanish (Muñoz, Vásquez,, Pastrana, Rodríguez, & Oneos, 1978; Lobo & Gimeno Aznar, 1981) and have been used in epidemiological studies in Spain (Muñoz, Vásquez,. & Madoz, 1983). Lobo, Pérez-Echeverria and Artal (1986) confirmed the validity of the Spanish version of the GHQ in its scaled 28-items version in a sample of 100 patients attending an internal medicine outpatient clinic.

Internal consistency was calculated using Cronbach's Alpha coefficients in samples of Venezuelan university students and it ranged from 0.73 to 0.94 (Guarino, Gavidia, Antor & Caballero, 2000).

- **Content**

The Spanish version of the GHQ-28 was used in Study 1 (Lobo & Gimeno Aznar, 1981; Lobo, Pérez-Echeverria & Artal, 1986). (Appendix 3)

- **Reliability**

Cronbach's alpha coefficient for the total questionnaire was 0.83 and for each scale ranged between 0.73 and 0.91. It revealed adequate internal consistency values.

State- Trait Anxiety Inventory

- **Background and Purpose**

The State-Trait Anxiety Inventory (STAI) was developed in the 1960s, and revised in 1983 (Spielberger, Gorsuch, Luchene, et al. 1983). It measures tendency to anxiety and current feelings of anxiety. The STAI is one of the most widely used measures of anxiety in psychological and clinical research. It has been translated to more than 20 languages and validated for use in cross-cultural studies (Bowling, 1995, 1997a).

The Alpha coefficient for the STAI has been reported to be high for state (r=0.93) and trait (r=0.90) anxiety, indicating internal consistency. Test-retest correlations with college students showed stability for the trait scale (0.65-0.86), but less so for the state scale (0.16-0.62), although lower repeatability of the state scale would be expected as it measures responses to transient situations (Spielberger et al., 1983). In relation to construct validity, the scale has been tested against other anxiety scales and produced correlations between 0.52 and 0.80, with the lower correlation probably reflecting weaknesses in one of the other scales. It also correlates well with other tests of personality (Bowling, 1995). The scale is able to distinguish between normal adults and different groups of psychiatric patients and the STAI-state showed higher mean values in stressful situations than in neutral or relaxed situations (Spielberger et al., 1983). Forsberg and Bjorvell (1993) reported that the STAI-state was significantly associated with the Rand Health Perceptions Battery. It would be expected that the

better the perception of health, the lower the rated anxiety. In a review of the scale, Chaplin (1984) concludes that the measure of state anxiety is stronger (in terms of validity) than the measure of trait anxiety (Bowling, 1995).

The scale was translated into Spanish and validated in different samples and different countries (Diaz-Guerrero & Spielberger, 1975; Granell & Feldman, 1981) for its use in Spanish populations. Reliability and validity were appropriate.

The state- anxiety scale was used in Studies 2 and 3, because their objective was to measure emotional state and feelings of tension and apprehension and heightened autonomic nervous system activity of women who perform multiple roles at particular times (Appendices 4 & 7).

- **Content**

The STAI consists of 20 items for measuring state anxiety and 20 items for measuring trait anxiety (Spielberger et al., 1983). The STAI is printed on a single sheet, with the state-anxiety scale on one side and the trait-anxiety scale on the other. Each state item is rated on a 4-points intensity scale (1= not at all to 4= very much so). Respondents are asked to indicate how they feel right now. Each trait item is rated on a 4-points scale (1= almost never to 4= almost always) (Bowling, 1995).

- **Reliability**

Cronbach´s alpha coefficient was 0.93 and it revealed adequate internal consistency values.

Depressive Symptoms Scale

- **Background and Purpose**

Depressive symptoms were measured by means of a 10-items questionnaire derived from Pearlin, Liberman, Menaghan and Mullan (1981). This questionnaire was based on Derogatis, Lipman, Covi and Rickles (1971) and Lipman, Rickless, Covi, et al. (1969) depression questionnaires. One question, about sexual activity, was excluded in an effort to avoid potentially threatening items. The scale includes questions on mood, sleeping problems, appetite, energy, crying, interest in normal activities and feelings about the future. The questionnaire was translated into Spanish and back translated into English. It has been used in different studies carried out in Latin America (Gómez et. al, 2000; Feldman, Bagés & Vivas, 1997) and in Sweden with healthy middle-aged women (Horsten et al., 1997). The scale had an adequate internal consistency (Cronbach´s alpha ranging between 0.71 and 0.85) and it significantly correlates (r= .71) with the Beck Depression Inventory (Horsten et al., 1997). This scale was used for Studies 2 and 3 (Appendices 4 & 7).

- **Content**

The questionnaire consists of 9-items to be responded to on a 4 points Likert scale where 1=No, never and 4= extremely.

- **Reliability**

The questionnaire had an appropriate internal consistency (Cronbach´s alpha= 0.72).

Symptoms Report List

- **Background and Purpose**

A self-report list of physical and psychological symptoms based on the Individual Excitability Questionnaire was used. This questionnaire was originally designed by Gunther (1980) and consisted of 54 items that measured the three components of the stress response: the subjective-cognitive, physiological and behavioural-motor responses. This questionnaire was translated into Spanish, adapted and validated by Canino, Groeger and Robles (1994). It consists of 49 items to be responded to on a 4-point scale (1= Never, not intense to 4= Always, very intense). The reported coefficient using Cronbach's Alpha and Guttman-Rulon ranged from 0.88 to 0.91. The Spanish version of the list was modified and reduced based on a factor analysis carried out by Canino et al. (1994) for the present research. The items selected, based on the factor analysis, load up to 0.45. This list was used in Study 2 and 3 (Appendices 4 & 7).

- **Content**

A 13-items list to be responded on a categorical scale (1= No, absence and 2= Yes, presence) was used.

- **Reliability**

The Cronbach's Alpha in the modified questionnaire was 0.74.

Self-esteem Scale

- **Background and Purpose**

Self-esteem is the overall affective evaluation of one's self-worth. It has long been viewed as a relevant variable in the study of adjustment to chronic illness (Moos & Tsu, 1977; Turk, 1979) and a protective factor against stress, psychopathology and

adversity (Pearlin et al., 1981; Rolf, Masten, Cicchetti, Nuechterlein & Weintraub, 1992).

Self-esteem was assessed by the widely used Rosenberg scale (Rosenberg, 1965), which describes self-esteem as self-acceptance or a basic feeling of self- worth. The scale consists of 10-items, scored from 1 to 4 (strongly agree to strongly disagree). Rosenberg (1965) developed the Self-Esteem Scale for a study of 5,024 students in public schools in New York. The measure was intended to be brief, global and unidimensional. It has been widely used in varied settings (Atchley, 1976; Ward, 1977). Reliability has been shown to be good. The reported coefficients ranged between 0.85 and 0.92 (Rosenberg, 1965; 1986). Also test-retest reliability showed appropriate reliability (0.85). Convergent and construct validity has been reported (Rosenberg, 1965; Robinson & Shaver, 1973). The scale is attractive due to its brevity and simplicity (Bowling, 1997a) and is highly recommended by George and Bearon (1980 c.b. Bowling, 1997a).

The scale was translated into Spanish and back translated into English and was used in studies 2 and 3. After a pilot study of 30 women of different educational levels, all the items were reworded in positive format (Appendices 4 & 7).

- **Content**

After the item analysis was carried out, 3 items were eliminated because of their low correlations with the total score. Finally, the 7-items Spanish version using the same 4-points scale was used.

- **Reliability**

Appropriate internal consistency was found using the Cronbach's alpha coefficient (0.852).

Self-perception of Physical Health

Physical health was measured using 5 points on a continuum scale (1= very poor; 2= poor; 3=good; 4= very good and 5= excellent). The question was: How do you perceive your physical health in general in the last six months?

Morbidity Indicators

To assess morbidity, participants were asked whether they had or had not seen a doctor or a mental health professional in the last 6 months and how many times, whether they had been hospitalised in the last five years and in the last 6 months, how many days they failed to go to work and stayed in bed due to health reasons in the last 6 months (Appendices 3,4 & 7).

Health Habits

Health habits were associated with health risk factors or factors protecting against certain diseases such as: smoking, number of cigarettes per day, participation in sport and its frequency, alcohol consumption and amount, sleeping problems (Appendices 4 & 7).

Well-being Scale

Well-being was measured through a 10-points scale (1= No satisfaction or Well-being to 10= Very much). Women had to evaluate their level of well-being or satisfaction with their life in the last 12 months.

Table 3.5 shows a summary of the different measures used in the quantitative studies

Table 3.5: Summary of the Measures used in the Quantitative Studies

MEASURES	STUDY 1	STUDY 2	STUDY 3
Role Quality	X	X	X
Social Support (Sources)	X		
Social Integration	-	X	X
Emotional Support	-	X	X
Household responsibilities	-	X	X
Work-Family Relationships	-	X	X
Self-perception of Physical Health	X	X	X
GHQ	X	-	-
Anxiety	-	X	X
Depression	-	X	X
Symptoms Report	-	X	X
Self-esteem	-	X	X
Well-being	-	X	X
Morbidity indicators	X	X	X
Health habits	X	X	X
Sociodemographic variables	X	X	X

CHAPTER 4

STUDY 1: " Multiple Roles, Role Quality, Social Support and Health in Working Women "

The present study has a special interest in exploring diverse aspects of role characteristics and social support in Venezuelan working women. Clerical workers were selected because according to the demand-control model of job stress (Karasek & Theorell, 1990), secretaries would fall within the quadrant of high-strain jobs with adverse health consequences.

4.1. - Objectives

The objectives of this study were: 1. To evaluate the impact of the number and types of social roles on mental and physical health in a group of working women. 2. To evaluate the quality of social roles and social support in working women and their relation to mental and physical health. 3. To test the moderating effects of social support dimensions on the relationship between role-concerns and health indicators.

4.2. - Method

Participants

Participants were selected from the total population of female employees (n=531) from a public university in Caracas-Venezuela. The sample was chosen at random and stratified according to age and occupational status. Two hundred (37.66% of the total population) participants were originally selected and 150 responded to the invitation to participate (75% response rate). Twenty-eight women were eliminated from the study because they did not return or fully completed the questionnaires. The final sample was composed by 122 women (mean age 38.9; SD= 9.04 years) who worked as clerical, secretaries and office staff.

Procedure

The participants who were originally selected by sampling procedures received a description of the project and an invitation to participate (Appendix 7). All employees who agreed to participate attended a meeting in a group of 30, and answered the questionnaires after the meeting. A total of five meetings took place. Those participants, who did not attend the first call, received a second reminder offering them the opportunity to attend another meeting and fill in the questionnaire. In order to ensure confidentiality each participant was assigned a random code number.

Statistical Analysis

The participants were described in terms of sociodemographic and health characteristics. The data were analysed using analysis of variance (One-way ANOVA) for the health and psychosocial variables according to the types of roles (single employed, employed mother, employed, mother and wife). *Post hoc* analyses were carried out using Bonferroni´s test.

Hierarchical Multiple Regression analysis was the statistical technique used to evaluate main and interactive effects among sociodemographical, psychosocial and health variables. Although this method is the most widely used in the literature on social roles, psychosocial variables and health in working women (Barnett & Baruch, 1985; Baruch, & Barnett, 1986; Aston & Lavery, 1993; Luchetta, 1995; Noor, 1995a, b; Christensen et al., 1998; Oster & Scannell, 1999; Gómez et al., 2000, among others), an exploratory analysis was performed using stepwise regression analysis, and the results between the two methods were very similar. Independent variables were entered in a predetermined sequence according to their theoretical and empirical support, and also in order to determine their specific contribution to the model (Cohen, 1978). Sociodemographical variables were

entered in the first steps. Age, education and having pre-school children or not were included in the first step, while the second step included role occupancy and the third step occupational level. Dummy variables were created for the three roles as well as for the occupational status. Social support was the first psychosocial variable to be entered in the regression due to the fact that, social support is one of the psychosocial factors that has accumulated more theoretical and empirical research in the last 30 years, especially in relation to health (Brown & Harris, 1978; Cohen & Willis, 1985; Cohen, 1990; Berkman & Syme 1979; Orth-Gomer et al. 1998; Orth-Gomer & Johnson, 1987; Chesney & Darbes, 1998; Sarason et al., 1990 among others). The last variable introduced was role quality since, comparatively, less attention has been given to it in the literature (Barnett & Baruch, 1985; Baruch & Barnett, 1986; Barnett & Marshall, 1991).

R square is reported for each step of the regression, with the significance of the inclusion of these variables in the regression analysis. The standardised beta coefficient for each variable in each step is reported.

To test for interaction terms, hierarchical regression analyses were constructed in the same way described in the preceding paragraph. Independent variables were entered into the analysis in a predetermined order, with control variables entered before the main-and interactive effect terms.

4.3. - Results

Sociodemographic and Health Characteristics

Most participants had an intermediate level of education (high school) although the proportion of less well-educated participants (having only primary school or part of secondary school) was also very high (35%). The sample was composed of clerical

workers, secretaries and office staff (Table 4.1). The number of women with and without a partner was similar. Around 70% of the women had children, and from this percentage 38% (n=35) had at least one child under 7 years old. According to Venezuela's Statistics and Informatic Central Office (OCEI) (1990) and COPRE (1989), this group is representative of the Venezuelan working women population in relation to marital status, education and type of work.

In relation to health indicators, most of the participants perceived themselves as healthy. Nevertheless, a percentage (12.5%) of the sample perceived their health as poor. Examination of health habits showed that the percentage of smokers (27,8%) was similar to that of the epidemiological figures for Venezuela as a whole (34%, Ministry of Health Report, (MSAS) 1998). A quarter of the women exercised regularly (25.5%).

Table 4.1 Sociodemographic and Health Characteristics of Venezuelan Women (*)

Variables		n	%
Age	Young (-36)	38	33.0
	Interm (37-50)	65	55.4
	Older (51-66)	13	10.9
Education	Primary school	41	35
	High school	46	39.3
	University degree	30	25.5
Marital status	With partner	58	48.3
	Without partner	62	51.7
Number of children	No children	21	18.1
	1	31	26.7
	2-3	60	51.7
	> 4	4	3.3
Number of roles	1	21	17.5
	2	40	36.0
	3	57	46.5
Children under 7 years old	Yes	35	37.6
	No	58	62.4
Self-reported Health Scale	Poor	14	12.5
	Good	85	75.9
	Very good	13	11.6
In bed last 6 months	Zero days	62	56.9
	1-5	36	33.1
	6-10	9	8.2
	> 11	2	1.8
Medical appointments last 6 months	0	46	40
	1-3	49	42.6
	4-6	13	11.2
	> 7	7	6.1
Psychological consultation	0	106	89.8
	1-3	9	7.6
	> 4	3	2.4
Work absenteeism last 6 months	0	51	46.4
	1-3	36	32.7
	4-8	7	6.3
Smoking	Yes	32	27.8
	No	83	72.2
Exercise reg. (1/week or more)	Yes	31	25.5
	No	91	74.5

N= 122 * In some cases percentages do not add to 100 due to missing values.

Emotional Distress

When comparing the GHQ scores with the type of roles (Table 4.2), there was a significant effect of type of role on somatic symptoms ($F= 4.79$; $p< 0.01$) and total score of GHQ ($F= 3.32$; $p< 0.05$). These effects were confirmed with *post hoc*

analyses. Women with children but no partner reported significantly more somatic symptoms and, in general, more emotional distress than working women who performed the three roles (worker, mother and partner).

Table 4.2: Means and Standard Deviations (DS) for Emotional Distress and Physical Health in Working Women with Different Roles

	Single Worker (n=21)		Paid worker, Mother (n=40)		Paid worker, Mother & Wife (n=57)		p
	Mean	SD	Mean	SD	Mean	SD	
Total GHQ	5.35	6.45	5.65	5.44	2.92	4.17	.05
Somatic Symptoms	1.40	1.84	2.43	2.42	1.14	1.79	.01
Anxiety /Insomnia	2.20	2.44	2.15	2.43	1.21	2.00	NS
Social & Cognitive Dysfunction	1.00	1.58	0.43	0.89	0.74	1.19	NS
Depression	0.75	1.88	0.12	0.33	0.32	0.94	NS
Self-Perception of Physical Health	3.40	0.82	3.43	0.78	3.30	0.89	NS

NS=non significance

Intercorrelation of Measures

The intercorrelations of the variables used in the present study are shown in Table 4.3 (Appendix 8). Significant and negative correlations were found between self-perception of physical health and staying in bed, work absenteeism and in general psychological distress. Job and mother concern were also related to worst perception of physical health. Education was associated with general support, job concerns and mother rewards. Number of children was not associated with any of the psychosocial or health variables. Having pre-school children was related to partner concerns and more psychological distress.

Role Quality

No significant statistical differences were found when comparing rewards and concerns of each role among the women performing different types of roles. That is, regardless of the fact of having or not having a partner and/or children, job,

mother and partner roles were equally satisfactory or stressful (Table 4.4).

Table 4.4: Means and SD of Role Quality and Social Support based on Type of Roles

Variables	Single Employed (n=21)		Employed mother (n=40)		Employed, Mother & Wife (n=57)		p
	Mean	SD	Mean	SD	Mean	SD	
Role Quality							
Rewards	3,00	0.57	2.89	0.56	3,17	0,51	NS
Concerns	1,46	0.49	1,52	0,47	1,47	0,45	NS
Partner role							---
Rewards	-	-	-	-	3,10	0,69	---
Concerns	-	-	-	-	1,39	0,55	
Mother Role							
Rewards	-	-	2,89	0,56	3,19	0,81	NS
Concerns	-	-	1,52	0,47	1,55	0,64	NS
Social Support							
Job Support	4.68	0.88	4.84	1.48	5.05	1.06	NS
Partner Support	---	---	---	---	6.96	2.50	---
Family Support	7.00	3.74	7.76	3.24	8.26	3.10	NS
General Support	4.60	0.89	4.92	2.01	5.54	1.71	.01
Groups/Religious support	3.40	0.89	4.76	1.69	4.88	2.12	NS
Total Social Support	30.40	6.38	31.76	9.13	36.40	7.30	.001

NS=non significance

Social Support

Significant statistical differences were found when comparing social support according to type of roles. These effects were confirmed with *post hoc* analyses. It was found that employed women with children and a partner perceived more social support ($F=23.69$, $df=2$, $p< .001$) and general support ($F= 4.53$, $df=2$, $p< .01$) compared to single employed and those women who only had children and no partner (Table 4.4).

Relationship between Sociodemographic variables, Role Quality, Social Support and Mental and Physical Health in Working Women with Multiple Roles.

Two hierarchical multiple regression analyses were performed. The first analysis was performed including Social Support (total score) and Role Quality (Table 4.5). The second equation considered the dimensions of Social Support in order to have a better scope of the dimensions of social support, which were specifically associated with health (Table 4.6). In both analyses, self-perception of physical health was controlled for depression and anxiety because significant higher correlations were found between those variables (Appendix 8, Table 4.3.). This was done in order to ensure that findings relating to self-perception of physical health are not contaminated by these covariates. Different studies suggest a relationship anxiety/depression and self-rated health and how mood could affect the association between psychosocial variables such as social support and health (Grosch & Murphy, 1998; Radanov, Schwartz; Frost & Augustiny, 1997). Only the significant health indicators were included in the table.

As Table 4.5. shows, a positive association between social support and health perception was found after controlling for anxiety and depression. However, the variable that explains the higher percentage of the variance was anxiety (17% of the explained variance).

Social support as well as job and partner concerns were related to lower levels of anxiety and general psychological distress (3% and 10% for social support and 14% and 20% for role quality, of the explained variance respectively).

Table 4.5. Hierarchical Regression Analysis for Social Support and Role Quality

Variables	Health Perception	Total GHQ	Anxiety
+ R^2 Incr.	.165		
F	12.55***		
Anxiety	-.306*		
Depression	---		
Sociodemographic Variables			
+ R^2.	.015	.050	.057
F	5.32***	NS	NS
Age	---	---	---
Education	---	---	---
Children < 7 years	---	---	---
Family Roles			
+ R^2 Incr.	.028	.040	.033
F	4.46***	NS	NS
Partner	---	---	---
Mother	-.195*	---	---
Social support			
+ R^2 Incr.	.031	.070	.100
F	4.62***	3.06**	4.69**
Total Social Support	.227*	-.419**	-.387***
RoleQuality			
+ R^2 Incr.	.016	.135	.195
F	2.73**	2.98**	5.95***
Job rewards	---	---	---
Job concerns	---	.241*	.386***
Partner rewards	---	---	---
Partner concerns	---	.203*	.443**
Mother rewards	---	---	---
Mother concern	---	---	---
Cumulative R^2	.255	.295	.385

NS=Non significance * * * p< .001 * * p< .01 * p< .05 N= 122

Note. + Indicates a new step in the regression analysis. At each step, standardised regression coefficients (Beta) are reported for variable entered in the regression at that step.

Table 4.6 showed that the partner and the support from groups and religion seemed to be the most important sources of support in this group when it is health related (6% to 22% of the explained variance). The greater the support provided by the partner, the lower the levels of anxiety and distress, and the less reports of mental health-related problems. Also a positive association between partner support and health perception was found after controlling for anxiety and depression. Individuals reporting high levels of emotional distress, somatic symptoms, social dysfunction and

depression, resorted less to support from groups, institutions and religion. Besides, the greater the perception of support from work, the less anxiety and in general, less emotional distress.

Table 4.6. Hierarchical Regression Analysis for Social Support Dimensions

Variables	Health Perception	Total GHQ	Somatic Symptoms	Anxiety	Social & Cognitive Dysfunction	Depression
+ R^2 Incr.	.125					
F	5.05**					
Anxiety	-.306*					
Depression	---					
Sociodemographic Variables						
+ R^2 Incr.	-.027	---	---	.095	---	.030
F	NS	NS	NS	2.99*	NS	2.93*
Age	---	---	---	---	---	---
Education	---	---	---	---	---	---
Children < 7 years	---	---	---	---	---	---
Family Roles						
+ R^2 Incr.	-.026	---	---	.020	---	.010
F	NS	NS	NS	2.88*	NS	2.83*
Partner	---	---	---	---	---	---
Mother	---	---	---	---	---	---
Social support						
+ R^2 Incr.	.135	.216	.163	.200	.215	.060
F	223*	2.74**	3.45***	3.91***	2.73**	2.44*
Job Support	---	-.187**	---	-.225**	---	---
Partner support	.360*	-.410**	-.217**	-.259***	---	---
Family Support	---	---	---	---	---	---
General SS	---	---	---	---	---	---
Groups &Religious support	---	-.236*	-.104*	---	-.507***	-.200*
Cumulative R^2	.207	.216	.165	.315	.215	.100

NS=Non significance * * * p< .001 * * p< .01 * p< .05 N= 122

Note. + Indicates a new step in the regression analysis. At each step, standardised regression coefficients (Beta) are reported for variable entered in the regression at that step.

Interactions between Role-Quality Concerns and Social Support Dimensions and Health

The moderating effects of social support dimensions between job, partner and mother concerns and health were tested in an exploratory analysis using the procedure described in the section on statistical analysis. Only significant interaction

effects will be presented. In the graphical representation of the interaction effects, independent and moderator variables were dichotomised according to the median (over and bellow the median) as suggested by Arnau (1986).

Job and Partner-Concerns

Significant interactions between Job concerns and Partner concerns, groups and religious support and depression were found (Table 4.7).

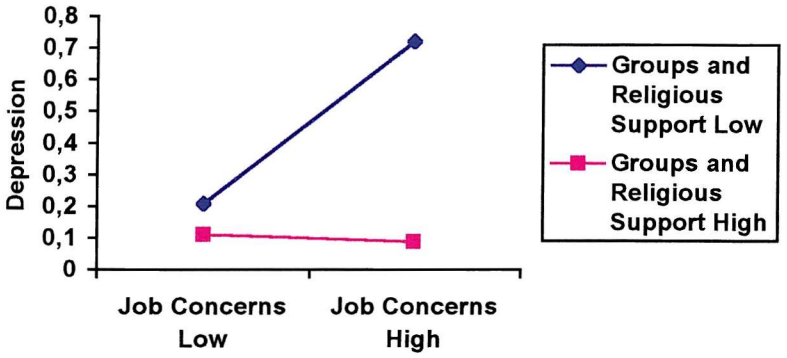
Table 4.7. Hierarchical Regression Analysis for Social Support and Role Quality

Variables	Depression	Depression
Sociodemographic Variables		
+ R^2 Incr.	---	---
F	NS	NS
Age	---	---
Education	---	---
Children < 7 years	---	---
Family Roles		
+ R^2 Incr.	---	---
F	NS	NS
Partner	---	---
Mother	---	---
Role Quality & Social support		
+ R^2 Incr.	.20	.11
F	4.99***	3.28**
Job Concern (JC)	.863***	
Groups &Religious support (GRSS)	---	
JC x GRSS	-.775***	
Partner Concern (PC)		.608**
GRSS		---
PC x GRSS		-.558**
Cumulative R^2	.20	.11

NS=Non significance * * * p< .001 * * p< .01 * p< .05 N= 122

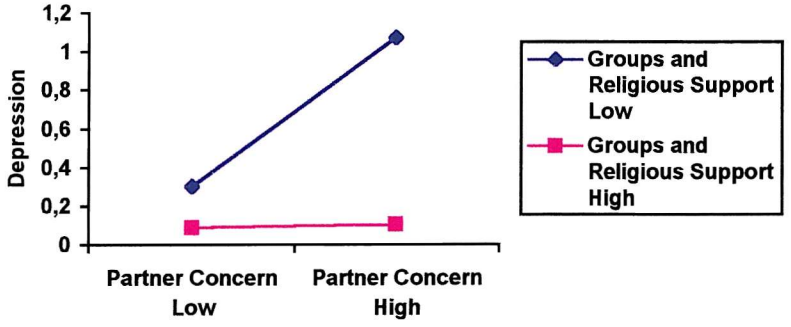
Note. + Indicates a new step in the regression analysis At each step, standardized regression coefficients (Beta) are reported for variable entered in the regression at that step

Figure 4.1: Interaction of Job-concerns and Groups & Religious Support on Depression



Figures 4.1 and 4.2 show that when job-concerns and partner-concerns are high but groups and religious support religion is low, depression increased. However, when the support coming from groups and religion is high, depression is not affected by the job or partner concerns.

Figure 4.2: Interaction of Partner-concerns and Groups & Religious Support on Depression.



4.4. - Discussion

The findings suggest four important issues about multiple roles and health in Venezuelan working women. First, the quality of experience within women's social roles rather than role occupancy was a major independent predictor of health. Second, paid work and partner roles were the major sources of stress in this group of working women. Third, the partner as well as groups and religion were the most important sources of social support due to their relationship with health when main effects were considered. But, support coming from groups and religion also acted as a protective factor against depression when women experienced high job and partner concerns. Fourth, family support was not associated with health.

The qualitative rather than the quantitative aspect of women's experiences in their social roles is the key to understanding their mental or physical perception of health. In this group, role quality variables were much stronger predictors of health outcomes than were role occupancy variables or education. These findings are consistent with previous studies on working women focusing on stress and health indicators (Barnett & Baruch, 1985; Baruch & Barnett, 1986; Hibbard & Pope, 1993).

Women reporting more work-related concerns showed twice as many symptoms of anxiety as compared to women with less concerns. This is an interesting result because, according to the literature on work-related tension and stress, women appear to be more vulnerable to concerns associated with domestic problems and specifically to marital tension, housework and the relationship with their children, which includes their education, health and maintenance (Baruch et al., 1987; Duxbury & Higgings, 1991). This finding also reflects the change women have experienced in the work field over the past decades.

The most frequent stressful situations associated with the quality of the job role were

work overload, lack of opportunity for career growth, dissatisfaction with their salary and lack of recognition. This finding is in line with that of Barnett and Marshall (1991) and Aneshensel (1986) who found that work overload predicted mental health problems in a group of working women and it increased when they perceived inadequate compensation. Narayanan, Menon and Spector (1999) reported that work overload and lack of control were the major stressors for clerical workers.

Partner concerns were related to more anxiety and distress. These results indicate that the perceived quality of the partner role appears to be a better predictor of mental health and well-being. According to Barling (1990), Piechowsky (1992), Almeida et al. (1993) and Rosenfield (1989) the protective or risk effect of having or not having a partner on the health and well-being of women is mediated by the presence of variables such as marital satisfaction or satisfaction with the partner, the fair distribution of home responsibilities and the perception of the control of family or labour conditions. In the present study, the rewarding aspects of the marital role were considered as indicators of marital satisfaction and were related to the expression of physical and sexual affection, being supportive and having a partner who is a good father.

An unexpected result was the lack of association between mother role quality and health. This is particularly surprising because in other studies the parental role had been considered as the major source of stress (Baruch & Barnett, 1985; Cohen et al., 1990).

The third finding concerning a better perception of physical health, and less mental health problems when the partner is perceived as more supportive, relates to the research by Smith, Smith, Kearns and Abbott (1993) who reported that the presence of partners' social support is associated with reduced symptoms and psychological distress and mitigates the adverse effect of housing stressors. This effect is further enhanced when the partner equally shares housework and the responsibility for child

rearing (Mederer, 1993; Rosenfield, 1992).

These results reflect how important the quality of partner role was for this group of working women. A supportive partner was a protective factor in dealing with stress while a conflictive partner relationship reflected negatively on health indicators. A partner was also a source of social support and social network. Regarding the perception of sources of social support, in the present study, working women with a partner and children perceived more opportunities for social relationships and social networks compared to women who had children but did not have a partner. These results are especially relevant for traditional Latin American culture, as Venezuela still is, were the masculine figure represents a source of security and quality of life, not only from an economic point of view but also socially and psychologically both for women as well as for the rest of the family (Recagno-Puente, 1998).

Religious and group support was also one of the most important sources of support for the women of this study not only considering their main effects but also their protective effects on health. The lower the perception of support from religion and groups, the worse perception of mental and physical health. Social networks and religious support has been linked to health and wellbeing (Maton & Wells, 1995; Ventis, 1995; Berkman & Syme, 1979). The role of groups and religious support on health has been corroborated by Meneses et.al. (1999) in a study conducted in Venezuela. Another study also showed that Venezuelan women resorted to religion as a strategy for coping with stress (Feldman-Naim, 1991). Groups and religious support was the only source of social support that protected this group of women from depression when they experienced high job and partner stress. These results highlight not only socio-cultural characteristics of the Latin American family, especially women, who are more often responsible for the education, moral and spiritual welfare of their children, but also religious institutions offer women a more structured and stable source of social network and groups support.

No relationship between family support (parents and siblings) and health was found. This result was unexpected considering that in the Venezuelan and in, general, Latin American culture, family is one of the most important sources of emotional as well as instrumental support. Latin American families have had a traditional pattern where extended families (i.e. grandparents) express high cohesion and support and have an active involvement in childcare and domestic issues. However, this finding may reflect a change in Venezuela's traditional family structures. Recently, family sociologists and psychologist have pointed out that the Venezuelan family structure has been subject to structural and functional transformations as a result of the new spaces open for women and also of the deteriorating social and economic circumstances that have affected the country, especially in the last 15 years (Recagno-Puente & Platone, 1998). These authors pointed out that migrations from agricultural areas, from less economically stable regions and countries, have isolated women from the extensive support nets of consanguineous families, thus creating more vulnerable conditions in times of crisis due to social and economic changes. Also more members of a family have been forced to look for paid work due to economic needs. Additionally, the percentage of women with small children has increased and 52% are born in an unmarried family and in a mother-centered home (Hurtado, 1995). In spite of the fact that family support is still considered a basic factor, due to the present social and economic circumstances, its affective and instrumental value has declined in importance and effectiveness.

A study carried out with other Latino women (Mexican, Cuban and Puerto Rican) found that significantly fewer women (88% compared with 95% of US women) have someone to call on for help when they have a problem (Ramirez de Arellano, 1996).

The results above indicate how the Latin American family's functioning has changed, having a more negative impact on middle and low middle class. The sample of the present study belonged to a mid-low socio-economic level.

CHAPTER 5

STUDY 2: " Psychosocial Factors Associated with Health in Women with Multiple Roles and Different Occupational Levels"

As the literature points out, occupational status is a characteristic that may influence the stressors to which people are exposed; those with higher occupational status are probably exposed to different experiences (stressful or rewarding) from those with lower skilled jobs (Karasek & Theorell, 1990).

As in Study 1 only clerical workers were considered, the present study was designed to examine the extent to which specific role experiences could affect women's health, with different occupational status. Four groups of working women were selected on the basis of different occupational prestige: blue-collar workers (cleaning and maintenance), clerical, school teachers and professionals (the majority of whom were academics). A group of housewives was also considered.

For the present study, a different measure of social support was used. It included two dimensions of the construct, which was used widely in the literature (Unden & Orth-Gomer, 1989; Orth-Gomer & Unden, 1990). First, Social Integration, which refers to the extent to which an individual is engaged in interactions/activities/interests of a secondary group nature. Second, Emotional support, which concerns the possibility of having close relationships with others as well as their support.

Distribution of household chores and childcare were other variables considered in the present study because of their close relationship with health and well-being (Biernat, 1991; Peterson & Gerson, 1992; Almeida et al., 1993). Home responsibilities have been considered as sources of conflict and stress between the spouses (Mayor, 1993).

Increases in rate of participation of women in the labour force, and particularly among married women with children, have highlighted the importance of studying the relationship between work and non-work domains, such as family and leisure time

(Kirchmeyer, 1995; Hugh & Galinsky, 1994; Hugh & Galinsky, 1988; Spitze, 1988; Westman & Etzion, 1995).

In Study 1 the measurement of mental health focused only on the presence or absence of negative effects associated with mental health. The present study included not only the measurement of indicators of mental health problems such as anxiety, depression, and symptoms reported but also subjective dimensions such as self-esteem and well-being.

5.1. - Objectives

The objectives of this study were: First, to examine how mental and physical health in women from different occupational levels are related to: a. - The type of social roles and, b) The quality of the social roles, social support, the distribution of home responsibilities and the relationship between the work and the family using an additive model. Second, to evaluate the moderating effects of the dimensions of role-rewards, social support, household responsibilities and work-family relationships on role quality-concerns dimensions and health.

5.2. - Method

Participants

The participants were faculty members, professionals, clerical and blue-collar workers from 5 higher education centres in the Metropolitan area of Caracas – Venezuela, who had a full time job, with or without a partner and with or without children. The group of participants also included a small number of schoolteachers and housewives.

Six hundred and ninety questionnaires were sent out (professionals n=300; school teachers n= 70; clericals n= 180; blue-collars n=75; housewives n=65). After all the data had been collected, the total number of participants amounted to 417. The total response rate was

58.07%. The professional group had the highest response rate (68%) while clerical workers (51.66%) and housewives (49.2%) the lowest.

Procedure

The authorities of the various universities, institutes and schools were informed about the objectives of the Woman, Work and Health Project (Appendix 7). Faculty members, administrative personnel, secretaries and blue-collar workers from the various institutions were located through payroll lists provided by the Department of Human Resources; the lists included names, position and departments for which they worked.

Having selected the female faculty personnel working full-time (6 to 8 hours per day) at the universities or educational institutions, the questionnaires were classified and coded according to the institute they worked for.

The questionnaire was posted with a letter explaining the objectives of the study and providing the telephone numbers of the investigators responsible for it, as well as instructions to return it in the sealed envelope within 72 hours. A week later those participants who did not reply received a notice reminding them to return filled in the questionnaire. The average response time was 5 days.

For the blue-collar group (maintenance and cleaning) the procedure was somewhat different. In Venezuela this group of people have a very low level of education and most of them are functionally illiterate. After a pilot test with 3 participants, it was found necessary to administer the questionnaire as an interview. This took between an hour and an hour and a half, with the interviewer reading each item and the alternatives, to ensure that the questionnaire was answered properly. Those blue-collars who did not attend to the first appointment, received a second call.

The housewives were contacted through university students. The students who had non-working mothers were asked to give them a sealed envelope containing the questionnaire and an explanatory letter that was identical to the one sent to the rest of the group. They were asked to answer the questionnaire and return it within a week. A week later those participants who did not reply received a reminding letter.

Statistical Analyses

A descriptive analysis was made for all the variables. The data were analysed using One-way ANOVA tests in order to compare the differences in the psychosocial variables and health indicators among the 4 groups of working women based on their number and type of roles (single employed, employed mother, employed wife, employed, partner and mother) and occupational status (blue-collar, clerical, school teacher and professional). *Post hoc* analyses were carried out using Bonferroni´s test. Since the housewives group consisted of women with a partner and children, it was only compared with the group of working women who also had two family roles. To compare these two groups a Student's "t" test was conducted. The differences were estimated at the level of 0.05 significance.

Hierarchical Multiple Regression analysis was the statistical technique used to evaluate main and interactive effects among sociodemographical, psychosocial and health variables. As was mention before in Chapter 4, it is the method most widely used in the literature on social roles, psychosocial variables and health in working women (Barnett & Baruch, 1985; Baruch, & Barnett, 1986; Aston & Lavery, 1993; Luchetta, 1995; Noor, 1995a, b; Christensen et al., 1998; Oster & Scannell, 1999; Gómez et al., 2000, among others). Independent variables were entered in a predetermined sequence according to their theoretical and empirical support, and also in order to determine their specific contribution to the model (Cohen, 1978). Sociodemographical variables were entered in the first steps. Age, education and having pre-school children or not were included in the first step, while the second step included role occupancy and the third

step occupational level. Dummy variables were created for the three roles as well as for the occupational status. Psychosocial variables were included in the next steps. As in Study 1, Social support was the first psychosocial construct to be entered in the analysis and role quality the last.

R square is reported for each step of the regression, with the significance of the inclusion of these variables in the regression analysis. The standardised beta coefficient for each variable in each step is reported. Cumulative R square is also reported.

To test for interaction terms, a hierarchical regression analysis was constructed in the same way it was described in the paragraph above. Independent variables were entered into the analysis in a predetermined order, with control variables entered before the main and interactive effect terms. R square increment is reported for each step of the regression, with the significance of the inclusion of these variables in the regression equation. The standardised beta coefficient for each variable in each step is reported.

5.3. - Results

Sociodemographic Characteristics

The participants were between 18 and 66 years of age, with an average of 37 years and 2 months (SD= 10.15). As shown in Table 5.1, most of the women had partners.

Seventy percent of the participants had children. Sixty one percent of the women had between one and three children and 39% at least one pre-school age child. The ages of their sons/daughters ranged from 3 months to 37 years (Table 5.1).

Fifty six percent of the participants had a university degree, followed by a group that had only completed elementary school and those who had completed high school. Five percent had not finished elementary school. As for the occupational status, almost half of the participants had jobs that required a college education, followed by those who did clerical

work. The rest were schoolteachers, cleaning and maintenance personnel and housewives (Table 5.1). Considering the number of working hours per week, 8.1% worked less than 15 hours per week (n=29), 21.3% (n= 76) worked between 15 and 35 hours, 60.2% (n=216) worked between 36-45 weekly hours and 11.5% (n= 39) of the women worked between 46 and 72 hours per week at the time of the data collection.

Table 5.1 shows the percentage of the distribution of the sample by the types of roles and occupational status. The ages of the partners ranged from 20 to 76 years, the mean being 41 years (SD =11.04). The partners' levels of education were broken down as follows: 4.6% (n=13) had not finished elementary school, 22.6% (n=64) had finished elementary school, 22% (n= 63) had finished high school, 6.7% (n= 19) technical college and 43.8% (n=124) had university degrees. Considering the occupational status of the partner, 14.8% (n=39) were blue-collar workers, 19.4% (n=51) had administrative jobs, 1.9% (n= 5) were schoolteachers, 17.8% (n=47) were traders and 46.2% (n=122) worked in their own profession.

Health Characteristics

Most of the participants perceived themselves to be healthy. Only 8% of the group perceived their physical health as poor or very poor. Thirty four percent of the women had seen a physician between 1 and 3 times and 6.1% said they had seen counsellors, psychologists or psychiatrists in the last 6 months. Thirty seven percent of the women reported that they had been absent from work between 1 and 3 days because of health problems in the last 6 months. Forty-seven percent of the participants had stayed in bed due to illness or for health reasons in the last 6 months (Table 5.1).

Seventy-four percent of the participants were non-smokers at the time of the evaluation, despite the fact that almost 50% had smoked in the past. The majority (56%) of the smokers smoked between 1 and 6 cigarettes per day and only 36% smoked 10 or more cigarettes. Only 36% of the sample participated in sports, mainly aerobics (89.4%). Sixty-seven point four percent of the women interviewed said they drank no alcohol. Twenty-

nine point seven percent of the participants reported having between 1 and 5 drinks per week, 3% between 6 and 10 drinks per week, and only 1 (0.2%) participant reported more than 15 alcoholic drinks per week. Forty-one percent (n=169) of the participants reported sleeping problems.

Table 5.1 Sociodemographic and Health Characteristics of Women (*)

VARIABLES		*n*	*%*
Age	Young (-36)	206	49.40
	Interm (37-50)	170	40.76
	Older (51-66)	41	9.8
Marital status	With partner	273	65.5
	Without partner	144	34.5
Number of children	No children	123	29.6
	1	96	23.1
	2-3	154	37.1
	> 4	42	10.2
Children under 7 years	Yes	137	39.1
	No	280	60.9
Type of roles	Single Employed	64	15.3
	Employed mother	80	19.2
	Employed & partner	59	14.1
	Employed mother-partner	182	43.6
	Housewives mother & partner	32	7.7
Education	Unfinished Primary school	19	4.6
	Primary school	87	20.8
	High school	76	18.3
	University degree	235	56.3
Occupational Status	Professionals	204	48.9
	School teachers	45	10.8
	Clericals	93	22.3
	Blue-collars	43	10.3
	Housewives	32	7.7
Self-reported Health Scale	Very poor & poor	30	7.7
	Good	223	53.3
	Very good	116	27.8
	Excellent	46	11.0
In bed last 6 months	Zero days	184	91.3
	1-3	140	33.5
	4 -9	36	8.6
	> 10	21	5.0
Medical appointments last 6 months	0	138	33.1
	1-3	234	56.1
	4-6	42	10.1
	> 7	3	0.6
Psychological consultation	0	391	93.8
	1-3	17	4.1
	> 4	10	2.0
Work absenteeism last 6 months	0	184	47.9
	1-3	140	36.6
	4-9	36	9.4
	>10	21	6.5
Smoking	Yes	107	25.7
	No	310	74.3
Exercise reg. (1/week or more)	Yes	150	36.0
	No	267	64.0
Alcohol	No	281	67.4
	1-5 drinks /week	124	29.7
	6-15 drinks/week	12	2.8
Sleeping problems	Yes	169	40.5
	No	248	59.5

N= 417 * In some cases percentages do not add to 100 due to missing values.

Mental Health and Symptoms Report

The means and standard deviations (SD) of the health indicators used in the analyses are shown in Table 5.2.

Table 5.2: Descriptive Statistics for Mental Health and Symptoms Report

Health Indicators	Mean	SD	Observed Range	Possible Range
Self-esteem	26.25	4.09	11 - 32	1 - 32
Well being	7.19	1.92	1 - 10	1 - 10
Anxiety	45.30	8.24	23 - 72	1 - 80
Depression	14.49	3.89	8 - 29	1 - 32
Symptoms Report	17.96	2.87	13 - 26	1 - 26

Among the symptoms assessed, the common ones in this sample were those related to muscle tension, headaches, forgetting where things go, stomach-ache and indigestion and losing one's train of thought (Table 5.3). Sixty five percent of the sample reported between 3 and 8 symptoms.

Table 5.3: Percentage of Symptoms Reported

Symptoms	Presence (%)
Muscular tension (nape, shoulders, back)	73.9
Headaches	67.5
Forget fullness	61.4
Stomach cramps, heartburn, indigestion	52.0
Losing the train of thoughts	39.8
Difficulty to concentrate	35.7
Chill or heat waves	30.7
Tachycardia, palpitations	27.1
Tendency to cramps	26.9
Cold feet and hands	23.0
Short breath	20.4
Excessive sweating	19.5
Dry mouth	18.2

A significant effect of type of role and occupational status on health indicators (Table 5.4) was found using ANOVA tests and Bonferroni *post hoc* comparisons. Employed women with a partner and employed partner and mother reported higher levels of well being compared to employed mother ($F=3.91$; $p< .01$). Single employed women reported lower levels of anxiety compared to the other groups ($F= 35.84$; $p< .001$). Employed mothers reported significantly more depressive symptoms compared to the other groups of

working women (F= 8.16; p< .001). Single employed women and employed women with a partner had a significantly better perception of physical health (F= 8.71; p< .001).

Table 5.4: Means and SD of Mental Health and Symptoms Report based on the Type of Roles

	Single employed (n= 64)		Employed mother (n=80)		Employed Partner (n=59)		Employed mother/partner (n=182)		
Health Indicators	Mean	SD	Mean	SD	Mean	SD	Mean	SD	p
Self-esteem	27.14	3.39	25.67	4.05	27.31	4.20	26.26	4.09	NS
Well-being	7.05	1.17	6.60	20.1	7.59	1.60	7.34	2.13	.01
Anxiety	37.38	10.51	46.71	6.66	47.63	4.90	47.27	5.84	.001
Depression	13.44	4.03	16.24	4.31	13.93	3.42	14.34	4.76	.001
Symptoms Report	17.47	2.53	18.49	3.04	17.89	2.95	17.86	2.76	NS
Self Perception of Physical Health	3.72	0.81	3.28	0.78	3.75	0.71	3.31	0.79	.001

In relation to occupational status, housewives reported the lowest level of self-esteem (F= 4.83; p< .001). Blue-collars and clerical workers had significant more depressive indicators compared to schoolteachers (F= 2.83; p< .05). Professionals and schoolteachers perceived themselves to have significantly better physical health compared to the other occupational groups (F= 7.02; p< .001) (Table 5.5).

Table 5.5: Means and SD of Mental Health and Symptoms Report based on the Occupational Level

	Blue collar (n=43)		Clerical (n = 93)		School Teachers (n =44)		Professionals (n = 204)		Housewives (n = 32)		
Health Indicators	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	p
Self-esteem	25.21	4.98	26.54	4.27	27.48	3.05	26.44	3.82	23.84	4.30	.001
Well-being	6.60	2.93	6.98	2.19	7.48	1.61	7.31	1.54	7.34	1.84	NS
Anxiety	46.30	8.49	45.49	7.54	43.42	9.60	45.92	7.27	42.06	12.34	NS
Depression	15.63	4.51	15.08	4.15	13.20	3.05	14.33	5.56	14.16	4.74	.05
Symptoms Report	18.0	3.17	18.04	3.01	17.70	2.73	17.90	2.69	18.28	3.41	NS
Self Perception of Physical Health	3.0	0.87	3.28	0.81	3.52	0.73	3.58	0.76	3.16	0.81	.001

Relationship between the Number and Age of Children and Mental and Physical Health.

The results obtained in the ANOVA test indicated that women with more children and those with pre-school children reported a worse perception of physical health (F= 4.86; p<. 001; F= 6.19;p<. 01, respectively) and more depressive symptoms (F= 2.50; p< .05; F= 7.77; p< .01). Women with more than 2 children reported higher levels of anxiety than those who had only one child (F= 4.05; p< .001). Women who had at least one pre-school child reported worse well being (F=9.34; p< .01) and more doctor's appointments (F= 5.22; p< .05).

Intercorrelations of Measures

In Appendix 9 can be found Table 5.6 with zero-order correlations between the measures. In relation to health variables, significant and positive correlations were found between alcohol consumption and work role and professional women as well as social integration. Sleeping problems were a very sensitive health indicator associated with a worst perception of physical health, less social integration, emotional support and more job, partner and mother concerns. A positive association was found between smoking and work role. Also working women had more household responsibilities. Number of roles was associated with more home responsibilities and partner concern. Blue-collar worker have more pre-school children.

Role Quality

A significant effect of type of role on work and partner role quality was found (Table 5.7). These effects were confirmed with *post hoc* analyses. Employed partner and single employed women perceived more job rewards than employed women with children and a partner and employed mother (F=6.63; p< .001). Working women with children also reported more stress situations at work than employed partner (F= 2.35; p< .05). In relation to the partner role quality, working women with a partner reported more rewards

(F= 10.0; p< .001) and significantly less concerns than women with a partner and children (F= 6.53; p< .001). No significant associations were found for Mother role quality.

Table 5.7: Means and SD of Role Quality based on the Type of Roles

	Single employed (n= 64)		Employed mother (n=80)		Employed partner (n=59)		Employed mother/partner (n=182)		
Role Quality	Mean	SD	Mean	SD	Mean	SD	Mean	SD	p
Work Role									
Rewards	3.12	0.34	2.88	0.46	3.20	0.43	3.03	0.46	.001
Concerns	1.73	0.35	1.78	0.42	1.60	0.35	1.72	0.38	.05
Partner Role									
Rewards	--	--	--	--	3.51	0.44	3.13	0.62	.001
Concerns	--	--	--	--	1.33	0.24	1.56	0.48	.001
Mother Role									
Rewards	--	--	3.36	0.41	--	--	3.41	0.40	NS
Concerns	--	--	1.69	0.39	--	--	1.65	0.39	NS

When occupational levels where considered (Table 5.8), school teachers and professionals reported more job rewards than clerical and blue-collar workers (F (3,384)= 32.83; p< .001). Blue-collar workers perceived more stressful work situations compared to the other occupational levels (F (3,384)= 12.69; p< .001).

Table 5.8: Means and SD in Role Quality based on the Occupational Level

	Blue collar (n=43)		Clerical (n = 93)		School Teachers (n = 44)		Professionals (n = 204)		Housewives (n = 32)		
Role Quality	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	p
Work Role											
Rewards	2.51	0.483	2.98	0.43	3.21	0.36	3.15	0.40	--	--	.001
Concerns	2.04	0.43	1.66	0.37	1.68	0.38	1.68	0.35	--	--	.001
Partner Role											
Rewards	2.99	0.43	3.13	0.53	3.33	0.45	3.26	0.46	3.14	0.36	NS
Concerns	1.53	0.27	1.54	0.41	1.43	0.32	1.50	0.35	1.51	0.31	NS
Mother Role											
Rewards	3.29	0.37	3.33	0.45	3.50	0.19	3.41	0.28	3.34	0.41	NS
Concerns	1.69	0.36	1.63	0.33	1.57	0.24	1.69	0.32	1.55	0.33	NS

Distribution of Household Responsibilities

As shown in Table 5.9, most home responsibilities and their performance and management rest upon the woman's shoulders. However, when the average score is compared with the highest value on the scale, it shows that the partner participates more in the tasks *per se* than in their management. A large number of women in the sample received help from third parties such as a maid, in activities such as ironing and cleaning the bathrooms in the house. Men helped in very specific tasks such as car maintenance and home repairs. To a lesser extent, they also helped in paying the bills. Both partners had an equal share of the responsibility for making decisions about money, children's education and home discipline, as well as planning weekends and meals. Specific activities such as organising parties, paying bills, playing with the children, rewarding or punishing children's behaviour were shared between men and women on an equal basis. Most or nearly all of the time, the activities performed by women included activities related to meals, house cleaning, making and attending children's appointments and school-related activities as well as children's personal care.

Table 5.9: Home Tasks Sharing Between the Partner and Others

Item	% Others	% Partner usually	% Partner Always	% Equal	% Wife always	% Wife usually
Management						
Plan meal	18.9	2.0	1.0	18.2	22.3	37.4
Make grocery list	13.9	2.9	1.4	15.5	20.6	45.6
Make medical appointments	12.7	1.9	1.4	12.5	23.8	47.7
Take money decisions	6.7	3.4	7.2	41.5	14.9	26.4
Decide about children's education issues	19.0	1.7	5.8	30.2	38.8	21.6
Decide about home discipline	2.9	1.7	5.3	59.5	7.9	22.8
Plan weekends and holidays	7.4	5.5	6.5	53.9	7.4	19.2
Tasks						
Grocery shopping	9.1	4.6	4.6	34.1	12.5	35.3
Prepare breakfast, lunch and dinner	24.5	2.6	1.2	23.0	18.0	30.7
Do laundry	26.6	2.2	1.2	12.2	12.0	45.8
Clean kitchen	31.2	2.4	1.2	16.5	10.1	38.6
Do the washing up	27.8	5.0	5.0	21.3	13.7	27.1
Clean home	38.8	2.9	8.9	10.5	9.6	29.3
Ironing	39.6	4.1	9.2	4.8	6.2	36.2
Clean bathrooms	41.0	3.4	10.5	7.0	6.5	31.7
Car maintenance	12.0	18.7	32.9	16.8	5.8	13.9
Do household repairs	19.4	21.8	22.7	16.5	6.5	12.9
Pay bills	7.4	13.2	12.7	38.1	7.2	21.3
Take care of pets	10.3	4.3	62.5	10.6	3.8	8.4
Take children to medical, dentist, etc. appointments	6.7	1.7	1.0	28.6	29.5	32.6
Attend school appointments	5.0	2.4	2.2	29.7	31.9	28.8
Organise birthday parties and parties at home	7.7	2.6	3.6	50.4	9.8	25.9
Check children's homework	3.6	1.4	2.4	54.7	9.4	28.5
Check children personal care	5.8	1.0	1.0	53.5	7.0	31.9
Check children study for exams	3.4	1.7	1.9	55.6	9.9	27.6
Punishment or reinforcement of behaviours	3.1	2.2	3.4	65.2	5.5	20.4
Prepare children's school lunch	12.0	1.2	0.2	53.7	6.0	25.9
Do the garden	20.6	7.2	23.8	10.6	9.8	28.1
Play games with children	4.3	1.0	3.8	70.2	8.4	12.2

Employed mothers had more home responsibilities compared to the other types of employed women in the management of the home ($F= 18.50$; $p< .001$) and home tasks ($F= 8.23$; $p< .01$). Housewives were the occupational group with the fewest home responsibilities (management ($F= 58.28$; $p< .001$) and tasks respectively ($F= 89.71$; $p< .001$) (Tables 5.10 & 5.11).

Table 5.10: Means and SD on Work-Family Relationship, Distribution of Household Responsibilities and Social Support based on the Type of Roles

	Single employed (n= 64)		Employed mother (n=80)		Employed Partner (n=59)		Employed mother/partner (n=182)		
Variables	Mean	SD	Mean	SD	Mean	SD	Mean	SD	p
Home Management	29.63	7.35	36.15	7.04	31.80	2.57	32.06	4.51	.001
Home Tasks Performance	88.55	13.70	99.42	20.09	89.24	10.04	90.15	15.91	.01
Emotional Support	3.35	0.74	3.09	0.87	3.45	0.59	3.23	0.79	.05
Social Integration	22.2	3.91	20.73	3.88	23.12	4.10	21.62	3.94	.01
Role Interferences	15.05	2.11	16.17	3.93	15.61	4.49	15.53	4.76	NS
Satisfaction between roles	9.94	0.91	9.70	2.26	8.73	2.19	9.48	2.27	.01

Table 5.11: Means and SD on Work-Family Relationship, Distribution of household Responsibilities and Social Support based on the Occupational Level

	Blue collar (n=43)		Clerical (n = 93)		School Teachers (n = 44)		Professionals (n = 204)		Housewives (n = 32)		
Variables	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	p
Home Management	33.13	5.75	33.35	6.50	31.30	5.54	32.19	5.56	16.38	5.47	.001
Home Tasks Performance	93.79	19.71	98.98	16.58	91.69	12.76	87.91	14.97	59.16	16.16	.001
Emotional support	3.18	0.93	3.08	0.89	3.33	0.82	3.33	0.67	3.10	0.60	NS
Social Integration	18.74	5.02	20.95	3.80	23.06	3.71	22.57	3.72	19.91	3.60	NS
Roles Interferences	16.40	5.02	14.04	3.34	13.76	3.71	16.55	4.22	-	-	.001
Satisfaction between roles	9.60	1.88	9.68	2.18	9.33	2.06	9.41	2.15	-	-	NS

Social Support

Employed mothers perceived themselves to have significantly lower levels of emotional support ($F= 2.77$; $p< .05$) as well as social integration ($F= 4.90$; $p< .01$) compared to employed women with partner. Blue-collar, clerical workers and housewives were the groups who reported less social integration ($F= 3.23$; $p< .01$). (Tables 5.10 & 5.11).

Work-Family Relationship

No differences were observed in Role interferences according to the types of roles (Table 5.10). *Post hoc* comparisons indicated that employed women with partners reported the lowest level of satisfactions between roles (F=3.80; p< .01). Professional and blue-collar women reported more role interferences than clerical workers and school teacher (F=11.61; p< .001) (Table 5.11).

Comparison Between Housewives and Working Women with Partner and Children

The housewives (who were all married and had children) were compared with employed women who also had a partner and children, using the "t" Student test. It was found that working women reported more social contacts and networks compared to housewives but also had significantly more responsibilities for home management and household tasks (Table 5.12).

Table 5.12: Comparison of Psychosocial Variables Between Employed Mother/Partner and Housewives Mother and Partner.

	Employed Wife / Mother		Housewives		"t" – Student
	Mean	SD	Mean	SD	
Role Quality					
Partner Role					
Rewards	3.12	0.61	3.13	0.36	NS
Concerns	1.56	0.47	1.50	0.30	NS
Mother Role					
Rewards	3.40	0.40	3.34	0.41	NS
Concerns	1.65	0.38	1.55	0.33	NS
Home Responsibilities					
Home Management	32.05	4.5	16.37	5.47	t = 17.51, p < 0.001
Home Tasks Performance	90.14	15.90	59.15	16.16	t = 10.14, p < 0.001
Social Support					
Emotional Support	3.23	0.79	3.43	0.71	NS
Social Integration	21.62	3.94	19.90	3.94	t = 2.27, p < 0.01

NS= Not significant, * p< 0.05, ** p < 0.01, *** p < 0.001

Relationship between Sociodemographic Variables, Role Quality, Home Responsibilities, Work-Family Relationship and Social Support and Mental and Physical Health in Working Women with Multiple Roles

As well as in Study 1 (Chapter 4), self-perception of physical health was controlled for depression and anxiety because significant higher correlations were also found between those variables (Appendix 9, Table 5.6.). This was done in order to ensure that findings relating to self-perception of physical health are not contaminated by these covariates. Different studies suggest a relationship between anxiety/depression and self-rated health since mood could affect the association between psychosocial variables such as social support and health (Grosch & Murphy, 1998; Radanov, Schwartz; Frost & Augustiny, 1997). Only the significant health indicators were included in the table.

The results indicated that after controlling for anxiety and depression education was related to physical and mental health (5% of the explained variance). Women with higher education reported better perception of physical health, higher levels of well-being and self-esteem and lower rates of depression. Women who had children less than 7 years of age reported lower levels of well-being and more depressive symptoms (Table 5.13).

When role occupancy was entered in the equation, an association between 1% and 10% of the variance was found with the health indices used. Having a worker role was related to higher levels of anxiety but at the same time to higher self-esteem. The role as a partner was associated with higher levels of well-being, lower levels of depression but also to higher levels of anxiety. Being a mother was associated with higher anxiety (Table 5.13).

When Social Support entered into the equation (3% to 11% of the explained variance), it was found that social integration and social network and emotional support were associated with higher self-esteem and well-being and lower levels of depression and symptoms report. Initially, a positive association was found between self-perception of

health and social integration (R^2= .003; F= 4.52, p< .001; Beta= .107, p< .05). However, this relationship disappears when self-perception of health was controlled by anxiety and depression (Table 5.13).

Role interference was also positively associated with the report of symptoms and depression and negatively related to well-being, explaining between 2% to 10% of the explained variance. Those women with work-family satisfaction also reported lower anxiety and higher self-esteem.

As shown in Table 5.13, Role Quality explained between 1% and 14% of the explained variance. Job rewards were associated with higher self-esteem and well-being but at the same time with more anxiety. Job concern was related to more anxiety and depressive symptoms but also to higher self-esteem. Partner rewards were related to more anxiety. Partner concerns were also associated with the report of depression. Mother rewards were related to higher self-esteem and well-being, and mother concern to higher levels of depression and anxiety.

Table 5.13: Hierarchical Regression Analysis of Sociodemographic and Psychosocial Variables with Health indicators

N=417	Health Perception	Anxiety	Depression	Self-esteem	Well-being	Symptoms
+ R^2 Incr.	.150					
F	36.39***					
Anxiety	---					
Depression	-..390***					
Sociodemographic Vs						
+ R^2 Incr.	.046	.008	.029	.017	.046	.006
F	20.07***	NS	4.08**	NS	6.70***	NS
Age	---	---	---	---	---	---
Education	.196***	---	-.127**	---	.133**	---
Children < 7 years	---	---	.107*	---	-.119*	---
Role Occupancy						
+ R^2 Incr.	.012	.103	.011	.019	.020	.007
F	13.38***	8.57***	2.81**	2.56**	4.79***	NS
Work	---	.225***	---	.131*	---	---
Partner	---	.259***	-.102*	---	.144**	---
Mother	---	.103*	---	---	---	---
Occupational Status						
+ R^2 Incr.	.010	.006	.019	.013	.011	.036
F	9.37***	5.40***	2.53**	2.07*	3.38***	NS
Blue-Collar	---	---	---	---	---	---
Clerical	---	---	---	---	---	---
School Teachers	---	---	---	---	---	---
Professionals	---	---	---	---	---	---
Housewives	---	---	---	---	---	---
Social Support						
+ R^2 Incr.	.000	.013	.114	.031	.038	.036
F	8.00***	4.96***	9.52***	3.26***	5.61***	3.29***
Emotional support	---	---	-.254***	.104*	.194***	-.100*
Social integration	---	---	-.260***	.151**	.132**	-.194**
Home Responsibilities						
+ R^2 Incr.	.005	.012	.011	.005	.003	.001
F	7.18***	4.62***	8.46***	2.92***	4.85***	2.21**
Home Management	---	---	---	---	---	.---
Home Tasks Performance	---	---	---	---	---	---
Work-Family relationship						
+ R^2 Incr.	.003	.024	.098	. 051	.068	.062
F	6.45***	5.01***	10.86***	3.97***	6.05***	3.81***
Roles Interferences	---	---	.309***	-	-.223***	.251***
Satisfactions between roles	---	-.177***	---	.207***	---	---
Role Quality						
+ R^2 Incr.	.010	.065	.071	.138	.104	.048
F	5.04***	5.42***	10.33***	6.71***	7..38***	3..94***
Job Reward	.128*	.147*	---	.386***	.205***	---
Job Concerns	---	.192***	.168**	.200***	---	.167***
Partner Reward	---	.138*	---	---	---	---
Partner Concern	---	---	.154*	---	---	---
	---	---	---	.178***	.095*	---
Mother Concern		.130**.	.144**	---	---	---
Cumulative R^2	.236	.231	. 353	. 274	. 290	.181

NS=Non significance * p<.05, ** p<.01, *** p< .001. Note. + Indicates a new step in the regression analysis. Standardised regression .coefficients (Beta) are reported for variable entered in the regression at that step.

Relationship between the dimensions of Role Quality with Sociodemographic Variables and Mental and Physical Health in Working Women

In this section a new hierarchical regression analysis was carried out considering the dimensions of Role Quality reported in Chapter 3. This analysis enables us to ascertain which specific aspects of role quality were associated with health in this group.

As seen in Tables 5.14, 5.15 & 5.16, the association between sociodemographic variables and health is similar to the regression reported in Table 5.13. When the different dimensions of Role Quality were entered into the equations it was found that there was a meaningful relationship between health indicators and the different dimensions of Job-Role Quality, which explained 10% to 43% of the variation. Supervisor support was clearly associated with higher self-esteem but at the same time with higher levels of anxiety and depression. Working women who perceived that they had job control reported higher levels of self-esteem and well-being and fewer symptoms of health problems. Co-worker support was associated with higher levels of self-esteem. Among the concerns generated by Job role, overload was clearly associated with depression and more physical and psychological symptoms, as well as lower perception of well-being. Monotony was related to higher levels of anxiety and depression but at the same time to higher levels of self-esteem. Dissatisfaction with the salary and the perception of lack of recognition, little possibility of job promotion and other negative job conditions were associated with anxiety symptoms (Table 5.14).

As for partner role-generated rewards, marital satisfaction/compatibility was the only dimension that entered the equation and was clearly associated with lower levels of anxiety. Women reporting marital dissatisfaction and lack of support and communication with their partner also reported higher levels of anxiety, depression symptoms and lower well-being. Partner's job problems were associated with a worse perception of physical health and well-being and more reported symptoms. Conflicts

caused by religious beliefs were related to higher self-esteem. Partner-Role Quality explained between 5% to 16% of the variation (Table 5.15).

As to mother rewards, the greater the satisfaction and pride felt, and the better the communication between mothers and their children, the higher the levels of self-esteem, but the greater the symptoms and general distress. Mothers who reported conflicts and disaffection with their children also reported higher levels of anxiety and depression. The perception of higher demands and interference with other roles and responsibilities was associated with lower levels of self-esteem. Financial strain, children's demands and adolescence stage were related to more depression indicators and a worse perception of well-being. Mother-Role Quality explained between 6% to 17% of the variation (Table 5.16).

Table 5.14. Hierarchical Regression Analysis of Sociodemographic and the Dimensions of Job Role Quality Variables with Health Indicators

N=417	Health Perception	Anxiety	Depression	Self-esteem	Well-being	Symptoms
+ R^2 Incr.	.124					
F	23.11***					
Anxiety	---					
Depression	-.366***					
Sociodemographic Vs						
+ R^2 Incr.	.030	.000	.030	.000	.030	.000
F	12.38***	NS	4.53**	NS	5.25***	NS
Age	---	---	---	---	.126*	---
Education	.171**	---	---	---	.114*	---
Children < 7 years	---	---	---	---	---	---
Role Occupancy						
+ R^2 Incr.	.020	.000	.050	.000	.002	.000
F	10.42***	NS	6.83***	NS	4.88***	NS
Work	---	---	---	---	---	---
Partner	---	---	-.238***	---	.160**	---
Mother	-.199**	---	---	---	---	---
Occupational Status						
+ R^2 Incr.	.004	.000	.000	.000	.018	.000
F	7.15***	NS	4.42***	NS	3.144***	NS
Blue-collar	---	---	---	---	---	---
Clerical	---	---	---	---	---	---
School Teachers	---	---	---	---	---	---
Professionals	.546*	---	---	---	---	---
Role Quality						
+ R^2 Incr.	-.011	.432	.119	.188	.100	.099
F	4.30***	3.81***	5.64***	5.31***	4.31***	3.27***
JR1	---	.237**	.236**	.140*	---	---
JR2	---	---	---	.280***	.276**	-.237**
JR3	---	---	---	---	---	---
JR4	---	---	---	.188**	---	---
JC1	---	---	.202***	---	-.173**	.242***
JC2	---	.312***	.225**	.258**	---	---
JC3	---	.233**	---	---	---	---
JC4	---	---	---	---	---	---
Cumulative R^2	.167	.432	.199	.188	.150	.109

NS=Non significance *p<. 05, **p<. 01, ***p<.001. Note. + Indicates a new step in the regression analysis. Standardised regression coefficients (Beta) are reported for variable entered in the regression at that step. JR1= supervisor support; JC1= overload; JR2= job control; JC2= monotony; JR3= satisfaction with the salary / promotion and recognition; JC3= Dissatisfaction with salary / lack of recognition and promotion; JR4= co-workers support and helping others; JC4= job conditions

Table 5.15: Hierarchical Regression Analysis of Sociodemographic and the Dimensions of Partner Role Quality Variables with Health Indicators

N=417	Health Perception	Anxiety	Depression	Self-esteem	Well-being	Symptoms
+ R^2 Incr.	.145					
F	36.39***					
Anxiety	---					
Depression	-.390***					
Sociodemographic Vs						
+ R^2 Incr.	.042	.000	.030	.010	.030	.000
F	20.07***	NS	4.16**	2.58*	4.29**	NS
Age	---	---	-.141*	---	---	---
Education	.196***	---	---	.137*	.529*	---
Children < 7 years	---	---	---	---	---	---
Role Occupancy						
+ R^2 Incr.	.005	.002	.00	.020	.000	.000
F	13.32***	2.41*	2.78**	2.53*	2.63**	NS
Work	---	.188**	---	.169*	---	---
Partner	---	---	---	---	---	---
Mother	---	---	---	---	---	---
Occupational Status						
+ R^2 Incr.	.003	.000	.02	.000	.000	.000
F	9.37***	NS	2.63**	1.99*	1.95*	NS
Blue-Collar	---	---	---	---	---	---
Clerical	---	---	---	---	---	---
School Teachers	--	---	---	---	---	---
Professionals	.524*	---	---	---	---	---
Housewives	---	---	---	---	---	---
Role Quality						
+ R^2 Incr.	-.001	.050	.210	.096	.163	.080
F	6.55***	2.30**	6.82***	3.38***	4.96***	2.54***
PR1	---	-.312**	---	---	---	---
PR2	---	---	---	---	---	---
PR3	---	---	---	---	---	---
PC1	---	.350**	.574***	---	-.274**	.236*
PC2	-.120*	---	---	---	-.150*	.199**
PC3	---	---	---	.180**	---	---
Cumulative R^2	.194	.700	.260	.126	.193	.080

NS=Non significance *p<.05, **p<.01, ***p< .001. Note. + Indicates a new step in the regression analysis. Standardised regression. coefficients (Beta) are reported for variable entered in the regression at that step.

PR1= marital satisfaction and compatibility
PR2= partner support
PR3= religious beliefs

PC1= marital dissatisfaction, lack of support and communications
PC2= partner job
PC3= religious beliefs

Table 5.16. Hierarchical Regression Analysis of Sociodemographic and the Dimensions of Mother Role Quality Variables with Health Indicators

N=417	Health Perception	Anxiety	Depression	Self-esteem	Well-being	Symptoms
+ R^2 Incr.	.145					
F	36.39***					
Anxiety	---					
Depression	-.390***					
Sociodemographic Vs						
+ R^2 Incr.	.042	.000	.030	.000	.040	.000
F	20.07***	NS	4.46*	NS	5.21***	NS
Age	---	---	---	---	---	---
Education	.196***	---	---	---	.133*	---
Children < 7 years	---	---	---	---	---	---
Role Occupancy						
+ R^2 Incr.	.005	.030	.050	.020	.002	.000
F	13.32***	2.79*	5.12***	2.14*	6.11***	NS
Work	---	.267*	---	.189**	---	---
Partner	---	---	-.243***	---	.156**	---
Mother	---	---	---	---	---	---
Occupational Status						
+ R^2 Incr.	.003	.010	-.010	---	.027	.000
F	9.37***	2.26*	3.40***	NS	2.87**	NS
Blue-Collar	---	---	---	---	---	---
Clerical	---	---	---	---	---	---
School Teachers	--	---	---	---	---	---
Professionals	.524*	---	---	---	---	---
Housewives	---	---	---	---	---	---
Role Quality						
+ R^2 Incr.	-.007	.067	.174	.134	.090	.060
F	6.36***	3.10***	6.69***	4.21***	4.35***	2.31**
MR1	---	.185*	.142*	.231**	---	.166*
MR2	---	---	---	---	---	---
MR3	---	---	---	---	---	---
MC1	---	.245***	.337***	---	---	---
MC2	---	---	---	-.131*	---	---
MC3	---	---	.170**	---	-.173**	---
Cumulative R^2	.188	.107	.244	.154	.159	.060

NS=Non significance *p<.05, **p<.01, ***p< .001. Note. + Indicates a new step in the regression analysis. Standardised regression coefficients (Beta) are reported for variable entered in the regression at that step.

MR1= satisfaction
MR2= support and communications
MR3= interaction
MC1= conflicts and dissatisfactions
MC2= overload
MC3=economical strain and adolescent period

Interactions between Role-Quality Concerns Dimensions, Psychosocial Variables and Health

The moderating effects of the dimensions of role-quality rewards as well as social support, household responsibilities and work-family relationships between the dimensions of role-quality concerns and health indicators were tested in an exploratory analysis using the procedure described in sections of the statistical analysis. Only significant interaction effects will be presented. In the graphical representation of the interaction effects, independent and moderator variables were dichotomised according to the median (over and bellow the median) as suggested by Arnau (1986).

Job-Concerns Dimensions

Significant interaction between Monotony and Job control factor in relation to self-esteem (Table 5.17).

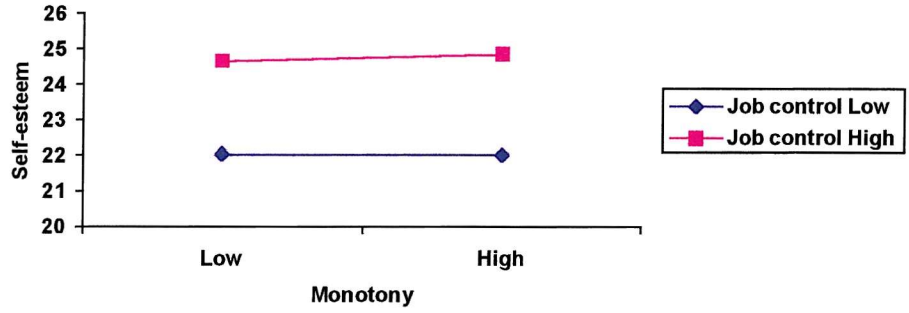
Table 5.17: Hierarchical regression analysis of Job-Concern, Health Indicators and Interactions

N=417	Anxiety	Anxiety	Self-esteem	Well-being
Sociodemographics Vs				
+ R^2 Incr.	.000	.000	.000	.039
F	NS	NS	NS	5.25**
Age	---	---	---	---
Education	---	---	---	.127*
Children < 7 years	---	---	---	-.115*
Role Occupancy				
+ R^2 Incr.	-.002	.096	.020	.019
F	8.57***	8.37***	2.56**	4.89***
Work	---	.201***	.131**	---
Partner	---	.255***	---	.160**
Mother	---	---	---	---
Occupational Status				
+ R^2 Incr.	.005	-.004	.000	-.001
F	5.40***	5.20***	2.07**	3.14**
Blue-Collar	---	---	---	---
Clerical	---	---	---	---
School Teachers	---	---	---	---
Professionals	---	---	---	---
Housewives	---	---	---	---
Role Quality				
+ R^2 Incr.	.050	.028	.135	.090
F	6.48***	.536***	6.88**	5.55***
JR2			.725***	
JC2			.745***	
JR2 ×JC2			-.468**	
Home Tasks	-.325*			
JC 1	-.471*			
Home tasks ×JC1	.752***			
Satisfaction between Roles		---		
JC2		.642***		
Satisfaction ×JC2		-.689**		
JR 2				---
JC3				-.662**
JR2 ×JC3				.515*
Cumulative R^2	.146	.120	.155	.147

NS=Non significance, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Note: + Indicates a new step in the regression analysis. Standardised regression coefficients (Beta) are reported for variables entered in the regression at each step.
Job Reward 2= job control Job Concern 1= Overload Job Concern 2= monotony.
Job Concern 3= disaffection with salary, lack of recognition and promotion

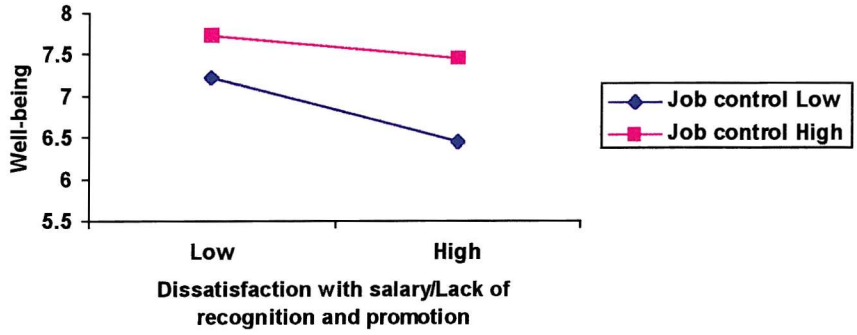
Self-esteem is always higher for those women with high job control and this is independent of the monotony of their jobs (Figure 5.1).

Figure 5.1: Interaction of Job Control and Monotony on Self-esteem



Dissatisfaction with the salary and lack of recognition and promotion at work was related to lower levels of well-being. Job control had a buffering effect on dissatisfaction with the salary and lack of recognition and promotion at job (Table 5.17). Those women with high job control reported higher levels of well-being compared to women with low job control regardless the level of dissatisfaction with salary and lack of promotion (Figure 5.2).

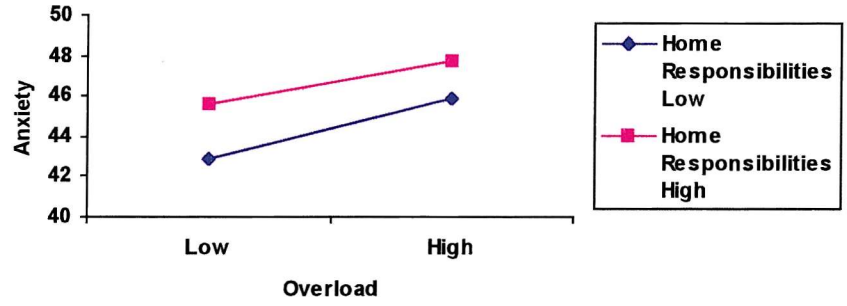
Figure 5.2: Interaction of Job Control and Dissatisfaction with Salary/Lack of recognition and Promotion on Well-being



Considering household responsibilities, tasks and job overload (Table 5.17), it was found that women experienced higher levels of anxiety when they had to carry on with

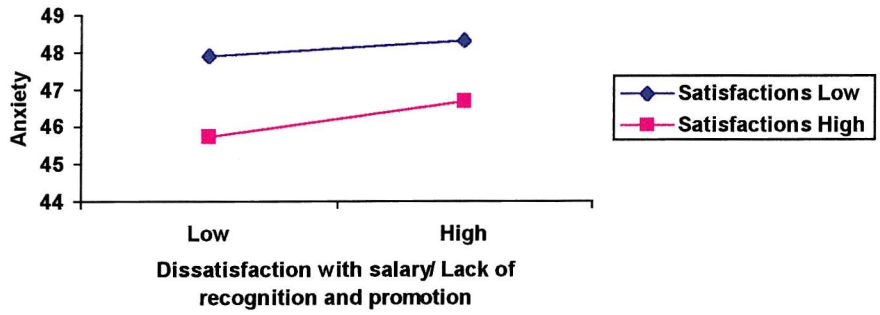
household chores and child care, but anxiety increased when job overload was higher (Figure 5.3).

Figure 5.3: Interaction of Home Responsibilities and Job Overload on Anxiety



The interaction between dissatisfaction with salary/lack of promotion and work-family roles satisfactions and anxiety showed that women with higher levels of satisfaction between roles reported lower anxiety compared to those with lower satisfaction (Table 5.17). However, anxiety feelings increased much more for those women who reported higher disaffection with the salary and lack of promotion and recognition (Figure 5.4).

Figure 5.4: Interaction between Satisfactions and Dissatisfaction with the Salary/Lack of recognition and Promotion on Anxiety



Partner-Concerns Dimensions

The perception of control on job conditions and abilities also had a protective effect for those women who reported marital dissatisfaction and lack of support from their partner (Table 5.18). As it was seen in relation to job concern, job control was associated with a better perception of physical health, after controlling for anxiety and depression Under conditions of high stress because of marital dissatisfaction and lack of support, the perception of physical health for those women who perceived job control was less affected compared to women with low perception of job control (Figure 5.5).

Figure 5.5: Interaction of Job Control and Marital Dissatisfaction, Lack of Support and Communication on Health Perception

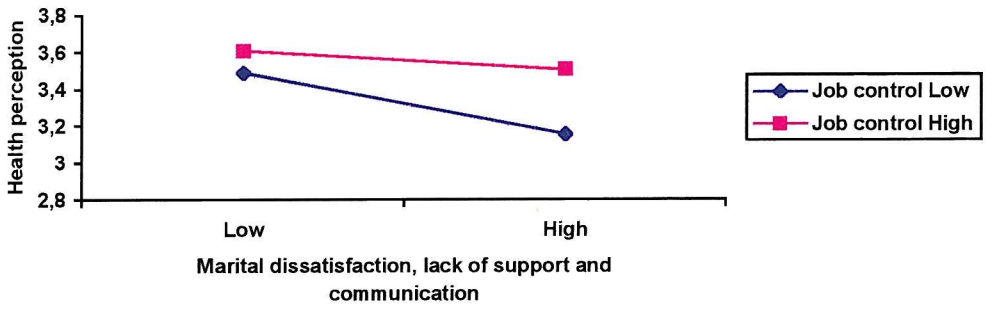


Table 5.18: Hierarchical Regression Analysis of Partner-Concern, Health Indicators and Interactions

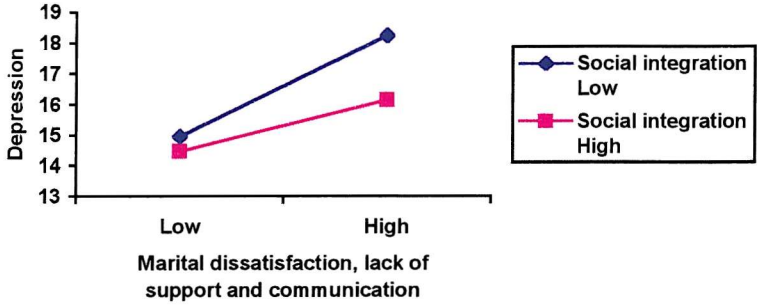
N=417	Health Perception	Depression
+ R^2 Incr.	.145	
F	36.39***	
Anxiety	---	
Depression	-.390***	
Sociodemographic Vs		
+ Adj. R^2 Incr.	.042	.022
F	20.07***	3.00*
Age	---	---
Education	.196***	---
Children < 7 years	---	---
Role Occupancy		
+ R^2 Incr.	.005	.008
F	13.38***	2.39*
Work	---	---
Partner	---	---
Mother	---	---
Occupational Status		
+ R^2 Incr.	.003	.018
F	9.37***	2.35**
Blue-Collar	---	---
Clerical	---	----
School Teachers	---	---
Professionals	.524*	---
Housewives	---	---
Role Quality		
+ R^2 Incr.	.006	.310
F	7.99***	12.54***
JR 2	.138**	
PC1	---	
JR 2 ×PC1	-.158*	
Social integration (SI)		---
PC1		.186***
SI×PC1		-.792**
Cumulative R^2	.159	0.358

NS=Non significance, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.
Note: + Indicates a new step in the regression analysis. Standardised regression coefficients (Beta) are reported for variables entered in the regression at each step

PC1= marital dissatisfaction, lack of support and communications
JR2= job control

An interaction was found between social integration and marital dissatisfaction and lack of partner support (Table 5.18). Women with higher social integration reported lower depression and it protected against depression in conditions where marital dissatisfaction is high (Figure 5.6).

Figure 5.6: Interactions of Marital Dissatisfactions/Lack of Support and Social Integration on Depression



Mother-concerns dimensions

Significant interactions were found between mother demands and satisfactions with work and family and emotional support (Table 5.19).

Table 5.19: Hierarchical regression analysis of Mother-Concern, Health Indicators and Interactions

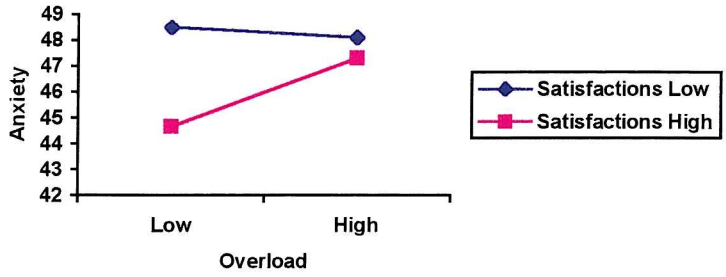
N=417	Anxiety
Sociodemographic Vs	
+ R^2 Incr.	.000
F	NS
Age	---
Education	---
Children < 7 years	---
Role Occupancy	
+ R^2 Incr.	.098
F	8.57***
Work	---
Partner	---
Mother	---
Occupational Status	
+ R^2 Incr.	-.002
F	5.40***
Blue-Collar	---
Clerical	---
School Teachers	---
Professionals	---
Housewives	---
Role Quality	
+ R^2 Incr.	.021
F	5.22***
Satisfaction between Roles	---
MC2	---
Satisfaction×MC2	-.189*
Cumulative R^2	.117

NS=Non significance, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.
Note: + Indicates a new step in the regression analysis. Standardised regression coefficients (Beta) are reported for variables entered in the regression at each step. MC2= overload

As Figure 5.7 shows, women with higher satisfactions regarding work and family lives reported lower levels of anxiety. However, when demands in mother's roles are high

anxiety significantly increased, especially for those women with higher satisfactions, becoming almost equal to that of women with lower satisfaction.

Figure 5.7: Interaction on Satisfactions and Overload on Anxiety



5.4. - Discussion

The findings reported suggest important issues about multiple roles, psychosocial factors and health in women. First, they replicate Study 1, which found that the impact of multiple roles in women's health depends mainly on how those roles are experienced and not on the number of roles. Second, despite the fact that the occupancy of a job role was positively associated with anxiety and self-esteem, it was found that job, as well as partner role quality, seemed to be much more important for explaining the relationship between multiple roles in women and health considering both additive and interactive models. Contradictory results were found in relation to the quality of mother role. Third, social integration as well as emotional support behaved as a protective psychosocial variable. Fourth, it was reconfirmed that distribution of household work needs to be considered in relation to a gender conception of work and family. Fifth, conflicts between work and family were a very sensitive variable when considering their relationship with health and the other psychosocial variables.

Job- Role Quality and Health

Previous cross-sectional and longitudinal studies have established a relationship between quality of experiences at work and psychological distress (Baruch & Barnett, 1986; Barnett, Marshall & Singer, 1992; Barnett, Marshall, Raudenbush and Brennan, 1993). Men and women who report positive job experiences also report low levels of anxiety and depression, whereas those whose experiences are negative indicated high levels of distress (Barnett & Brennan, 1995). In the present study, contradictory results were found in relation to job-role quality when main effects were analysed. Although the reward of work was associated with higher levels of well-being, self-esteem and a better perception of physical health, it also generated higher levels of anxiety.

When considering which specific aspects of work predicted mental and physical health, it was found that supervisor support was clearly the variable that best explained the high percentage of variance of job rewards, associated with self-esteem, depression and anxiety. The support derived from co-workers and helping others was also related to higher self-esteem. Many studies confirm the importance of supervisor and co-workers support in reducing job-related stress and increasing well-being in the workplace (Barnett & Marshall, 1991; Beehr, 1985; Cohen & Willis, 1985; LaRocco & Jones, 1980). However, other studies have found negative, very little or no relationship between work support and strain (e.g. Beehr, 1976; Aston & Lavery, 1993). In the present study these mixed results cannot be seen as independent associations. While work support improves self-confidence and self-esteem, at the same time, this support could be perceived as an extra demand and compromise that could be reflected in more distress.

A combination of rewarding situations related to autonomy/control and skill discretion entered in the same dimension of the factor analysis carried out in the present study. These two predominant features of the workplace are frequently cited in research

focusing on the impact of work on individuals and in relation to stress and health (Karasek & Theorell, 1990; Pugliesi, 1988; Repetti, 1987). Decision authority is related to task control and autonomy; skill discretion refers to challenge, variability of work tasks, using of skills, abilities and interests. Jobs that are low in skill discretion and low in decision authority have been associated with psychological distress. The combination of both aspects has been called job control (Karasek & Theorell, 1990; Cheng et al., 2000).

Working women who perceived that they had job control reported better physical health, higher levels of self-esteem and well-being and fewer symptoms of health problems. These results are in line with those of Pugliese (1988) who also found direct effect of control/autonomy on self- esteem. The more interested, challenged and skilled a person is at his/her work, the greater their happiness and well-being.

Job-concerns were associated with higher levels of anxiety, depression and symptoms reported. Specifically, overload, monotony, dissatisfaction with the salary, lack of recognition and promotion were related to higher levels of anxiety and depression, more symptoms and lower levels of well-being. These results reconfirm the findings of Study 1 and those of other studies in the literature (Barnett & Marshall, 1991; Aneshensel, 1986). The relationship between job stress and health were also reported by Aston & Lavery who found that low extrinsic rewards (e.g. promotion, salary) and high extrinsic concerns (overload, monotony, conflicts with supervisor) are related to increased symptomatology and are similar to the finding that daily hassles predict somatic illness (DeLongis, Coyne, Dakof, Folkman & Lazarus, 1980).

In the present study, job control also acted as an important protective factor against stress, especially in relation to psychosocial work stressors such as monotony, dissatisfaction with the salary and lack of recognition and promotion. High perceptions of job control buffer the effects of work stress on women's subjective well-being, self-esteem and self-perception of physical health. Job control has been increasingly recognised as a topic of major importance in the context of research into work

conditions and their impact on satisfaction and well-being (Parkes, 1989; Theorell, 1989; Noor, 1995a).

One of the hypotheses of the Job Demand-Control Model (JDC) states that control can buffer the potentially negative effects of high demands on health and well-being (Karasek, 1979; van der Doef & Maes, 1998). The majority of the studies on JDC focused on the strain hypothesis and the research in relation to the buffer hypothesis has been supported by few studies and has focused mainly on male populations (van der Doef & Maes, 1998). In the present study the association was found for other psychosocial work variables and not for job demands. Also it was found that the satisfactions (rewards) which jobs provide enriched family life and increased social network and support, buffered stress related with disaffection with the salary and lack of recognition and promotion. The present findings can provide theoretical contributions in relation to job stress in women.

Partner-role Quality, Health and Bell-being

Having a partner was negatively related to depression and had a positive relationship with well-being. According to these results, marriage appears to benefit women in terms of reduced distress. Nevertheless, when the quality of the partner is taken into account, marital dissatisfaction, lack of partner support and partner demand was associated with higher levels of depression, anxiety, reported symptoms and a low perception of well-being. Also, partner's job/career problems were related to a worse perception of physical health in women. Marital satisfaction was negatively associated with depression. These findings suggest that when the quality of marriage is taken into account, the impact on well-being and health is stronger. These results are not surprising and are in line with investigations such as Ross, Mirowsky & Goldsteen (1990); Ross (1995); Tucker, Friedman, Windgard and Schwartz; Stack and Eshleman (1998), among others.

The present study also showed that the rewards of perceived control over job conditions as well as social integration and networks protect working women from the effects of the stress related to marital conflicts and partner's lack of support on health perception and depression. These results indicated that the buffering hypothesis of social support is similar in concept to Karasek's job-demand control model. Both models indicate that some variables (worker control or social support) interact with stressors in such a way that the effect of stressors upon well-being and health is lessened (Daniels & Guppy, 1994). Also these findings reflected how work and nonwork domains interact and the relevance of considering both aspects in the study of stress and health.

Emotional support played an important buffer role against the perception of physical health in relation to partner concerns but its effects vary according to the stressor. A worse perception of physical health in conditions of high conflicts because of partner's job was reported (e.g. partner job instability, salary is not enough, high demands, argued because of economic problems). These results reflected the importance of men's traditional role as a breadwinner. Economic support constitutes a very important and sensitive issue that contributes to family quality of life and well-being. However, women with high emotional support were less affected by men's job conditions.

In conflicts between the couple because of lack of respect and sharing of religious beliefs, it was found that for those women with low emotional support, the perception of physical health decreased significantly but improved for those women with high emotional support. This finding pointed out that emotional support acted as a coping strategy for this stressful situation.

Mother-role Quality and Health

Considering the mother-role quality dimensions, contradictory results were found. Satisfaction with the children was positively associated with self-esteem but also to anxiety and depression. Likewise, the higher the satisfactions the mother experienced

with her children the more symptoms she reported. Conflicts and disaffection with the children as well as economic strain and having adolescents were related to anxiety and depression and a lower perception of well-being. Overload was associated with lower self-esteem.

When interactions were considered, the satisfactions generated through work proved to protect the mental health of working mothers when demands to their maternal role were low, but ceased to be protective when they were exposed to greater demands and interferences.

It was surprising that, compared to the other roles there were no protective factors for women with children. Based on these findings we can conclude that for this group, being a mother was a source of psychological distress and produced the worse perception of health, which increased especially when these women experienced high demands and interferences because of the children. These results agree with Dixon et al. (1991) and Kessler and McRae (1981) who also found worse symptoms of anxiety and depression in their groups of working mothers. Barnett and Baruch (1985) and Cohen et al. (1990) also reported that the parental role is a very important source of stress among women. However, studies such as that performed by Verbrugge (1986) point out that women with children have better mental health than those without children.

As we mentioned before, the performance of all roles does not always become positive or negative for all women and the perception of the role quality is crucial. In addition, it is important to take into account other variables such as age and number of children, who the person responsible for their care is, marital and working status of the mother and whether she gets any help at home.

Social Support and Health

Social integration was clearly associated with socio-demographic variables such as age, role occupancy, occupational level and health indicators. It was found that women with a higher educational and occupational level had more social contacts and networks. However, consistent effects of education on support are not found in the literature (Pugliesi, 1988). Working women with small children reported less social integration compared with those who are single or only have a partner. Also housewives reported less contacts and social networks compared with working women with children and a partner.

When considering how social support affected health, it was found that social integration was associated with a higher self-esteem and well-being as well as less self-reported symptoms and depression. Also those women with more social networks and social integration perceived less job, partner and parental concerns and more job and partner rewards. Also social integration protected women from depression when they had marital problems.

These results confirm the relevance of social integration and support networks that has been widely reported in the literature because of their impact on health and well-being (Berkman & Syme, 1979; Cohen, 1990). The frequency of social contacts, the number of available persons and the amount of social activities seem to have a substantial effect on health and survival (Orth-Gomer & Unden, 1987; Oxman, Freeman & Manheimer,1995). Hirsch and Rapkin (1986) argued that for women, the response of network members is so important, first, because women are more likely than men to be socialised into an expressive role emphasising emotional nurturance and support and second, women are particularly vulnerable to inter role conflict between work and family as well as overload from both sets of responsibilities.

Emotional support behaves also as a main protective factor because of its association with higher self-esteem and well-being and lower depression and symptoms, but also as

a moderator of partner job problems and conflicts because of religious beliefs and health, as mentioned above.

Household work and well-being

In this research it was found that older women reported less home responsibilities. When considering the role occupancy it was found that working women, especially those who have children, reported having more responsibility for home management and home tasks compared to housewives. Women who had a partner perceived that distribution of home responsibilities was fairer. No statistical differences were found when considering the occupational levels of working women. Those women who had to manage households reported less partner rewards and more partner and mother concerns. Housewives reported lower involvement in household work, however, this group was significantly older and did not have small children.

When considering the interaction effects, only household tasks interacted with job overload. Women with more household chores and childcare responsibilities reported more anxiety, which significantly increased when they also had job overload. In this sample, women reported more responsibilities both in household work and caring of the children. This burden is heavier during child rearing years. The studies of Goldscheider and Waite (1991), Moen and Dempster-McClain (1987) are in line with this latter finding. These results also indicated that women and men still conform to the traditional gender conception concerning the division of household work.

Work-Family Relations

In the present study we evaluated the positive and negative aspects of work on family, leisure time and social life. Conflict between work and family was a sensitive variable when considering the main relationship of this variable with health and other psychosocial variables. Interference of work into family life was associated with a worse perception of physical health, higher levels of depression and self-reported

symptoms and lower levels of well-being. Women with higher educational levels also reported more interference. On the other hand, satisfactions between the different domains of women's life were associated with lower levels of anxiety and higher self-esteem. Working women with a partner revealed more satisfactions than those who did not have a partner.

The satisfactions women experienced in their job - which enrich their family lives- buffered the level of anxiety due to dissatisfactions with the salary and the lack of recognition and promotions at work. However, these satisfactions cease to be protective when the women experience an overload of work in their role as mothers, as mentioned previously.

These results indicated that the processes investigated here were very complex and are part of a larger phenomenon: the work-family interface. Both positive and negative influences need to be studied further and not independently.

CHAPTER 6

STUDY 3: " The Influence of Role Quality, Household Responsibilities, Work-Family Relationship and Social Support on the Physical and Mental Health of Venezuelan Working-Women: A Longitudinal Study"

The findings of studies 1 and 2 showed that certain experiences within the work role were related to women's health and well-being. The studies also showed that the quality of the partner's role had an important impact on working women's health. Contradictory results were found regarding the mother role. Other psychosocial variables considered in previous studies such as social integration, emotional support, distribution of household and child caring responsibilities and work-family relationship showed also an important effect on health outcomes. However, as the studies were cross-sectional in design, these results represent only one particular moment in the life of women.

In the present study, a longitudinal design was used to test predictive relationships. The potential causal influence of the dimensions of role variables on self-reported physical and mental health as well as social support, household responsibilities and spillover were examined. In the present study, data were collected at two different points in time (spaced over a period of 16 months). Health variables assessed at Time 1 were also used to predict health and well-being at Time 2. In addition, control for pre-existing levels of health and well-being were introduced by entering Time 1 outcomes at the first stage of the regression analysis.

As in Study 2, different groups of employed women were studied. In the present study, three occupational levels were selected. The first group were blue-collar workers, mainly cleaners, the second were secretaries and the third consisted of women from within the professional occupations, the majority of whom were academics. As was pointed out in the previous studies, type of occupation is a characteristic that may influence the stressors to which people are exposed; those with higher occupational status often experienced

different stressful situations than those with low status jobs. Even when exposures to stressors are similar for the three groups of women, the effects of these stressors on health may well be influenced by occupational status (Noor, 1995b).

The main objective of this study was to examine the predictive contributions of the work and family-role experiences, distribution of household responsibilities, work-family relations and social support in relation to women's health considering different occupational levels.

6.1. - Method

Participants

The participants were working women from two of the five higher education centres of the metropolitan area of Caracas who participated in Study 2. The respondents worked as professionals, clerical and blue-collar workers.

A total of 210 women who participated in Study 2 (Time 1-June 96) were contacted for the proposed longitudinal study 16 months later (Time 2-October 97). Initially 196 (blue-collar n=36; clerical n=65; professional n= 95) responded to this call (93.3%) and 130 returned the questionnaires (a response rate of 66.3% of those willing to participate). The analyses to be described in this chapter were based on these 130 subjects (blue-collars =32; clericals= 34; professionals= 64).

No statistical differences in the outcome measures were found between the sample (n= 130) and the rest of the women who participated in Study 2 and were invited to participate in the longitudinal study but never replied to the invitation (n= 80).

Procedure

Working women from two of the five institutions who had participated in Study 2 were contacted 16 months later. A letter of invitation was sent informing them the objectives of the proposed longitudinal study including the phone numbers and email of the researcher (Appendix 7).

The questionnaires were delivered to the working women who agreed to participate, instructing them to return the enclosed envelope within 72 hours to the place where it was delivered or via the institution's internal mail, where it would be picked up by the researcher. A reminder letter was send a week after.

The questionnaires related to physical health (self-perception of physical health and report of symptoms), morbidity measures and mental health were administered again, including a question at the end related to changes in each role and a description of these changes. The psychosocial variables (Quality of the Role, Distribution of Household Responsibilities, Work-Family Relations and Social Support) were measured only at Time-1.

Statistical Analyses

A descriptive analysis was made of all the variables. The data were analysed using one-way ANOVA tests in order to compare the differences in the psychosocial variables and health indicators among the 4 groups of working women based on their number and type of roles (single employed, employed mother, employed wife, employed/partner and mother) and occupational levels (blue-collar, clerical and professional) for Time-1 and Time-2. *Post hoc* analyses were carried out using Bonferroni's test.

In order to evaluate the relationship between health, psychosocial and sociodemographic variables, a series of Hierarchical Multiple Regression analyses were

carried out for Time-1 and Time-2. Independent variables were entered in a predetermined sequence. R square is reported for each step of the regression, with the significance of the inclusion of these variables in the regression equation. The standardised beta coefficient for each variable in each step is reported. Age, education and having pre-school children or not were included in the first step, while the second step included role occupancy (partner, mother), and the third step occupational level. Dummy variables were created for the partner and parental roles as well as occupational level. For Time-2, initial levels of health outcomes were controlled in order to control the *healthy worker effect*.

6.2. - Results

Sociodemographic Characteristics in Time-1

The participants were between 20 and 66 years of age, with an average of 38 years (SD= 8.91). Since the age range was rather large, a better picture of the sample was obtained by considering the participants within certain age groupings. As can seen in Table 6.1, the majority of the subjects (92.4%) were in the age range of 22 to 50 years and most of the women had partners (68%).

Ninety two percent of the women participating in the study had children. Seventy six percent had between one and three children and 44 % at least one pre-school age child (Table 6.1). The ages of their children ranged from 3 months to 37 years old.

As regards the educational level, 49% of the participants had a university degree, nine percent had not finished elementary school. As for the occupational status of the participants, almost half were professionals (Table 6.1). They worked between 32 and 47 hour per week with a mean of 38.8 (SD= 12,28).

Table 6.1: Sociodemographic and Health Characteristics of the Sample (*)

		Time-1		Time-2	
		N	%		%
Age	Young (-36)	52	43.4		
	Interm (37-50)	63	49		
	Older (51-66)	10	8		
Marital status	With partner	88	67.7		
	Without partner	42	32.7		
Number of children	No children	10	7.9		
	1	39	30.7		
	2-3	57	44.8		
	> 4	21	16.5		
Children under 7 years old	Yes	57	43.8		
	No	73	56.2		
Type of roles	Paid worker mother	42	32.3		
	Paid worker & partner	10	7.7		
	Paid worker-mother-partner	78	60		
	Yes			60	46.5
Changes in roles in T2	No			69	53.5
1	No finished primary school	12	9.2	12	9.2
Education	Primary school	36	27.7	36	27.7
	High school	12	9.2	12	9.2
	University degree	64	49.2	64	49.2
Occupational Status	Professionals	64	49.2	64	49.2
	Clericals	34	26.2	34	26.2
	Blue-collars	32	24.6	32	24.6
Self-reported Health Scale	Very poor & poor	9	7	10	7.7
	Good	78	60	69	53.1
	Very good	34	26.2	43	33.1
	Excellent	9	6.9	8	6.2
In bed last 6 months	Zero days	83	64.8	86	66.7
	1-3	30	23.5	30	23.3
	4 -9	11	8.5	10	7.7
	> 10	4	3.2	3	2.4
Medical appointments last 6 months	0	43	33.1	28	21.7
	1-3	68	52.3	81	62.8
	4-6	17	13.1	14	11
	> 7	2	1.6	6	4.8
Psychological consultation	0	122	93.8	114	88.4
	1-3	6	4.6	8	6.3
	> 4	2	1.6	7	4
Work absenteeism last 6 months	0	66	52.4	63	48.8
	1-3	42	33.3	40	32.6
	4-9	8	6.4	16	12.6
	>10	10	8	8	6.4

N= 130 *In some cases percentages do not add to 100 due to missing values

Table 6.2 shows the characteristics of the sample according to occupational status. Blue-collar workers were significantly younger, worked more hours per week, had more children and 60% had no partner.

Table 6.2: Descriptions of Samples by Occupational Status

	Blue-collar (n=32)		Clerical (n=34)		Professional (n=64)	
	Mean	***SD***	***Mean***	***SD***	***Mean***	***DS***
Age	34.50	9.90	35.53	9.46	41.19	6.98
Number of hours worked per week	46.64	14.45	31.98	13.56	38.23	7.98
	Frecuency	***%***	***Frecuency***	***%***	***Frecuency***	***%***
Number of children						
0	1	3.4	3	9.4	6	9.4
1	4	13.8	11	34.4	24	37.5
2-3	13	44.8	13	40.6	29	45.4
<4	11	37.9	5	15.6	5	7.8
Children under 7 years old						
Yes	16	50	20	62.5	19	29.7
No	16	50	12	37.5	45	70.3
Marital status						
With Partner	13	40	25	78.2	44	68.8
Without Partner	19	60	7	21.8	20	31.2
Partner occupation						
Blue-collar	17	53.1	10	41.7	--	--
Clerical	--	--	--	--	--	--
Officers	--	--	10	41.7	2	--
Professional	1	1	3	12.5	57	4.5
Salesman	--	--	1	4.2	5	84.1
						11.4

Comparison of Time-1 and Time-2 Measures on the Health Variables

As Table 6.1 shows most of the participants perceived themselves to be healthy at both Time 1 and Time 2. Only a small percentage of the group perceived their health as poor or very poor. Table 6.1 also shows the percentage of the sample that stayed in bed due to ill health, attended medical and psychological consultations and had been absent from work at Time 1 and Time 2.

No difference was observed between Time-1 and Time-2 related to smoking, exercise, alcohol consumption and sleeping problems (Table 6.1).

The means and SD of the health indicators used in the analyses in Time 1 and Time 2 are shown in Table 6.3. Anxiety and Symptoms report were significantly lower at Time 2, whereas Depression increased in the follow-up measure.

Table 6.3: Comparisons of Physical and Mental Health Indicators at Time-1 and Time- 2

VARIABLES	Paired "t" tests	Mean	
		Time 1	**Time 2**
Self-perception of Physical Health	-.59 NS	3.32	3.32
Well-being	2.71 NS	7.15	7.54
Anxiety	8.87***	47.38	38.95
Self-esteem	-1.44 NS	23.02	23.45
Depression	-7.97 ***	15.13	18.04
Symptoms report	-1.79**	18.16	17.56

NS= Non significance, * p<0.05, ** p<0.01, *** p<0.001

Intercorrelation of Measures

Appendix 10 shows Table 6.4 with intercorrelations between the sociodemographic, psychosocial and health variables at Time1 and Time 2.

Health Indicators According to the Type of Roles and Occupational Status

Table 6.5 (Appendix 11) shows the comparison of the Health Indicators according to the types of roles. *Post hoc* comparison indicated that employed mothers reported the highest levels of Depression at Time-1 ($F= 8.32$; $p< .001$). Also, employed women with partners reported significantly more Symptoms at Time-1 ($F = 4.11$; $p< .01$). Employed mothers and partner reported the highest levels of Well-being at Time-1 ($F= 3,62$; $p< .05$). No differences were observed in any of the health indicators according to the type of roles at Time-2.

When the health indicators were compared at Time-1 and Time-2 according to the occupational status, post hoc comparisons showed only statistical differences in Self-Perception of Physical Health in Time-1 ($F= 4.10$; $p< .01$). Professional women reported a better perception of physical health compared to clerical and blue-collar workers (Appendix 11, Table 6.6).

Psychosocial VariablesAaccording to Type of Roles and Occupational Status

Table 6.5 (Appendix 11) presents the means and SD of the psychosocial variables measured a year before according to the types of roles. *Post hoc* comparisons showed statistical differences only for the management of household chores ($F= 26.06$; $p< .01$). Employed mothers are the group of working women who had more responsibilities in the management of household chores and childcare.

When *post hoc* comparisons were made according to occupational status (Table 6.6, Appendix 11), it was found that professional women had significantly more job rewards ($F= 19.81$; $p< .001$); more social integration ($F = 5.66$; $p< .001$) but at the same time reported more role interferences ($F = 7.65$; $p< .001$). Blue-collar workers were the group

who perceived more responsibilities in the management of household chores and childcare ($F = 10.93$; $p < .001$).

Clerical workers were the occupational group with the least home responsibilities (tasks) ($F=4.12$;$p<.01$).

Relation of the Sociodemographic and Psychosocial Variables to the Physical and Mental Health Evaluated in Time 1 and in Time 2.

In order to explore the independent contributions of the sociodemographic and psychosocial variables to health outcomes, a hierarchical regression analysis was used. The independent variables were entered in a pre-determined order, with control variables entered first. In both, Time-1 (cross-sectional analysis) and Time-2 (longitudinal analysis) the control variables were, in the first step age, education, having or not having children under 7 years old; in the second step, role occupancy (partner and mother) and in the third step, occupational status. Each psychosocial predictor variable was entered in a separate step in the regression analysis in order to establish the percentage of explained variance of each psychosocial variable. As well as in Studies 1 and 2, self-perception of physical health was controlled in Time-1 for anxiety and depression.

The hierarchical regression analysis carried out with the longitudinal data was similar to the one described for the Time-1 cross-sectional data. However, in this case, Time-1 outcome scores were entered as first step predictors. This statistical procedure tests the effects of Time-2 predictors on the Time 1-Time 2 changes on the outcome (Cohen and Cohen, 1983). In each regression analysis, the outcome measures were self-reported perception of physical health, anxiety, depression, self-esteem, symptoms and well-being.

In relation to Time-1, education was the sociodemographic variables associated with health. Working women with a higher level of education reported a better perception of physical health after controlling for anxiety and depression (Table 6.7).

When the psychosocial variables entered in the regression analysis, emotional support and social integration explained between 3% to 29% of the explained variance. Emotional support was related to lower depressive indicators, lower symptoms and well-being. Social integration was associated with less depressive symptoms (Table 6.7).

Table6.7: Hierarchical Multiple Regression Analysis of Sociodemographic and Psychosocial Variables with Health Indicators in Time-1 and Time-2

	Self-perception of physical health						Anxiety						Depression					
	Time-1			Time-2			Time-1			Time-2			Time-1			Time-2		
N=130	Incr. R^2	F	Beta	Incr. R^2	F	Beta	Incr. R^2	F	Beta	Incr. R^2	F	Beta	Incr. R^2	F	Beta	Incr. R^2	F	Beta
+ Self-perception physical health	.095	6.63**		.091	9.79**	.267***												
Anxiety			--							.041	5.45*	.202*						
Depression			-.310***													.280	50.30** *	.582***
Time-1																		
+ Sociodemographic Vs	.042	3.94*		.019	3.07**		.024	NS		.066	3.75**		.020	NS		.030	13.30** *	
Age			--			--			--			--			--			--
Education			.193*			--			--			-.284**			--			--
Children < 7 years			--			--			--			--			--			--
+Role Occupancy	.018	3.19**		.003	2.10*		.011	NS		.045	2.48*		.126	.423***		.014	10.52**	
Partner			--			--			--			--			-.363***			
Mother			--			--			--			--						-.247**
+Occupational Status	.011	2.36**		.025	NS		.007	NS		.056	2.81**		.029	.321**		.044	8.14***	
Blue-Collar			--			--			--			--			--			--
Clerical			--			--			--			--			--			--
Professionals			--			--			--			.704*			--			--
+Social Support	.029	2.35**		.003	NS		.061	NS		.178	3.80***		.292	4.52***		.020	6.86. ***	
Emotional support			--			--			--			-.243**			-.255***			--
Social Integration			--			--			--			-.160*			-.165**			--
+Home responsibilities	.022	2.27**		.018	NS		.005	NS		.010	3.69***		.008	4.39***		.012	5.91***	
Management			--			--			--			.178*			--			--
Tasks			--			--			--			--			--			--
+ Work-family relationships	.003	1.98*		.014	NS		.004	NS		.039	4.37***		.018	4.40***		.002	5.12***	
Interferences			--			--			--			.271***			.203**			--
Satisfactions			--			--			--			--			--			--
+Role Quality	.061	1.90*		.069	NS		.155	1.86*		.029	3.41***		.023	3.23***		.033	4.21***	
Job rewards			--			--			.373***			-.225*			--			--
Job concerns			--			--			.456***			--			--			--
Partner rewards			--			--			--			--			--			--
Partner concerns			--			--			--			--			--			.212**
Mother rewards			--			--			--			--			--			--
Mother concerns			--			--			--			--			--			--
Cumulative R^2	.245			.217			.267			.464			.516			.435		

NS=Non significance *p<.05, **p<.01, ***p< .001. Note. + Indicates a new step in the regression analysis. Standardised regression coefficients (Beta) are reported for variable entered in the regression at that step.

Table 6.7: Continued

	Self-esteem						Well-being						Symptoms Report					
	Time-1			Time-2			Time-1			Time-2			Time-1			Time-2		
N=130	Incr. R^2	F	Beta	Incr. R^2	F	Beta	Incr. R^2	F	Beta	Incr. R^2	F	Beta	Incr. R^2	F	Beta	Incr. R^2	F	*Beta*
+ **Self-esteem Time-1**				.355	70.56***	.596***												
Well-being Time-1										.040	5.25*	.199*				.263	45.76***	.513***
+ Sociodemographic Vs	.011	NS		.028	19.38***		.062	2.77*		.063	3.60**		.067	3.00*		.011	11.80***	
Age			--			--			--			--			--			--
Education			--			--			--			-.241**			--			--
Children < 7 years			--			--						--			--			--
+Role Occupancy	.008	NS		.018	13.08***		.052	3.19**		.010	2.62**		.022	2.41*		.006	7.98***	
Partner			--			--			.291**			--			--			--
Mother			--			--			--			--			--			--
+Occupational Status	.045	NS		.007	9.17***		.013	2.20*		.057	2.72**		.034	2.11*		.002	5.24***	
Blue-Collar						--			--			--			--			--
Clerical			--			--			--			--			--			--
Professionals			--			--			--			--			.741*			--
+Social Support	.030	NS		.016	7.88***		.147	4.49**		.005	2.28**		.121	3.83*		.024	4.73***	
Emotional support			--			--			.369*			--			-.174*			--
Social Integration			--			--			--			--			--			--
+Home responsibilities	.010	NS		.013	6.92***		.034	4.33**		.004	1.94*		.014	3.797**		.017	4.25***	
Management			--			-.165*			--			--			--			--
Tasks			--			--			--			--			--			--
+ Work-family relationships	.008	NS		.006	6.04**		.011	3.84**		.024	1.93*		.031	3.34***		.002	3.63***	
Interferences			--			--			-.186*			--						--
Satisfactions			--			--			--			--			-.268**			--
+Role Quality	.155	1.98**		0.078	5.60***		.040	3.05**		.056	1.91**		.060	2.91***		.010	2.58**	
Job rewards			.518***			.352**			--			1.91**			--			--
Job concerns			--			--			--			--			--			--
Partner rewards			--			--			--			--			--			--
Partner concerns			--			--			--			--			.276**			--
Mother rewards			--			--			--			--			--			--
Mother concerns			--			--			--			-.190*			--			--
Cumulative R^2	.267			.521			.359			.259			. 349			.335		

NS=Non significance *p<.05, **p<.01, ***p< .001. Note. + Indicates a new step in the regression analysis. Standardised regression coefficients (Beta) are reported for variable entered in the regression at that step.

Neither management nor home responsibilities tasks entered in the equation for Time-1. When Work-family relationship entered, interferences were related to higher depression and lower well-being. Satisfactions were associated with fewer reported symptoms (1% to 3% of the explained variance).

When Role Quality entered in the analysis, job rewards and concerns were associated positively with anxiety. Job rewards were also related to self-esteem. Partner concerns were associated with more reported symptoms. None of the mother-role variables entered at the final step were significant (6% to 16% of the explained variance).

The results of the regression analysis in Time-2 are shown on the right-hand side of Table 6.7. As can be seen, the scores of all the health outcomes at Time-1 were predictors of the scores of health outcomes at Time-2. As for the sociodemographic variables in Time-2, age was negatively associated with symptoms and education was also negatively associated with well-being and more anxiety.

Emotional support and social integration at Time-2 were negatively associated with anxiety. Also, women who reported having to be in charge of the management of household chores and reported work-family interferences at Time-1, reported more anxiety 16 months later.

In relation to Role Quality, job rewards were positively associated with self-esteem and to well being and negatively to anxiety at Time-2. Job concern was related to anxiety. Partner concern was related to depression and mother concern, which was negatively related to well-being.

A stepwise regression analysis was carried out in order to establish which specific dimensions of the role-quality were related to the health indicators.

In relation to the dimensions of Job-role quality in Time-1, dissatisfaction with the salary/lack of recognition and promotion (Beta= .434; p< .001), overload (Beta= .217; p< .01) as well as supervisor support (Beta= .504; p< .001) were related to anxiety in Time-1 (R^2 = .201; F=11.813, p<. 001). In Time-2, the psychosocial variables related to anxiety (R^2 = .215; F=4.93, p<. 001) were Job control (Beta= -.311; p< .001) and overload (Beta= .365; p< .001) as well as anxiety in Time-1 (Beta= .202; p<. 05).

Depression was related to job role dimensions but only at Time-1. Overload was associated positively to depression (Beta= .279; p< .001) but negatively to Job control Beta= -.313; p< .001). Overload was also associated positively to symptoms (R^2 = .081; F= 12.42, p<. 001; Beta= .298; p< .001) at Time-1 as well as negatively to well-being (R^2 = .169; F=14.11, p<. 001; Beta= -.232; p< .001).

In relation to Self-esteem, it was found that satisfaction with the salary/promotion and recognition (Beta= .212; p< .05), as well as co-workers support/helping others (Beta= .257; p< .01), were the job-rewards dimensions positively related to self-esteem in Time 1(R^2 = .144; F= 11.77, p<. 001). Job control (Beta= 203; p< .001) was associated with self-esteem (R^2 = .405; F=41.81, p<. 001) in the follow-up measure as well as self-esteem in Time-1 (Beta= .549; p< .001). Supervisor support was also related to self-esteem in Time-2 (Beta= .188; p< .01).

When considering partner concerns, marital dissatisfaction was the only psychosocial variable that entered in the equation and it was related to depression in Time-1 (R^2 = .057; F= 8.30, p<. 01; Beta= .254; p< .01) and Time 2, (R^2= .304; F= 2.31, p<. 01; Beta= .188; p< .01) as well as to symptoms report (R^2 = .052; F= 4.55, p<. 01; Beta= .395; p< .01). The report of depression symptoms in Time-1 also entered in the regression analysis in Time-2 (Beta= .537; p< .001).

Conflicts and disaffection with the children was the only dimension of mother-concern related to well being in Time-2 (R^2 = -.110; F= 3.26, p<. 001; Beta= -.275; p< .01). The report of well-being in Time-1 was NS in Time-2.

Reported Changes in each Role at Time-2

Fifty four percent of the participants said that they had undergone no changes in their roles (work, wife and mother) 16 months after, whereas 47% reported changes in the performance of their different roles.

Upon comparison of the sociodemographic and psychosocial variables in participants who reported changes and those who did not, we found that women who reported changes in the job-role in Time-2 perceived more rewards in their work (t (104) = -2,41; p< .01).

Younger women reported changes in the partner role, whereas the older ones did not (t (119)= 2,29; p< .01). No significant results were observed regarding changes in the mother- role.

6.3. - Discussion

Considering that many of the studies of stress and other related psychosocial variables in working women have been cross-sectional, the main objective of this study was to examine the predictive contributions of the work and family-role experiences, distribution of household responsibilities, work-family relations and social support in relation to women's health in those at different occupational levels. Using a longitudinal design the results extend previous findings concerning the relationship between psychosocial variables, as those mentioned above, in relation to women's health.

The analysis of psychosocial variables and health showed that after initial levels of health outcomes (Time-1) were controlled and sociodemographic variables taken into account, the following main results were found. First, emotional support and social integration predicted lower levels of anxiety and depression. Second, interferences and management of household responsibilities a year before predicted higher levels of anxiety. Third, job-role quality, both rewards and concern, was the role with more significant associations with health in the first measure and after 16 months. Fourth, marital dissatisfaction was also related to depression in both times. Considering the mother role quality, conflicts and disaffections with the children predicted lower levels of well being at Time-2. Fifth, higher levels of education predicted lower well-being. Mothers reported lower levels of depression a year later compared with those who were not mothers. Professional working women reported more anxiety than those who were not professionals.

Social Support and Health

Social support measured through emotional support and social integration acted as a main protective factor in relation to health. In Time-1, emotional support and social integration were associated with lower levels of depression and after 16 months to lower levels of anxiety. These findings are consistent with previous studies reporting a negative relationship between social support, distress and maladjustment using both cross-sectional and longitudinal methodologies (Holahan & Moos, 1981; Henderson et al., 1980; Cramer, 1991). These social support measures had been reported in other studies as significant predictors of CHD events in multivariate analysis controlling for other risk factors (Orth-Gomer, Rosengren & Wilhelmsen, 1993; Horsten, Wamala, Vingerhoets & Orth-Gomer, 1997).

Work-Family Relations, Distribution of Household Responsibilities and Health

Interferences between work and family was a sensitive variable, which affected different health indicators both in the first measure as well as after 16 months. Work-Family

relationship is a critical challenge for individuals and organisations considering the increase of women who are now combining the roles of paid worker, spouse and mother. There is considerable evidence that employment itself seems to have a positive effect on women's psychological well-being. However, certain situations at work such as overload, conflicts with supervisor and monotony, could increase vulnerability to psychological distress, and affect family life well-being (Barnett & Marshall, 1991). Women who perceived their roles as conflicting are more depressed, less satisfied as parents, experienced reduced life satisfaction, poor morale and poor mental health (Duxbury & Higgins, 1991). Chan, Lai, Ko and Boey (2000) found in a sample of six professional groups that work-family conflicts and performance pressure were perceived to be the most stressful aspects of work and negatively associated with work satisfaction. In the present study, professional women reported more interference between work and family compared to blue-collars and clerical workers and they also reported more anxiety and symptoms.

The findings of the present study showed that work-family conflict affected women's mental health, both in the first measure and in the follow-up, supporting a main effect model. However, it only focused on how work affected family life, which means that it explores only some aspects of complex phenomena. How family conditions interact with work and which personal or environmental variables could buffer or moderate these complex relationships along time are aspect which could be considered in future studies.

In relation to the Distribution of Household labour and health, it was found that the management of household and children's care were associated on a long-term basis to anxiety. No association with health was found for the tasks dimension. This result showed that "management" and "tasks" allocation contribute independently and differently to the relationship with working women's health and well-being. We could interpreted that this group of women experienced psychological distress when they realised that they had the obligation and responsibility of housework and child care and that they had to manage how these responsibilities and tasks would have to be undertaken. Probably it was at that moment when they perceived and were aware of how fair or unequal these responsibilities

were compared to the other members of the household. This takes us to the "invisible orchestration of family work" (Mederer, 1993) and the importance of considering different dimensions of housework, both quantitative and qualitative. The construct is much more complex and it needs to examine the meaning and value of family work for women and for men too and not only the number of tasks or time involved in each task. As Mederer (1993) and Ferre (1991) pointed out, household management activities may reflect the notion of caring for family members, a crucial part of the definition of wife, and the ability to implement decisions. These need to be included as a dimension of housework to understand their value to women. Also, as housework is an integral part of the gender definition of mother and wife, gender explanations need to be considered when this variable is included in the study.

Role Quality and Health Outcomes

The analysis of roles and health outcomes showed that after controlling levels of health indicators as well as sociodemographic variables, job-role quality was the dimension that showed more association with health in a short and long time. These findings are an indicator that work conditions have a strong impact on women's mental health and well-being. Job-overload was one of the stressors linked to health manifestations both in the cross-sectional measure and in the follow-up one. In the present study, it predicted anxiety over time as well as depression, symptoms and affected psychological well-being in Time-1. Both epidemiological, psychophysiological and occupational stress research identified work overload, together with low autonomy and poor social relations, as major psychosocial risk factors (Frankenhaeuser, 1991; Karasek & Theorell, 1990; Rydstedt, Johansson & Evans, 1998). Also, job control emerged as a stress protective factor associated with self-esteem and lower levels of anxiety both in Time-1 and in the follow-up. This finding has enough support in the literature on occupational stress and health (Karasek & Theorell, 1990; Bosma et al. 1997; Cheng et al. 2000).

Supervisor support was related to anxiety at Time-1 and also predicted self-esteem in the follow-up. Support coming from the supervisor could influence individuals psychologically, creating a feeling of security, protection, promotion of a positive mood and all of these have a positive effect on their feelings of worth and value. Vanier Institute of the Family, (1993, cited by Warren & Johnson, 1995) said: " *It is immediate supervisors who are primarily responsible for defining what the working experience of their employee will be like.*" (p.15). Those employees who have a supervisor who is supportive, flexible and sensitive to their needs may experience lower levels of distress and work-family interferences and probably they will be more productive, more efficient in their jobs and they will experience higher job satisfaction (Pugliesi, 1988; Terry, Nielsen & Perchard, 1993; Landsbergis, 1988).

The support coming from co-workers and helping others was also related to self-esteem. This result is in line with Barnett and Marshall (1991), Cohen and Willis (1985), LaRocco and Jones (1978), among others, who pointed out that this type of support, as well helping others, increased well-being and reduced psychological distress in the workplace.

The other dimension associated with Job-Role Quality was dissatisfaction with the salary/ lack of promotion at work, which predicted anxiety at Time-1. These sources of work stress are very frequent and have been reported before in another study carried out in Venezuela on gender and occupational status (Feldman, Chacón, Bagés & Pérez, 2000). In that study, dissatisfaction with the salary and lack of promotion and recognition were the most stressful sources for working women.

Inequalities with the salary and lack of career progress, promotion and recognition are problems that working women have been facing in all cultures and organisations since they were incorporated to the labour force. These problems had been reported widely in the literature. Working women earn 30 to 40% less compared to working men of the same occupational status (Marquez & Lejter, 2000; Lee, 1998). In Venezuela this percentage is around 25% (El Universal Newspaper, March 8, 2000. p. 1-2. Caracas). There is

considerable agreement on the barriers faced by working women in their jobs. Stereotypes and preconceptions about women's abilities and suitability for leadership positions, lack of careful planning job assignments, exclusion from informal networks of communications, managers aversion to placing women in line management positions, absence of effective management training and the failure to hold managers accountable for developing and advancing female employees, inflexibility in defining work schedules and the absence of programs to enable employees to balance work-family responsibilities are some of the obstacles working women face in their careers (Quick, Quick, Nelson & Hurrell, 1997). There is a consensus that these work stressors are associated with a range of short-term or long-term quality of life and health outcomes (Repetti, 1993).

Having a partner was protective for these women because it was related to lower depression and higher well-being. Nevertheless, as was found in Study 2, when the quality is taken into account, those women who reported conflicts with their partners and marital disaffection experienced more depression in the follow-up. Fincham (1998) reported that both retrospective reports and data from prospective longitudinal studies are consistent with the view that marital distress is implicated in the aetiology of depression.

Considering the mother role quality, conflicts and disaffections with the children predicted lower levels of well being only in the follow-up. This result was not a surprise because, according to some studies, the mother role seems to be the major source of stress among women (Baruch et al., 1983; Barnett & Baruch, 1985; Cohen et al., 1990). Mothers consider themselves and are considered by others as responsible for the well-being of their children according to their traditional role in the society (Pugliesi, 1988). It is probable that for this group of working mothers, having problems and conflicts with their children affects them more intensely because of their guilty feelings and the anxiety that this situation generates. In Study 2, it was found that mothers who reported conflicts and disaffection with the children also reported higher levels of anxiety and depression.

CHAPTER 7

STUDY 4: "Multiple Roles, Satisfactions, Stress, Social Support, Household Responsibilities, Work-Family Relationship and Health in Venezuelan Working Women: A Qualitative Study"

In order to gain a deeper understanding of the results obtained in the quantitative research performed on the psychosocial factors associated with the health of women with multiple roles and different occupational levels, a qualitative study was carried out using a semi-structured interview and content analysis method.

7.1. - Objectives

The objectives of this study were:

1. - To describe the experience of working women with multiple roles in relation to their satisfaction and stress related to their roles as a mother, wife or companion and employee, their perception of the work-family relationship, the distribution of household responsibilities and how all these factors relate to their mental and physical health.
2. To describe certain recurrent psychosocial themes that emerged during the interviews.

7.2. - Method

Participants

The participants were women employed at two institutions of higher education in the metropolitan area of the city of Caracas, who worked as professionals, clerical or blue-collar workers who had been part of Study 2 described in Chapter 5. The main criteria for selection was that the participants be employed in full-time jobs and had different occupational status. Both married and unmarried women, as well as women with or without children were eligible to participate in the study.

Fifty-six women who fulfilled the criteria were randomly selected from a population of 150. Of these, 32 agreed to participate (response rate was 57 %). The main reason given

by the women approached for not participating in this study was lack of time and that they were very busy.

Of the 32 women, 13 were professionals (40.6%), 11 were clerical (34.4%) and 8 were blue-collar workers (25.0%). The 32 women interviewed were all mothers, 16 (50%) had children younger than 7 and 16 (50%) had children over the age of 7. The majority of the participants (93.7%) had stable spouses/companions and only 2 (6.3%) did not have a spouse/companion. Their ages ranged from 22-56 years with a mean of 35 (SD= 10.6).

Interview data analysis: Content Analysis

Content analysis was the chosen method to analyse the interviews in the qualitative study. This type of data analysis has been used in the literature on multiple roles, working women and health (Meleis et. al., 1996). It is considered a good method to be used for triangulation purposes because it can used in conjunction with different types of measures like questionnaires, interviews or/and observations (Robson, 1993). Also the best content-analytic studies use both quantitative and qualitative methods. They use numbers and tables in combination with quotations that are the direct expression of meanings and feelings (Weber, 1990).

A central idea in content analysis is that the many words of the text are classified into much fewer categories that are relevant to the research purpose and sort all occurrences of relevant words into these categories. Then the frequency of occurrences of each category is counted, and certain conclusions can be drawn (Tesch, 1990). These conclusions require a theoretical basis for the results to be meaningful. The analysis can be supplemented with quotations from the interviews to illustrate conclusions (Breakwell, 1995).

Content analysis became very popular at the beginning of the 20th century due to a series of quantitative analysis of the messages conveyed in the mass media (Henwood, 1996). More recently, content analysis has been used in a variety of psychological and sociological areas, and in particular for the analysis of qualitative interviews and questionnaire data (Robson, 1993).

According to Weber (1990), compared with other data generating and analysis techniques, content analysis has several advantages: 1. - It operates directly on text or transcripts of human communications, so it is an unobtrusive measure. 2. - The data are in permanent form and can be subject to re-analysis, allowing reliability checks. 3. - It also provides a low cost form of longitudinal study when a series of documents of a particular type are available (Robson, 1993).

To make valid inferences from the text, it is important that the classification procedure be reliable and consistent. It means that different people should code the same text in the same way (Weber, 1990). Also, it is highly desirable that the categories be exhaustive and mutually exclusive. The former ensures that everything relevant to the study can be categorised. The categories also have to be operationalized, that is, an explicit specification has to be made of what indicators one is looking for when making each of the categorisations (Robson, 1993).

Procedure and Analysis

Three researchers conducted the interviews. Prior training in interviews of this nature was given, directed by professionals with expertise in qualitative interviews. The training consisted of rehearsing with people not involved in the research sample, supervised by experts who made sure that the style of interview was consistent for the three interviewers. The researchers were also familiar with content analysis and the different issues that would be explored in the interviews.

The next step was to start contacting each of the participants by telephone in order to invite them to be interviewed. The participants were informed of the objectives of the study and the need for a deeper understanding of some of the findings evaluated in the previous quantitative studies. If the answer was affirmative, an appointment was set up. The researchers then went to the educational centre and interviewed the participant. The interview was conducted in a quiet, private place and was tape-recorded with the participant's permission.

A transcription of each interview was prepared after all the interviews had been conducted. The material was distributed between each of the three researchers for individual analysis. Prior to starting the definition of the different categories and the identification of each indicator, each researcher once again read the transcribed interviews several times so as to become immersed in the raw data, as suggested by Pope et al. (2000).

The researchers identified and defined the general categories and subcategories that were used to analyse the interviews based on a literature review on women's social roles, role quality, social support and work-family relationships as well as the results obtained in the quantitative studies. These categories were used for the purposes of extracting a series of indicators.

A format was designed (Appendix 12) where each rater wrote down the indicators, which had been found for each category and subcategory, allowing only indicator in per category (Weber, 1990). At the same time, each rater had to mark in the transcribed interviews sections that identified and were representative of stated indicators (phrases, words, paragraphs, etc). Each rater could make annotations and highlight recurring themes in each interview. Likewise, each researcher identified new categories that arose.

The three researchers met in order to discuss the coded indicator found in each of the interviews and also to check inter-grader reliability. A high inter-grader reliability is a minimum standard in content analysis (Weber, 1990) The extent of agreement among raters was calculated by applying the following formula: [agreements/(agreements + disagreements)] x 100%. A level of agreement of at least 70 per cent is recommended (Sque, 1996). An agreement of eighty-nine percent was reached finally among the judges. The lowest level of agreement was 65 percent while the highest 90 percent. When the same indicators were not found, the interview coding was revised once again until an agreement was reached. After this procedure, a final coding structure was designed for each interview, grouping all categories, subcategories and indicators mentioned by the participants. Appendix 13 contains some examples of the definitions for different categories.

7.3. - Findings

The Meaning of Women's Social Roles

Taking into consideration the changes women have experienced through their incorporation into the job market with respect to the traditional roles of women in society, the first question analysed dealt with their perception of the most important role in their life.

As shown in Table 7.1, more than half of the women believed that the role of mother was the most important one. The following response was typical of this category: *" The most important role is that of mother. Isn't it? Not so much for the fact that as a woman one wants to satisfy the desire to carry in one's womb a being that you will educate, love, care for, but also deep down inside, to understand what it is to be a mother and to transmit this to another being...and to transmit what my parents transmitted to me... to lead them down the right path. Before I leave this world, I aspire to fulfil this obligation, which is a rather important one..."* (Secretary a).

Participants expressed that the role of mother was linked to the essence itself of what it means to be a woman through motherhood and it represents obligations and responsibilities. This meaning of responsibility and obligation, together with the satisfaction is expressed by another blue-collar worker, who stated: *" I say that the role of mother is the most important, because of the obligation one has to one's children. They are one's happiness. Besides, being a mother is the first experience one has as a woman"* (Blue-collar a). For the present participant the role of mother is a role that supports the other roles and complements them, and it seems as if life is not entirely satisfactory without the presence of children. *"...It is one of the most relevant activities of being a woman. It is a constructive activity, so to speak, and brings about many good moments, perhaps no direct recompense but a very ample life. I think that through children, one can globalise a couple's love for each other and the welfare you can give them, thanks to your work..."* (Professional a). For these women to be a mother goes beyond the satisfaction of carrying a living being in your body, a great responsibility that goes beyond the

education and love professed, it is a life mission associated with the transmission of moral values and a sense of transcendence that comes from the continuation of the values learnt.

Another group of working women (22%) said that the three roles have the same importance and must be kept in balance: "*I never thought about choosing, I have always thought about performing the three roles and doing them to the best of my ability, I never have thought that one is more important than the other. For me, the three are important*" (Professional b). This position is reaffirmed by another participant: "*...It would be very difficult to say that this one is more than the other because in my opinion I feel that these three aspects converge into something that one tries to balance...*" (Secretary b).

For another group of participants (9 %), family roles are the most important and the professional role is complementary and necessary due to the element of economic security it implies. The handling of roles is done in a practical fashion: " *For me, being a mother and being part of a couple is very important, the professional role is an additional aspect that contributes to keep these other two going. It is what enables me to give my children what they need and it contributes to household-related bills.... and I also help my other half, the responsibility is for both of us.*" (Professional c). A slightly lower percentage expressed that the mother and working roles are the most important (6 %): "*Right now for me the most important roles are being a mother and a working woman. The role of mother, because of all aspects related to the children, what they do and what they don't do...I like my job, one feels useful, that means, one does something that one likes...*" (Secretary, d). This clearly reflects how the maternal role is associated with responsibility and the working role to a gratifying activity exclusively for her, where she also feels she's doing something of value.

Only one participant stated that the working role was the most important because it had a sense of challenge although at that moment the job was very stressful and her professional development was a priority in her life: "*Work for me is like a challenge. In my department there are 12 people, 4 of which are professional so there is a degree of competition. Right now there are many demands placed on us and that stresses me out. I'm also going to graduate school....*" (Secretary e).

Table 7.1: The Perceived Importance of Women Social Role

INDICATORS	FREQUENCY (N=32)
a. Role of mother is the most important	18
b. The three roles have the same importance	6
c. Role of mother and spouse are the most important	3
d. Role of mother and worker are the most important	2
e. Role of employee is the most important	1

Letters indicate which of the quotations belong to the present indicators

Role Quality

This category evaluates each participant's perception of her role as a mother, wife and working woman, taking into account the satisfaction as well as the stress related to each role. This category has six sub-categories: satisfaction for mothers, concerns for mothers, satisfactions for wives, concerns for wives, satisfaction for a working woman, concerns for a working woman.

- **Mother Satisfactions**

Table 7.2 shows the indicators for the subcategory of Rewards or Satisfactions for mothers.

For the participants of this study the most satisfying aspect of motherhood (72%) was their childrens´ behaviour, their honesty, integrity and work capacity: "*for my kids to be more or less within the normal range: responsible with their studies, diligent, responsible... this fills me with much satisfaction. I would have stopped working more than 5 years ago, but the cost of living.... I was mom and dad...*" expressed a single-mom secretary (Secretary a). Likewise, another mother expressed: "*... Slowly getting my children to become independent and have a sense of achievement, ever since they were small. I made sure that they had that feeling of accomplishment, with responsibilities according to their age but with independence, with affection... To celebrate their successes in the small things that they can improve every day...*" (Professional a).

For these women it is very important to see how all the effort they have invested in the education and upbringing of their children is reflected in their behaviour and attitudes to life, as once again expressed by this professional woman: *"...Deep down inside, my pride is having given them an education so they can be moral, honest individuals. I feel proud of them"* (Professional a). Some are even amazed to see how they have been able to raise their children in spite of all the difficulties they have encountered: *"... The fact that I could, by myself for a certain period of time when I was alone ... (and see that) my children are diligent in their studies and are responsible, fills me with satisfaction..."* (Secretary a). Or we see the expression of this professional woman, who said: *".. I have two daughters that are now university students and I see them and I'm amazed I see them as mature and complete individuals I think I did a good job, even better than I thought I would do as a mother, especially because when I got married I was studying and thought I would have a professional career..."* (Professional a). Although this source of satisfaction is intimately linked to a sense of fulfilment of their mission as mothers, always highlighting the responsibility this implies and a reinforcement that they are doing their duty well, the possible interference of work with carrying out this responsibility to their children properly, is always present.

Other mothers´ rewards were to spend time with their children and their children's´ demonstrations of affection, loving care and love (47%). They liked being with their children, their companionship and the love they express to one another. For example, one woman stated that: *"I love to be with them, they are very attached to us, I love talking with them... sharing things with them, I love it, whatever it is. Sometimes, reading, doing homework, going to the movies, I go with them"* (Professional b). Another woman said: *".... The nice thing about my children is that they are very affectionate with me, that pleases me a lot, in fact it is reciprocal "* (Secretary b).

Other sources of satisfaction reported were having healthy and happy children, the successes and growth of their children (22%). *"... To see them healthy, to see them, you know, looking forward to continue in this life that's quite hard. Isn't it?"* (Secretary c). In this sense this woman gives us the idea that her life has not been easy and that she is happy to see her children healthy and happy. For another participant, the mere fact of seeing her daughter smile is a source of great satisfaction and compensates for all the

efforts carried out: *"... To see my daughter's smile every day, that is, to see her happy."* (Professional c). The successes of their children turn out to be a reward for all their efforts: *"...when I see my daughter's school report card or I see her at her swimming lessons, the medals that she has won... I forget my tiredness and it gives me joy and pride that's worth the effort and the sacrifices..."*(Professional d).

Table 7.2: The Perceived Rewards of the Mother Role

INDICATORS	FREQUENCY (n= 32)
a. Children's good behaviour	23
b. Children's expression of love and affection.	15
c. Spending time with the children	15
d. Children's health and happiness	7
e. Children's goals, professional and economic success	7
f. Children's development (growth, learning).	7

Letters indicate which of the quotations belong to the present indicators

- **Mother Concerns**

The relevant indicators founded for the subcategory of Concerns for mothers are shown in Table 7.3.

Seventy eight percent of the women in this study expressed that what most generated stress in their maternal roles was a lack of time to dedicate to their children as well as the overload due to all the demands and requirements related to family- and work-related responsibilities and their children having behavioural problems. These situations generated a lot of tension, tiredness and anxiety. Even when these indicators were independently defined, they are clearly linked, as observed in the various quotes. With respect to the lack of time to dedicate to their children, this is clearly linked to a feeling of guilt and work-family conflicts where women once again consider the location of their role in this society and their mission in life. The time they have to dedicate to their work keeps them from being a mother the way they would like to. They worry not only about the day-to-day care of their children, but also about the consequences that not being at home might have for their children in the future, as was expressed by this participant: *"My main concern, and it's what I'm always asking myself, is whether all this effort that I'm making is worthwhile in the long run ...my children need me and I almost never have*

time for them. I arrive home at night, tired, and although I sit down with them and talk and help them with their homework, I think it's not sufficient... sometimes, I'm so tired that they talk to me and I don't even know what they are saying... and they are no fools and they complain to me for this... this makes me feel very bad, very guilty... time marches on and I'm losing out on seeing every day how the are growing up, it scares me to think that when the time comes for me to gather their trust, it might be too late.." (Professional a). Another professional woman expressed her dilemma between dedicating herself to her personal and professional development and the cost this represents to her family: *" I have this permanent feeling of remorse from leaving the girl such a long time at the day care centre due to my decision to go to work because this is what I want for myself as a person; therefore I am always trying to compensate for those moments when I'm not with her, as right now I consider this a priority..."* (Professional a). Although this concern is largely observed in mothers, it is greater in mothers of small children.

The work overload and tiredness that are the product of all the demands of the family and work roles was another aspect that was highlighted by the majority of these women: *"...I am a very balanced, calm person. Nevertheless, the fact of having such a hard day and being in such a demanding position - I am a head of department - and bearing all that load, afterwards, going to the grocer's, the dry cleaners, picking up the kids, getting home, helping them with the homework, Mom, do this for me. Day to day this makes me very, very high-strung and I feel exhausted"* (Professional b). Another woman, a secretary, expressed it as follows: *"Well, sometimes I am overloaded with work, stressed out because, to begin with, I live very far away, in Maracay. So, I only have the nights left when I arrive at six, to cover all home matters, the child, and on Saturdays and Sundays I wash, iron, cook, go to the market."* (Secretary b). They also expressed their concern that their children may have behaviour-related problems and may be led into the wrong way in life and that their children do not heed their advice: *"...I am very worried that my children be led astray, you know, through drugs, associating with bad company, friends are very influential at that age I always talk to them, I tell them but what if they don't heed my advice?"* (Secretary c).

These women also said that as mothers they are concerned that their children might not achieve an adequate academic or educational level (75%). However, the perception of

what it means to be prepared and educated in life has a different meaning depending on if the mothers are professionals or blue-collar workers. For the professionals, it is associated with being prepared for the future and to be able to be self-sustaining: *"I'm concerned about their education, will they do something with their lives and particularly if they achieve a sufficient level of preparation for them to care for themselves..."* (Professional d). Whereas, blue-collar women workers are concerned that they may not be able to help their children to do their school-related activities and hope that their children will have a better future than they themselves had: *" I am concerned that when they are doing their homework, they might not understand and that I will not be able to help them, that worries me... I am worried about their education...I wish that when they grow up they are better prepared than I am I hope they have that chance..."* (Blue-collar d).

The women's social and educational status differentiate occupational groups in this sense.

Twenty of the mothers (63%) mentioned that they worried about their children getting sick, expressing once again how little time they dedicated to them. One blue-collar woman said that she was very worried that her children might fall sick and that she would not be able to care for them because she had to go to work: "... *I am worried that if they get sick and I have to go to work and don't see them during the day; if I don't work, I don't get paid and I will have no money to buy medicines"* (Blue-collar d). Once again, a conflict arises in these women with respect to the time that work takes away from being able to be with their children and care for them and the guilt this generates:
" Sometimes I feel that I have abandoned them because of my work, that makes me feel sad... my baby is alone, I don't know what he's doing, I don't know how he is, I know my neighbour takes good care of him when he's sick but it's not the same, who's his mommy?" (Blue-collar d).

The women participating in this study also stated that they were worried about the integrity and safety of their children, a result of the socio-economic crisis that currently affects the country. This tension has physical manifestations in these women as anxiety and sleeping problems as well as a lack of control in handling the situation. These concerns are expressed in the following quotes: *"...What worries me the most has nothing to do with me but with the country, their future, their safety in this country and*

now I have a son who is almost at the legal age for driving, he's sixteen and a half and the personal safety issue worries me a lot." (Professional f). Another blue-collar worker said: *" I have only one son, he's 19 years old and goes out at night and comes back late. It's very dangerous in the streets at night, in the slums, there are many dangerous hooligans in the street and anything could happen, this worries me a lot, I can't sleep until he arrives and I feel very nervous..."* (Blue-collar f).

The lack of a father in the home, whether because he is nonexistent or is absent for extended periods of time due to his work also constitutes a source of stress that worries 31% of the mothers. This concern is reflected in feeling that they are carrying a greater share of the responsibility, that they don't know if what they are doing is the right thing as regards the disciplining of their children: *"My husband works out-side the city and comes home only on weekends, so I have to make almost all the decisions I would like him to spend more time at home because sometimes I don't know if what I'm doing is correct, especially when I have to punish my children. It is too heavy a responsibility for me... I wish we could share it more"* (Professional g). They are also concerned that their children might not have a good father image and that this may have repercussions on them as future parents: *"My husband does not live at home... we have been separated for several years now. He used to be a heavy drinker and beat me and I didn't want my children to witness this...I am worried because now they hardly see him... I am very worried about the image they will have of their dad, and they will be parents one day. And then what?"* (Blue-collar f). Once again, all this indicates that the woman feels completely responsible for the destiny of her children.

Table 7.3: The Perceived Concerns of the Mother Role

INDICATORS	FREQUENCY (n=32)
a. Insufficient time to dedicate to the children	25
b. Work overload and demands	25
c . Bad behaviour	25
d. Lack of professional or academic status	24
e. Children's health	20
f. Children's integrity and security	15
g. Father's absence	10

Letters indicate which of the quotations belong to the present indicators

- **Partner Satisfactions**

In Table 7.4 we can see the different indicators for the subcategory of Partner's Satisfaction.

Table 7.4: The Perceived Rewards of the Partner Role

INDICATORS	FREQUENCY (n=30)
a. Partners support	19
b. Good relationship	16
c. Spending time together	10
d. Expressions of affection	10
e. Share the same beliefs, values, ideas and problems	9

Letters indicate which of the quotations belong to the present indicators

Fifty seven percent of the women interviewed reported that the most pleasing thing for them as a partner was to receive the support of their spouse/companion. However, these participants refer to different types of support. For some, emotional, affective support is the most important. *"Well, to feel his support, sometimes the material support. Isn't that so? Rather than the other type, the moral, emotional support. Isn't it true? For me that's the most important."* (Secretary a). Others refer to sharing duties, specifically sharing household duties: "*While I cook he washes the dishes, or if I'm cooking he hangs out the clothes, he fills the water jugs, he sweeps, he helps me a lot"* (Blue-collar a) and to taking care of the children: *"He has been supportive, so much so that when I had to do my graduate studies... he himself proposed that he go to Caracas with the girls and leave me here to finish my studies... I had many doubts, I had never been separated from the family but the support was so categorical that I took the chance "*(Professional a).

Another satisfactory aspect was an adequate relationship with the spouse/companion. This relation is expressed in good communication, intimacy, reciprocal feelings of affection, companionship and also that the relationship is based on sharing: "*Maintain good communication, we are very similar people, we love one another a lot, we are willing to fight together and get ahead"* (Professional b). The following expression is also an example in this category: *"Companionship, intimacy, comfort, that is maybe why it is so complex, that one feels perfect with it... it is the element that one misses when one works individually... it is always important to have someone at one's side that complements one... to have someone to share things with... that is one's friend... we've*

been married for 11 years and, although the novelty is gone, one still feels it and it brings much satisfaction..." (Professional b).

The participants (33%) also indicated that sharing activities with their spouse/companion and demonstrations or expressions of affection between them was also gratifying: "*We do sports together, we go to parties together, right now we are going on holidays... a well-deserved rest for us both, so we still have many dreams we can share together. I think this is very pleasant..."* (Professional c). A secretary, for instance, said: "*..I love for instance... when we go to parties, we enjoy ourselves a lot at parties because I love to dance with my husband and afterwards when we return back home, that's good too...."*(Secretary c). Other manifestations of affection are reflected in the following expressions: ".. *During the years I've been with him, he has been very affectionate, very conscientious with me, I feel he cares"* (Blue-collar d) or in this one: "*..Details that my husband may have with me, details, for instance, nonsense, all of a sudden he cares about what I like and well... If I like a particular sweet one day, he comes home and brings me the sweet"* (Secretary d). The importance of affections and sharing in the couple's relationship is observed.

Finally, five of the participants (30%) were of the opinion that they were pleased to share the same beliefs, values, ideas and problems with their companion which was also linked to the parental role: ".. *We totally and absolutely agree on the things we deem fundamental in life... in the fundamental values and what we want to transmit to our children"* (Professional e).

- **Partner Concerns**

As can be observed in Table 7.5, in the subcategory of Partner concerns, 22 of the women in a couple relationship (73%) reported that their main concern in this role was the lack of time to be with their partners and to meet their demands or expectations: "*Usually there's no time... sometimes one arrives and you are sleepy, tired and worn out and you didn't deal with the issue as you should have because you fell asleep... Two days have gone by and you weren't able to tell him because there was no time... Well, he says, let's go to the movies, but sometimes one can't... Of course, there is the question of doing something different but the problem is time.."* (Professional a). *"Time to share with my*

spouse/companion, I wish we could have more time together, the children and my work absorb me a lot... this makes me feel sometimes sad and despondent and even frustrated as a woman.." (Secretary a). Another participant expressed: *"My husband is ill, he needs lots of care and attention and I cannot give him that attention that he demands from me and this creates a lot of tension for me..."* (Professional a). These expressions indicate how once again the time factor is perceived as a stress-inducing element in any of the roles covered by women, for which they feel guilty and responsible. An interesting element appears here, that refers not only to women's relationship with others (i.e. children and/or couple) but also with herself, with her own concerns and expectations as a woman.

These participants also reported that they were concerned over the little support received from their husbands (67%). Most of this support is related to managing the house and the children, where the distribution of household chores is perceived as unequal: ".. *At home I have always been in charge of the house, it has always been my responsibility, and he helps me but it's only help. He does not take the reins and he is a very demanding person, he wants everything to be right and me too, so many times I feel exhausted"* (Professional b). *"I feel sometimes full of responsibilities, you know? Once he was reluctant to participate, he did not want to go to the doctor with my kid and said he couldn't go. So I spoke to him, I got annoyed because I never have time for anything and if one wants things to be done one has to look for the time, especially if it is an important matter..."* (Professional b). These expressions reflect the effects of gender differences in the socialization process. The man seems to feel that he has no house-related responsibilities and rather is in a position to demand an optimal working level in the home and the woman to some extent accepts this, although finally she ends up demanding his participation and feels worn out due to all these demands.

Another stress-inducing aspect has to do with marital problems, as reflected in poor communication, affecting 50% of the participants: "*Somehow the relationship with my husband is not very communicative at home... I'm not sure that if I spent more time at home, that would improve my communication with him. I think that there are other factors that have to do with difficulties in communication"* (Professional c). This expression once again reflects the guilt experienced by women from not dedicating

sufficient time to family members due to the time spent at work and it also indicates how women perceive that the responsibility for everything working properly falls on their shoulders.

Another stressful aspect in the couple's relationship was related to the partner's lack of coping abilities to face difficult situations (33%). *"I am a little concerned and it has always worried me... his weakness of character that I sometimes feel. He's such a sensitive person and sometimes the problems he faces... he's a little weak to handle that type of things"* (Professional e): *" He is too passive, he makes no decisions"* (Secretary e) and also to the financial strain if the partner is not working or has an insufficient salary: *"Well, right now we have some economic problems because he is not working... this has created many problems"* (Blue-collar d); *"...There are many economic difficulties in the family right now, we are in a serious situation because we bought a car and it's giving trouble. His efforts are lacking. I have had to make all the payments, practically all the expenses"* (Secretary d).

Table 7.5: The Perceived Concerns of the Partner Role

INDICATORS	FREQUENCY (n=30)
a. Lack of time and partner demands	22
b. Lack of partner support	20
c. Conflictive relationship	15
d. Financial stress	15
e. Partner inappropriate coping abilities	10

Letters indicate which of the quotations belong to the present indicators

- **Job Satisfactions**

In the subcategory of Satisfaction or Rewards as a working woman (Table 7.6), we can observe that seventy-eight percent of the participants reported that their most important source of satisfaction at work was the co-workers' support. *"I am delighted to have contact with the colleagues at the university and with those who are not colleagues but that oftentimes share common interests and we help each other... "* (Professional a).

"... I have very good relations with all my co-workers , I've done my best to avoid any type of discussion or disagreement, for me their support is very important, we share our work-related doubts and problems and we always help each other, especially when one of

us has any problem with the children, you know, when they get sick or when we have to take them to school..." (Secretary a). *"Well, at least my co-workers, all the people in the workplace, treat me well, this is very valuable for me..."* (Blue-collar a). These expressions indicate the importance placed by women on interpersonal relationships and the emotional as well as instrumental support they receive.

Sixty nine percent of working women (69%) mentioned that what most gratified them in this role was that they liked the type of job they were carrying out. Professional women and secretaries, especially those with academic support tasks, most often expressed this source of satisfaction. *"Well, I think that the job I have is a godsend, I mean, I feel very satisfied, I feel great earning my income and doing something I like, something I have chosen and which gives me pleasure when I do it "* (Professional b); *". I feel very rewarded when I see that our academic department is bearing the fruit we all expected but did not realise and, more than rewarding, this is so gratifying that I am already retired and am still working."* (Secretary b). Work represents something very stimulating when, apart from doing something that is highly gratifying for the woman, it also involves the welfare of others. Once again the perception women have of their work is projected onto the mother role.

The participants also reported that other pleasures derived from this role came from being able to help other people (56%) and feeling that their work has served to influence other people, that their work has a sense of transcendence to it: *"I am contributing at the university with things that are good for the academic formation of the students... The day I leave I am going to feel I have left something positive that will benefit others "* (Professional c). One secretary expressed: *"... The part that I like about working with students is that it's very rewarding. I like the days when they are all there and I help them"* (Secretary c). The ideas in the former paragraph are reaffirmed in this indicator, in the sense that women project maternal role- related elements in their work role as fundamental aspects that are enriching and gratifying.

Spending time with other people also turned out to be another source of satisfaction at work (50%). Nevertheless, this interaction has different expressions, depending above all on whether the woman is a professional or a blue-collar worker. For professional women,

these contacts are more closely linked to personal growth: *"... I have learnt a lot about human relations and I like it, I like to work with people, I like to deal with people"* (Professional d) and to intellectual growth: *"... I speak with people here and I become enriched culturally, intellectually.... Contact with the students is enriching.."* (Professional d). Blue-collar workers perceive work as a very different space from their homes, it is work but also a distraction and a way of enjoying themselves and interacting with different people: *"Well, at work there is another atmosphere, another system of life... one enters into contact with many people, with the secretaries, one laughs and at home I don't have that "* (Blue-collar d).

The challenge of proposing and reaching goals for oneself, *"The achievement of goals, i.e. there is a challenge, I feel I challenge myself, I set myself goals, to achieve what I have proposed for myself... for me that is very important"* (Professional e) and feeling competent, *" I love it when I have a lot of work because it makes me feel active and when my boss assigns a task that is challenging, that makes me feel competent, I feel valuable"* (Secretary e) as well as recognition constituted other sources of gratification for these women, which increase their self-esteem. *"...To know that one receives recognition, that the effort has its merits, that its important, I feel I am a valuable person"* (Professional f); *"At work when things turn out right and I receive congratulations and they tell me... Your work is beautiful, it's pretty, congratulations, this helps me to be better, and one tries to do things even better"* (Secretary f).

Work is also seen as a source of economic security and constitutes a source of rewards for this group regardless of the occupational level. *" My work allows us to have an income and stability that contributes to a better quality of life for our children"* (Secretary g).

Table 7.6: The Perceived Satisfactions of the Job Role

INDICATORS	FREQUENCY (n=32)
a. Co-workers' support	25
b. They liked the work they do	23
c. Helping others	18
d. Being with other people	16
e. The job is stimulating, challenging, and makes them feel competent	15
f. The recognition they get from their work	15
g. Financial security	15

Letters indicate which of the quotations belong to the present indicators

- **Job Concerns**

Table 7.7 shows the different indicators of the Job Concerns Subcategory. In relation to the subcategory Concerns as a working woman, we found that 23 of the interviewed women (72%) reported that the most stressful aspect for them was too much work and the excessive demand this requires. *"... I like to do my job, not have anything pending... When it accumulates because I have too many meetings or something like that, I start to get stressed"* (Professional a). *"Look, in my job specifically I have many responsibilities and my boss, my supervisor delegates a lot to me.."* (Secretary a) *"... Sometimes one has to work a lot and finish all the work.."* (Blue-collar a).

Another worrying aspect of this role was again the lack of time to cover all the activities and this has an effect on women's psychological well-being and physical health. This situation was reported by 63% of the group and specifically by the professionals and secretaries *"I am worried about time... not dedicating enough time and I have many things to write but have no time to do so, I also must attend classes, meetings, I have a lot on my hands and most of it due yesterday... then I start to feel unwell, I get stomach disorders, I smoke and become impatient and angry..."* (Professional b). One *secretary* expressed the following*: " I am very organized but there are times in the term that are very complicated... many procedures to fulfil, all on the same day and my boss is rather lazy, I have to do a lot of things and I don't have enough time.... this makes me very anxious because I am very responsible and I like to do everything right..."* (Secretary b). From these expressions it can be observed that the lack of control over time is something that causes great stress.

The participants of this study also stated that their concern in this role was that their work was very routine (63%). This situation was reported as stress inducing for secretaries and blue-collar workers. For instance, this secretary said: *"You know that in the office everything is very routine, it becomes boring, I always have to do the same things, filing, answering the phone.."* (Secretary c). A blue-collar worker stated that when her work becomes boring and tedious, she gets more nervous and sometimes feels sleepy: "... *My job sometimes is rather boring, I have to mop, sweep the rooms and sometimes I spend a lot of time sitting in an office until my supervisor sends me to another building... I always*

have to do the same chores and this bores me and makes me feel sleepy. I like it when my boss does not give me many instructions.... that way I can do new things...when I'm bored I get restless".

Forty-seven percent of women mentioned that they were concerned about the friction, misunderstandings or disagreements that could arise in the workplace *" When there is a discussion due to some issue, even if I'm not in it, it makes me feel uneasy... I spend days thinking about it... I even lose the desire to eat... and I get home in a foul mood..."* (Secretary d) *"... If one tells them anything, all the office knows afterwards and the other person knows. It's as if one tells someone and it circulates through the whole office... Those in charge tell the others: this and that is all right, but when they see the supervisor, they come and say no, she's lazy, she's this, she doesn't clean well, or she gets in late or she does so and so, but when they see you they say: girl, you do this well. Hypocrites.."* (Blue-collar d). Once again the importance of interpersonal relationships is observed at work for this group of women and the degree of interference caused by these problems on their welfare.

Two other aspects that are relevant and that affected 31% of the group were associated with conflicts with the supervisor, affecting their health and attitude towards works: " *At this moment I have serious problems with my boss, she is a very difficult person who at all times looks to point out the negative aspects and it is impossible to have a rational conversation with her, every time I have to talk to her I end up feeling sick and I don't even feel like going to work..."* (Professional e), as well as the lack of recognition: *" I carry out all the effort in doing things properly but I am not recognised.... one little word and that would make me feel contented... often times I get home from work and I feel frustrated... I understand that work is a responsibility but one's efforts must also be recognised..".* (Secretary f). It is interesting to see how this recognition does not necessarily have to be related to a promotion or salary increase but rather to the value given by others to the work performed.

Table 7.7: The Perceived Concerns of the Job Role

INDICATORS	FREQUENCY (n=32)
a. Work overload and demands	23
b. Lack of time for undertaking all the activities	20
c. Routine work	20
d. Conflicts with co-workers	15
e. Conflicts with supervisor	10
f. Lack of recognition	10

Letters indicate which of the quotations belong to the present indicators

The Perception of Being a Woman

This category arose from the interviews and encompasses all the beliefs, values, attitudes, responsibilities and activities that are perceived to be part of being a woman (Table 7.8).

Seven of the women interviewed (22%) mentioned that for them the family role should be taken on by women. These views indicate that for these women, their motherhood-related responsibilities cannot be substituted by anyone else: "*..The role of mom is very important, nobody can take that role on, not even the best father in the world, this is definite, a mother is a mother*" (Professional a). As this belief is so ingrained even paternal responsibilities are invaded, such as in this case*: "I think one absorbs even the role of the father, this means to say that one takes away some of the father's responsibilities and one takes them on... one absorbs all those responsibilities as a woman*" (Secretary a). This sense of obligation is also reflected in the manner in which household responsibilities are taken on: "*..If we could say the total responsibility of the house, for the home affairs... what needs to be bought, I think that this is one of my responsibilities that is not really shared by my husband... I would say it is more mine, but I think that the fault is mine ... I have taken them on... and do you feel that that is your responsibility? Yes, sometimes I have thought that this is a very macho-style, very southern-hemisphere style*" (Professional a & c). Sexual stereotypes as to what a man or a woman should do or be are clearly reflected in this expression: "*Well, mostly regarding care, attention, the mother almost always takes care of the child when he comes home from school, checks to see whether he does his homework and reviews it. Men hardly take care of that*" (Secretary c).

Another group of participants (19%) expressed that for women duty comes first and then pleasure: *"...I sacrifice myself a lot and that is something that my husband always frets about, I mean my family comes first and then my own things. I don't know if that is good or bad. I know it's what my mother taught me"* (Professional b). It is interesting that the mother has transmitted this point of view, as if putting family first corresponds basically to women.

Another recurring aspect already reflected in other categories is linked to the feeling of guilt mothers experience through not dedicating enough time to their children. " *If at home, I am available, but it's that the time I'm there is very short... This has made me feel very bad, I feel guilty"* (Professional d). For this blue-collar working mother, not dedicating more time to her children makes her feel that she has failed as a mother: *"...Not having sufficient time to be with my children... worries me because sometimes I think that I'm failing as a mother"* (Professional d).

The final element in this category reflects changes experienced by women in the last three decades, mainly since they have been incorporated into the job market, with the changes that this has brought about at the family level. This is reflected in the importance of work as a source of self-improvement and satisfaction in the lives of women: "*I think that the fact that a woman keeps working creates more self-esteem for the woman."* (Professional e). For this secretary, work has represented something very important and has added a meaning to her life: *". It is very important, at least, I have been working at the university for almost 18 years ... and for me these eighteen years have meant a lot in my life, they have helped me to improve in all respects, I have become an example for my family and it has helped me to offer something better to my children..."* (Secretary e).

Table 7.8: Beliefs, Values, Responsibilities and Activities Related to the Role of Being a Woman

INDICATORS	FREQUENCY (N=10)
a. Family roles have to be assumed by the woman	7
b. Duty first, pleasure second	6
c. Social stereotypes of man and woman	6
d. Guilty feelings by not dedicating enough time to the children because of work or leisure time	3
e. Work is an important aspect of women life	3

Letters indicate which of the quotations belong to the present indicators

The Woman as Caring Daughter

During the interviews, a role that was not initially contemplated arose spontaneously. It is important to include it explicitly in the life of some participants as an additional role. This role is the daughter role. It was reported by two women, one of which (Secretary) admitted that it was a role that generated added responsibilities that she took on with pleasure even though it caused some pressure on her when attempting to share it with her other roles, especially given that her parents lived in the eastern part of the country and she usually visits them ".. *every 15 or 20 days sometimes; last year one of my children was sick and I couldn't go to visit (my parents) for over a month and that gave me a bad feeling... because I have a certain amount of responsibility, of course, a responsibility that I myself have willingly taken on, isn't that so ? Because they are my parents... And I say, well, not everyone can and I can, I have the opportunity (to take it on), it pleases me to do so... but sometimes I have to sacrifice other things. Look, sometimes, working during the week, everything stays in a mess because I have to go and visit them and when I come back I have to see how I manage to do all the things that are pending at home".*

In the case of the other woman, her commitment to her parents was assumed as an imposition by them that was not pleasant to her: " *My husband sometimes tells me... I don't have to take on the burden of your mother and your father because they have their own world, if we can go we'll go. But I think that my father has taken this as our obligation because he takes care of my daughter at times so I have an obligation towards him, a duty and a responsibility"* (Secretary).

We thus find a role that is additional to those foreseen that interacts with them and may also interfere with them. However, it is also complied with because, even though it may generate added worries and stress, its affective significance is important.

Work-Family Relationship

The aim in this category was to evaluate how the work-family relationship is perceived, taking into account the different types of interference as well as the satisfactions between the two.

Interferences Between Work-Family Relationship

As can be observed, and as previously reported in the roles subcategory, we can notice that, in general, the indicators presented are related to work interfering in family life and not vice versa (Table 7.9). Work interferences in family life are fundamentally related to the time factor, which predominantly affects all matters relating to the care of the children and daily household activities: "*..Perhaps if I did not have to spend so much time here (at work) my home would be better looked after, right?"* (Professional a). "*Because of my work I feel I have no time to fulfill my other activities at home, (to be with) my daughters..*" (Professional a).Much guilt is also reflected and this has an effect on the psychological state of the participants: "*With respect to the children, I always feel somewhat guilty, as I am not always with them, this depresses me, it makes me feel sad because they are not to blame for my decision to work and they need me..*" (Secretary a). Another professional mother said: "*Yes, at home I am available but the time that I am available is so scarce.... this has made me feel very bad, I feel guilty. I have many dilemmas in this respect..*" (Professional a).

The couple relationship is also affected as a result of the time these women have to dedicate to their work life, as expressed by this professional woman: "*Because of work sometimes my husband asks me to go with him on a trip and I cannot go, not only because of my girls but because of my work"* (Professional b) or this secretary: *".., I think my work has been (a) negative (influence)... with my husband, first because he*

feels neglected, my husband objects to this and complains a lot to me about this.." (Secretary b).

Other women also stated that work interferes with the time dedicated to other activities and time for themselves. *"Now, my work interferes strongly with what I want to do... that is, to take care of myself a little... To do whatever takes my fancy, I would like to go swimming once a week, and I would like to visit my mom... I would like to have an afternoon off to have a facial. Sometimes that bothers me a lot, not having time, but the fault lies with my work, not at home"* (Professional c & d). In only one case did one participant express that her role as a couple interfered with her work and this was due to illness.

Table 7.9: Interference in the Work-Family Relationship

INDICATORS	FREQUENCY (N=32)
a. Job interferes with childcare and household activities	15
b. Job interferes with spending time with their spouses/companions	8
c. Job takes time away from the other activities (family, leisure time, etc)	4
d. Job interferes with the time they can dedicate to themselves	4

Letters indicate which of the quotations belong to the present indicators

Satisfactions Between Work-Family Relationship

The participants (28%) reported that their work has enabled them to control and moderate tensions at home, thereby improving their family life (Table 7.10). This, thanks to skills and lessons learnt at work: *"To handle so many different people and to realise other people's problems helped me improve my relationship with my daughter. It helped me with my husband because... work made me become a little more aware of some things in my relationship with my husband. So my husband feels now that we can talk about a lot of things, he can help me and now I don't get so tense with him and at home things are working better.."* (Professional a). One blue-collar worker said that work helps her forget her family and household problems and that that is one of the factors that gratifies her most from working: *"In my job I completely forget about all the problems I have at home. I take a breath and get my strength back for when I return home.."* (Blue-collar a).

Likewise, work has contributed to increasing their network of social support, as expressed by this secretary and this has made her feel more satisfied: " *Thanks to my work I have more friends, I meet with them outside working hours, we have fun and I can count on them during hard times... that makes me feel very happy"* (Secretary a).

Another source of satisfaction for these women has been acquiring new skills, a common expression for the 3 occupational groups. Thus, for instance, for this professional woman, work has enabled her to know human beings better: *"... I believe that having multiple interests helps also because in the work environment not only does one do a specific task, one also has human contacts. One learns a lot through human contact, one learns a lot about teaching"* (Professional b). In turn, for this secretary, work has favored her personal growth: *"I, for instance, learn. One learns new things and that helps me to be a better person.."* (Secretary b). For this blue-collar worker, work has given her more tools to solve family problems and she thus feels more self-assured: *"I have had experiences at work that have helped me at home to analyze if certain things must be done or not... I feel more secure about the decisions I make, I have more criteria"* (Blue-collar b).

Finally, the participants also stated that their work has enriched their family life and vice versa: "*Work has helped me a lot, especially regarding the education of my children... because one tries to, at least, one sees, observes, listens, do you understand? Then those ideas one tries to impart them to one's children, at least to strive to be better every day, isn't it true*?" (Secretary c).

Table 7.10: Satisfactions in the Work-Family Relationship

INDICATORS	FREQUENCY N=32
a. Job has allowed them to control and moderate home tensions and social networks	9
b. Job has allowed them to learn new things	8
c. Job has allowed to enriched their family roles and vice versa	7

Letters indicate which of the quotations belong to the present indicators

Distribution of Household Responsibilities

This category evaluates the perception of how home activities are distributed according to women and how equal or not this distribution is.

As can be observed from Table 7.11, the vast majority of the women participating in this study were responsible for managing and carrying out household duties. *"Undoubtedly I am the one who does the most work; now, others are willing... usually I do it but in rare cases they do it"* (Professional a). *".. I receive no help in that regard, so the work always accumulates"* (Secretary a). *"I have the most part. Practically all of it"* (Blue-collar a).

In general, these women reported that home tasks and the responsibility for the care of their children made them feel very overburdened. *"I feel that I have all the responsibility in my home, I do the shopping, I take the children to the doctors, if I don't go to the market and my husband does, I am the one who has to make the list of things to buy, he doesn't know what to buy... I arrive from work and see everything I have to do... fix dinner, make sure the kids did their homework, ufff... I feel exhausted.."* (Secretary a).

A smaller percentage (28%) reported that their partner helps them with the home tasks and in the care of the children or otherwise they have domestic help: *"... I have tried to motivate my husband to do things at home that I consider he can do...He's in charge of the car maintenance, of paying the light bills, of taking the child to the day-care center..."* (Professional b).

Nineteen percent of the women said that their daughters and parents, specially their mothers helped them with the household chores as this participant who said: *"Well the kids, I put the girl to clean the dishes, to tidy her room and the smallest one has to pick up her shoes, she must not leave them all over the place"* (Secretary d).

Table 11: Distribution of Household Responsibilities

INDICATORS	FREQUENCY (N=32)
a. Woman manages, makes the decisions and carries out the household chores	22
b. Partner support	9
c. Maid help	9
d. Support from daughters	6
e. Support from parents	6

Letters indicate which of the quotations belong to the present indicators

Health

The health category specifically describes the main psychological states, emotions and physical symptoms these women manifested in relation to their multiple roles and work-family relationship (Table 7.12.).

Table 7.12: Negative and Positive Indicators of Mental Health

INDICATORS	FREQUENCY (N=32)
Negative	
a. Sadness, melancholy	11
b. Apathy, lack of energy	7
c. Exhausted, crying easily	7
d. General tension, anxious, nervous	7
e. Irritability, anger, bad mood	6
f. Feeling nervous, restless, agitated	6
Positive	
a. Happiness, satisfaction, sensation of enjoyment	7
b. Satisfied with their abilities, proud of themselves	6
c. Sure that they have done their best	4
d. Capacity for solving things	4
e. Sense of life, optimism	3

As can be observed in Table 7.12, the participants reported more negative than positive emotions in their coping with their multiple roles. The negative emotions are more associated with depressive states and anxiety and the positive states are experienced as feeling competent, higher self-esteem and optimism.

In evaluating the psychophysiological symptoms most often presented in this group of women, we found that muscular tension was the most common symptom (61%), followed by tiredness and headaches (53%).

7.4. - Discussion

This study describes the experience of working women in relation to their family and work roles, their perception of satisfaction and stressors in relation to their roles, work and family relationships, the distribution of household responsibilities and the consequences on their physical health, mental health and well-being.

After analyzing the data from the in-depth interviews of 32 working women, several issues emerged. First, being a mother was the central role for women, around which the other roles are found. Being a mother represented, on the one hand, the mission in life for which a woman was conceived: having children and guaranteeing their descendants - thus finding here the presence of socially induced sexual stereotypes and cultural values. This view of motherhood refers not only to the physical aspect (of conceiving) but also represents an enormous burden of responsibility for the upbringing, care and transmission of moral and spiritual values to the children. "*Transmitting what my parents transmitted to me, leading them down the right path...*" On the other hand, children give these women satisfactions through their behavior, love and companionship as well as their successes, expressed also in higher self-esteem and security for the women and a sense of self-realization through them. This is more markedly observed in women who have had to raise their children alone or without a partner. Bernal and Meleis (1995) also found in women employed as domestic help that the companionship of their children, watching their children grow up and nurturing their children provided them with pride and deep satisfaction. According to these authors, children give their mothers a very deep sense of security because the children "*tend always to be there*".

Women are also nurtured by seeing their children grow and by being able to give them a better life than the one they probably have, due to lack of opportunities and economic resources (Meleis, Douglas, Eribes, Shib & Messias in press). For this reason these women manifest such concern over the academic success and preparation for the future of their children. This finding was more related to women in the lowest SES.

The maternal role is at the same time a significant source of stress in women's lives (Barnett & Baruch, 1985; Baruch & Barnett, 1986). Particularly, working mothers report the high cost of parenthood for them, more marked in working women with young children (Gore & Mangione, 1983; Shipley & Coats, 1992). For this group, the main sources of stress were not having enough time to dedicate to the children as well as work overload and great demands exerted by the role of mother and behavioral problems in their children. These women reported that they felt anxious, exhausted, tense and even some experienced depressive symptoms. The lack of time to dedicate to their children is always linked to feelings of guilt, and conflicts are experienced between the dedication to their work and their family roles. For them, work prevents them from fully dedicating themselves to their role of mother and their partner role, which constitute their primary responsibilities (Simon, 1995). In turn, the guilt over not fulfilling this mission, not being available for their family, seems to have relentless consequences, reflected not only in the present situation of their children but also in their children's future. These consequences may even include the responsibility over marital problems due to the combination of family and work roles in the case of women (Simon, 1995). Mothers have traditionally been blamed by health professionals for their children's problems (Caplan & Hall-McCorquodale, 1985). According to Bernal and Meleis (1995) the experiences and worries of working women regarding their children's behaviors and the roles of the fathers are usually not reported in the literature. Apart from what these authors found in their research, the participants of the present study attribute their children's bad behavior, illnesses and lack of educational achievements to the few hours parents spend at home. Notwithstanding this affirmation, most women recognize that work provides them with economic stability that contributes to a greater or lesser degree to guarantee a better future for their children.

On the other hand, because the majority of mothers assume that home tasks continue basically to be their responsibility, we find that the participation of others is taken as help or collaboration. Cooperation by the couple is in no case seen in the end as an obligation, therefore it is always up to the man to determine which tasks he will help with. The man even has the right to demand the manner in which the household is to be run without necessarily feeling committed to cooperate, as he does not consider it to

be his duty. This lack of equity and support generates much unease in the woman and resentment towards her partner, as well as tension and overtiredness. These findings have been corroborated by Bethencourt (1998) in Venezuelan working mothers in urban populations.

It is interesting to note how cultural patterns and sexual stereotypes are transmitted from one generation to the next (Lara, 1999). In the present study we find that some mothers report that those who help them with household chores are the daughters. The mothers train their daughters and not their sons in handling home tasks. They teach them to keep their rooms tidy, to clean the house and even to care for a smaller sibling. From a tender age, daughters - as future mothers - learn their role and their household responsibilities. Likewise, the grandmothers (whether they live in the same home or not) also provide support to their working daughters by taking care of the children and household chores.

With respect to the partner role, the majority of women expressed that it is a very important role in their lives. This relationship gives them emotional, affective and instrumental support in managing home matters and the care of the children as well as economic support. On the other hand, feeling loved, having a spouse/companion with whom to share good times and bad, as well as the moral, spiritual and religious values of their mates gives them much satisfaction. This type of relationship satisfies them as women. Although many live in constant conflict with their partners, few spoke of separation or abandonment.

As regards stress-inducing aspects associated with their role as a partner, once again the time factor presents itself as one of the elements working against the relationship and associated with demands imposed by the other. As was previously expressed, the woman tends to take on the responsibility for the smooth functioning of her marital relationship. However, in having to balance different roles and establish priorities, the parental role and the work role take top priority above the marital role. For some women, this has to do with time and energy savings, as expressed by Simon (1995). Under these circumstances, women once again feel frustrated, guilty or unsatisfied for not complying with social expectations. This comment is in harmony with the new

category, which arose from the interviews: the perception women have of their own role as women. One of the indicators pointed out that, for them, duty comes first, pleasure is second.

These women hope that their partners will actively exercise their role in the family as well as make decisions and take more responsibility in maintaining the home. The fact that their partners do not fulfill these expectations constitutes a source of stress and annoyance for these women. This reflects the marked influence of traditional gender stereotypes in this group of women.

With respect to the labour role, it is interesting to note that for these women the most gratifying aspects associated with their working life refer mostly to interpersonal relationships and then, to a lesser degree, to the characteristics inherent in the job itself, recognition and economic security. Interpersonal relationships are linked to instrumental as well as emotional support, but work also represents for them a space to spend time with others and learn, as well as an extension of the role of mother, to feel useful and to feel that they are of help to others. This strengthens their self-esteem and produces a great feeling of well-being.

Work constitutes for these women the only role that they themselves chose and that somehow does not constitute an obligation (as represented by the family roles). Although the work-family relationship turns out to be extremely difficult for the majority of these participants, many highlight the importance for them in deciding what type of work they want to do and the importance of self-realization in spite of family pressures and the feelings of guilt generated. Work means independence, increased social networks, new lessons learned and a greater perception of control. This confirms the results obtained in other research in the sense that working women enjoy better mental health than those who do not work (Martikainen, 1995).Work-associated stressful situations referred to aspects traditionally mentioned in studies on labour-related stress. Once again, the perception of lack of time is highlighted as a stress-inducing element in these women. Bages et al (2000) found that the perception of the lack of time as one trait associated to the type A behavior pattern was much more frequent in women than in men. This is probably also linked to multiple roles.

CHAPTER 8: SUMMARY OF MAIN FINDINGS

What have we learned?

Relatively few studies have been carried out that investigate this topic from the perspective of women's health in Latin America. The few reports known by the author have appeared in regional (Spanish) scientific literature (Meneses et al. 1999; Gomez et al. 2000) that local researchers have access to, but they fail to contribute to a wide-spread, world wide knowledge regarding the realities of psychosocial factors and health in working women with multiple roles.

The strength of this dissertation lies in the multiple aspects and methodologies used. Both quantitative and qualitative approaches were used in order to enrich the overall findings to add complexity and depth to the topics scarcely explored in the regional literature. Moreover, the two cross-sectional and one longitudinal studies conducted represent another promising new direction for research on multiple roles. These types of studies could be considered in the future to provide information about how psychosocial factors behave at one particular time in women's lives. They could also be useful to test the predictive causal influence of psychosocial variables on self-reported physical and mental health.

Relevant psychosocial variables according to the literature, such as role-quality, social support, distribution of household responsibilities and the way work influences family life, were investigated in relation to working women's health. Socio-demographic variables such as age, education and having pre-school children, as well as family roles and different occupational status, were also considered in the different studies carried out. Various health indicators were used for measuring mental and physical health. Additive and interactive models were used in order to get a better understanding of this phenomenon, considering not only the main effects of the psychosocial variables but also their moderating effect on health.

A series of instruments had to be adapted, validated and/or designed for this research and have later been used by other national researchers (Blanco, 1996; Carrasquel,

1997) and regional researchers (Gomez et. al, 2000) interested in this subject, thus enabling the comparison of results.

The main findings from the four studies of this thesis will be integrated and discussed in the following sections. Table 8.1 presents a summary of the results of the four studies. Limitations of the studies will be acknowledged adding some recommendations to overcome them. Suggestions and implications for future studies will also be presented.

8.1. Role Occupancy and Women's Health

It is not the accumulation of roles but rather the type of role-played by women what explained the relationship between multiple roles and health. It was found that women with partners reported higher levels of well-being and less symptoms of depression than women with no partners. Likewise, women with children and no partner report more symptoms of depression. This finding is in line with that of Waldron et. al (1996) and Stack and Eshleman (1998) who demonstrated that having a partner is associated to better physical and mental health in men as well as in women.

Working women experience more anxiety but in turn enjoy higher levels of self-esteem in comparison to non-working women. These results would seem to indicate that work affects women both positively and negatively.

Mixed results were obtained on the mother role, depending on whether the study was cross-sectional or longitudinal. Women with a larger number of children and women with pre-school children reported a worse perception of physical health, more anxiety, depression and less wellbeing in the cross-sectional study. When controlled for prior levels of depression, mothers in the follow-up reported less depression relative to non-mothers. This type of conflicting results is also found in the literature related to mother's role. Although some studies claim that the mother role seems to be the major source of stress among women (Baruch & Barnett, 1985; Elliot & Huppert, 1991), other investigations have found no association with health indicators or have found that women with children have a slight advantage over those who have no children

(Verbrugge, 1984; Baruch & Barnett, 1986;Waldron & Jacobs, 1989). The advantage depends on the age, number of children, marital status, type of work and whether the woman receives social support from her partner (Haynes & Feinleib, 1982; Walker & Best, 1991). This indicates that roles cannot be studied independently. Social roles may have interactive effects and their relationship with health depends on many other variables as well as the quality thereof.

8.2. Characteristics of Women's Social Roles and Their Mental and Physical Health

Role quality was the most important psychosocial variable in this thesis, considering the main effect (explaining the higher percentage of the explained variance) and interactive effects, and either strained or enhanced women's health or well-being. This was confirmed through the qualitative interviews.

8.2.1. Job-role Quality and Health

The quantitative studies determined that the job role has a greater impact on women's health and wellbeing. The qualitative study also highlighted the importance of a working life for this group of women. Within the work dimension, the role of the supervisor and co-workers was found to be the source of both support and stress and, together with job control, it was the most health-related relevant aspects.

Supervisor and Co-worker Support

Supervisor support was the job condition related to both rewards and stress with an important impact in working women's health and wellbeing. It was specifically related to more anxiety and depression, but at the same time to higher self-esteem. Supervisors play an important role because they can provide instrumental and informational support by giving information about the task requirements, or by helping to reduce overload and giving clear guidelines concerning role expectations. A supervisor can reduce stressors such as role ambiguity, role overload, role conflict and future uncertainty. All these aspects can promote positive worth and self esteem causing

positive feelings. Supervisor support was also related to anxiety because women can feel that they have to compensate for what they have received, perceiving this support as an extra demand and responsibility toward work, as was demonstrated in the present findings. As Fenlason & Beerhr (1994) pointed out, supervisor support is formally the most powerful source of support in the organisation and has been significantly related to work satisfaction and intentions of not quitting (Donovan, Drasgow & Munson, 1998)

No differences were found between occupational status in the present research. This means that for the women participating in this study, supervisor support had the same importance and impact for a blue-collar worker as for a clerical or professional worker. It could be possible that, especially for working women with children, independently of their occupational status, support coming from a supervisor also represented instrumental and emotional support to cope with work-family stressors as well. Prior studies carried out in Venezuela with different samples of working women revealed the importance of the supervisor as a resource that diminishes or increases stress at work (Micale, 1991; Blanco, 1996). The present finding is in conflict with that of Marcelissen, Winnubst & Buunk (1988) who found that for persons with lower educational levels, the supervisor's support plays an important role in eliminating and reducing stressful circumstances at work, while this is not the case for persons higher up in the occupational hierarchy.

The relationship with co-workers was another important aspect increasing satisfaction, well being and self-esteem at work, or generating stress. Frone (2000) found that conflicts with co-workers were predictive of psychological health outcomes (depression, self-esteem and somatic symptoms). In general, the relevance of interpersonal relationships is a common element characterising this group of women, as corroborated in both the quantitative and the qualitative studies.

Work-related interpersonal conflicts seem to have as much weight as other stressful situations reported, such as salary dissatisfaction and the lack of recognition and promotion as sources of stress. The following expression by a secretary in the qualitative study is a clear example of this: "...When I have had a problem with my

boss or co-worker at work, this affects me a lot. I feel a lot of anxiety every time I think about it. I cannot concentrate and I think about it all the time. At one time, I almost made the mistake of quitting... thank heavens I didn't. Getting along with people is the most important factor for me at work... This makes me feel good...". This seems to coincide with studies that have empirically shown that women have a greater tendency to base their self-esteem on social relationships (e.g. Josephs, Markus and Tafarodi, 1992).

Job Control as a Protective Factor

Job control was the most important aspect of work in relation to women's health in both cross-sectional and longitudinal studies. Women who perceived that their job allows control and autonomy, as well as a sense of challenge in using their abilities and a variety of work tasks, also perceived better physical health, higher levels of self-esteem and wellbeing, less stress-related symptoms and lower anxiety levels in the follow-up. Many studies have pointed out the relevance of this aspect in relation not only to health but also to productivity and satisfaction at work (Karasek & Theorell, 1990; Parkes, 1989; Noor, 1995).

Job control also acted as a moderating psychosocial factor between monotony, dissatisfaction with the salary, lack of recognition and promotion and different health indicators such as health perception, self-esteem and wellbeing. Although monotony and lack of recognition and promotion turned out to be important stressors in the lives of these women, when they perceive that they have control over their conditions at work, the effect of these stressors is minimised or compensated for, with lower implications over their self-perceived health and psychological well-being. These results show how women perceive their work environment and reflect which elements in that environment are important to them. According to some comments by the participants in the qualitative study, it seems that this could have a bearing on coping strategies for handling conflict between the work and family roles (... "*this job gives me the advantage that my vacations coincide with those of my kids, besides I can work at home, I earn less but it's compensated by that, office work is sometimes very boring, tedious, I have to answer the phone... do the same things over and over... but if my*

daughter falls ill, I can manage... I talk to my boss, I ask for help from my co-worker... there is always a way out... or I compensate by working another day").

It would be interesting to investigate in the future if the moderating effect of job control over these variables may be related to coping strategies for managing work-family conflicts. It is possible that the sacrifice represented by these work practices may be compensated for through autonomy and control at work.

Salary dissatisfaction and the lack of recognition and promotion constitute sources of stress reported by women in Anglo-Saxon as well as Latin American countries. This indicates that in spite of the great strides made by women, they are still being discriminated against in these ways (Feldman et. al, 2000; Marquez & Lejter, 2000, Brannen, 1998).

In the literature on occupational stress, work overload constituted an important source of stress due to its consequences on health and well-being. In the cross-sectional studies, overload was associated with higher levels of depression, anxiety and somatic symptoms and to a lesser degree of well-being. In the long term, women who reported overload manifested more anxiety. Work overload and demands were the most frequent indicators reported by women in the qualitative study. This is not surprising because epidemiological, psychophysiological and occupational stress research has identified work overload, together with low autonomy and poor social relations, as major psychosocial risk factors (Frankenhaeuser, 1991; Karasek & Theorell, 1990; Rydstedt, Johansson & Evans, 1998).

Unlike the proposal in the model by Karasek and Theorell (1990), work overload in this study was neither moderated nor associated with job control, unlike household responsibilities. Women experiencing high levels of overload, who also expressed having many house-related responsibilities, reported more anxiety than those with low levels of overload. These results indicate that for women, work and home are intimately interrelated.

8.2.2. Partner-Role Quality and Health

In this thesis, the quality of partner relationship constituted a very important aspect related to the health and well-being of working women in this thesis, much more than the mere fact of having a partner or not, a common aspect to all the studies carried out. Rewards associated with the partner role were related to less anxiety whereas stressors were related to higher degrees of depression. Likewise, statistically significant associations were observed between alcohol consumption and sleep disorders in women with greater marital concerns. These findings indicate that when the quality of the role is taken into account, the impact on health and wellbeing is greater, as confirmed by other studies (Ross et. al, 1990; Tucker et. al, 1998; Barnett et. al. 1994, among others).

Marital dissatisfaction and lack of partner support were associated with health indicators such as more anxiety, depression, and somatic symptoms and less wellbeing in cross-sectional studies and were related to long-term depression and symptoms. Marital conflict is a very frequent problem in western civilisation. According to O'Leary (1998), conflicts among partners occur in 75% of the cases and have been repeatedly associated with depressive symptoms.

The qualitative study also confirmed that conflictive relationships, lack of support from the partner and the demands and lack of time to dedicate to the partner were the situations that most affected women. Additionally, this study identifies an element later observed when discussing the mother role: the feelings of guilt and the sense of responsibility that these women take upon themselves related to home and family. Not being able to fulfil these expectations, or to comply with the social expectations assigned to the role of being a woman, makes them feel frustrated and dissatisfied and also for not Also, "lack of time" is constantly present in their expressions, as observed in the qualitative study. This constitutes a real complaint and could be a consequence of the effort women makes to balance their various roles.

Perceived job control as well as social integration were found to protect working women from stress related to marital conflicts with respect to their health perception

and depression. Again, these findings reflected firstly, the interrelationships between work and non-work domains and, secondly, that the Karasek job-demand model and the buffering hypothesis of social support function in the same direction, in the sense that by interacting with the stressors - in this case job control or social integration - their relation to health indicators is altered positively (Daniels & Guppy, 1994).

Man's traditional role in society as a breadwinner was also reflected in this thesis. If the woman's partner has job instability, insufficient salary and/or work-related problems, these have an important effect on the woman's health. However, if women perceive high emotional support, the negative effect on their health is diminished. Economic support constitutes a very sensitive issue affecting the family's quality of life, having much more impact at times of economic crisis, as has been the case in Venezuela over the last 10 years. This aspect was also clearly reflected in the qualitative study.

8.2.3. Mother-role Quality and Health

The parent role has traditionally been considered a source of stress for women (Barnett & Baruch, 1985). Nevertheless the results found in the literature are not consistent (Baruch & Barnett, 1986; Verbrugge, 1983). Two important results on this topic were obtained in this thesis. First, satisfactions associated to the mother role had positive as well as negative results on health and second, compared to other roles, none of the psychosocial factors studied acted as health protectors in working women with children.

In relation to the first result, mother's satisfaction with her children was positively associated to self-esteem but also to anxiety, depression and somatic symptoms. Mothers consider themselves, and are consider by society, to be responsible for the well-being, care, success or failure of their children, as was also pointed out by Pugliesi (1988), Simon (1995) among others. Recent research has focused on the study of the significance of each role in order to better understand the psychosocial mechanisms that would explain the effect of social roles, particularly on mental health (Simon, 1995, 1997; Burton, 1998).

Conflicts and dissafections with the children, as well as economic strain and having adolescents, were related to anxiety, depression and a lower perception of well-being. Conflicts and dissafections with the children was the only mother-quality dimension which predicted lower levels of well-being after 16 months. It is probable that for these working women, the feelings of guilt arising from having to work and not having enough time to dedicate to their offspring, as expressed in the qualitative study, makes them perceive their conflicts with their children more intensely, thus affecting their mental health. For these women, work does not allow them to fully engage in the roles that constitute their primary obligation: the mother and partner roles. Simon (1995) reached similar conclusions.

No psychosocial factors to protect working women with children were found. When interactions were considered, the satisfactions generated through work protected the mental health of working mothers when demands to their maternal role were low, but ceased to be protective when exposed to greater demands and interferences. Based on these findings, for this group being a mother was a source of psychological distress and produced the worse perception of health, which especially increased when women faced high demands and interferences because of the children. These results agree with Dixon et al. (1991) and Kessler and McRae (1981) who also found worse symptoms of anxiety and depression in their groups of working mothers. Barnett and Baruch (1985) and Cohen et al. (1990) also reported that the parental role is a very important source of stress among women. Nevertheless, variables such as the age of the children, the marital status, socio-economic level and whether the woman can counts on her partner's support must be considered in these results.

8.3. Social Support

The results of the different studies highlighted the relevance of social support as a health-protecting factor as well as a moderator of the effect of stress-inducing circumstances in the women participating in this study. Sufficient empirical evidence exists in the literature in relation to both proposed hypotheses (e.g. Cohen & Wills, 1985, Cohen, 1990).

Amongst the sources of social support, the job, the partner and the support provided by groups and religion and support at work turned out to be the most relevant, due to their direct relation with health and wellbeing in women. Similar findings have been previously reported (Maton & Wells, 1995; Ventis, 1995; Berkman & Syme, 1979). From these sources of support, only the support by groups and religion turned out to be moderators between work stressors and partner stressors and the levels of depression. In contrast to Anglo-Saxon countries where very well structured and organised support groups exist, in Latin America and specifically in Venezuela, these support networks have traditionally come from the family and not from socially created groups. Due to changes in society and the family in the last few years arising from economic and social crises (Recagno-Puente & Platone, 1998), religious institutions have taken on this support role to a certain extent, offering structure and emotional, spiritual and instrumental support, especially to women who feel responsible for solving problems related to the household, the education of the children and their moral and spiritual development (Williams, 2000). Besides, this constitutes a coping strategy that helps women manage stress (Feldman-Naim, 1991). For groups with diminished resources, religious institutions constitute a support not implying additional expenses.

The availability of emotional support and social integration was clearly linked to less symptoms of depression as well as to higher levels of well-being and self-esteem in cross-sectional evaluations and, in the long term, to lesser degrees of anxiety in these women when their main effects on health were studied. Functions such as feelings of belonging, practical help received, the support of extended networks and emotional support mainly from family and friends, may serve as protective functions against physical and psychological morbidity and mortality (Orth-Gomer, Rosengren & Wilhelmsen, 1993; Owman et al. 1995; Achat, Kawachi, Levine, Berkey & Coaktley, 1998). Emotional support, as well as social integration, acted as partner-related stressor moderators. Thus, women who could count on an ample and important social support network in times of marital turmoil and lack of support by their partners, reported significantly less levels of depression in comparison to women lacking that network. On the other hand, the perception of physical health was significantly affected in women who counted on low degrees of emotional support when faced with partner-

related problems arising from conflicts due to lack of support and respect for their religious beliefs or because their partner had economic problems and work-related instability. In this sense, having someone close to trust their problems to and having other support networks moderated the stressful effects these situations had on their health. Some authors pointed out that for women the response by network members is so important because they are more likely than men to be socialised into an expressive role emphasising emotional nurturing, part of which includes giving or seeking social support (Hirsch & Rapkin, 1986; Fuhrer et. al, 1999).

8.4. Household Responsibilities

The results of this thesis confirm that women's work, and especially household-related chores, is clearly gender-oriented. Although household-related chores are not gratifying for the majority of women, they are accepted as part of their responsibilities and this is transmitted to their daughters, as reflected in the qualitative study. Cultural factors and social stereotypes continue to mark the behaviour of these women, regardless of their education or occupational level (Lara, 1999). Although it was expected that, with the incorporation of women into the workforce, men would start to participate more actively in household tasks, this expectation has not materialised and women continue to be in charge of the housework and the care of children (Noor, 1997), this being an aspect generally observed in most cultures.

Garcia (1993), in a study carried out in Venezuela, also demonstrated the imbalance existing between men and women as far as domestic activities are concerned. This author measured the time per week that working men and women dedicated to this activity, including the care of children. Women dedicated about 20 hours per week, compared to men who dedicated 5 1/2 hours. No statistically significant differences were observed in hours of domestic work compared to social class, although all women, regardless of their SES, spend close to half a day or more in domestic activities compared to men.

This study did not evaluate the time dedicated by each one of the members to household activities. Given its importance, this variable must be included in future

studies as well as the perception of fairness, which surfaced in the qualitative study. Other researchers have considered this as a key variable in understanding the relationship between household-related responsibilities and wellbeing in women (Glass & Fujimoto, 1994; Hawkins, Marshall & Meiners, 1995; Sanchez & Kane, 1996).

It is interesting to see how domestic work by men does not interfere with their formal work activities, but women must constantly balance their work and their domestic chores, to which they assign an important value. As the women interviewed in the qualitative study are full-time working women, it is not surprising that the time dedicated by them to domestic chores could be affecting their health and need for rest and recreation *"While we are all together watching TV, I seize the occasion to iron clothes and do other chores"; " I get home in a rush to see if the kids have done their homework, I warm up the food and I don't even have time to change my clothes"; "on weekends I clean the house thoroughly, because during the week I have no time"*. It is not rare that this desire to combine family and work roles could be leading these women to inadequate coping styles and health habits, with negative consequences on their physical and mental health in the short- and medium term. An association between household tasks and sleep problems was found. On the other hand, the longitudinal study demonstrated that the management of household and children's care were associated with lower self-esteem in the first measure and to anxiety in the follow-up. Bird (1998) pointed out that men's lower contribution to household labour explains part of the gender differences in depression.

8.5. Work-Family Relationships

Research examining the relation between work and family and general health outcomes has increased substantially during the past decade. This work has grown out of several general job stress models, suggesting that a lack of fit at the interface between work and family roles represents a potent stressor that can influence employee's health and health-related behaviours. Most research on this topic has centered on studying the work-family relationship from the point of view of conflicts (e.g. Frone, Russell & Cooper, 1993,1997; Higgins, Duxbury & Irving, 1992). Little research has evaluated the positive aspects in this relationship (e.g. Barnett &

Marshall, 1992; Barnett, Marshall & Sayer, 1992; Adams, King & King, 1996; Glezer & Wolcott, 1998). This thesis looked at both aspects.

The measure of work's interferences on family life was a very sensitive measure when evaluating the main effects on the health of working women. More interference meant worse perceptions of physical health, more depression and somatic symptoms and less wellbeing. In the long term, interferences were associated to higher levels of anxiety and sleep disorders. Prior cross-sectional and longitudinal research suggests that work-family conflicts were related to health outcomes (Frone et. al, 1997; Carrasquel, 1997; Campbell & Moen, 1992).

On the other hand, satisfactions at work spill into the family arena and are related to less anxiety and more self-esteem. When interactions were studied, it was found that high levels of satisfaction from job to family mitigated anxiety due to dissatisfactions with salary and lack of recognition. However, work satisfactions cease to be protective in mothers with high levels of family overload, as mentioned previously. Barnett and Marshall (1991) found that women with rewarding jobs were protected from the negative mental-health effects of troubled relationships with their children. This protection accrued to employed mothers regardless of their partnership status or the age of the children. In another study, Barnett, Marshall and Sayer (1992) reported that having a rewarding job per se did not automatically mitigate family stress. A challenging job was the only job-reward factor that mitigated the distress associated with disaffection in the relationship with their children. Other investigations have found differences in these relationships when variables such as the age of the children, the number of work hours, marital status and social support are considered (Schwartz, 1989; Glezer & Wolcott, 1998; Adams et. al, 1996).

Although throughout the interviews, work-family relationships were evaluated in both directions, as opposed to evaluations based on questionnaires, results only reflected interferences and satisfactions from work to family and not vice versa. This finding agreed with Glezer and Wolcott (1998) who found that for 28% of the women who experienced work interfering with home life, 1 in 5 agreed that home was interfering with work.

8.6. Sociodemographic Variables, Psychosocial Factors and Health

Age, education, number and age of children, marital status, type of roles and occupational level were considered throughout this thesis with respect to psychosocial variables as well as their relationship to various health indicators. Vast empirical support exists to justify their inclusion. In fact, a large part of research on multiple roles, working women and health are based on these types of variables. It was found that the group comprising employed mothers is at a greater disadvantage. On the one hand, single working mothers reported lower levels of wellbeing, higher levels of depression and a worse perception of physical health. They also reported less work rewards, more household-related responsibilities and less social support. These results have been reconfirmed in other cultures (Macran et. al, 1996; Elliot & Huppert, 1990; Walker & Best, 1991; Khlat et.al, 2000, among others). Education was related to a better perception of physical health, wellbeing and lower depression but also to higher levels of interference between work and family. In relation to occupational status, blue-collar and clerical workers had significantly more depressive symptoms. They also reported significantly lower job rewards and the highest level of job stress, and housewives reported the lowest self-esteem.

This thesis found that once these sociodemographic variables were controlled, the percentage variation explained by these variables was very low. These results indicate that in the present thesis when psychosocial variables were included - and of these, the role quality in particular - they explained the most relationship with health.

8.7. Theoretical Implications

8.7.1. Theoretical Models for Multiple Roles

The Lazarus and Folkman´s Interactionist Model of Stress constitute a solid and useful theory for the study of the impact of work and family in women's health. The results of this dissertation pointed out that the performance of work and family roles in

women could be a source of stress or not, depending upon individual appraisal, personal resources and social contexts.

From a more specific point of view, this thesis confirmed the Role Integration Hypothesis (RIH), which considers that the effect of multiple roles on the health of women depends on the quality of the experiences within roles and not merely on role occupancy (Barnett & Baruch, 1985; Barnett et al. 1991). Although the RIH does not explicitly mention their relation to Lazarus and Folkman approach (1986), upon analysing it, their statements are closely related to this hypothesis.

8.7.2. Women's health issues

The literature on multiple roles has demonstrated a connection between women's emotional and psychological well-being and their experiences in the work- and family-roles (Belle, 1982; Repetti, 1998a; Chesney & Ozer, 1995). This study highlights the relevance of the psychosocial variables on health, over and above structural variables such as the type of role and occupation. The quality of the social roles had an enormous impact on the mental health of women and their perception of physical health and also influenced their habits and lifestyles. As mentioned by Burman & Margolin (1992), poor marriages, parenthood and stressful jobs have compromising effects on health related-outcomes and those effects have been observed most clearly in psychological well-being.

The present thesis showed also how experiences in the work and family roles can shape behaviours such as alcohol consumption and other health-enhancing or maintaining behaviours like getting enough sleep, having good nutrition habits and exercising regularly. Thus, time demands, the amount of available social support and stressors associated with women's multiple roles influence the practice of healthy behaviours, increase risk factors and the way women cope with stressors, with clear implications on their health. Other researchers have also found similar results (Green & Johnson, 1990; Greenberg & Grunberg, 1995).

In general, it can be stated that multiple roles can be considered as a promise paradigm for the study of women's health research.

8.7.3. Work and Family Relationship

The findings of this thesis reinforced Eckenrode and Gore's (1990) model in the sense that it is indispensable to consider work- and family- roles simultaneously in relation to women's health. Both the workplace and the family need to be considered as semi-open systems with permeable boundaries. However, progress on work-family research theory needs to be made since most of the findings in this area are generally post-hoc derived descriptions of results obtained from studies measuring work and family variables (Zedeck, 1992). The majority of these studies have focused on this relationship from the point of view of conflict, thus limiting even more its understanding (Higgins & Duxbury, 1992; Allen, Herst, Bruck & Sutton, 2000; Higgins, Duxbury & Irving, 1992; Frone, Russell & Cooper, 1997 among others). Few studies, proportionally, have broached this from the point of view of the positive aspects in this relationship (Grzywacz & Marks, 2000; Barnett, 1994; Barnett, Marshall & Sayer, 1992). Limitations with respect to well-defined constructs, consistent terminology and testable propositions are necessary for the development of a firm theoretical framework (Westman & Piotrkowki, 1999).

This thesis included both the positive and negative spillover between work and family and their relations to health. The additive and interactive models significantly contributed to explaining this relationship on women's health. The qualitative study also enriched the quantitative findings, showing more clearly the manner in which women perceive this relationship. This latter study reflected that, for women, work really had a perturbing effect on family and not vice versa, indicating that for them the family role was the fundamental one. In this sense, this dissertation made an effort to overcome some of the theoretical and methodological limitations of this construct.

8.7.4. Social Support and Multiple Roles

Social support is the best studied of the potential health-promoting resources associated with social roles (Reppetti, 1998). Research has shown that social support can have direct positive impact on mental and physical health, and that it can act indirectly as a buffer against the debilitating effects of stress. Both hypotheses were tested in the present thesis. Social support was related to lower levels of depression, symptoms and a higher self-esteem and well-being. Job support, partner support, and groups and religious support were found as important sources of support related to the different outcomes used in the present thesis. Further, the findings on religious support can be considering as a contribution because limited number of studies have addressed health outcomes associated with this variable considering it direct and buffer effect.

8.8. Methodological Issues

8.8.1. Sample

The samples in this thesis were volunteers rather than a random sample, except for Study 1, which used a stratified random sample controlled by age and occupational level, but only secretaries were included. On the other hand, the participants, independently of their occupational level, work in the education sector (mostly university). Thus, the women participating in this study do not constitute a representative sample of labour sectors and generalisation of results can only be applied to the education sector. Although different education centres were included to give the study more variability, all were centres for higher education.

In the occupational levels, the professionals were mainly academics and the blue-collar workers were cleaning and maintenance workers. Future research should include women from different domains. What differences exist between a blue-collar worker in a factory, sitting in front of a machine, and a cleaning worker? Even within the secretaries group, there may be different work characteristics, depending on the type of organisation or company. It would be important to consider these distinctions (Chan,

Lai, Ko & Boey, 2000; Bacharach, Bamberger & Conley, 1991; Phelan et al. 1991). More heterogeneous, larger and random samples are suggested for future studies.

The present study considered only women as women with a partner and children have constituted an important group in the work force, future studies should be undertaken on dual-career couples. Research of this nature will aid in understanding how aspects such as gender, work family and marriage affect work life, family life and personal wellbeing.

A higher response rate was found across the different studies carried out in the present dissertation. Although the highest response rate was found in the professional women, in general in the other occupational groups the response rate surpassed 50%. This is unusual in comparison with other studies on psychosocial factors and health in Venezuela (Bagés, 2000). A possible explanation is that this thesis touches on a sensitive issue for working women where the participants found a space they could express aspects which touch on them *day to day* life.

8.8.2. Self-report Measures

Self-report was the method of data collection used in this research. Questionnaires with appropriate reliability and validity were used, as well as, a semi-structured interview in the qualitative study. Both methods have advantages and disadvantages (Chapter 3).

Serious questions have been raised about the common practice of relying on self-report measures to assess subjective role experiences on the one hand and both mental and physical health symptoms on the other (Noor, 1996, 1997). Some has argued it, but certainly not by all researchers (Spector, Zapf, Chen & Frese, 2000), that self-report measures reflect a common underlying dimension of negative affectivity (NA), a stable tendency toward negative emotionality. Individuals high in NA, compared to those low in NA, are more likely to experience distress and dissatisfaction (Burke, Brief & George, 1993). Hence, the relation between perceived role experience and self-report

of distress would be overestimated due to the relation between NA and the predictor and the outcome (Brennan & Barnett, 1998).

In the present thesis, self-perception of physical health was controlled for depression and anxiety in order to ensure that findings relating to self-perception of physical health are not contaminated by these covariates (Grosch & Murphy, 1998; Radanov, Schwartz; Frost & Augustiny, 1997). Also, a longitudinal study was carried out which constitutes a way to mitigate the effects of a stable variable such as NA. Insofar as NA is viewed as a stable personality trait, it would not play a role in the relations between changes in a time-varying predictor, such as social-role quality and changes in levels of distress or positive mental health (Brennan & Barnett, 1998).

It is recommended that future research should complement self-reporting with more objective indicators (e.g. physiological indicators of health). Research using these last indicators have strengthened this area and have demonstrated the impact of multiple roles on women's health (Luecken et al, 1997; Steptoe et al, 2000; Hibbard & Pope, 1991, 1993; Gomez et al. 2000). They would also strengthen the measurements for physical health used in this thesis. Daily-report measures (Repetti, 1998b) as well as the report by other informants such as the partner, the supervisor or co-workers (Bages, Warwick-Evans & Falger, 1997), represents another promising new direction for research on multiple roles that can be considered in the future and that may also contribute to overcome the problem associated with method variance.

8.8.3 Combination of Methodologies and Designs

The combination of quantitative and qualitative methods constitutes another contribution by this thesis. In the literature reviewed by the author, few studies are reported that opt for this methodological option when discussing multiple roles and health in working women (Shipley & Coats, 1992; Simon, 1995, 1997; Meleis et al, 1996). The integration of both methods enriched the results obtained. Thus, for example, less association with health regarding the quality of the mother role was found in the quantitative studies upon evaluating the main effects as well as the interaction. However, the qualitative study reflected the significance of this role for

these women, it emerged as the most important role in their lives. The significance that is given to the mother role may explain in part these apparent contradictions. Whether due to cultural reasons or inherently evolutionary reasons, these women seem to accept their role as mothers as a natural one, but do not accept job and partner roles in the same way, as reflected in a greater reactivity to stress-inducing conditions in those roles. These results require further in-depth analysis and study.

The effect of social support and interpersonal relationships was another aspect that was more fully understood through the integration of methodologies.

As for the types of design used (cross-sectional and longitudinal), as the research progressed limitations were overcome. The first cross-sectional study was performed solely on secretaries and other occupational levels were considered in the second, as well as other relevant psychosocial variables. Only the outcomes indicating a risk to health or negative outcomes for mental health were used in Study 1, so protective aspects such as self-esteem and wellbeing were included in Study 2. Nevertheless, this type of design does not allow for causal interpretations. This was the purpose of the longitudinal study. Data at two moments in time were taken, spaced out during a 16-months period. The control of baseline levels for each of the outcomes was made before considering the extent to which the predictive model explained the Time-2 levels in the health indicators used. The findings of this study served to strengthen the argument that the perception of role experience, as well as the other psychosocial variables evaluated, plays a causal role in relation to changes in mental health indicators.

8.9. Recommendations for the Future

In light of the findings outlined above, recommendations can be made regarding social roles, psychosocial factors and health in working women.

8.9.1. Interventions Targeted at Women and/or Their Family

More effective stress-handling programmes for working women with multiple roles must be designed and evaluated in order to test their effectiveness. These programmes should also involve the entire family for the purposes of optimising their effects. The acquisition of inadequate health habits, the reporting of symptoms such as anxiety and depression and feelings of guilt are some of the consequences that working women must deal with in their attempt to balance their various roles.

8.9.2. Organisational Interventions and Policies

Organisations are responsible for the psychological and physical health of their employees and their families. In light of these findings, organisations need to adopt policies and programmes to support the interrelationships between work and family. Organisations that allow flexibility for personal and family needs by providing flexible working hours, childcare facilities, part-time work, home-based work and by respecting the concerns and needs of children and family increase morale and productivity. This has been suggested by researchers (Barling, 1990; Marshall & Barnett, 1994). Organisations must also be aware of a specific high-risk group of working women, specifically single mothers with small children.

Organisations should develop clear-cut incentive policies, and also a promotion and recognition policy, so as to avoid stress-inducing situations caused by salary dissatisfaction and lack of recognition, as was observed in this thesis. A systematic, flexible career development plan may assist in minimising this problem (Quick et al, 1997).

As was shown by the findings of this thesis, organisations must become aware of the work-related aspects, which moderate or influence wellbeing and satisfaction. These aspects can vary according to gender and the results could have practical organisational implications, especially in the enactment of preventive stress management programmes and the implementation of salary- and promotion- related policies. Organisations could then improve and implement changes that would benefit both the workers and the organisations themselves, at a lower implementation cost for sensitive changes such as job design, salaries and promotions and recognition-oriented organisational policies (Quick et al, 1997).

8.9.3. Government Policies

One of the main obstacles to women's participation in the work field has to do with concrete ways in which family tasks are solved in society, since women receive the brunt of these responsibilities. The statistics presented in Chapter 2 indicate that the insertion of women into the workforce is a reality that is increasing worldwide. Because organisations seem either unwilling or unable to confront the family needs of their employees voluntarily, then governments will have to enact specific laws compelling organisations to comply with the support programmes required for men and women to be able to satisfactorily perform their family and work functions. Likewise, women are still found in specific jobs where employment conditions are relatively unfavourable and this affects women's health, as the present findings showed. For example, women's jobs have specific characteristics (repetition, monotony and multiple simultaneous responsibilities) that may lead over time to diminished physical and mental health. Organisations must be aware of this and must implement programmes and policies aimed at women's occupational health problems.

Although Venezuela, as in most countries, has implemented laws for the protection of equal opportunities regardless of gender, women continue to experience discrimination and dissatisfactions with respect to their salaries and chances of getting a job. A recent study in Venezuela indicated that in the past few years, labour conditions for women have got worse. Salaries are 30% lower than those of men and this difference is observed at all levels, even at the professional and managerial levels.

On the other hand, the probability of poverty in the female population went from 12.5% to 33.2% between 1988 and 1999, whereas in the male population it changed from 1.8% to 11.5% during the same period (OCEI, 1999). If we take into consideration that 52% of Venezuelan homes have women as the heads of the household, this situation becomes even more critical. Investing in women, an expression used by Buvinic (1994) during a conference organised by international entities such as the Interamerican Development Bank, CEPAL and UNIFEM, is a governmental obligation: "... If you educate a boy you educate a human being. If you educate a girl, you educate generations." (Buvinic, 1997). It is the government's responsibility to take concrete actions to avoid this situation from worsening, particularly in countries like Venezuela.

8.9.4. Societal Interventions

This thesis demonstrated the presence of social stereotypes and misconceptions related to women's traditional role in society, which to a certain extent compete with their role as working women. This affects their personal well-being and health and has an impact on their family and labour lives. Due to the increasing participation of women in the labour market and the larger number of families where both spouses work, it becomes imperative to design educational programmes and information geared towards the gradual change of social attitudes, beliefs and misconceptions related to work and family and to the feminine and masculine roles. The use of the media and a shift in the school curriculum constitute some of the possible effective ways of starting the process aimed at changing this social reality.

8.10. Conclusions

The health of Venezuelan working women performing multiple roles is conditioned by multiple factors of a sociodemographical and psychosocial nature. An integral approach to working women's health is required which would simultaneously consider work as well as family spheres, taking into account the close interaction between these.

For the sociodemographical variables, only the level of education and having pre-school children turned out to be predictors for the health indicators used. In general, women with partners reported better health than women without partners.

The characteristics of women's social roles (rewards and stressors) were the most important psychosocial variables in this thesis, considering the main and interactive effects that either put a strain on, or enhance women's health and wellbeing. As part of the work role, support by the supervisor and co-workers, as well as the perception of control at work, were the most important protective aspects. Social relations at work played a fundamental role on the mental health of these women, moderating important work-related stressing conditions such as dissatisfaction with the salary and the lack of recognition and promotion. The quality of the relationship with one's partner was directly related to their perception of health. Job control and social integration protected this group of working women from stress related to marital conflict. Unlike the work and partner roles, none of the psychosocial factors studied for the mother role acted as protectors against the effects of this role on women's health.

Table 8.1. Summary of the four reported studies

Studies	Objectives	Participants	Methodology/ Design/ assessment	Variables	Main results
Study 1	1.-Evaluate the impact of types of social roles, the quality of social roles and social support on mental and physical health in working women (secretaries) and 2.- -To test the moderating effects of social support on the relationship between role-concerns and health indicators	122 women university (secretaries)	Quantitative / cross-sectional/ questionnaires	Age, education, pre-school children, role occupancy, role quality, social support and health indicators	The quality of social roles was a major predictor of health. Paid worker and partner roles were the major sources of stress. Partner and religious support were the most important sources of support. Religious support acted as a protective factor against depression when women experienced high job and partner concerns
Study 2	1-To examine how mental and physical health in women from different occupational level are related to: a. type of roles, b. Role quality, social support, home responsibilities and work-family relationship. c. Evaluate the moderating effects of role-rewards, social support, household responsibilities and work-family relationships on role-quality concerns and health	417 university employed (blue-collar, clerical, professionals and school teachers) and non-employed women	Quantitative / cross-sectional/ questionnaires	Age, education, pre-school children, role occupancy, occupational level, role quality, social support, household responsibilities, work-family relationships, health habits and health indicators	Reconfirm that the quality of social roles was a major predictor of health. Job as well as partner role quality were much more important for explaining the relationship between multiple role in women and health considering both additive and interactive models. Social integration and emotional support behaved as protective factors. Conflicts between work and family were a very sensitive variable. Household responsibilities was gender-oriented.

Table 8.1. Continued

Studies	Objectives	Participants	Methodology/ Design/ assessment	Variables	Main results
Study 3	To evaluate the predictive contributions of role-quality, social support, household responsibilities and work-family relationships in relation to women's health considering different occupational levels	130 university employed women who participated in Study 2 from three occupational levels (blue-collar, clerical and professional)	Quantitative / longitudinal (16 months follow-up)/ questionnaires	Age, education, pre-school children, role occupancy, occupational level, role quality, social support, household responsibilities, work-family relationships measured in Time-1. Health habits and health indicators measured in Time-21 and Time-2.	Job overload was related to anxiety in the first measure and in the follow-up and job control was related to self-esteem. Marital conflicts was also related to depression in both times. Conflicts with the children predicted lower well-being. Emotional support and social integration predicted lower level of anxiety and depression. Interferences between work-family and management of household chores predicted higher anxiety. Higher education predicted lower well-being.
Study 4	To describe the experience of working women in relation to their satisfaction and stress related to each role they played, their perception of work-family relationship, social support and household responsibilities and how are related to their mental and physical health	32 university working women from three occupational levels	Qualitative/ semi-structured interview/ content analysis	Occupational level, role occupancy, satisfactions, stressors related to each role, meanings, work-family relationship, health effects, other issues emerged in the interviews	Being a mother was the central role for women around which the other roles are found. It is a source of satisfaction and stress at the same time. Guilty feeling and lack of time were constantly expressed especially in relation to family roles. Cultural patterns and gender stereotypes were reflected in relation to household responsibilities. Supervisor support and co-worker support, and interpersonal relationships at work were the most job rewarding aspects.

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APPENDIX 1

Table 2.1: Selected studies on multiple roles, sociodemographic, psychosocial variables and women's health carried out between 1900-2000

AUTHOR/S	SAMPLE	DESIGN & ASSESSMENT	MEASURES	FINDINGS
Adelmann, Antonucci, Crohan & Coleman. 1990 USA	Representative national sample of 463 midlife women ages of 40-64. Comparison sample contained 566 women aged 21-39.	Cross-Sectional Questionnaires	Age. Education Number of hours worked per week. Marital status. Parental status. Self-report of Physical Health .	Employment had a positive relationship with health. Married women with children had better health but were likely to work fewer hours for pay
Ebi-Kryston, Higgins & Keller. 1990 USA & U.K	Epidemiological research of determinant of health and disease in Tecumseh-Michigan. Women aged 20-44 years, categorized as employed or housewives at the baseline and follow-up. N=	Longitudinal. Questionnaires Medical histories Physiological measures	Age. Personal and family characteristic. Employment status. Smoking habits. Alcohol consumption. Pregnancy and gynecologic symptoms and conditions. Blood pressure. Symptoms/illness.	Few significant differences were found among working women and housewives. Prevalence of respiratory conditions were slightly higher at follow-up for working women, while prevalence roles of cardiovascular conditions were higher for housewives, who reported higher rates of heart attacks.
Emmons, Biernat, Tiedje, Lang & Wortman. 1990 USA	135 women professionals (businesswomen and university professors) with preschool children	Cross-sectional Interviews Questionnaires	Age Education Marital status Parental status Number and children's age Income Spillover Spouse support Perceived division of household tasks Perceived division of	Women reported feelings of being overwhelmed in the home and at work as a result of balancing multiple roles. Planning and time management were positively correlated with job and parenting satisfaction and well-being, and with lower depression, marital and job stress.

			child-care tasks Perceived role-conflict and role overload Inter-role conflict Coping Role-quality Depression Well-being	
Bolger, DeLongis, Kessler & Wethington 1990 USA	166 volunteers married couples who participated in a community survey about marital stress and coping	Repeated measures Questionnaires Diary data	Age Education Employment status Marital status Parental status Religion Income Stress overload at work and at home Interpersonal stress Anxiety Depression	Distress is higher among housewives compared to working women but the presence of children at home is associated with increased distress in working women.
Reifman, Biernat & Lang. 1991 USA	Random sample of 200 working women with stable partner, at least one child between 1-6 years at home who worked 35 hours per week.	Longitudinal Interviews and questionnaires.	Stress indices. Social support. Depression.	Lack of authority and influence on the job, sex discrimination, workload, work, and family imposing on relaxation and role conflict were related to health indicators in time 1.Social support was beneficial but only under low level of stress.
Theorell. 1991 Sweden	National sample of 600.000 working men and 400.000 working women to the risk of becoming hospitalized during a following-up period of 1 year.	Longitudinal Interviews.	Gender Employment status. Psychosocial work conditions. Symptoms. Type of occupations. Risk of hospitalization.	Women in occupations in which a high proportion report of subjective symptoms such as fatigue and headache have a higher risk of MI. For men no associated were found. Women in occupations in which overtime was reported had higher risk of MI. Men in nonlearning or

				"heche" occupations had higher incidence of hospitalization for MI than other men. It was no significant for women.
Walker & Best. 1991 USA	A random sample of 330 mothers with infants 2-11 months old. Finally 78 full time employed mothers and 70 housewives were considered for the study.	Cross-sectional. Questionnaires.	Age Race. Education. Employment status Myself as a Mother Children's age. Perinatal data. Mothers stress. Perceived Stress. Health Lifestyle Profile.	Full time employed mothers of infants reported greater perceived stress and less healthy lifestyles compared to housewives.
Dixon, Dixon & Spinner. 1991 USA	Intentional sample of 202 women who had received a master's degree in nursing between 1941-65; ages 50-70 yr.	Longitudinal. Questionnaires.	Age Number of children Employment status Dual role stress Career involvement and career success Cardiovascular disease grouping. Smoking habits. Overweight. Lifetime work intensity.	Two scales from the CLBI (Career-sacrifices and interpersonal sacrifices) appeared to play an important role in distinguish those women experiencing serious cardiovascular disease.
Barnett, Davidson, & Marshall. 1991 USA	Stratified random sample of 403 women employed as nurses and social workers. The sample consisted of 248 social workers and 155 nurses (mean age=39.5) and was stratified on race, parental and marital	Cross-sectional Interviews.	Age Race Marital and parental status Role Quality. Medical Symptoms.	Work rewards were related to lower levels of physical symptoms. Work concern was associated to higher symptoms report among employed mothers. Satisfaction with salary was negatively related to physical health symptoms. Women who were partnership rewarding experienced physical health benefits from

	status.			helping others at work and from supervisor support.
Elliott & Huppert. 1991 U.K.	Sample of 1.797 women who were married; ages 44 and up who was collected in three phases from the English, Scottish and Wales electoral registers yielded interviews with 9003 individuals.	Cross-Sectional Interviews. Questionnaires. Physiological measures.	Age SES. Number of children. Occupational status. Children's age. Symptoms. Social support and social control. Attitudes and Beliefs about Health. Diet. Leisure. Smoking and alcohol. Height, weight and blood pressure. Cognitive Function. Psychological distress Neuroticism. Type A Behavior.	Women with youngest children reported more psychological disturbance. Interaction between employment status and husband social class were found. Paid employment, particularly, full-time work, was associated with good physical health for middle class women but not for working-class women.
Wortman, Biernat & Lang. 1991 USA	200 female business, executives and university professors employed at least 30 hours per week, be married and have at least one child 1 to 5 years of age	Cross-sectional Interviews	Age Race Education Type of occupation Marital status Parental status Number and children's age Income Objective stress indicator in each role Coping Personality characteristics Social support	Seventy five percent of women reported that they experiment conflict between work-home. Women were very critical than their husbands in relation to their own perception their multiple role performance. Women's job overload was associated with marital strain, decreased satisfaction with sex, increased depression and symptoms. Academic and businesswomen report different type of stressors. Businesswomen have less flexibility and academics report m.ore

			Self-reported physical health Depression Symptoms report Marital satisfaction Job demands and control Sex satisfaction	overload
Arber 1991 U.K.	Sample of over 25.000 men and women from the 1985 and 1986 British General Household Survey. Analysis were restricted to men and women aged 20-59	Cross-sectional Interviews	Age Marital status Parental status Self-reported of limiting long-standing illness Occupational level Employment status Housing tenure Access to car	Health inequalities for men are associated with unemployment, occupational class and to a lesser extend with living in local authority housing. The picture is more complex for women. Health status is even more likely to be poor for structurally disadvantaged women than for equivalent men. Health disadvantage for women is associated with non-employment (either being a housewives or unenployment), being in a manual class, being divorced, separated or widowed, living in local authority housing and not having dependent children. Women with dependent children report better health irrespective of their employment status. Employed women report better health irrespective of marital and parental status.
Amatea & Fong. 1991 USA	Intentional sample of 117 professional women; ages from 28-68 yr.	Cross-sectional. Questionnaires.	Age Career commitment. Number of roles. Psychological distress. Role conflict. Work stress.	Women who experienced higher levels of personal control and social support as well as a greater number of roles, reported lower levels of strain symptoms.

			Coping. Social Support. Sense of personal control	
Hibbard & Pope. 1991 USA	Random sample 1.160 women, 997 men; ages 18-65. Survey completed by the Center for Health Research of the Northwest Region of Kaiser Permanente	Longitudinal study. Interviews.	Age Occupational status. Marital status. Parental status. Number of children. Education. Self reported of health. Morbidity indicators. Mortality.	The combination of employment and domestic roles had no health treat to women and may provide some advantage. Multiple roles are unrelated to mortality and morbidity outcomes among men. Employment provides some longevity advantage for working women. Married women in lower status occupation had a greater risk of death. Having at least one child at home decreased the risk of ischemic heart disease among employed women and increase the risk among housewives for up to 10 years post interview.
Lawler & Schmied. 1992 USA	64 female clerical workers	Longitudinal Questionnaires Physiological measures	Age Marital status Life events Hardiness Locus of control Type A Physiological reactivity Illness	Locus of control and hardiness buffer the effects of stress on illness. However, the predictive power of hardiness in these women is largely accounted for by the contributions of locus of control. Type A was associated with greater illness frequency
Barnett, Marshall & Singer. 1992 USA	Stratified random sample of 403 employed women at least half-time in one or two health-care professions ages 25-55 years. The sample was stratified by race, partnership and parental status	Longitudinal Interviews	Age Race Occupation Partner and parental status Anxiety Depression SES Initial level of psychological distress	Among single women and women without children, as job-role quality declines, levels of psychological distress increased. Among partnered women and women with children, change in job-role quality was unrelated to change in psychological distress

			Job-role quality	
Shipley & Coats. 1992 U.K.	44 volunteers working mothers with children. One dependent child at home below the age of 14 years.	Longitudinal Interviews and questionnaires.	Age Education Number of working hours per week Marital status Income Coping Role conflicts. Self-Esteem. Locus of Control. Psychological distress. Social Support at Home.	Low-income single women reported greater levels of stress financial and child-care stress and work stress. Dual-role conflict was clearly reported in interviews but this was nor reflected in the questionnaires. Evidence of dual-role stress was found. However many women appeared to obtain important benefits from going to work, had good coping. Both quality of job and quality of domestic support were very important.
Lennon & Rosenfield. 1992 USA	Included data from two women's studies. One community sample (stratified sample of household .n= 541 ages 19-59) and one national sample n=540 married women, ages 21-60 whose spouses were employed	Cross-sectional Interviews	Age Education Family income Race Family demands Employed status Job control	The most negative situation for women is the effect of combination of greater demands with little control on the job. The greatest job control appears to offset the effect of more family responsibilities, at least in terms of number of children
Moen, Dempster-McClain & Williams. 1992 USA	Random sample of 426 women who were wives and mothers were interviewed in 1956. In 1986, 313 were re-interviewed.	Longitudinal Interviews and structured questions.	Age Education Marital status. Number of children. Duration of marriage. Household composition. Duration of time spend of	Occupying multiple roles in time 1, participating in volunteer work and belonging to a club organization were positively related to different health measures in time 1 and it was also positively related to occupying multiple roles in time 2.

			caring children and others relatives. Serious disease or disability. Functional ability. Health appraisal. Health status Illness condition Social integration. Timing and duration in employment and volunteering.	
Eaker, Pinsky & Castelli. 1992 USA	749 women of the Framingham study. ages 45-64 yr. who were free of coronary disease.	Longitudinal Interviews Questionnaires. Physical examination Physiological measures.	Age. Occupational level. Life satisfaction. Social support. Vacations and leisure time. Attitudes toward children, religion, money. Body Mass Index. Systolic blood Pressure. Smoking. Diabetes. Anger. Situational Stress. Somatic strain. Anxiety. Appetite. Sleep.	After controlling by age systolic blood pressure, HDL, total cholesterol, diabetes, smoking and body mass index, the predictor of the 20 year incidence of MI or coronary death were among employed women, perceived financial strain only, among housewives symptoms of tension and anxiety, being lonely during the day, difficulty falling asleep, infrequent vacation and housework. Among low educational level, tension and lack of vacations.
Haertel, Heiss, Filiplak & Doering. 1992 Germany	Sample of 1.990 women from the MONICA project in Germany; ages 25-64 yr.	Cross-sectional & Longitudinal.	Age Employment status. Employment position. Educational level.	Both in cross-sectional and longitudinal studies it was found that women's employment status was significantly associated with HDL cholesterol

		Interviews. Questionnaires. Physiological measures. Physical examinations. Electrocardiograms.	Marital status. Smoking habits. Consumption of coffee or alcohol. Cholesterol. Previous Pregnancy. Oral contraceptive. Post-Menopausal. Estrogen. Height and weight. ECG	compared to housewives.
Houston, Cates & Kelly. 1992 USA	Intentional sample of 94 women employed full-time and 95 housewives; ages 21-65 yr.	Cross-sectional Questionnaire.	Employment status. Number of children Social support. Psychosocial work conditions. Marital Satisfaction Psychological distress Physical health problems	For both groups overload was associated with more tension and health problems. Overload was also associated with marital dissatisfaction only for housewives. Less reported tension was related with overall social support for homemakers and social support from supervisor. For employed women support from supervision and co-workers moderate some of the relation between job stress and psychosocial strain.
Bartley, Pope & Plewis. 1992 UK	The sample was drawn from electoral registers by three stage methods. For this study the sample was composed by 2.479 women aged 18-59 years	Cross-Sectional Questionnaires.	Age Employment status. Domestic condition. Number of dependent children. Marital status. Presence of older persons. Self-report of physical health. Physical and psychological symptoms.	Women with full-time and part-time paid work experienced lower levels of physical and psychological symptoms than housewives. The advantage of full-time work for psychological on physical health appears to be absent for women in managerial or professional occupations.

			Medical treatment for disease Long-standing illness. Physical activity limitation.	
Barnett, Marshall, Raudenbush & Brennan. 1993 USA	Random sample of 300 dual-earner couples residing in eastern Massachusetts.	Cross-sectional Interviews.	Age Education. Household income. Year together. Parental status Role quality. Occupational prestige Psychological Distress.	Job roles quality was significantly negatively associated with psychological distress for women and men.
Greenberger & O'Neil. 1993 USA	102 fathers and 194 mothers of a pre-school child.	Cross-Sectional Questionnaires.	Age. Education. Rewards and stress. Work role tenure (# years). Marital role tenure. Parental role tenure. Role commitments. Social support. Well-being.	High Commitment to roles was not uniformly associated with greater well being. Diverse source of social support were related to women's psychological status.
Arber & Lahelma. 1993 U.K. & Finland	The British data was based on the General Household Survey for 1985-1986 which include adults aged 16 and over in about 10.000 households each year. The Finish data was based on the 1986 Level of Living Survey which interviewed a sample about 12.000 non-	Cross-sectional Interviews	Age Marital status Parental status Self-reported of limiting long-standing illness Occupational level Employment status Housing tenure Access to car	British employed women in each class report less limiting long-standing illness than their Finish counterparts. British housewives report significantly poor health. These differences related to the variations in the participation of women in paid employment in the two countries. Occupational level is associated with ill-health amongst women in both countries, but housing tenure and family roles are additional factors only among British women. In Britain, previously married

	institutionalised people aged 15-84.			have poor health
Hibbard & Pope. 1993 USA	The sample were 1160 women and 997 men part of a household interview survey completed in 1970-71 by the Center for Health Research; ages 18-65 yr.	Longitudinal. Interviews.	Age. Education Number and children's age. Marital status. Employment status Role quality. Morbidity indicators. Mortality. Self-report of physical health	For women particular qualities of the marital and work role are predictive of morbidity and mortality. For married women equality in decision making and companionship in married are protective against death. Work support was protective against death malignancy and stroke among employed women and work stress increased the risk of IHD among employed men. None of the parental role characteristics were significant predictors of health outcome for men and women. No interactions were found.
Bird & Ross. 1993 USA	National probability sample of 2.031; ages 18-90.	Cross-sectional. Telephone interview	Age. Sex. Race. Marital status. Education. Number of children. Household income. Psychosocial work conditions. Sense of control	Domestic work was more routine and it provides less intrinsic gratification than paid work. Also they reported lower sense of control than do paid worker. However housewives reported more work autonomy.
Aston & Lavery. 1993 Canada	120 volunteers working women, 43 were in managerial and professional occupations and 73 in clerical jobs.	Cross-Sectional Questionnaires.	Age. Marital Status. Education. Self-Esteem. Depression. Quality of life. Health.	The beneficial effects of social support in the workplace were not specific, however a cynical attitude can influence the value of work role, especially in clerical worker. Intrinsic rewards at work were associated with psychological well being.

			Quality of paid worker. Social support. Personality.	
De Salvo Rankin. 1993 USA	118 employed women with pre-school age children. aged 23-43.	Cross-Sectional Telephone Interviews.	Rewards And Stress.	62% of the participants reported high levels of stress. The mayor stressors were: lack of time, child related problems and maternal guilt. Rewarding aspects were personal benefits, financial rewards and improves family life.
Graetz. 1993 Australia	National sample of all people aged 16-25 in Australia. 7871 respondents remained in the active sample at wave 2, 7110 at wave 3, 6151 at wave 4.	Cross-sectional and longitudinal. Interviews.	Age. Income. Marital Status. Gender. Employment status. Work quality. Psychological distress.	Employed people reported significantly lower levers of health disorders than students and the unemployed. However the health consequences are directly contingent upon work quality.
Hunt & Annandale 1993 UK	Two-stage stratified random sample. Men (n= 327) and women (n= 270) in any kind of work for 10 or more hours with a partner.	Longitudinal Questionnaires & Interviews	Age SES Number of hours worked in the job and at home Domestic responsibility Domestic technology Spouses employment status Number of children Physical symptoms Psychological symptoms Physical condition of paid work Shift work Paid condition Monotony, challenge,	Domestic work alone has some effect on women´s health. Paid and domestic work has an enhancement effect for women on health.

			stressfulness, anxiety and emotional support at work General anxiety	
James, Schulssel & Pickering. 1993 USA	80 volunteers healthy premenopausal women; ages 20-50 yr; Employed in technical and clerical jobs.	Repeated measures -Physiological measures. -Questionnaires. -Medical examinations	Income. Work hours. Employment status. Marital status. Educational level. Number of children. Height. Weight Smoking. Drink coffee. Race Family history of hypertension. Urine samples. Blood pressure. Stress at work and at home.	Work stress and sociodemographic characteristics may derive a daylong sympathetic response that increases blood pressure in working women..
Bullers. 1994 USA	National representative sample of adults ages 18 years and older. By selecting women between the ages of 18-65, the sample size was reduced finally to 763.	Cross-sectional Questionnaires	Age Education Race Income Work status Marital status Parental status Job satisfaction Marital satisfaction Family satisfaction Perceived Control Self-report of physical health	Employment was the only role associated with health and perceived control dies modify this relationship slightly. Both high and low quality employment roles predict better health, whereas only high quality marital role predict better health. While perceived control does mediate slightly the effects of job quality on health, the positive effects of marital status on health are suppressed by perceived control.

Glass & Fujimoto. 1994 USA	National representative sample of adults. This analysis only include married or cohabitant couples	Cross-sectional Interviews Questionnaires	Age Education Presence of a disability Number and children's age Income Years of marriage Employment status Labour hours Work schedule Hours of household work Quality of work: job satisfaction, fairness of paid work Fairness of household work Depression	Perception of equity of fair distribution of labour across spouses was related to lower depression.. Paid employment was related with reduced depression among husbands and wives until work hours exceed an upper threshold.
Lennon. 1994 USA	Stratified sample of 300 employed women, 302 employed men and 202 full-time housewives; ages 20-54 yr.	Cross-sectional. Telephone interviews.	Age. Education. Employment status Marital Status. Number of Children at Home. Income. Work hours Employment status Work Conditions: Autonomy Time pressure. Responsibility For Things Outside One's Control. Interruption. Physical effort. Routine. Well-being.	Housewives reported more autonomy, more interruptions, and greater physical effort, more routine, less pressure than paid work. Differences in work activities between employed wives and housewives have also implications for well being. The responsibility for things outside her control and routine activities were associated with greater depressive symptoms among women. As a result of the different work conditions employed wives and housewives experience on average similar levels of depressive symptoms.

Weatherall, Joshi & Macran. 1994 U.K.	The OPCS longitudinal study links information collected at death registration to information collected at the decennial censures. For this study only married women were included.	Longitudinal.	Work status. Mother status. SES. Husband's education. Number and age of children Occupational level Mortality	The combination of employment and child rearing produced any signs of overload. Poorer health among those with neither employment nor children but theses effects did not interact. The stresses and strain of combining job and parental role do not appear to result in early death.
Ross & Bird. 1994 USA	Representative national sample of 2.031 adults aged 18-90	Cross-sectional Telephone interviews	Age, Gender, Education Marital status Number of children Children's age Employment status Income Economic hardship Housework Work-role quality Perceived control Depression and anxiety Well-being Habits (Exercise, smoking, overweight). Self-perception of physical health	Women are more likely to work part-time, have lower incomes and more economic hardship, and do more domestic labor than men, all of which except domestic labor are associated with poor health. Women also report more distress and fewer subjective work rewards, both of which are associated with poor health. People who feel in control of their lives report significantly better health. No differences were found according to sex. Marriage and education positively affects health
Sogaard, Kritz-Silverstein & Wingard. 1994 Finland	3103 healthy women aged 20-49 years from a population-based sample	Cross-sectional Questionnaires Physiological measures	Age Education Employment status Marital status Parental status Place of residence Blood pressure Cholesterol Triglycerides	Unmarried women with young children had the highest rate of coping problems and parenthood not employment status was the most important factor for psychological health problems in rural areas. Housewives reported more psychological problems

			Weight Height Chronic disease Symptoms Household responsibilities Dietary habits Coping Dissatisfaction with life Loneliness Depression Insomnia Risk behaviors Physical health information	
Ross & Mirowsky. 1995 USA	National probability sample of householder (n=930 males and 1.497 females); ages 20-64 yr.	Longitudinal. Telephone interview.	Age. Race Employment status Marital status. Family income. Education. Self-report of physical health. Physical functioning.	Full-time employment predicts slower declines in perceived health and physical functioning compared to nonemployment to both men and women. Housewives predicts greater declines in health.
Hong & Mailick Seltzer. 1995 USA	Intentional sample of 461 families with adult children with mental retardation who lived in either Wisconsin or Massachusetts.	Longitudinal Interviews. Questionnaires.	Age. Gender Level of retardation Number and type of Roles. Maternal education. Family income. Perceived mother's physical health. Declining health. Depression. Number of problems	Holding multiple roles was significantly and negatively related to depression.

			behavior.	
Burke, & McKeen. 1995 Canada	Intentional sample of 792 female business; ages 20-51 yr.	Cross-sectional. Questionnaires.	Age Education Income Organizational characteristics. Job satisfaction. Intention To Quit. Job Involvement. Career Satisfaction Life satisfaction. Psychosomatic Symptoms. Emotional exhaustion	Work experiences and work outcomes were fairly consistently and significantly related to self-reported emotional well being.
Fry. 1995 Canada	104 volunteers female employed in executive levels of management. 79% were between 36-52 years of age and 11.8% were over 52 and 10% were between 30-34.	Cross-sectional Questionnaires	Perfectionism. Coping Humor. Optimism. Self-Esteem. Burn-out Daily hassless Symptoms report	Perfectionism Humor and optimism moderate the deleterious effects of daily hassles on self-esteem, emotional exhaustion and physical health.
Langan-Fox & Poole. 1995 Australia	163 managerial and professional women participated. 57% were married and 40% had children under 18 years.	Cross-sectional Questionnaires	Occupational Stress. Role stress. Role Overload.	The wife role was the most stressful role. Women with 3 or more children reported poorer physical health and having parental status was associated with headaches, exhaustion, overeating, smoking and drinking. They also reported high job satisfaction. Single women scored highest for type A behavior.
Barnett, Raudenbysh, Brennan, Pleck & Marshall. 1995 USA	Random sample of 300 dual-earned couples. 21 full-time employed dual-earned couples constituted the present sample. On average,	Longitudinal and cross-sectional. Interviews. Questionnaires.	Occupational prestige. Education. Household income. Marital status Years together Parental status.	Change over time in job role quality was significantly associated in the change overtime in distress. Change over time in marital role quality was associated with change in distress but the magnitude of the association depended on gender.

	mean has 35.4 years and women 34.8.		Employment status. Psychological distress. Role quality. Negative Afectivity.	
Greenstein. 1995 USA	National longitudinal survey of 3.284 women who experienced a first married between 1979-1990.	Longitudinal. Interviews.	Marital stability. Gender ideology. Wife's annual weeks employed. Average hours employed per week. Wife's marital earning. Husband's earning	Numbers of hours of paid employment peer week was negatively related to marital stability for women holding nontraditional gender ideology but not for women with traditional view.
Martikainen. 1995 Finland	The study was based on the 1980 census records in Finland linked with death during the period 1981-85. The sample included middle class women between 35-64 year of age.	Longitudinal	Marital status. Parental status. Age and number of Children. Gender. Mortality by cause of death.	Women carrying multiple roles had lower mortality than any other group of women. Only lone mothers with 2 or more children had a higher mortality.
Lucheta. 1995 USA	Non-random sample of 106 working women; ages 25-45yr; with at least one child living in the home.	Longitudinal. Questionnaire.	Family stress. Work stress. Chronic stressors. Psychological distress. Symptoms.	Parental role commitment and occupational role value significantly interact with corresponding role related stressors in predicting prospective health outcomes.
Noor. 1995 U.K.	Volunteers of working women. 89 secretaries, 91 professional; ages 22-68 yr.	Longitudinal Questionnaires.	Age. Education. Number of hour worked per week. Marital status. Partner occupation. Number and children's age.	Only overload predicted distress in time 2. High occupational status of the professional were moderated the negative effects of work overload. The secretaries were adversely affected by work overload. The family roles were not related to

			Neuroticism. Role quality. Life satisfaction. Psychological distress. Recent negative events.	wellbeing.
Noor. 1995 Malaysia	Full-time working woman. Mean age of 33.24 yr.	Cross-Sectional Questionnaires.	Age. Education. Number of hour worked per week. Marital status. Partner occupation. Number and children's age. Recent negative events. Role quality. Locus of control. Neuroticism. Social support. Life satisfaction. Psychological distress.	Neither locus of control nor work support independently moderate. The effects of job challenger however, locus of control and work support combined interactively to moderate the impact of job challenger or happiness, For distress, no significant interactions was found.
Simon, R 1995 USA	Subset of stratified random sample of employed/married and parent. Men=40, Women=40	Cross-sectional Interviews	Age Race Education Income Employment status Number of children < 18 Marital status Spouse employment status Meaning of work and family roles	Work and family roles have different meanings for female and males and that these differences may be partially responsible for why the mental health advantage of combining multiple roles are fewer for women than for men
Moen, Robison & Dempster-McClain. 1995 USA	Representative random sample of 427 wives and mothers between the ages of 23 and 50	Longitudinal Interviews	Age Education Number of roles Caregiving activity	The findings point out the importance of examining the impact of the different social roles in the context of other roles and resources encourages or hinders

			Mastery Self-esteem Social integration Depression Life satisfaction Religious involvement Gender-role orientation Role conflict	psychological health at various life stages
Warren & Johnson 1995 USA	116 employed mothers, in a position where they had an immediate supervisor, with at least one preschool age child	Cross-sectional Questionnaires	Age Marital status Educational level Work-family role strain Organizational culture Supervisor support Use of family –oriented benefits Work-related demands Occupational role commitment Family role commitment Use of outside help Satisfaction with outside help	Perceptions of work environment support and supervisor flexibility, as well as the use of family-oriented benefits, are associated with lower levels of strain between work and family roles.
Makowska. 1995 Poland	Intentional sample of 98 women employed in manual and nonmanual occupations ages 22-54 years	Cross-Sectional Questionnaires.	Perceived stress Psychological strain Psychosocial work environment Work-Family relationship Stressful life events Anticipation of job loss	Psychosocial characteristics of the women occupational work and their family significantly affect experienced stress and psychological well-being
Collijn, Appels & Nijhvis. 1996 The Netherlands	Intentional sample of 79 female patients with a myocardial infarction and 90 female controls.	Case Control study Interviews.	Age. Education. Work status. Marital status.	Multiple social roles do not constitute a risk factor for a first myocardial infarction. Classic risk factors seem to be more

			Parental status. Financial problems. Life style. Classical risk factor for CVD. Smoking and coffee consumption. Vital Exhaustion.	important. Women with 3 roles can be considered healthier than women with one social role. -Neither the scarcity Hypothesis nor the Enhancement Hypothesis is confirm in connection with a first MI.
Beatty. 1996 Canada	Random sample of 500 professional and managerial women. Final sample of 193.	Cross-sectional. Questionnaires.	Organizational stressors. Role overload, Role ambiguity, Role conflict, future ambiguity and pay fairness. Spousal support. Work family conflict. Type A. Anxiety. Depression. Irritability-Hostility. Marital and Work Satisfaction.	Successful professional and managerial women did not exhibit high levels of anxiety depression and hostility, nor did theses outcomes increase for women in higher position. Negative outcomes pressure was not higher for those with children nor did work stress and work family interact to produce more negative consequences.
Meleis, Douglas, Eribes, Shih & Messias. 1996 USA	41 auxiliary nursing personnel who were mothers and/or partners ages 22-48 who lived in Mexico	Cross-sectional Interviews and questionnaires	Ag Education SES Marital status Parental status Role satisfactions Role stressors Coping strategies	Role overload had implication for women's health. Employed mothers experienced stressful aspects of functioning in multiple roles. The centrality of the family was a very important issue
Macran, Clarke & Joshi. 1996 U.K.	Women aged 18-59 from the Health and Lifestyle Survey. Analysis was restricted to women of working age (n= 2353)	Cross-sectional Questionnaires Physiological and physical measures	Age Marital status Parental status Employment status Occupation	After controlling for age , psychological symptoms experienced showed the greatest social variation. Full-time lone mothers with dependent children were found to have particularly poor psycho-

			Income Household composition Self-assessed health Disease/disability Symptoms report Psychological well-being Blood pressure Body mass index Lung function	social health after controlling for household income, employment status and occupation. The combination of paid work and family roles made no differences to married mothers on any of the health measures.
Roxburgh. 1996 Canada	Intentional sample of 1384 residents. 789 women and 605 men members of a community of mental disorders; ages 18-55 yr,	Cross-sectional. Questionnaires.	Age Gender. Education. Marital status. Psychological distress. Job demands. Coworker social support. Occupational self-direction.	After controlling for exposure, marital status and income, women are more vulnerable to the negative effect of job routinization.
Ali & Avison. 1997 Canada	Intentional sample of 405 single mothers and 455 married mothers.	Longitudinal Interviews	Age. Education. Employment status. Number of children under 18. Income. Number of hours worked per week. Parental status. Marital status Depression. Financial strain. Life events. Mastery. Self-Esteem. Social support.	Single mothers who left their job reported more distress than married mothers. For single mothers taking a job for pay did not reduce their feelings of distress. Among married mothers transition into employment was associated with the climes in distress but not caregiving strain.

Braboy Jackson. 1997 USA	National Survey of Families and Households conducted in 1987-88 The sample was of non-Hispanic whites (n=9.419); African American (n=2.391); Mexican Americans (n=630) and Puerto Ricans (n=191).	Cross-sectional Interviews.	Age. Education. Income Number of roles. Marital status. Employment status. Parental status. Race. Depression. Life satisfaction. Long-term health problems.	Racial / Ethnic variation affects the relationships between role accumulation and mental health. Blacks and Puerto Ricans do not benefit from role accumulation compared to Mexicans and whites. All ethnic groups benefit from the spousal role but there is no consistent effect of either employment or parenthood. Having a sibling was relate to better mental health among all ethnic groups except Puerto Ricans. The psychological benefits of occupying the three roles were more evident among non-Hispanic white and Mexicans Americans.
Luecken, Suarez, Kuhn, Barefoot, Blumenthal, Siegler & Williams. 1997 USA	109 volunteers women; ages 21-61 yr, employed in clerical and customer service jobs at a large corporation.	Repeated measures Physiological measures. Questionnaires.	Education Income Race Occupation Cortisol Interpersonal Support. Strain at work and at home.	Working women with children at home independent of marital status or social support excrete greater amounts of cortisol and experience higher levels of home strain than those without children at home.
Miller, Wilbur, Montgomery & Chandler. 1997 USA	107 women who were either black or white, had all three roles and menopausal status were known. Aged 35-65 years	Cross-sectional Questionnaires.	Age Occupation Marital status Number and children's age. Education. Income. Race. Role quality	After controlling by race, occupation and menopausal status, partner role quality was significantly related to well-being. Parent-role quality was related to life satisfaction and job- role quality was not related to either.

			Life satisfaction Depression Positive and negative affection Menopausal status	
Rivera, Torres & Carré. 1997 USA	Multistage probability sample of Mexicans, Puerto Ricans and Cuban American. The sample includes 1.502 Latin heads of households and wives who were 16 years of age or older. Employed= 791; Nonemployed= 711	Cross-sectional Questionnaires.	Age Education Family income Latino ethnic group Language Employment status Marital status Occupation Parental status Annual number of work hours Self report of physical health	Annual employment work hours, occupation, childcare and housework significantly affect self-reported health status.
Noor 1997 UK	153 employed married women	Cross-sectional Questionnaires	Age Employment status Occupational level Estimates of time in household chores Husband support Psychological distress	Employed married women estimate of their husbands' time spent doing housework was a better predictor of their distress symptoms than their estimates of their own time. This was mediated by their perceptions of husbands support.
Horwitz, MCLaughlin & Raskin White 1997 USA	458 subjects who got married and remained married at some point during the study	Longitudinal Questionnaires	Gender Marital status Marital quality Problematic relationships Supportive relationships Relational balance Strain Depression	Parental and financial strains predict problematic and supportive relationship with spouses. Problematic relationships with spouses have considerably stronger impacts than supportive relationships on depression. Relational quality has a greater impact on mental health of wives than husbands.

Arber, S. 1997 UK	National representative sample of about 26.000 men and women ages between 20-59 years	Cross-sectional Interviews	Gender Education Occupational level Employment status Marital status Housing tenure Car ownership Self-report of chronic illness Self-report of physical health	Women's limiting long-standing illness can be explained solely by their own labour market characteristics, whereas self-assessed health relates to wider aspects of a woman's everyday life. A women whose partner is unemployed has twice odds ratio of reporting poor health compared. with a women married to an employed man, after controlling for her labour market characteristics and partner's occupational class
Burton. 1998 USA	Probability sample of 2.248 men and women; ages 18 + yr.	Cross-sectional Interviews.	Age. Education. Race. Gender Psychological distress. Global meaning of life. Social roles.	Social roles have a salutary relationship on distress and that integrative meaning mediate these effects. The effects of marriage and parenting roles on distress are the most affected by mediating effects of integrative meaning.
Matthews, Hertzman, Ostry & Power. 1998 U.K	All births in one week in 1958 in England, Scotland and Wales of a totaling of 17.417 respondents 11.407 subjects were re-interviewed a of after 33 years.	Longitudinal Interviews	Gender Psychosocial work characteristics. Employment status. Occupation Self-report of physical health	Women reported more negative work characteristics that men. Women in full-time job reported fewer negative characteristic than part-time or housewives. A social gradient was found for all employment status groups. Part-time work was associated with higher frequency of negative work characteristics than full-time work
Christensen, Parris Stephens & Townsend. 1998 USA	Non-random sample of women who occupied the roles of caregiver to a chronically ill or disabled parent , wife and em parent-in-law, mother, wife and employee.	Cross-sectional Structured interviews	Age Race Occupational level Marital status Parental status Children < 25 years Income	Mastery in the three traditional roles was related to psychological well-being, whereas mastery in the employee role was related to both physical and mental health. The more roles in which women experienced higher levels of mastery, the greater their satisfaction with life.

	n=296, aged 25-60 years		Mastery Depression Life satisfaction Dispositional optimism Self-report of physical health Satisfaction with their health If Daily activities were limited by their health	Women who occupied more roles may benefit from the increased opportunity to enhance their feelings of mastery.
Shibley Hyde, DeLamater & Hewwitt. 1998 USA	570 pregnant women and their partners who were over age of 18, living with a partner and between 12 and 21 of pregnancy	Longitudinal Interviews Questionnaires	Age Education Income Employment status Race Number of work hours Job-role quality Work salience Fatigue Sleep problems Sexual variables Depression	Multiple roles scarcity hypothesis was not confirm.
Lee & Duxbury 1998 Canada	Employed parents (226 fathers, 264 mothers)	Cross-sectional Telephone interviews	Gender Family type (traditional vs dual income) Marital status Life cycle phase Spousal support desired and received Organizational support desired and received Social support desired and received	The participants received tangible and emotional support from their partners. In the workplace, family-responsibility leave, flexible work arrangements and supportive supervisor were very important. Friends provided emotional and practical support in balancing work and family demands.

Waldron, Weiss & Hughes. 1998 USA	Multistage probability sample of 331 women; ages 14-24 yrs.	Longitudinal Interviews	Age. Race. Education. Health status. Employment status. Marital status. Parental status.	Employment had beneficial effect on health for unmarried women but little for married women. Marriage had beneficial effects on health for women who were not employment. Combination of employment and motherhood had little effects in health. Neither longer hours of employment nor having more children resulted in harmful effects on health.
Orth-Gomer, Horsten, Wamala, Schenck-Gustafsson, Kirkeeide, Svane, Mittleman & Ryden 1998 Sweden and USA	131 women aged 30 to 65 who were hospitalised for an acute coronary event	Cross-sectional Questionnaires Physiological measures	Age, Lifestyle factors. Social support. Cardiological examination Angiography,Blood pressure.Anthropometric measures.Cholesterol Triglycerides.Menopausal status	Lack of social support contributes to the severity of coronary artery disease in women, independently of standard risk factors.
Meneses, Feldman & Chacón. 1999 Venezuela	Seventy three full-time working women with partner and children aged between 22 to 57 years	Cross-seccional Questionnaires	Age Education Marital and partner status Supervisory position Age and number of children Stress Social support Psychological strain Self-report of physical health	Women with support from their job and partner reported better perception of physical health. Women in supervisory positions, with high stress perception and low job and religious support reported worsened emotional health.
Bartley. Sacker, Firth & Fitzpatrick. 1999 U.K.	Representative sample of women aged 20-59 were taken from HALS, N= 2.743 (1984) and HSFE, N= 4.936 (1993)	Comparative design Interviews	Age Marital status Parental status Employment status Children at home	Health differences between women in different combinations of social roles were not the same in 1993 an in 1984. Older women without work rather than younger never married lone mother as

			Social position Social inequality Self-reported of physical health	being at greatest disadvantage in terms of health in the 1990´s.
Oster & Scanell. 1999 Australia	192 employed mothers 26-45 years of age who either had one or more children under 11 years of age	Cross-sectional Questionnaires.	Employment status Marital status Parental status Role conflict Change in role perception Well-being Self-esteem Anxiety	Role conflict and change in role perception predicted psychological health
Milkie & Peltola. 1999 USA	National probability sample of 209 women and 260 men who were employed and married	Cross-sectional Interviews	Age Family income Education Gender Number of work hours per week from the respondent and spouse Number of children< 6 years Number of children 6-12 years Number of children 13-17 years Marital happiness Types of sacrifices at work and at home Perception of household division	The found gender differences. For men imbalance is predicted by longer work hours, wives who work fewer hours, perceived unfairness in sharing housework, marital unhappiness and tradeoffs made at work for family and at home for work. For women, only marital unhappiness and sacrifices at home are imbalancing, and for women who are employed full-time young children are
Reid & Hardy. 1999 USA	National representative sample of men and women aged 51-61 (N= 5.116)	Cross-sectional Questionnaires.	Age Race Depression Alcohol consumption	Once the demand and satisfactions associated with multiple role is controlled, the number of roles has no affect their health.

			SES Role occupancy Role demand Role satisfaction Marital status Self-perception of physical health	
Emslie, Hunt & Macintyre. 1999 UK	Random stratified sample from British banking sector considering gender and occupation. n= 2200	Cross-sectional Questionnaires	Age Gender Marital status Children< 5 years Occupational level Perceived work condition Gender orientation Work-home conflict Time spend in domestic chores Job equality Attitude to traditional gender role Psychological distress Malaise symptoms Physical symptoms	Significant gender differences were found In health dimensions. Women reported significantly more malaise symptoms and GHQ scores. No occupational differences were found according to gender. The experiences of paid work was associated with health.
Pittman, Teng, Kerpelman & Solheim 1999 USA	27 married childless graduate student couples	Daily records Questionnaires	Satisfaction with own performance of housework Satisfaction with spouse's performance of housework Time on housework Estimates of spouse's time on housework Outcome quality Stress	Satisfaction was a function of time spend, quality of outcomes, stress and approval by spouses for performance. The relation between time contributions and satisfactions was partially mediated by quality of outcomes.

Bird 1999 USA	Representative sample of 1.189 adults (581 men and 608 women)	Longitudinal Questionnaires	Gender Age Education Marital status Employment status Hours of housework Perceived control Well-being Psychological distress Mental health status Social support	Men's lower contributions to household labor explain part of the gender differences in depression. Inequity in the division of household labor has a greater impact on distress than does the amount of household labor. Employment status moderates the effect of the division of labor on depression. Social support mediates the effect of the division of household labor. Social support was associated with lower levels of depression for women than men.
Voydanoff & Donelly. 1999 USA	National probability sample of adults. Subsample of 1342 mothers and 998 fathers of 1416 children (10-17 years old) and had parents between60-70 years old or older.	Cross-sectional ? Questionnaires & Interviews	Age- Education-Race Number of hours helping a parent (s) Paid work hours Marital satisfaction Job satisfaction-Family closeness Physical health Depression Number of hours with partner Number of hours in household Work spillover	The number of hours helping parents was positively related to distress only for mothers. The findings support the role-enhancement approach.
Martire, Parris,Stephens & Towsend. 2000 USA	296 women who occupied the roles of primary caregiver to an impaired parent or parent-in law, wife, mother and employee	Cross-sectional Questionnaires.	Age Race Education Number and children's age Parent's functional impairment Role stress Role centrality	Greater centrality of the parent care, mother, wife and employee roles was associated with better psychological well-being. Centrality was shown to exacerbate the effects of stress in the wife and employee roles. Mother centrality protected women from the negative effects of stress in the mother role.

			Income Depression Life satisfaction	
Gómez, Pérez, Feldman, Bagés & Vivas. 2000 Colombia	Non-random sample of 340 working women from 4 occupations (managers, clerical, nurses, blue-collar workers) aged between 30 to 55 years	Cross-sectional Questionnaires Physiological measures	Age Education Number and children's age. Employment status Occupational level Number of roles Marital and Parental status Health report Cholesterol Triglycerides Blood pressure Anxiety Depression Self-esteem Role quality Work-family spillover Anger Household responsibilities	The results confirmed the enhancement hypothesis. Role quality of each role is more important than the number of roles. Job-role quality was related to social support, decision latitude. Managers and nurses had a better perception of their job-role quality. Stress associated to family roles were related to depression. Nurses was the occupational group with a higher risk of CVD.
Khlat, Sermet & Le Pape. 2000 France	2.942 women aged between 30 to 49 years from a representative national survey	Longitudinal Interviews	Age Marital status Parental status Employment status Income Self-perception of physical health Physical health condition Chronic diseases Malaise symptoms Health related behaviours	Lone mothers was the most disadvantage group in terms of mental health conditions and housewives in terms of physical health conditions. Higher household income was clearly associated with better health. In the top and in the bottom income no differences were found between working women and housewives with children.

Pavalko & Woodbury. 2000 USA	National representative sample of 2.929 late midlife women	Longitudinal Interviews	Age Income Education Race Marital status Employed change Work characteristics Caregiving change Physical health limitation Depression Happiness Psychological distress	Psychological distress increases as women have into and continue caring for an ill person. Caregiving has a weaker effect on physical health but increases physical limitation prompt specially for non-employed women.
Steptoe, Lundwall & Cropley. 2000 U.K.	162 teachers aged 22 to 58 years selected on the basis of high or low job strain	Repeated measures Interviews Questionnaires Physiological measures	Age Gender Employment position Marital status Parental status Social support Job strain Body mass Heart rate Blood pressure	No indicators of multiple role strain was found for full-time working mothers. Day-evening fall in systolic blood pressure was moderated by social support.
Beehr, Jex, Stacy & Murray 2000 USA	198 university student who worked full-time in a door-to-door book company's summer programme for book dealers	Cross-sectional Questionnaires	Job-stressors (chronic and acute) Role overload Workload variability Co-worker support Contents of communication with co-worker Psychological distress Depression Performance measures	Job-specific measure of chronic stressor was the strongest predictor. Social support predicted psychological strains, although it was only weakly related to performance. Social support did not moderate the effects of any of the stressors.

APPENDIX 2

Protocol for the Semi-structure Interview

Instructions:

The objective of this taped interview is to explore in detail some aspects of your life in general, specially those related with each of your roles. This information is confidential and that is why you will be identified with this code number: (MENTION THE CODE NUMBER).

1.-¿ Which is your most important role ?

2.-Depending on the answer, explore in each role (Worker, partner and mother) the following aspects:

Rewarding aspects, how she feels about them.

Stressful aspects, perception of demand (pressures, obligations, task, impositions). How she handles with them. Explore the effects over her health

(physical and psychological symptoms).

3.- Explore any other relevant role (as a daughter, as a caregiver, etc). Rewarding and stressful aspects related.

4.- Explore the work-family relationships. How work affect family and vice versa. Effects on health and well-being. How they handle? Is a source of satisfaction or a source of stress?

5.- Household responsibilities: How they share? Equity?. Effects on health and well-being.

General instructions: Let the participant to feel free to express any other relevant issue. To express their values, believes, expectations.

APPENDIX 3

UNIVERSIDAD SIMON BOLIVAR
PROYECTO: MUJER-TRABAJO-SALUD

CODIGO:_____

DATOS SOCIODEMOGRAFICOS.

Por favor, responda las preguntas que se presentan a continuación de forma cuidadosa y detallada.

1. Fecha de nacimiento_____ 2.Edad:_____

3.Estado civil:

Unida____ Casada____ Soltera____ Divorciada____
Separada____ Viuda____

4. Tiempo de unida o casada con su actual pareja_____

5.Ocupación:_____ 6. Institución donde trabaja_____

7. Tiempo en su actual trabajo_____ 8. Cargo que ocupa_____

9. Número de horas semanales de trabajo_____

10. ¿Tiene Ud. otro trabajo aparte del que realiza diariamente? Sí____ No____
Tipo de trabajo_____

11. Nivel Educativo:

___ Primaria incompleta
___ Secundaria incompleta
___ Técnico superior incompleto
___ Universitaria incompleta
___ Primaria completa
___ Secundaria completa
___ Técnico superior completo
___ Universitaria completa

12.Fuentes de Ingreso:

____Fortuna heredada o adquirida
____Comercio, ganancias y beneficios
____Sueldo mensual
____Salario semanal
____Donaciones públicas o privadas

13. Vivienda:

____Propia
____Alquilada
____Alquilada en una habitación
____Vive con familiares
____Vive con amigos
____Otros

14. ¿Cuántas personas viven en su casa?
Adultos____ Niños____

15. Edad de su actual pareja____

16. Ocupación de su pareja_____ 18. Cargo que ocupa_____

17. Nivel educativo de su actual pareja:

___ Primaria incompleta
___ Secundaria incompleta
___ Técnico superior incompleto
___ Universitaria incompleta
___ Primaria completa
___ Secundaria completa
___ Técnico superior completo
___ Universitaria completa

18. Tiene Hijos?

Si___ Cuántos hijos tiene?_____ Edad de los hijos_____

19. ¿Quien cuida de sus hijos mientras Ud. trabaja?
Guardería____ Abuelos____ Otros____

Niñera____ Otros familiares____
Sus hijos mayores____ Vecinos____

DATOS SOBRE SU SALUD.

1. ¿Cómo percibe su estado de salud en general?
Muy deteriorado____ Deteriorado____ Bueno____ Muy Bueno____ Excelente____

2. ¿Cómo considera su estado de salud en comparación con otras personas de su misma edad?
Mejor____ Igual____ Peor____

3. ¿Cómo considera sus condiciones de salud en comparación a cinco años atrás?
Mejor____ Igual____ Peor____

4. ¿Ha consultado algún(os) médico(s) en los últimos 6 meses?
Sí____ No____ ¿Cuántas veces?_____

5. ¿Ha consultado a profesionales de la psicología o psiquiatría en los últimos 6 meses?
Sí____ No____ ¿Cuántas veces?_____

6. ¿Ha estado hospitalizada(o) en los últimos 5 años?
Sí____ No____ ¿Cuántas veces?_____

7. ¿Ha estado hospitalizada(o) en los últimos 6 meses?
Sí____ No____ ¿Cuántas veces?_____

8. ¿Cuántos días ha faltado al trabajo por motivos de salud en los últimos 6 meses?_____

9.¿Cuántos días ha permanecido en cama por motivos de salud en los últimos 6 meses?_____

10. ¿Usted fuma? Sí____ No____ ¿Cuántos cigarrillos al día?_____

11.¿Ha fumado en el pasado?Sí____ No____ ¿Cuándo dejó de fumar?_____

12. ¿Usted hace algún deporte? Sí____ No____
¿Cuál y con qué frecuencia?_____

APOYO SOCIAL

A continuación encontrará una serie de afirmaciones. Cada una está seguida por una escala para que usted marque la respuesta que más se ajuste a su caso personal. Por favor, conteste de acuerdo a como son las cosas para Ud. y no a como querría que fuesen.

	No, nunca	Algunas veces	Con frecuencia	Si, siempre
1.- Cuando era niña(o) recibí mucho apoyo por parte de mis padres.	1	2	3	4
2.- Soy miembro de algún grupo social (religioso, clubes, equipos, etc).	1	2	3	4
3.- Pido el apoyo de otros.	1	2	3	4
4.- Tengo en quien confiar.	1	2	3	4
5.- Mi familia me proporciona satisfacciones y un sentimiento de seguridad.	1	2	3	4
6.- Las personas deberían poder contar con orientación religiosa para obtener apoyo y tranquilidad.	1	2	3	4
7.- Cuando me siento infeliz o bajo estrés hay gente a quien puedo recurrir para obtener apoyo.	1	2	3	4
8.- En la actualidad tengo una buena relación con mi esposo(a)/pareja.	1	2	3	4
9.- Cuando tengo problemas me los guardo para mi misma(o).	1	2	3	4
10.- Puedo recurrir a mis padres cuando tengo algún problema.	1	2	3	4
11.- Con frecuencia me siento sola(o), como si no tuviera a nadie cera.	1	2	3	4
12.- Tengo amigos que me apoyarán, no importa lo que haga.	1	2	3	4
13.- Mis hermanos y mis hermanas me brindan apoyo.	1	2	3	4
14,.- Mi esposo(a)/pareja es un buen apoyo para mi.	1	2	3	4

15.- En mi trabajo, tengo una buena relación con mi supervisor.	1	2	3	4
16.- Me gusta trabajar sola(o).	1	2	3	4
17.- En mi trabajo, tengo una buena relación con mis compañeros.	1	2	3	4
18.- Prefiero trabajar en equipo.	1	2	3	4

CUALIDAD DEL ROL

Parte 1: ROL LABORAL

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos gratificantes o agradables de su vida laboral.** Por favor , encierre en un circulo la respuesta que se aplique a su caso:

	No, Nunca	Poco	Bastante	Mucho
1.- El horario se adapta a mis necesidades	1	2	3	4
2.- Tengo estabilidad laboral	1	2	3	4
3.- Recibo aprecio y reconocimiento por mi trabajo	1	2	3	4
4.- La gente con la que trabajo es agradable	1	2	3	4
5.- Ayudo a otros, me siento necesaria	1	2	3	4
6.- Me agrada mi jefe	1	2	3	4
7.- Obtengo logros, soy competente	1	2	3	4
8.- Realizo tareas variadas y estimulantes	1	2	3	4
9.- Tengo la oportunidad de aprender	1	2	3	4
10.- El ambiente físico de mi trabajo es apropiado	1	2	3	4
11.- Es estimulante salir de la casa hacia el trabajo	1	2	3	4
12.- - Puedo trabajar por mi cuenta	1	2	3	4
13. Ayudo a otros a desarrollarse	1	2	3	4
14.- Mi trabajo está de acuerdo con mis habilidades e intereses				
15.-Tengo un buen sueldo	1	2	3	4
16.- Tengo buenas fuentes de apoyo a mi disposición	1	2	3	4
17.- Tengo oportunidad de avanzar	1	2	3	4
18.- Mi trabajo es un reto estimulante	1	2	3	4
19.- Tomo decisiones en el trabajo	1	2	3	4

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos generadores de tensión o preocupantes de su vida laboral.** Por favor, encierre en un circulo la respuesta que se aplique a su caso

	No,Nunca	Poco	Bastante	Mucho
1.-Tengo demasiadas cosas que hacer	1	2	3	4
2.-Tengo inestabilidad laboral	1	2	3	4
3.- Se me presentan conflictos entre el trabajo y otras responsabilidades	1	2	3	4
4.- Me desagrada mi jefe	1	2	3	4
5.- Tengo que realizar varias tareas a la vez	1	2	3	4
6.- Me falta el reconocimiento que merezco	1	2	3	4
7.- Mi trabajo se puede realizar sin las destrezas que tengo	1	2	3	4

8.- Mi trabajo es rutinario	1	2	3	4
9.- Las condiciones físicas del lugar de trabajo son malas	1	2	3	4
10.- No recibo reconocimiento, aprecio	1	2	3	4
11.- Mi trabajo es monótono	1	2	3	4
12.- Mi salario me causa insatisfacción	1	2	3	4
13.- Tengo problemas en el trabajo por ser mujer	1	2	3	4
14.- Tengo que hacer cosas aparte del trabajo que no me corresponden	1	2	3	4
15.- Me faltan oportunidades para el crecimiento laboral	1	2	3	4
16.- Algunas actividades de mi trabajo son innecesariamente laboriosas	1	2	3	4
17.- No tengo retos	1	2	3	4
18.- Me desagrada la gente con quienes trabajo	1	2	3	4
19.- El volumen de trabajo es muy agotador	1	2	3	4

<u>Si no tiene cónyuge o pareja estable, no conteste la Parte 2 del cuestionario y pase a la Parte 3.</u>

<u>Parte 2: ROL DE ESPOSA</u>

A continuación encontrará una serie de afirmaciones relacionadas con los **<u>aspectos gratificantes o agradables</u> de su vida marital o de pareja.** Por favor, encierre en un círculo la respuesta que se aplique a su caso

	No, Nunca	Poco	Bastante	Mucho
1.- Mi pareja es mi compañero	1	2	3	4
2.- Mi pareja cuida de mi	1	2	3	4
3.- La relación con mi pareja es fácil de llevar	1	2	3	4
4.- Hay demostraciones de afecto entre mi pareja y yo	1	2	3	4
5.- Mi pareja es un buen padre	1	2	3	4
6.- Puedo comentar los problemas con mi pareja	1	2	3	4
7.- Las relaciones sexuales entre mi pareja y yo son buenas	1	2	3	4
8.- Mi pareja me respalda	1	2	3	4
9.- Disfruto haciendo cosas para mi pareja	1	2	3	4
10.- Mi pareja me ve como alguien especial	1	2	3	4
11.- Mi pareja me proporciona lo que necesito	1	2	3	4
12.- La personalidad de mi pareja coincide con la mía	1	2	3	4
13.- Mi pareja está dispuesto a compartir el trabajo de la casa	1	2	3	4
14.- Hay buena comunicación entre mi pareja y yo	1	2	3	4
15.- Mi pareja desea tener hijos	1	2	3	4

A continuación encontrará una serie de afirmaciones relacionadas con los **<u>aspectos generadores de tensión o preocupantes</u> de su vida marital o de pareja**. Por favor encierre en un círculo la respuesta que se aplique a su caso.

	No,Nunca	Poco	Bastante	Mucho
1.- Percibo a mi pareja distante, inaccesible	1	2	3	4
2.- Entre mi pareja y yo la comunicación es pobre	1	2	3	4
3.- La salud de mi pareja es mala	1	2	3	4
4.-Mi pareja y yo discutimos por dificultades económicas	1	2	3	4
5.- No tengo suficiente reconocimiento por parte de mi pareja	1	2	3	4
6.- Tenemos conflictos por los hijos	1	2	3	4
7.- Mi pareja tiene problemas en su trabajo o profesión	1	2	3	4
8.- Tengo problemas en nuestras relaciones sexuales	1	2	3	4
9.- Entre mi pareja y yo hay falta de compañerismo	1	2	3	4
10.- Mi pareja tiene inestabilidad laboral	1	2	3	4
11.- Mi pareja tiene altas demandas laborales	1	2	3	4
12.- Mi pareja tiene problemas emocionales	1	2	3	4
13.- Mi pareja y yo tenemos problemas para llevarnos bien	1	2	3	4
14.- Tenemos conflictos por el trabajo de la casa	1	2	3	4
15.- Mi pareja no me da suficiente apoyo emocional	1	2	3	4
16.- Mi pareja y yo tenemos conflictos por los niños	1	2	3	4

Parte 3: ROL DE MADRE

Si no tiene hijos, no conteste esta parte del cuestionario.

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos gratificantes o agradables de su desempeño como madre.** Por favor, encierre en un círculo la respuesta que se aplique a su caso.

	No, Nunca	Poco	Bastante	Mucho
1.- Mis hijos me necesitan	1	2	3	4
2.- Me dan placer los éxitos y logros de mis hijos	1	2	3	4
3.- Ayudo a mis hijos a desarrollarse	1	2	3	4
4.- Mis hijos me demuestran amor	1	2	3	4
5.- Me siento orgullosa de la forma como se desenvuelven mis hijos	1	2	3	4
6.- Me gusta el tipo de personas que son mis hijos	1	2	3	4
7.- Comento mis problemas con mis hijos	1	2	3	4
8.- Comparto actividades con mis hijos	1	2	3	4
9.- Mis hijos me brindan ayuda	1	2	3	4
10.- Mis hijos le dan significado a mi vida	1	2	3	4
11.- Soy la persona que le proporciona el mejor cuidado a mis hijos	1	2	3	4
12.- Mis hijos se llevan bien entre ellos	1	2	3	4
13.-Veo a mis hijos madurar y cambiar	1	2	3	4
14.- Mis hijos me hacen cambiar para mejorar	1	2	3	4

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos generadores de tensión o preocupantes de su desempeño como madre.** Por favor, encierre en un círculo la respuesta que se aplique a su caso.

	No, Nunca	Poco	Bastante	Mucho
1.- Tenemos problemas financieros debido a la crianza de los niños	1	2	3	4
2.- Me siento atada por los niños	1	2	3	4
3.- Me preocupa mi bienestar físico	1	2	3	4
4.- Las relaciones entre mis hijos son conflictivas	1	2	3	4
5.- Mis hijos me imponen grandes demandas y responsabilidades	1	2	3	4
6.- Me preocupa la etapa de adolescencia de mis hijos	1	2	3	4
7.- Me siento insegura de hacer lo correcto	1	2	3	4
8.- Mis hijos tienen dificultades para expresar su amor y aprecio hacia mí	1	2	3	4
9.- Tengo problemas con la educación/escuela de mis hijos	1	2	3	4
10.- Me desilusiona la forma de ser de mis hijos	1	2	3	4
11.- Tengo problemas para controlar a mis hijos	1	2	3	4
12.- Mis hijos me necesitan menos a medida que crecen	1	2	3	4
13.- Tengo demasiados conflictos y discusiones con mis hijos	1	2	3	4
14.- Mis hijos interfieren en la relación con mi pareja	1	2	3	4

CUESTIONARIO DE SALUD GENERAL DE GOLDBERG
(Scaled - 28)

POR FAVOR, LEA CUIDADOSAMENTE:

Nos gustaría saber si Vd. ha tenido algunas molestias o trastornos y cómo ha estado de salud en las últimas semanas. Por favor, conteste a TODAS las preguntas, simplemente rodeando con un círculo las respuestas que, a su juicio, se acercan más a lo que siente o ha sentido Vd. Recuerde que no queremos conocer los problemas que ha tenido en el pasado, sino los recientes y actuales.

Es importante que trate de responder a TODAS las preguntas.

Muchas gracias por su colaboración.

ULTIMAMENTE:

A.1. ¿Se ha sentido perfectamente bien de salud y en plena forma?
☐ Mejor que lo habitual ☐ Igual que lo habitual ☐ Peor que lo habitual ☐ Mucho peor que lo habitual

A.2. ¿Ha tenido la sensación de que necesita un reconstituyente?
☐ No, en absoluto ☐ No más de lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

A.3. ¿Se ha sentido agotado y sin fuerzas para nada?
☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

A.4. ¿Ha tenido la sensación de que estaba enfermo?
☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

A.5. ¿Ha padecido dolores de cabeza?
☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

A.6. ¿Ha tenido sensación de opresión en la cabeza, o de que la cabeza le va a estallar?
☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

A.7. ¿Ha tenido oleadas de calor o escalofríos?
☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

B.1. ¿Sus preocupaciones le han hecho perder mucho sueño?
☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

B.2. ¿Ha tenido dificultades para seguir durmiendo de un tirón toda la noche?
☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

B.3. ¿Se ha notado constantemente agobiado y en tensión?
☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

B.4. ¿Se ha sentido con los nervios a flor de piel y malhumorado?

☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

B.5. ¿Se ha asustado o ha tenido pánico sin motivo?

☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

B.6. ¿Ha tenido la sensación de que todo se le viene encima?

☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

B.7. ¿Se ha notado nervioso y «a punto de explotar» constantemente?

☐ No, en absoluto ☐ No más lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

C.1. ¿Se las ha arreglado para mantenerse ocupado y activo?

☐ Más activo que lo habitual ☐ Igual que lo habitual ☐ Bastante menos que lo habitual ☐ Mucho menos que lo habitual

C.2. ¿Le cuesta más tiempo hacer las cosas?

☐ Más rapido que lo habitual ☐ Igual que lo habitual ☐ Más tiempo que lo habitual ☐ Mucho más tiempo que lo habitual

C.3. ¿Ha tenido la impresión, en conjunto, de que está haciendo las cosas bien?

☐ Mejor que lo habitual ☐ Aproximadamente lo mismo ☐ Peor que lo habitual ☐ Mucho peor que lo habitual

C.4. ¿Se ha sentido satisfecho con su manera de hacer las cosas?

☐ Más satisfecho ☐ Aproximadamente lo mismo que lo habitual ☐ Menos satisfecho ☐ Mucho menos satisfecho

C.5. ¿Ha sentido que está jugando un papel útil en la vida?

☐ Más tiempo que lo habitual ☐ Igual que lo habitual ☐ Menos útil que lo habitual ☐ Mucho menos útil que lo habitual

C.6. ¿Se ha sentido capaz de tomar decisiones?

☐ Más que lo habitual ☐ Igual que lo habitual ☐ Menos que lo habitual ☐ Mucho menos capaz que lo habitual

C.7. ¿Ha sido capaz de disfrutar sus actividades normales de cada día?

☐ Más que lo habitual ☐ Igual que lo habitual ☐ Menos que lo habitual ☐ Mucho menos que lo habitual

D.1. ¿Ha pensado que Vd. es una persona que no vale para nada?

☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

D.2. ¿Ha venido v viendo la vida totalmente sin esperanza?

☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

D.3. ¿Ha tenido el sentimiento de que la vida no merece la pena vivirse?

☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

D.4. ¿Ha pensado en la posibilidad de «quitarse de en medio»?

☐ Claramente, no ☐ Me parece que no ☐ Se me ha cruzado por la mente ☐ Claramente lo he pensado

D.5. ¿Ha notado que a veces no puede hacer nada porque tiene los nervios desquiciados?

☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

D.6. ¿Ha notado que desea estar muerto y lejos de todo?

☐ No, en absoluto ☐ No más que lo habitual ☐ Bastante más que lo habitual ☐ Mucho más que lo habitual

D.7. ¿Ha notado que la idea de quitarse la vida le viene repetidamente a la cabeza?

☐ Claramente, no ☐ Me parece que no ☐ Se me ha cruzado por ☐ Claramente lo he

UNIVERSIDAD SIMON BOLIVAR
PROYECT: WOMEN, WORK and HEALTH

CODE NUMBER:_____

PERSONAL BACKGROUND

1.Sex : M___ W___ 2.Age:_____

3.Marital status:

Cohabiting____Married____ Single____ Divorced____
Separated____ Widow____

4. How long have you being living with your partner (married or not)?_____

5. Occupation_____ 6. Work place_____

7. Time at your current job_____ 8. Job position _____

9. How many hours/week do you work?_____

10. Do you work at another job beside your regular one? Yes____ No____
Job description_____

11. Level of education:
____None
____Elementary school incomplete ____Secondary school complete
____Elementary school complete ____Vocational school or Junior school
____Secondary school incomplete ____University studies

12. Sources of income:
____Inheritance ____Weekly wages
____Business ____Public or private donations

____Monthly salary

13. Main home:
____Optimal luxurious sanitary conditions
____Optimal not luxurious sanitary conditions
____Optimal sanitary conditions in reduced space
____Good sanitary conditions in reduced space
____Without sanitary conditions.

14. Home:

____Owned apartment/house
____Rented an apartment/house
____Rented room
____Living with relatives
____Living with friends
____Others

15. How many people live in your household?

Adults____ Children____

16. Partner's age____

17. Partner's occupation____ 18. Partner's job position_____

19. Partner's educational level:

____None
____Elementary school incomplete
____Elementary school complete
____Secondary school incomplete
____Secondary school complete
____Vocational school or Junior school
____University studies

20. Mother's educational level:

____None
____Elementary school incomplete
____Elementary school complete
____Secondary school incomplete
____Secondary school complete
____Vocational school or Junior school
____University studies

21. Your mother:

A home maker____ Working outside home____

-If working outside home, what was your mother's occupation?_____

22. Father's education level:

____None
____Elementary school incomplete
____Elementary school complete
____Secondary school incomplete
____Secondary school complete
____Vocational school or Junior school
____University studies

23.Father's occupation_____

24. Are you the only one economically responsible for your children?

Yes____ No____

SOCIAL SUPPORT

This questionnaire presents a series of affirmations, each one followed by a scale for you to mark off the response that is the closest to your personal case. Please answer as to how these affirmations **are** for you and **not** how you would like them to be.

	No,never	Sometimes	Frequently	Yes, always
1.When I was a child I received a lot of support from my parents.	1	2	3	4
2.-I am a member of a social group (religious group, clubs, teams, etc.).				
3. I ask for other persons' support.				
4. I have someone I trust in.				
5. My family gives me satisfactions and a sense of security.				
6. Persons should count on religious orientation for support and peace of mind.				
7. When I feel unhappy or stressed out there are people I can go to receive support.				
8. I have a good relationship at present with my husband/couple.				
9. When I have problems I keep them to myself.				
10. I can resort to my parents whenever I have a problem.				
11. I feel lonely, as if I had no-one close by.				
12. I have friends that will back me up no matter what I do.				
13. My brothers and/or sisters give me support.				
14. My husband/partner is supportive of me.				
15. I have a good relationship with my supervisor at work.				
16. I like to work alone.				
17. I have a good relationship with my co-workers.				
18. I prefer to work in a team.				

ROLE QUALITY MEASURES

Part 1: Job Role Quality

Job Rewards

When you think about your current job, how much, if at all, are the following items a rewarding part of your job: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely? We'd like you think about how it is right now. We're not asking how you **wish** it were, but how it **actually** is.

	No at all	Somewhat	Considerably	Extremely
1. The working hours fit my needs	1	2	3	4
2. I enjoy job security.				
3. I receive appreciation and recognition for my job.				
4. The people I work with are agreeable and pleasant.				
5. I help others; I feel needed.				
6. I like my boss.				
7. I reach my goals; I am competent at my job.				
8. I carry out a variety of tasks.				
9. I have learning opportunities.				
10. The physical conditions in my work environment are good.				
11. It is stimulating for me to leave my home and go to work.				
12. I can work on my own.				
13. I help others develop themselves.				
14. My job is in accordance to my interests and skills.				
15. I earn a good salary.				
16. I have good sources of support available to me.				
17. I have opportunities to advance in my job.				
18. My work is a stimulating challenge.				
19. I take work-related decisions.				

Job Concerns

When you think about your current job, how much, if at all, are the following items a concern for you: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely?. We'd like you to think about how it is now.

	No at all	Somewhat	Considerably	Extremely
1. I have too many things to do.	1	2	3	4
2. I have no job stability.				
3. Conflicts arise between my work and other responsibilities.				
4. I do not like my boss.				
5. I have to carry out several tasks at a time.				
6. I do not receive the recognition I deserve.				
7. My work does not require me to use my skills and interests.				

8. My work is too routine.
9. The physical conditions in my work environment are poor.
10. I do not receive neither recognition nor acknowledgement.
11. My job is monotonous.
12. I am not satisfied with my salary.
13. I have problems at work because I am a woman.
14. I have to carry out tasks that are not part of my job description.
15. Job-related growth opportunities are lacking.
16. Some work-related activities are unnecessarily arduous.
17. There are no challenges.
18. I do not like the people I work with.
19. The volume of work is very exhausting.

If you have no spouse or stable partner, do not answer Part 2 of the questionnaire. Please go straight to Part 3.

Part 2: Marital Role Quality

Marital Role Rewards

When you think about your relationship with your husband/partner, how much, if at all, is each of the following items a rewarding part of your relationship: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely?. We'd like you to think about how it is now. We're not asking how you **wish** it were, but how it **actually** is.

	No at all	Somewhat	Considerably	Extremely
1. My partner is my companion.	1	2	3	4
2. I have someone that takes care of me.				
3. The relationship with my partner is easy to maintain.				
4. My partner and I physically demonstrate our affection for each other.				
5. My partner is a good father.				
6. I can comment my problems with my partner.				
7. The sexual relations with my partner are good.				
8. My partner backs me up.				
9. I enjoy doing things with my partner				
10. My partner sees me as someone special.				
11. My partner is a good provider.				
12. My partner´s personality coincides with my own.				
13. My partner is willing to share house chores with me.				
14. The communication between my partner and I is good.				
15. My partner wishes to have children.				

Marital Role Concerns

When you think about your relationship with your husband/partner, to what extent, if at all, is each of following items a concern for you: (1) Not at all, (2) Somewhat, (3) Considerably, (4) Extremely?. We'd like you to think about how it is now.

	No at all	Somewhat	Considerably	Extremely
1. I perceive my partner to be distant and inaccessible.	1	2	3	4
2. The communication between my partner and I is not good.				
3. My partner´s physical health is poor.				
4. My partner does not give me enough recognition.				
5. We have children-related conflicts.				
6. My partner has problems at work or in his profession.				
7. I have problems with our sexual relationships.				
8. There is a lack of companionship between my partner and I.				
9. My partner has no job stability.				
10. My partner´s job demands are very high.				
11. My partner has emotional problems.				
12. My partner and I do not get along.				
13. We have work-related conflicts at home.				
14. My partner does not give me enough emotional support.				
15. My partner and I have conflicts with the children.				

Part 3. Parent Role Quality

Parent Role Rewards.

When you think about yourself as a parent, how much, if at all, is each of the following items a reward for you: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely?. We'd like to think about how it is now. We're not asking how you **wish** it were, but how it **actually** is.

	No at all	Somewhat	Considerably	Extremely
1. My children need me.	1	2	3	4
2. My children´s successes and achievements give me pleasure.				
3. 3. I help my children develop themselves.				
4. My children show me their love.				
5. I feel proud of the way my children behave in life.				
6. I like the type of persons my children are.				
7. I comment my problems with my children.				
8. I do things with my children.				
9. My children offer me their help.				
10. My children give meaning to my life.				
11. I am the person that best cares for my children.				
12. My children get along well with each other.				
13. I see my children grow up, mature and change.				
14. My children make me change for the better.				

Parent Role Concerns.

When you think about yourself as a parent, how much, if at all, is each of the following items a concern for you: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely?. We'd like you to think about how it is now.

	No at all	Somewhat	Considerably	Extremely
1. We have financial problems.	1	2	3	4
2. I feel bored and trapped.				
3. I am concerned about my physical well-fare.				
4. My children do not get along well with each other.				
5. My children impose great demands and responsibilities on me.				
6. I am worried about my children´s adolescent years.				
7. I am not sure that I am doing the right thing.				
8. My children do not show me their love and appreciation.				
9. I have problems with my children´s education/schooling.				
10. I am disillusioned at the way my children are.				
11. I do not have enough control over them.				
12. My children need me increasingly less as they grow up.				
13. I have too many conflicts and discussions with my children.				
14. My children interfere in my relationship with my partner.				

THANK YOU VERY MUCH FOR YOUR COOPERATION !!!

Translation and adaptation of the questionnaire from Role Quality by Baruch, G. and Barnett, R. (1986, Journal of Personality and Social Psychology 51:578-585) carried out by the Section on Psychophysiology and Human Behaviour.

APPENDIX 4

UNIVERSIDAD SIMON BOLIVAR
PROYECTO: MUJER-TRABAJO-SALUD

CODIGO:_____

DATOS SOCIODEMOGRAFICOS.

Por favor, responda las preguntas que se presentan a continuación de forma cuidadosa y detallada.

1. Fecha de nacimiento_____ 2.Edad:_____
3.Estado civil:

Unida____ Casada____ Soltera____ Divorciada____
Separada____ Viuda____

4. Tiempo de unida o casada con su actual pareja_____
5.Ocupación:_____ 6. Institución donde trabaja_____
7. Tiempo en su actual trabajo_____ 8. Cargo que ocupa_____
9. Número de Horas semanales de trabajo_____

10. ¿Tiene Ud. otro trabajo aparte del que realiza diariamente? Sí____ No____
Tipo de trabajo_____

11. Nivel Educativo:
___ Primaria incompleta
___ Secundaria incompleta
___ Técnico superior incompleto
___ Universitaria incompleta
___ Primaria completa
___ Secundaria completa
___ Técnico superior completo
___ Universitaria completa

12.Fuentes de Ingreso:
____Fortuna heredada o adquirida
____Comercio, ganancias y beneficios
____Sueldo mensual
____Salario semanal
____Donaciones públicas o privadas

13. Vivienda principal:
____Condiciones sanitarias óptimas, con lujo
____Condiciones sanitarias óptimas, sin lujo
____Condiciones sanitarias óptimas, espacio reducido
____Condiciones sanitarias buenas, espacio reducido
____Sin condiciones sanitarias.

14. Vivienda:

____Propia
____Alquilada
____Alquilada en una habitación
____Vive con familiares
____Vive con amigos
____Otros

15. ¿Cuántas personas viven en su casa?

Adultos____ Niños____

16. Edad de su actual pareja____

17. Ocupación de su pareja_____ 18. Cargo que ocupa_____

19. Nivel educativo de su actual pareja:

__ Primaria incompleta
___ Secundaria incompleta
___ Técnico superior incompleto
___ Universitaria incompleta
___ Primaria completa
___ Secundaria completa
___ Técnico superior completo
___ Universitaria completa

20. Nivel educativo de su madre:

____Primaria incompleta
____Secundaria incompleta
____Técnico superior incompleto
____Universitaria incompleta
____Primaria completa
____Secundaria completa
____Técnico superior completo
____Universitaria completa

21. ¿Su mamá trabajó?

- En casa____
- Fuera del hogar____ Si este último es afirmativo. Ocupación_____

22. Nivel de educación de su padre:

____Primaria incompleta
____Secundaria incompleta
____Técnico superior incompleto
____Universitaria incompleta
____Primaria completa
____Secundaria completa
____Técnico superior completo
____Universitaria completa

23. Ocupación de su padre_____

24 . ¿Es usted la única responsable de mantener económicamente a sus hijos?

Sí____ No____

25. ¿Quien cuida de sus hijos mientras Ud. trabaja?

Guardería____ Abuelos____ Otros____
Niñera____ Otros familiares____
Sus hijos mayores____ Vecinos____

DATOS SOBRE SU SALUD:

1. ¿Cómo percibe su estado de salud en general?

Muy deteriorado____ Deteriorado____ Bueno____ Muy Bueno____ Excelente____

2. ¿Cómo considera su estado de salud en comparación con otras personas de su misma edad?

Mejor____ Igual____ Peor____

3. ¿Cómo considera sus condiciones de salud en comparación a cinco años atrás?

Mejor____ Igual____ Peor____

4. A continuación se presenta un listado de diferentes reacciones fisicas y/o mentales que pueden aparecer en un momento dado, Por favor, responda si ha experimentado o no estas reacciones **en los ultimos 6 meses.**

	Ausencia	**Presencia**
1. Perder el hilo de las ideas	1	2
2. Tensión estomacal, ardor, indigestión	1	2
3. Escalofríos o calores repentinos	1	2
4. Manos o pies fríos	1	2
5. Dolores de cabeza	1	2
6. Tendencia a los calambres	1	2
7. Sequedad de la boca	1	2
8. Respiración entrecortada	1	2
9. Sentir tensión muscular (nuca, hombros, espalda)	1	2
10.Excesiva sudoración	1	2
11.Olvidar, no saber donde se ha puesto algo	1	2
12.Taquicardia, aceleración del corazón	1	2
13.Dificultades para concentrarse	1	2
14. Otros. (describa)	1	2

5. ¿Ha consultado algún(os) médico(s) en los últimos 6 meses?

Sí____ No____ ¿Cuántas veces?_____

6. ¿Ha consultado a profesionales de la psicología o psiquiatría en los últimos 6 meses?

Sí____ No____ ¿Cuántas veces?_____

7. ¿Ha estado hospitalizada(o) en los últimos 5 años?

Sí____ No____ ¿Cuántas veces?_____

8. ¿Ha estado hospitalizada(o) en los últimos 6 meses?

Sí____ No____ ¿Cuántas veces?_____

9. ¿Cuántos días ha faltado al trabajo por motivos de salud en los últimos 6 meses?_____

10.¿Cuántos días ha permanecido en cama por motivos de salud en los últimos 6 meses?_____

11. ¿Usted fuma? Sí____ No____ ¿Cuántos cigarrillos al día?_____

12. Si la respuesta es afirmativa, ¿Al fumar aspira? Sí____ No____

13.¿Ha fumado en el pasado?Sí____ No____ ¿Cuándo dejó de fumar?_____

14. ¿Con frecuencia está en lugares donde otros fuman? Sí____ No____

15. ¿Usted hace algún deporte? Sí____ No____

¿Cuál y con qué frecuencia?_____

16.¿Usted consume bebidas alcohólicas? Sí____ No____ Si la respuesta es afirmativa; ¿Cuántos tragos consume por semana aproximadamente? 1 - 5____ 6 - 10____ 11 - 15____ Más de 15____

17.¿Ha tenido problemas de sueño en los últimos 6 meses (insomnio, pesadillas, etc.)? Sí____ No____ ¿Cuáles?_____

18. ¿Cuántas horas duerme normalmente? Menos de 4____ 4-6____ 7-9____ Más de 9____

19. ¿Usted se encuentra en la etapa:

Pre-menopáusica____

Menopáusica____

Post-menopáusica____

Si ese es su caso¿Qué manifestaciones ha tenido (irritabilidad, calores,etc)_____

19. ¿Tiene o ha tenido alguno de los siguientes problemas de salud?

Tensión alta____ Infarto____ Angina (dolor) de pecho____ Asma____

Bronquitis____ Ulcera____ Diabetes____ Otros (especifique)____

APOYO SOCIAL:

1. En relación a su familia y amigos, ¿Cuántas personas estarían dispuestas a escucharla hablar de manera franca y espontánea, sin importar de que se trate el tema?

Ninguna____ 6 - 10____

1 - 2____ 11 - 15____

3 - 5____ Más de 15____

2. Si en alguna ocasión, está molesta o tiene un problema que la hace sentir contrariada o disgustada, ¿Cuenta con alguien, que no esté involucrado en la situación, con quien pueda comentar libremente lo que le sucede?

Sí____

Depende de la situación____

No____

3. Cuando está contenta, ¿Existe una persona en particular con la cual pueda compartir lo que siente, y está segura de que se sentirá contenta, debido a que Ud lo está?

Sí____ No____

4. ¿Hay ocasiones en las que Ud se siente confortada al ser abrazada por alguien?

Sí ----___ No---- ____

5. En la semana, ¿Cuántas personas que están a su alrededor (trabajo, vecindario, familia, etc) tienen algún contacto con Ud?

Ninguna____ 6 - 10____

1 - 2____ 11 - 15_____

3 - 5____ Más de 15____

6. En estos días, ¿Cuántas personas con sus mismos intereses, tienen contacto Ud.?

Ninguna____ 6 - 10____

1 - 2____ 11 - 15_____

3 - 5____ Más de 15_____

7. ¿Cuántos amigos tiene, a quienes pueda visitar sin necesidad de que la inviten

Ninguno____ 6 - 10____

1 - 2____ 11 - 15____

3 - 5____ Más de 15____

En ese caso, podría estar segura que si llega de visita sin avisar, será bien recibida?

Sí____ No____

8. ¿Cuántos amigos tiene que puedan llegar a su casa y tomar alguna cosa que necesiten sin apenarse, aún cuando la casa esté desordenada o por ejemplo se encuentre comiendo?

Ninguna____ 6 - 10____

1 - 2____ 11 - 15____

3 - 5____ Más de 15____

9. En el presente, ¿Tiene a alguien a quien pueda confiar sus sentimientos más intimos (confidencias)?

Sí____ No____

VARIABLES PERSONALES

A continuación encontrará una lista de expresiones que las personas suelen usar para describirse a sí mismas. Por favor trace un círculo alrededor del número que mejor indique como **se siente ahora**

ANSIEDAD	No, Nunca	Poco	Bastante	Mucho
1. Me siento calmada	1	2	3	4
2. Me siento segura	1	2	3	4
3. Estoy tensa	1	2	3	4
4. Estoy contrariada	1	2	3	4

5. Estoy a gusto	1	2	3	4
6. Me siento alterada	1	2	3	4
7. Estoy preocupada por un posible contratiempo	1	2	3	4
8. Me siento descansada	1	2	3	4
9. Me siento ansiosa	1	2	3	4
10. Me siento confortable	1	2	3	4
11. Tengo confianza en mi misma	1	2	3	4
12. Me siento nerviosa	1	2	3	4
13. Me siento agitada	1	2	3	4
14. Me siento irritable	1	2	3	4
15. Me siento reposada	1	2	3	4
16. Me siento satisfecha	1	2	3	4
17. Estoy preocupada	1	2	3	4
18. Me siento muy excitada y aturdida	1	2	3	4
19. Me siento alegre	1	2	3	4
20. Me siento bien	1	2	3	4

DEPRESION	No, Nunca	Poco	Bastante	Mucho
21.Tengo pocas ganas de comer	1	2	3	4
22.Me siento sola	1	2	3	4
23.Siento que tengo poco interés por las cosas	1	2	3	4
24.Tengo problemas para quedarme dormida	1	2	3	4
25.Lloro fácilmente	1	2	3	4
26.Me siento sin energía	1	2	3	4
27.Tengo muchos planes para el futuro	1	2	3	4
28.Me siento deprimida e inquieta	1	2	3	4
29.Tengo entusiasmo para emprender proyectos	1	2	3	4

AUTOESTIMA	No, Nunca	Poco	Bastante	Mucho
30.Siento que me valoro como persona	1	2	3	4
31.Siento que tengo muchas cualidades	1	2	3	4
32.Tengo una actitud positiva conmigo misma	1	2	3	4
33.Estoy satisfecha conmigo misma	1	2	3	4
34.Mucha gente piensa que yo tengo buen sentido del humor	1	2	3	4
35.La gente que me conoce piensa muy bien de mi	1	2	3	4
36. Me siento orgullosa de mí misma	1	2	3	4

CUALIDAD DEL ROL

Parte 1: ROL LABORAL

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos gratificantes o agradables de su vida laboral.** Por favor , encierre en un circulo la respuesta que se aplique a su caso.

	No, Nunca	Poco	Bastante	Mucho
1.- El horario se adapta a mis necesidades	1	2	3	4
2.- Tengo estabilidad laboral	1	2	3	4
3.- Recibo aprecio y reconociniento por mi trabajo	1	2	3	4
4.- La gente con la que trabajo es agradable	1	2	3	4
5.- Ayudo a otros, me siento necesaria	1	2	3	4
6.- Me agrada mi jefe	1	2	3	4
7.- Obtengo logros, soy competente	1	2	3	4
8.- Realizo tareas variadas y estimulantes	1	2	3	4
9.- Tengo la oportunidad de aprender	1	2	3	4
10.-Mi supervisor respeta mis habilidades	1	2	3	4
11.-Tengo sentido de logro y superación en mi trabajo	1	2	3	4
12.- El ambiente fisico de mi trabajo es apropiado	1	2	3	4
13. -Es estimulante salir de la casa hacia el trabajo	1	2	3	4
14.-Tengo amigos entre mis compañeros de trabajo	1	2	3	4
15.-Tengo un buen sueldo comparado con otras personas que trabajan en mi misma área	1	2	3	4
16.-Puedo trabajar por mi cuenta	1	2	3	4
17.-Mi trabajo está de acuerdo con mis habilidades y destrezas	1	2	3	4
18.-Ayudo a otros a desarrollarse	1	2	3	4
19.-Puedo trabajar en equipo o en grupo	1	2	3	4
20.-Mi supervisor se preocupa por el bienestar de sus supervisados	1	2	3	4

21.-Mi trabajo se adecúa a mis intereses	1	2	3	4
22.-Estoy satisfecha con mi sueldo	1	2	3	4
23.-Tengo buenas fuentes de apoyo a mi disposición	1	2	3	4
24.-Tengo la autoridad que necesito para realizar mi trabajo	1	2	3	4
25.-Tengo la oportunidad de ser promovida en mi cargo	1	2	3	4
26.-Mi trabajo es un reto estimulante	1	2	3	4
27.-Tengo beneficios en mi trabajo, por ejemplo, permisos por enfermedad, etc.	1	2	3	4
28.-Mi supervisor presta atención a lo que yo le digo	1	2	3	4
29.-Tomo decisiones en el trabajo	1	2	3	4
30.-Recibo la colaboración de mis compañeros de trabajo	1	2	3	4
31. -Otros:	1	2	3	4

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos generadores de tensión o preocupantes de su vida laboral.** Por favor, encierre en un circulo la respuesta que se aplique a su caso

	No, Nunca	Poco	Bastante	Mucho
1.-Tengo demasiadas cosas que hacer	1	2	3	4
2.-Tengo inestabilidad laboral	1	2	3	4
3.- Se me presentan conflictos entre el trabajo y otras responsabilidades	1	2	3	4
4.- Me desagrada mi jefe	1	2	3	4
5.- Tengo que realizar varias tareas a la vez	1	2	3	4
6.- Me falta el reconocimiento que merezco	1	2	3	4
7.- Mi supervisor es incompetente	1	2	3	4
8.- Mi trabajo se puede realizar sin las destrezas que tengo	1	2	3	4
9.- Mi trabajo es rutinario	1	2	3	4
10.-Las condiciones físicas del lugar de trabajo son malas	1	2	3	4
11.-En el trabajo estoy expuesta a enfermedades y accidentes	1	2	3	4
12.-Mi trabajo es monótono	1	2	3	4
13.- Mi salario me causa insatisfacción	1	2	3	4
14.-Tengo problemas en el trabajo por ser mujer	1	2	3	4
15.-En el trabajo tengo que hacer cosas que van en contra de mi buen juicio	1	2	3	4
16.-Tengo que hacer cosas aparte del trabajo que me correponden	1	2	3	4
17.-Me faltan oportunidades para el crecimiento laboral	1	2	3	4
18.-Mi supervisor desvaloriza mi trabajo	1	2	3	4
19.-Mi trabajo me impide tener retos	1	2	3	4

20.-Me desagrada la gente con quienes trabajo	1	2	3	4
21.-Enfrento discriminación en mi trabajo debido a mi raza o religión	1	2	3	4
22.-El volumen de trabajo es muy agotador	1	2	3	4
23.-Gano menos que otras personas que estan en mi línea de trabajo	1	2	3	4
24.-Tengo dificultades para controlar las actividades o tareas que tengo que realizar en el trabajo	1	2	3	4
25.- En mi trabajo faltan oportunidades para que me promocionen en mi cargo	1	2	3	4
26.-En mi trabajo tengo que hacer frente a situaciones emocionales díficiles	1	2	3	4
27.-Tengo dificultades para controlar a las personas con quienes trabajo	1	2	3	4
28.- Otros:	1	2	3	4

Si no tiene cónyuge o pareja estable, no conteste la Parte 2 del cuestionario y pase a la Parte 3.

Parte 2: ROL DE ESPOSA

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos gratificantes o agradables de su vida marital o de pareja.** Por favor, encierre en un círculo la respuesta que se aplique a su caso

	No, Nunca	Poco	Bastante	Mucho
1.- Mi pareja es mi compañero	1	2	3	4
2.- Existe atracción fisica entre mi pareja y yo	1	2	3	4
3.- Mi pareja cuida de mi	1	2	3	4
4.- La relación con mi pareja es fácil de llevar	1	2	3	4
5.- Mi compañero está orgulloso de mi	1	2	3	4
6.- Hay demostraciones de afecto entre mi pareja y yo	1	2	3	4
7.- Mi pareja es un buen padre	1	2	3	4
8.- Puedo comentar los problemas con mi pareja	1	2	3	4
9.-Las relaciones sexuales entre mi pareja y yo son buenas	1	2	3	4
10.-Mi pareja me respalda	1	2	3	4
11.-Mi pareja se preocupa por miembros de mi familia (padres, hermanos, etc)	1	2	3	4
12.-Disfruto haciendo cosas para mi pareja	1	2	3	4
13.-Mi pareja me ve como alguien especial	1	2	3	4
14.-Mi pareja me proporciona lo que necesito	1	2	3	4
15.-Mi pareja contribuye por igual a los gastos de la familia	1	2	3	4

16.-La personalidad de mi pareja coincide con la mía		1	2	3	4
17.-Mi pareja está dispuesto a compartir el trabajo	de la casa	1	2	3	4
18.-Mi pareja me encuentra físicamente atractiva		1	2	3	4
19.-Hay buena comunicación entre mi pareja y yo		1	2	3	4
20.-Mi pareja desea tener hijos		1	2	3	4
21.-Mi pareja y yo disfrutamos de las mismas actividades		1	2	3	4
22.-En mi pareja tengo un buen amigo		1	2	3	4
23.-Puedo estar en desacuerdo con mi pareja sin que esto dañe la relación		1	2	3	4
24.-Tengo buenas relaciones con la familia de mi pareja		1	2	3	4
25.-Cuando es necesario, mi pareja me hace críticas constructivas		1	2	3	4
26.-Mi pareja comparte conmigo las creencias religiosas		1	2	3	4
27.-Mi pareja y yo compartimos actividades religiosas		1	2	3	4
28.-Mi pareja respeta mis creencias religiosas		1	2	3	4
29.-Mi pareja me estimula a aprovechar las oportunidades que me brinda mi trabajo		1	2	3	4
30.-Mi pareja comprende que yo tenga que trabajar horas extras		1	2	3	4
31.-Mi pareja asume las tareas que me corresponden en el hogar, cuando tengo exceso de trabajo.		1	2	3	4
32.-Otros		1	2	3	4

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos generadores de tensión o preocupantes de su vida marital o de pareja**. Por favor encierre en un círculo la respuesta que se aplique a su caso.

	No, Nunca	Poco	Bastante	Mucho
1.- Percibo a mi pareja distante, inaccesible	1	2	3	4
2.- Entre mi pareja y yo la comunicación es pobre	1	2	3	4
3.- Mi pareja y yo discutimos por dificultades económicas	1	2	3	4
4.- Mi pareja tiene problemas de salud física	1	2	3	4
5.- No tengo suficiente reconocimiento por parte de mi pareja	1	2	3	4
6.- Tenemos conflictos por los hijos	1	2	3	4
7.- Mi pareja exige emocionalmente más de lo que yo puedo dar	1	2	3	4
8.- Mi pareja tiene problemas en su trabajo o profesión	1	2	3	4
9.- Tengo problemas en nuestras relaciones sexuales	1	2	3	4
10.- Entre mi pareja y yo hay falta de compañerismo	1	2	3	4
11.-Mi pareja casi nunca esta en la casa	1	2	3	4
12.-Mi pareja depende económicamente de mi	1	2	3	4
13.-Mi pareja tiene inestabilidad laboral	1	2	3	4
14.-Mi pareja tiene altas demandas laborales	1	2	3	4

15.-Discuto mucho con mi pareja	1	2	3	4
16.-Mi pareja es muy absorbente	1	2	3	4
17.-Mi pareja tiene problemas emocionales	1	2	3	4
18.-Mi pareja y yo tenemos problemas para llevarnos bien	1	2	3	4
19.-Tengo dificultades para recibir el apoyo de mi pareja	1	2	3	4
20.-Tenemos conflictos por el trabajo de la casa	1	2	3	4
21.-Mi pareja y yo tenemos conflictos por los niños	1	2	3	4
22.-Mi pareja tiene un sueldo insuficiente	1	2	3	4
23.-Mi pareja se niega a compartir conmigo las creencias religiosas	1	2	3	4
24.- Me resulta dificil compartir actividades religiosas con mi pareja	1	2	3	4
25.-Mi pareja irrespeta mis creencias religiosas	1	2	3	426.
	1	2	3	4

Parte 3: ROL DE MADRE

Si no tiene hijos, no conteste esta parte del cuestionario.

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos grartificantes o agradables de su desempeño como madre.** Por favor, encierre en un círculo la respuesta que se aplique a su caso.

	No, Nunca	Poco	Bastante	Mucho
1.- Me dan placer los éxitos y logros de mis hijos	1	2	3	4
2.- Ayudo a mis hijos a desarrollarse	1	2	3	4
3.- Mis hijos me demuestran amor	1	2	3	4
4.- Mi opinión es tomada en cuenta por mis hijos	1	2	3	4
5.- Me siento orgullosa de la forma como se desenvuelven mis hijos	1	2	3	4
6.- Me gusta el tipo de personas que son mis hijos	1	2	3	4
7.- Comento mis problemas con mis hijos	1	2	3	4
8.- Comparto actividades con mis hijos	1	2	3	4
9.- Mis hijos me piden consejo	1	2	3	4
10.-Soy una persona importante para mis hijos	1	2	3	4
11.-Mis hijos me brindan ayuda	1	2	3	4
12.-Mis hijos le dan significado a mi vida	1	2	3	4
13.-Tengo bastantes cosas en común con mis hijos	1	2	3	4
14.-Mis hijos se llevan bien entre ellos	1	2	3	4
15.-Mis hijos me hacen cambiar para mejorar	1	2	3	4
16.- Comparto con mis hijos actividades religiosas	1	2	3	4
17.-Otros	1	2	3	4

A continuación encontrará una serie de afirmaciones relacionadas con los **aspectos generadores de tensión o preocupantes de su desempeño como madre.** Por favor, encierre en un círculo la respuesta que se aplique a su caso.

	No, Nunca	Poco	Bastante	Mucho
1.- Tenemos problemas financieros debido a la crianza de los niños	1	2	3	4
2.- Siento que tengo que hacer mucho por mis hijos	1	2	3	4
3.- Me siento atada por los niños	1	2	3	4
4.- Las relaciones entre mis hijos son conflictivas	1	2	3	4
5.- Mis hijos evaden sus responsabilidades	1	2	3	4
6.- Mis hijos me imponen grandes demandas y responsabilidades	1	2	3	4
7.- Me preocupa la etapa de adolescencia de mis hijos	1	2	3	4
8.- Me siento insegura de hacer lo correcto en relación con mis hijos	1	2	3	4
9.-Mis hijos tienen dificultades para expresar su amor y aprecio hacia mí	1	2	3	4
10.-Tengo problemas con la educación/escuela de mis hijos	1	2	3	4
11.-Me desilusiona la forma de ser de mis hijos	1	2	3	4
12.- El tiempo que tengo para mi es limitado por culpa de mis hijos	1	2	3	4
13.-Tengo problemas para controlar a mis hijos	1	2	3	4
14.-Mis hijos me necesitan menos a medida que crecen	1	2	3	4
15.-Tengo demasiados conflictos y discusiones con mis hijos	1	2	3	4
16.-Mis hijos interfieren en la relación con mi pareja	1	2	3	4
17.-Mis hijos son infelices	1	2	3	4
18. Otros:	1	2	3	4

19 Si usted tuviera que evaluar su nivel de bienestar o satisfacción con su vida en los últimos doce meses ¿Cómo lo calificaría en base a la siguiente Escala?

Nada Satisfactorio **Muy Satisfactorio**

0 1 2 3 4 5 6 7 8 9 10

RELACIONES TRABAJO Y FAMILIA

Por favor, lea cuidadosamente cada una de las situaciones y trace un círculo alrededor del número que mejor indique como **se siente ahora**

	No, en lo Absoluto	Un poco, Casi nada	Bastante	Mucho
1. Los logros en mi trabajo me han permitido enriquecer mi relación de pareja	1	2	3	4
2. Cuando regreso a casa después del trabajo no tengo energía para dedicarme a mis labores de madre.				
3. Las preocupaciones de mi trabajo interfieren en mi relación de pareja				

4. En mi trabajo he aprendido cosas que me sirven para ser mejor madre
5. Mis horas de trabajo interfieren con el tiempo que debo dedicar a mis hijos
6. Mi trabajo me ha permitido hacer nuevas amistades
7. Después de mi trabajo estoy demasiado cansada como para realizar otras actividades con mi esposo
8. Se me dificulta realizar las tareas del hogar debido a mi trabajo
9. Cumplir mi trabajo me resulta tan fácil como realizar las tareas del hogar
10. El tiempo que dedico al trabajo interfiere con mi tiempo libre.
11. Cuando regreso del trabajo a la casa, me falta energía para realizar las tareas del hogar
12. Estoy demasiado cansada después del trabajo para ver a mis amigos con la frecuencia que quisiera
13. Otros:

RESPONSABILIDADES EN EL HOGAR

Por favor, marque con un "X"en la casilla correspondiente a o las personas que usualmente se encargan de realizarlas. No conteste las preguntas que no apliquen en su caso (por ej. en caso de no tener hijos).

	Usted Siempre personas	Usted casi siempre	Las comparte con su ñero(a)	Su compa- ñero(a) compa-	Su compa- ñero siempre siempre	Otras casi
ADMINISTRACIÓN						
1.- Planificar las comidas	( )	( )	( )	( )	( )	(
2.- Elaborar la lista del mercado	( )	( )	( )	( )	( )	(
3.- Concertar las citas médicas	( )	( )	( )	( )	( )	0
4.- Tomar decisiones de dinero	( )	( )	( )	( )	( )	(
5.- Decidir sobre la educación de los niños	( )	( )	( )	( )	( )	0
6.- Decidir sobre la disciplina en el hogar	( )	( )	( )	( )	( )	(
7.- Planificar los fines de semana y vacaciones	( )	( )	( )	( )	( )	(
TAREAS						
1.- Hacer el mercado	( )	( )	( )	( )	( )	(
2.- Preparar las comidas	( )	( )	( )	( )	( )	(
3.- Lavar la ropa	( )	( )	( )	( )	( )	(
4.- Limpiar la cocina	( )	( )	( )	( )	( )	(
5.- Lavar los platos	( )	( )	( )	( )	( )	(
6.- Limpiar la casa	( )	( )	( )	( )	( )	(

Usted	Usted Siempre personas	Las casi siempre	Su comparte con su	Su compa- ñero(a)	Otras compa- ñero compa-	
	siempre	casi	ñero(a)		siempre	
7.- Planchar la ropa	( )	( )	( )	( )	( )	)
8.- Lavar los baños	( )	( )	( )	( )	( )	(
9.- Mantenimiento del carro	( )	( )	( )	( )	( )	(
10.-Reparaciones del hogar	( )	( )	( )	( )	( )	(
11.-Pagar las cuentas	( )	( )	( )	( )	( )	(
12.-Cuidar las mascotas	( )	( )	( )	( )	( )	(
13.-Llevar a los niños al médico, al dentista, etc	( )	( )	( )	( )	( )	(
14.-Atender citas del colegio	( )	( )	( )	( )	( )	(
15.-Organizar fiestas y reuniones	( )	( )	( )	( )	( )	(
16.-Revisar las tareas de los niños	( )	( )	( )	( )	( )	(
17.-Chequear el aseo de los niños	( )	( )	( )	( )	( )	(
18.-Estar pendiente si los niños estu- diaron para los exámenes	( )	( )	( )	( )	( )	(
19.-Premiar o castigar a los niños por su comportamiento	( )	( )	( )	( )	( )	(
20.-Preparar las loncheras de los niños	( )	( )	( )	( )	( )	(
21.-Cuidar las matas	( )	( )	( )	( )	( )	()
22.-Jugar con los niños	( )	( )	( )	( )	( )	()
23-Otras tareas (describa)	_____					
	_____					

Por favor señale si hay alguna otra persona que contribuya en los quehaceres de su casa (por ejem. parientes, servicio,jóvenes, etc)_____

POR FAVOR, ASEGURESE DE HABER RESPONDIDO TODAS LAS PREGUNTAS

!!!MUCHAS GRACIAS POR SU COLABORACIÓN!!!

UNIVERSIDAD SIMON BOLIVAR
PROYECT: WOMEN, WORK and HEALTH

CODE _____

PERSONAL BACKGROUND

1.Sex : M___ W___ 2.Age:_____

3.Marital status:

Cohabiting____ Married____ Single____ Divorced____
Separated____ Widow____

4. How long have you being living with your partner (married or not)?_____

5. Occupation_____ 6. Work place_____

7. Time at your current job_____ 8.Job position _____

9. How many hours/week do you work?_____

10. Do you work at another job beside your regular one? Yes____ No____
Job description_____

11. Level of education:
____None
____Elementary school incomplete
____Elementary school complete
____Secondary school incomplete
____Secondary school complete
____Vocational school or Junior school
____University studies

12. Sources of income:
____Inheritance
____Business
____Weekly wages
____Public or private donations
____Monthly salary

13. Main home:
____Optimal luxurious sanitary conditions

____Optimal not luxurious sanitary conditions
____Optimal sanitary conditions in reduced space
____Good sanitary conditions in reduced space
____Without sanitary conditions.

14. Home:

____Owned apartment/house
____Rented an apartment/house
____Rented room
____Living with relatives
____Living with friends
____Others

15. How many people live in your household?

Adults____ Children____

16. Partner's age____

17. Partner's occupation____ 18. Partner's job position_____

19. Partner's educational level:

____None
____Elementary school incomplete
____Elementary school complete
____Secondary school incomplete
____Secondary school complete
____Vocational school or Junior school
____University studies

20. Mother's educational level:

____None
____Elementary school incomplete
____Elementary school complete
____Secondary school incomplete
____Secondary school complete
____Vocational school or Junior school
____University studies

21. Your mother:

A home maker____ Working outside home____

-If working outside home, what was your mother's occupation?_____

22. Father's education level:

____None
____Elementary school incomplete
____Elementary school complete
____Secondary school incomplete
____Secondary school complete
____Vocational school or Junior school
____University studies

23.Father's occupation_____

24. Are you the only one economically responsible for your children?

Yes____ No____

25. Who takes care of your child/ children while you're working?

____Daycare center	____Older brothers or sisters
____Babysitter	____Other relatives
____Grandparents	____Friends
____Neighbors	____Others

26. Do you pay for your children care?

Yes____ No____

Please: Remember the following information for each of your children: Sex (Male or Female), Birth weight (Lbs), Time of breastfeeding (in months), time shared together daily (in cares, play, ...) and your satisfaction with this dedication of time.

HEALTH

1. What do you think of your general health?

Very poor____ Poor____ Good____ Very good____ Excellent____

2. What do you think of your general health compared to others in your age group?

Better____ Some____ Worse____

3. What do you think of your health conditions compared to 5 years ago?

Better____ Some____ Worse____

4. The followings physical and/or mental reactions can happen at any given moment. Please answer if you have had any of these **in the last six months**

	No	**Yes**
1. Loose the train of thought	1	2
2. Stomachcramps, Heartburn, indigestion	1	2
3. Chill or heat waves	1	2
4. Cold feet and hand	1	2
5. Headaches	1	2
6. Tendency to cramps	1	2
7. Dry mouth	1	2
8. Shortness breath	1	2
9. Muscular tension (nape, shoulders, back)	1	2

10.Excessive sweating	1	2
11.Forget fullness	1	2
12.Tachicardi, palpitation	1	2
13. Difficulty to concentrate	1	2
14. Others	1	2

5. Have you visited a doctor in the last 6 months?
   Yes____ No____ How many times?_____

6. Have you visited a psychologist or psychiatrist in the last 6 months?
   Yes____ No____ How many times?_____

7. Have you been hospitalized the last 5 year?
   Yes____ No____ How many times?_____

8. Have you been hospitalized the last 6 month?
   Yes____ No____ How many times?_____

9. How many days have you missed work, for health reasons, in the last 6 months?_____

10.How many days have you stayed in bed, for health reasons, in the last 6 months?_____

11. Do you smoke? Yes____ No____ How many cigarettes a day?_____

12. Do you aspire the smoke? Yes____ No____

13. Have you smoked in the past? Yes____ No____ When did you stop smoking?_____

14. Are you frequently in places where there are others smoking Yes____ No____

15. Do you practice any sport? Yes____ No____
   Which one and how often?_____

16. Do drink alcoholic beverages? Yes____ No____ If you answer is Yes, How many drinks do you have a week approximately? 1 - 5____ 6 - 10____ 11 - 15____ More than 15____

17. Have you had sleep problems in the last 6 months (insomnia, nightmares, etc)?
Yes____ No____ What kind?_____

18. How many hours do you normally sleep? Less than 4____ 4-6____ 7-9____ More than 9____

19. Are you in any of there stages:
Pre-menopausic____
Menopausic____
Post-menopausic____
If you answer in Yes, What symptoms have you had (irritability, heat waves, etc) _____

20. Have you ever had any of the followings problems?
High blood-pressure____ Heart a hack____ Angina pectoris____ Asthma____
Bronchitis____ Ulcer____ Diabetes____ Others____

SOCIAL NETWORK AND SUPPORT

1. Among your family and friends, how many people are there who are immediately available to you whom you can talk frankly, without having to watch what you say?
None____
1 - 2____
3 - 5____
6 - 10____
11 - 15____
More than 15____

2. If something unpleasant happens or you have a problem which makes you upset or angry, do you have someone you can go to who isn't involved and with whom you can freely discuss what has happened?
Yes____
Depends on the situation____
No____

3. When you are happy, is there any particular person you can share this with someone you feel sure will be happy simply because you are?
No-one____
Yes____

4.Are there times when you are comforted by being held in someone's arms?

No____ Yes____

5. In an ordinary week, how many people whom you already know would you say you have contact with?

None____ 6 - 10____

1 - 2____ 11 - 15____

3 - 5____ More than 15____

6. These days, how many people with similar interests to you do you have contact with?

None____ 6 - 10____

1 - 2____ 11 - 15____

3 - 5____ More than 15____

7. How many friends do you have who could come to your home at any time and take things as they find them: they wouldn't be embarrassed if the house were untidy or you were in the middle of a meal?

None____ 6 - 10____

1 - 2____ 11 - 15____

3 - 5____ More than 15____

8. How many friends do you have whom you could visit at any time, without waiting for an invitation. You could arrive without being expected and still be sure you would be welcome?

None____ 6 - 10____

1 - 2____ 11 - 15____

3 - 5____ More than 15____

9. At present do you have someone you can share your most private feelings with (confide in) or not?

No one____ Yes____

PERSONAL VARIABLES

Here you will find a list of expressions that people used to describe themselves. Please make a circle around the number that best expresses how you feel now

ANXIETY	*No at all*	*Somewhat*	*Considerably*	*Extremely*
1. I feel calm	1	2	3	4
2. I feel secure	1	2	3	4
3. I feel tense	1	2	3	4
4. I feel confused	1	2	3	4
5. I feel fine	1	2	3	4
6. I am worry about a possible problem	1	2	3	4
7. I feel rested	1	2	3	4
8. I feel anxious	1	2	3	4
9. I feel comfortable	1	2	3	4
10. I feel self confident	1	2	3	4
11. I feel nervous	1	2	3	4
12. I feel stressed	1	2	3	4
13. I feel irritable	1	2	3	4
14. I feel relaxed	1	2	3	4
15. I feel satisfied	1	2	3	4
16. I am worry	1	2	3	4
17. I feel very excited and confused	1	2	3	4
18. I feel happy	1	2	3	4
19. I feel okey	1	2	3	4
20. I have little enthusiasms to undertake anything	1	2	3	4

DEPRESSION	*No at all*	*Somewhat*	*Considerably*	*Extremely*
21. I have poor appetite?	1	2	3	4
22. Felt lonely?	1	2	3	4
23. Felt bored or has very little interest to do things?	1	2	3	
		4		
24. Had disturbances with sleeping or keeping to do things?	1	2	3	4
25. Have you found it easy to cry or felt like crying?	1	2	3	4
26. Felt depressed or upset?	1	2	3	4
27. Felt weak or without energy?	1	2	3	4
28. Felt hopeless about the future	1	2	3	4
29. I have plans for the future	1	2	3	4

SELF-ESTEEM	*No at all*	*Somewhat*	*Considerably*	*Extremely*
30. I feel that I am a valuable person	1	2	3	4
31. I feel that I have many good qualities	1	2	3	4
32. I feel that I do not have much to be proud of	1	2	3	4
33. I have a positive attitude about myself	1	2	3	4
34. I am generally satisfied with myself	1	2	3	4
35. Most people that know me well think highly of me	1	2	3	4
36. Most people think I have a good sense of humor	1	2	3	4

ROLE QUALITY SCALES

Part 1: Job Role Quality

Job Rewards

When you think about your current job, how much, if at all, are the following items a rewarding part of your job: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely? We'd like you think about how it is right now. We're not asking how you **wish** it were, but how it **actually** is.

	No at all	*Somewhat*	*Considerably*	*Extremely*
1. My schedule fits my needs	1	2	3	4
2. I have a stable job				
3. I recognition set and appreciation in my job				
4. My co-workers are pleasant people				
5. I help others, I feel necessary				
6. I like my supervisor				
7. I feel competent and I achieve my objectives				
8. I do a variety of stimulation task				
9. I have the opportunity for learning new things				
10. My supervisor respects my abilities				
11. I get feelings of achievement and improvement in my job				
12. The physical environment at work is appropriate				
13. It is exciting to go to work				
14. I have friends among my co-workers				
15. I am making good money compared with other people in my field				
16. I can work on my own				
17. My job's fits my skills				
18. I help others to develop				

19. I am able to work as part of a team or group
20. My supervisor is concerned about the wellbeing of those under him her
21. My work and my interest agree
22. I am satisfied with my income
23. I have good support available
24. I have the authority needed to get my job done
25. I have the opportunities for advancement
26. I have a challenging or stimulating work
27. My job offers benefits like paid sick leave, etc
28. My supervisor pays attention to what I
29. I can make decisions regarding my work
30. My co-workers are supportive

Job Concerns

When you think about your current job, how much, if at all, are the following items a concern for you: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely?. We'd like you to think about how it is now.

Not ***at all***	***Somewhat***	***Considerably***	***Extremely***
1	2	3	4

1. I have too much to do
2. I don't have job security
3. There are conflicts between my work and my others responsibilities
4. I dislike my boss
5. I have to juggle several tasks or duties at the same time
6. I don't have the recognition I deserve
7. My supervisor lacks competence
8. My job doesn't require my skills
9. My job is just routine
10. The physical conditions of my job are inadequate
11. I am exposed to illness or injury in my work
12. My work is dull, monotonous or lacks variety
13. I am not satisfied with my salary
14. I face discrimination at my job because of my sex
15. I have to do things against my better judgment
16. I have to do tasks I don't feel should be a part of my job

17. I have little chance for the advancement I deserve
18. My supervisor underrates my work
19. My job is unchallenged
20. I dislike the people I work with
21. I face discrimination at my job because of my race, religion or ethnic background
22. The volume of work is exhausted
23. I make less money than other people in my line of work
24. I have difficulties to control the activities or task that I have to get done
25. I don't have opportunities for promotion
26. I have to deal with emotionally difficult situations
27. I have difficulties to control the people I work with

Part 2: Marital Role Quality

Marital Role Rewards

When you think about your relationship with your husband/partner, how much, if at all, is each of the following items a rewarding part of your relationship: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely?. We'd like you to think about how it is now. We're not asking how you **wish** it were, but how it **actually** is.

Not ***at all***	***Somewhat***	***Considerably***	***Extremely***
1	2	3	4

1. My partner is my friend
2. There is physical attraction between my partner and myself
3. My partner takes care me
4. I have a partner who is easy to get along with
5. My partner is proud of me
6. There is physical affection between us
7. My partner is a good father
8. I can talk over problems with my partner
9. Our sexual relationship is good
10. My partner backs me up in what I want to do
11. My partner concern about the members of my family, such as my parent, brothers or sisters, etc
12. I enjoy doing things for him
13. My partner think I am somebody special
14. My partner provides for my needs
15. My partner share family expenses on an equal basis
16. My partner's personality agrees with mine

17. My partner does his fair share of home
18. My partner finds me physically attractive
19. There is good communication between us
20. My partner wants children
21. My partner and I enjoy
22. I have a good friend in my partner
23. We are able to disagree without threatening the relationship

Not ***at all***	***Somewhat***	***Considerably***	***Extremely***
1	2	3	4

24. I have good relationship with my partner's family
25. My partner gives me constructive criticism when I need it
26. My partner shares my religions beliefs
27. My partner and I participate together in religious practices
28. My partner respect religious beliefs
29. My partner encourages me to take advantages
30. My partner understand when I have to work out of my schedule
31. My partner takes over your housechores when I have a lot of work

Marital Role Concerns

When you think about your relationship with your husband/partner, to what extent, if at all, is each of following items a concern for you: (1) Not at all, (2) Somewhat, (3) Considerably, (4) Extremely?. We'd like you to think about how it is now.

No at all	***Somewhat***	***Considerably***	***Extremely***
1	2	3	4

1. I feel my partner as distant, inaccessible
2. The communication is poor between my partner and I
3. We argue over economic difficulties
4. My partner has physical health problems
5. I am not setting enough appreciation attention than what I can give him
6. We have conflicts because of children
7. My partner emotionally demands are greater than what I can give me
8. My partner has problems in his job or profession

9. We have problems in our sexual relation
10. There is a lack of companionship between us
11. My partner is seldom at home
12. My partner depends on me financially
13. My partner has job instability
14. My partner has high job demands

Not at all	*Somewhat*	*Considerably*	*Extremely*
1	2	3	4

15. I argue with my partner
16. I argue with my partner is very absorbing
17. My partner has emotionally problems
18. My partner an I have problems settings alone
19. I find difficult to have my partner support
20. We have problems over the home
21. We have conflicts over the children
22. My partner's salary is not enough
23. My partner refuse to share my religious beliefs
24. - It is difficult for me to share religious activities
25. My partner doesn't respect my religious beliefs

Part 3. Parent Role Quality

Parent Role Rewards.

When you think about yourself as a parent, how much, if at all, is each of the following items a reward for you: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely?. We'd like to think about how it is now. We're not asking how you **wish** it were, but how it **actually** is.

No at all	*Somewhat*	*Considerably*	*Extremely*
1	2	3	4

1. I am pleased with my children's successes and accomplishments
2. I help my children
3. My children show love to me
4. My children accept my opinions
5. I feel proud of how they are turning out
6. I like the kind of people they are
7. I talk my problems with my
8. I share interest or activities with them
9. My children for advice
10. I am a very important for my children
11. My children give me support
12. My children give meanings to my life

13. I have a lot of thinks in common with my children's
14. My children get along well
15. My children make me change for the better
16. I share religious activities with my children

Parent Role Concerns.

When you think about yourself as a parent, how much, if at all, is each of the following items a concern for you: (1) Not at all, (2) Somewhat, (3) Considerably, or (4) Extremely?. We'd like you to think about how it is now.

	No at all	*Somewhat*	*Considerably*	*Extremely*
	1	2	3	4

1. We have financial strain because of the children
2. I feel I have to do the children
3. I feel tied down because of the children
4. My children don't get along well
5. My children evade their responsibilities
6. My children impose great demands and responsibilities
7. I am worried about my children's adolescence
8. I am not sure I am doing the right thing for them
9. My children find it difficult to express their love and appreciation to me
10. I have problems with my children's educational/school
11. I am disappointed with my children personality
12. I am not having any time for myself because of the children
13. I have problems to control my children
14. My children need me less as they grow
15. I have too many arguments and conflicts with them
16. My children interfere in the relationship with my partner
17. My children are unhappy

18. Please, indicate if you participate in activities such as (neighbor hood association, parents and teachers associations)
_____
_____
_____
_____
_____

20. Are you at present taking any courses or workshops to improve your professional status?

Yes____ Describe_____ Hours per week_____

No____

21. I would have to evaluate your wellbeing or satisfactions in the last 12-month. How do you?

Not Satisfactory_____ Very satisfactory_____

Work-Family Relationships Scale:

	No at all 1	*Somewhat* 2	*Considerably* 3	*Extremely* 4
1. The achievements in my job help me have a better relationship with my partner				
2. When I get home from work I often do not have the energy to be a good parent				
3. Worries about my job are interfering with my relationship with my partner				
4. I have learned things in my works that help me be a better mother				
5. My working hours interfere with the amount of time I spend with my child(ren)				
6. My job a let me make new friends				
7. After work I am often too tired to do others activities with my partner				
8. My job interferes with setting things done around the house				
9. Having a job makes it easier for me to get my household chores done				
10. The amount of time I spend working interferes with my free time				
11. When I get home from my work, I do not have the energy to do work around the house				
12. Because I am often tired after work, I don't see friends as much as I would like				

CHECKLIST OF RESPONSIBILITIES IN THE HOME

Instructions:

Please tic the box that relates to the way you usually organize things in your home.

	Wife Usually	Wife Always	Equally	Husband Usually	Husband Always	Others
Management						
1. Plan meal	( )	( )	( )	( )	( )	( )
2. Make grocery list						
3. Make medical appointments						
4. Take money decisions						
5. Decide about children's education issues (school achievement, demands)						
6. Plan Weekends and holidays						
Tasks						
1. Do grocery shopping						
2. Prepare breakfast, lunch and dinner						
3. Do laundry						
4. Clean kitchen						
5. Do the washing up						
6. Tidy up home						
7. Clean home						
8. Do ironing						
9. Clean bathrooms						
10.Car maintenance						
11.Do household repairs						
12.Pay bills						
13.Take care of pets						
14.Take children to medical, dentist, etc. Appointments						
15.Attendance school appointments						
16.Organize birthday parties						
17.Organize parties at home						
18.Organize friend's dinners						
19.Check children's homework						
20.Check children study for exams						
21.Make sure children study for exams						
22.Punish children for misbehaviour						
23.Reinforcement of children's good behaviours						
24.Prepare children's school lunch						
25.Do the garden						
26.Other tasks (describe) _____						

Is there anybody else who contributes to house chores? (e.g.. relatives, younger children, maid, etc)._____

THANKS FOR YOUR COLLABORATION!!!

APPENDIX 5

PREDICTIVE VALIDITY

Table 3.1: Role Quality Scales. First version.

Variable	Job Concern	Partner concern	Mother concern	Job Reward
GHQ	.398***	.436***	.261**	-
Self perception of physical health	-.238**	-	-.236**	
Morbidity indicators:			-	-
Stay in bed	.198*	-	-	-
Medical consultation	-	-	-	-.207*
Psychological consultation	-	-	-	-.307***

* p < .05 ** p< .01 *** p< .001

Table 3.2: Role Quality Scales. Second version.

	r					
Variable	Job Reward	Job Concern	Partner Reward	Partner Concern	Mother Reward	Mother Concern
Self perception of physical health	.261***	-.201***	.192 ***	-.241***	-	-.154**
Well being	.346 ***	-.299 ***	.361***	-.400***	.235***	-.286***
Symptoms report	-.174***	.293***	-.184***	.310***	-	.270***
Depression	-.387***	.367***	.303***	.472***	-	.419 ***
Self-esteem	.230 ***	-	.287 ***	-	.344***	-
Anxiety	-	.147 **	-	-	-	.119 *

* p < .05 ** p< .01 *** p< .001

Table 3.3: Social Support Questionnaire

Variable	r Social Support
Total GHQ	-.351**
Dimension of GHQ	
Anxiety	-.315**
Social dysfunction	-.384 ***
Depression	-.289 **
Perception of physical health	.246**

* p < .05 ** p< .01 *** p< .001

Table 3.4: Social Integration and emotional Support

Variable	r Social Integration	Emotional Support
Self perception of physical health	.204**	.138**
Anxiety	-	-.102*
Depression	-.359**	-.359**
Symptoms Reports	-.173**	-.218**
Self-esteem	.225**	.151**
Well-being	.234**	.268**

* p < .05 ** p< .01 *** p< .001

Table 3.5: Work-family Relationships Questionnaire

Variable	r Satisfaction	Interferences
Anxiety	-.168 p<.001	
Depression		-.140 p<.004
Well being		-.284 p<.001
Self-esteem		-.162 p<.001

* p < .05 ** p< .01 *** p< .001

Table 3.6: Home responsibilities Questionnaire

Variable	r Management	Task
Anxiety	.135 p<.006	.118 p<.01
Depression	.125 p<.01	.142 p<.004

* p < .05 ** p< .01 *** p< .001

APPENDIX 6

ROLE QUALITY SCALES

Factor structure and loadings for Job Reward Analysis Factor

Factors	F1	F2	F3	F4
Factor 1 Supervisor Support				
6.I like my Supervisor.	0.781			
28.My supervisor pays attention to what I.	0.779			
10.My supervisor respects my abilities.	0.722			
20.My supervisor is concerned about the wellbeing of those under him her.	0.707			
3. I recognition set and appreciation in my job.	0.512			
1. My schedule fits my needs.	0.401			
Factor 2 Job Control (Decision authority / Skill discretion)				
11. I get a feeling of achievement and improvement in my job.		0.692		
8. I do a variety of stimulating task.		0.687		
7. I feel competent and I achieve my objectives.		0.606		
18. I help others to develop.		0.654		
9. I have the opportunity for learning new things.		0.572		
21. My work and my interest agree.		0.521		
17. My job fits my skills.		0.512		
29. I can make decisions regarding my work.		0.472		
16. I can work on my own.		0.472		
26. I have a challenging or stimulating work.		0.403		
24. I have the authority needed to get my job done.		0.266		
Factor 3 Satisfaction with the salary/promotion and recognition				
22. I am satisfied with my income.			0.811	
15. I am making good money compared with others people in my field.			0.699	
25. I have the opportunities for advancement			0.477	
23. I have good support available			0.425	
12. The physical environment at work is appropriate			0.343	
27. My job offers benefits like paid sick leave, etc.			0.383	
Factor 4 Co-workers support and helping others				
4. My co-workers are pleasant people				0.688
30. My co-workers are supportive				0.686
14. I have friend among my co-workers				0.680
19. I am able to work as part of a team or group				0.510
13. It is exciting to go to work				0.477
5. I help others, I feel necessary				0.443

Factor structure and loading for Job Concern Analysis Factor

Factors	F1	F2	F3	F4
Factor 1 Overload				
5. I have to juggle several tasks or duties at the same time.	0.738			
22.The volume of work is exhausting.	0.737			
1. I have too much to do.	0.691			
16.I have to do tasks I don't feel should be a part of my job.	0.571			
3. There are conflicts between my work and my others responsibilities.	0.577			
26.I have to deal with emotionally difficult situations.	0.490			
24.I have difficulties to control the activities or task that I have to get done.	0.433			
Factor 2 Monotony				
9. My job is just routine.		0.763		
12.My work is dull, monotonous or lacks variety.		0.752		
8. My job doesn't require my skills.		0.672		
19. My job is unchallenging.		0.517		
Factor 3 Dissatisfaction with the salary / lack of recognition and promotion.				
17. I have a little chance for the advancement.			0.719	
25. I don't have opportunities for promotion.			0.686	
13. I am not satisfied with my salary.			0.673	
23. I make less money than other people do in my line of work.			0.628	
6. I don't have the recognition I deserve.			0.531	
Factor 4 Job conditions				
20. I dislike the people I work with.				0.576
15. I have to do things against my better judgment.				0.456
11. I am exposed to illness or injury in my work.				0.456
10. The physical conditions of my job are inadequate				0.451
27. I have difficulties to control the people I work with.				0.435
14 I face discrimination at my job because of my sex.				0.405

Factor structure and loadings for Partner Reward Analysis Factor

Factors	F1	F2	F3
Factor 1 Marital satisfaction and Compatibility			
19.There is good communication between us.	0.787		
6.There is physical affection between us.	0.783		
9.Our sexual relationship is good.	0.763		
2.There are physical attraction between my partner and myself.	0.762		
12.I enjoy doing things for him.	0.755		
22.I have a good friend in my partner.	0.737		
10.My partner backs me up in what I want to do.	0.674		
1.My partner is my friend.	0.673		
3.My partner takes care me.	0.672		
8.I can talk over problems with my partner.	0. 670		
13.My partner thinks I am somebody special.	0.666		
14.My partner provides for my needs.	0.659		
4.I have a partner who is easy to get along with.	0.659		
11.My partner provides for my needs.	0.595		
5.My partner is proud of me.	0.575		
7.My partner is a good father.	0.548		
18.My partner finds me physically attractive.	0.545		
16.My partner's personality agrees with mine.	0.540		
21.My partner and I enjoy.	0.502		
15.My partner shares family expenses on an equal basis.	0.488		
23.We are able to disagree without threatening the relationship.	0.455		
Factor 2 Partner support			
31.My partner takes over your house chores when I have a lot of work.		0.806	
17.My partner does his fair share of home.		0.757	
30.My partner understands when I have to work out of my schedule.		0.644	
29.My partner encourages me to make the most of opportunities at work.		0.512	
24.I have good relationship with my partner family.		0.351	
20.My partner wants children.		0.337	
Factor 3 Religious beliefs			
26.My partner shares my religious beliefs			0.852
27.My partner and I participate together in religious practices.			0.748
28.My partner supports my religious beliefs			0.746

Factor structure and loadings for Partner Concerns Analysis Factor

ITEM	F1	F2	F3
Factor 1 Marital dissatisfaction, lack of support and communications			
18.My partner and I have problems setting along.	0.829		
19.I find difficult to have my partner support.	0.827		
2.The communication is poor between my partner and I.	0.808		
10.There is a lack of companionship between us.	0.791		
1.I feel my partner as distant, inaccessible.	0.741		
20.We have problems over the home.	0.678		
21.We have conflicts over the children.	0.673		
5.I am not setting enough appreciation attention than what I can give him.	0.645		
6.We have conflicts because of children.	0.610		
15l argue with my partner.	0.595		
9.We have problems in our sexual relation.	0.588		
17.My partner has emotionally problems	0.570		
11.My partner is seldom at home.	0.540		
7.My partner emotionally demands are greater than what I can give me.	0.438		
16.I argue with my partner is very absorbing.	0.331		
Factor 2 Partner Job			
12.My partner depends on me financially.		0.737	
13.My partner has job instability.		0.723	
22.My partner's salary is not enough.		0.641	
8.My partner has problems in his job or profession		0.638	
3.We argue over economic difficulties.		0.344	
14.My partner has high job demands.		0.318	
Factor 3 Religious beliefs			
23. My partner does not share my religious beliefs.			0.816
24. My partner and I do not share religious activities.			0.747
25.My partner doesn't support my religious beliefs.			0.726

Factor structure and loadings for Mother Rewards Analysis Factor

Factors	F1	F2	F3
Factor 1 Satisfaction			
6. I like the kind of people they are.	0.757		
1. I am pleased with my children's successes and accomplishments.	0.738		
5. I feel proud of how they are turning out	0.722		
12. My children give meanings to my life.	0.621		
2. I help my children.	0.621		
3. My children show love to me.	0.601		
10. I am an important person for my children.	0.493		
15.My children make me change for the better.	0.425		
Factor 2 Support and Communication			
7. I talk my problems with my children		0.827	
9. My children for advice.		0.809	
11.My children help me.		0.620	
14.My children get along well.		0.461	
4. Mi opinión es tomada en cuenta		0.393	
Factor 3 Interaction			
13. I have a lot of things in common with my children.			0.668
16. I share religious activities with my children.			0.620
8. I share interest or activities with them.			0.499

Factor structure and loadings for Mother Concerns Analysis Factor

Factors	F1	F2	F3
Factor 1 Conflicts, dissatisfactions			
11.I am disappointed with my children personality.	0.734		
15I have too many arguments and conflicts with them.	0.727		
4.My children don't get along well.	0.717		
9.My children find it difficult to express their love and appreciation to me.	0.680		
10.I have problems with my children's educational/school.	0.619		
17.My children are unhappy.	0.548		
13.I have problem to control my children.	0.537		
5.My children evade their responsibilities.	0.513		
8.I am not sure I am doing the right thing for them.	0.507		
Factor 2 Demands and interferences.			
3.I feel tied down because of the children.		0.791	
12.I am not having any time for myself because of the children.		0.698	
6.My children impose great demands and responsibilities.		0.647	
16.My children interfere in the relationship with my partner.		0.595	
Factor 3 Economical strain, adolescent period			
1.We have financial strain because of the children.			0.619
2.I feel I have to do the children.			0.597
7.I am worried about my children's adolescence.			0.549

SOCIAL SUPPORT QUESTIONNAIRE (Study 1)
Factor structure and loadings for social support analysis factor

Factors	F1	F2	F3	F4	F5	F6
Factor 1: Family support						
10. I can resort to my parents whenever I have a problem.	.788					
5. My family gives me satisfactions and a sense of security.	.752					
1. When I was a child I received a lot of support from my parents.	.728					
13. My brothers and/or sisters give me support.	.694					
Factor 2: Partner support						
8. I have a good relationship at present with my husband/couple.		.892				
14. My husband/partner is supportive of me.		.891				
4. I have someone I trust in		.456				
Factor 3: Perception of Availability of General support						
16. I like to work alone.			-.809			
18. I prefer to work in a team.			.805			
3. I ask for other persons' support.			.507			
Factor 4: Religious and groups support						
6. Persons should count on religious orientation for support and peace of mind.				.725		
2. I am a member of a social group (religious group, clubs, teams, etc.).				.625		
7. When I feel unhappy or stressed out there are people I can go to receive support.				.572		
Factor 5: Job support						
17. I have a good relationship with my co-workers.					.798	
15. I have a good relationship with my supervisor at work.					.792	
9. When I have problems I keep them to myself.					.708	
Factor 6: Lack of support						
11. I feel lonely, as if I had no-one close by.						.548

WORK-FAMILY RELATIONSHIP QUESTIONNAIRE
Factor structure and loadings Work-Family Relationship analysis factor

Factors	F1	F2
Factor 1: Interferences		
11.When I get home from my work, I do not have the energy to do work around the house.	0.827	
8.My job interferes with setting things done around the house.	0.817	
7.After work I am often too tired to do others activities with my partner.	0.733	
12.Because I am often tired after work, I don't see friends as much as I would like.	0.684	
3.Worries about my job are interfering with my relationship with my partner.	0.598	
2.When I get home from work I often do not have the energy to be a good parent.	0.560	
10.The amount of time I spend working interferes with my free time.	0.547	
5.My working hours interfere with the amount of time I spend with my child(ren).	0.516	
9.Having a job makes it easier for me to get my household chores done.	0.408	
Factor 2: Satisfactions		
4. I have learned things in my works that help me be a better mother.		0.805
1. The achievements in my job helps me have a better relationship with my partner.		0.700
6. My job a let me make new friends.		0.613

DISTRIBUTION OF HOUSEHOLD RESPONSIBILITIES QUESTIONNAIRE

Factor structure and loadings of the management of household responsibilities analysis factor

Factors	F1	F2
Factor 1 General Management and Decisions		
5 Decide about children's education issues.	0.861	
4. Take money decisions.	0.814	
6. Decide about the discipline at home.	0.812	
7. Plan Weekends and holidays	0.750	
3. Make medical appointments.	0.443	
Factor 2 Management of the meals		
1. Plan meal.		0.846
2. Make grocery list.		0.840

Factor structure and loadings for household responsibility tasks analysis factor

Factors	F1	F2	F3	F4
Factor 1 Tasks related with home				
3. Clean home.	0.86260			
15. Clean bathrooms.	0.84517			
14. Do ironing.	0.82367			
11. Clean kitchen	0.79857			
12. Do the washing up	0.72316			
10. Do laundry	0.64351			
27. Prepare children's school lunch	0.41577			
Factor 2 Children Care				
25. Check children study for exams		0.82102		
24. Check children's hygiene		0.77072		
21. Attendance school appointments		0.75553		
23. Check children's homework		0.69572		
20. Take children to medical, dentist appointments		0.69356		
26. Punish or reinforcement of children for behavior		0.60502		
22. Organize birthday parties		0.57069		
29. Play games with children		0.50913		
Factor 3 Others tasks				
9. Prepare the meals			0.69670	
28. Do the garden			0.67403	
19. Take care of pets			0.57703	
Factor 4 Home Maintenance				
17. Do household repairs				0.70167
16. Car maintenance				0.70117
18. Pay bills				0.67751
8. Do grocery shopping				0.50547

APPENDIX 7

UNIVERSIDAD SIMON BOLIVAR
PROYECTO: MUJER-TRABAJO-SALUD

CODIGO:_____

DATOS SOBRE SU SALUD:

1. ¿Cómo percibe su estado de salud en general?
   Muy deteriorado____ Deteriorado____ Bueno____ Muy Bueno____ Excelente___

2. ¿Cómo considera su estado de salud en comparación con otras personas de su misma edad?
   Mejor____ Igual____ Peor____

3. ¿Cómo considera sus condiciones de salud en comparación a un año atras?
   Mejor____ Igual____ Peor____

4. ¿Cómo considera sus condiciones de salud en comparación a cinco años atras?
   Mejor____ Igual____ Peor____

5. Si usted tuviera que evaluar su nivel de bienestar o satisfacción con su vida en los últimos doce meses. Cómo lo calificaría en base a la siguiente escala?

Nada Satisfactorio Muy Satisfactorio

0 1 2 3 4 5 6 7 8 9 10

6. A continuación se presenta un listado de diferentes reacciones que pueden aparecer en un momento dado, Por favor, responda si ha experimentado o no estas reacciones **en los últimos 6 meses.**

	Ausencia	**Presencia**
1. Perder el hilo de las ideas	1	2
2. Frecuentes ganas de orinar	1	2
3. Escalofríos o calores repentinos	1	2
4. Manos o pies frios	1	2
5. Dolores de cabeza	1	2
6. Tendencia a los calambres	1	2
7. Sequedad de la boca	1	2
8. Respiración entrecortada	1	2
9. Sentir tensión muscular	1	2
10.Excesiva sudoración	1	2
11.Olvidar, no saber donde se ha puesto algo	1	2
12.Taquicardia, aceleración del corazón	1	2
13.Dificultades para concentrarse	1	2

7. ¿Ha consultado algún(os) médico(s) en el último año?
   Si____ No____ ¿Cuántas veces?_____

8. ¿Ha consultado a profesionales de la psicología o psiquiatría en el último año?
   Si____ No____ ¿Cuántas veces?_____

9. ¿Ha estado hospitalizada(o) en el último año?
   Si____ No____ ¿Cuántas veces?_____ Por qué?_____

10. ¿Cuántos días ha faltado al trabajo por motivos de salud en los últimos 6 meses?___

11.¿Cuántos días ha permanecido en cama por motivos de salud en los últimos 6 meses?_____

12. ¿Usted fuma? Si____ No____ ¿Cuántos cigarrillos al día?_____

13.. ¿Al fumar aspira? Si____ No____

14.¿Ha fumado en el pasado? Si____ No____ ¿Cuándo dejó de fumar?_____

15. ¿Con frecuencia está en lugares donde otros fuman? Si____ No____

16. ¿Usted hace algún deporte? Si____ No____
¿Cuál y con qué frecuencia?_____

17.¿Usted consume bebidas alcohólicas? Si____ No____ Si la respuesta es SI; ¿Cuántos tragos consume por semana aproximadamente? 1 - 5____ 6 - 10____ 11 - 15____ Más de 15____

18.¿Ha tenido problemas de sueño en los últimos 6 meses,(insomnio, pesadillas, etc.)? Si____ No____ ¿Cuáles?_____

19.¿Cuántas horas duerme normalmente? Menos de 4_____ 4-6_____ 7-9_____ Más de 9_____

20. Han ocurrido cambios importantes, en el último año en su:
Rol Laboral No_____ Si _____ Explique _____
Rol de Pareja No _____ Si _____ Explique _____
Rol de Madre No _____ Si _____ Explique _____

VARIABLES PERSONALES

A continuación encontrará una lista de expresiones que las personas suelen usar para describirse a sí mismas. Por favor trace un círculo alrededor del número que mejor indique como **se siente ahora**

	No, Nunca	Poco	Bastante	Mucho
1. Me siento calmada	1	2	3	4
2. Me siento segura	1	2	3	4
3. Estoy tensa	1	2	3	4
4. Estoy contrariada	1	2	3	4
5. Estoy a gusto	1	2	3	4
6. Me siento alterada	1	2	3	4
7. Estoy preocupada por un posible contratiempo	1	2	3	4
8. Me siento descansada	1	2	3	4
9. Me siento ansiosa	1	2	3	4
10. Me siento confortable	1	2	3	4
11. Tengo confianza en mi misma	1	2	3	4
12. Me siento nerviosa	1	2	3	4
13. Me siento agitada	1	2	3	4
14. Me siento irritable	1	2	3	4
15. Me siento reposada	1	2	3	4
16. Me siento satisfecha	1	2	3	4
17. Estoy preocupada	1	2	3	4
18. Me siento muy excitada y aturdida	1	2	3	4
19. Me siento alegre	1	2	3	4

20. Me siento bien	1	2	3	4
21.Tengo pocas ganas de comer	1	2	3	4
22.Me siento sola(o)	1	2	3	4
23.Siento que tengo poco interés por las cosas	1	2	3	4
24.Tengo problemas para quedarme dormida	1	2	3	4
25.Lloro fácilmente	1	2	3	4
26.Me siento sin energía	1	2	3	4
27.No espero nada del futuro	1	2	3	4
28.Me siento deprimida e inquieta	1	2	3	4
29.No tengo entusiasmo para emprender proyectos	1	2	3	4
30.Siento que me valoro como persona	1	2	3	4
31.Siento que tengo cualidades	1	2	3	4
32.Tengo una actitud positiva conmigo misma	1	2	3	4
33.Estoy satisfecha conmigo misma	1	2	3	4
34.Mucha gente piensa que yo tengo buen sentido del humor	1	2	3	4
35.La gente que me conoce piensa muy bien de mi	1	2	3	4

!!!!MUCHAS GRACIAS POR SU COLABORACION!!!!

UNIVERSIDAD SIMON BOLIVAR
PROYECT: WOMEN, WORK and HEALTH

CODE NUMBER: _____

HEALTH

1. What do you think of your general health?
Very poor____ Poor ____ Good____ Very good____ Excellent____

2. What do you think of your general health compared to others in your age group?
Better____ Some____ Worse____

3. What do you think of your health conditions compared to 1 year ago?
Better____ Some____ Worse____

4. What do you think of your health conditions compared to 5 years ago?
Better____ Some____ Worse____

5. How would you evaluate your well-being or life satisfaction in the last 12 months?

Not Satisfactory Very satisfactory

0 1 2 3 4 5 6 7 8 9 10

6. The following physical and/or mental reactions can happen at any given moment.

Please answer if you have had any of these **in the last six months**

	No	**Yes**
1. Loose the train of thought	1	2
2. Stomach cramps, Heartburns, indigestion	1	2
3. Chill or heat waves	1	2
4. Cold feet and hand	1	2
5. Headaches	1	2

6. Tendency to cramps	1	2
7. Dry mouth	1	2
8. Shortness breath	1	2
9. Muscular tension (nape, shoulders, back)	1	2
10.Excessive sweating	1	2
11.Forgetfullness	1	2
12.Tachicardia, palpitation	1	2
13. Difficulty to concentrate	1	2
14. Others	1	2

7. Have you visited a doctor in the last year?
   Yes____ No____ How many times? _____

8. Have you visited a psychologist or psychiatrist in the last year?
   Yes____ No____ How many times? _____

9. Have you been hospitalized the last year?
   Yes____ No____ How many times? _____ Why? _____

10. How many days have you missed work, for health reasons, in the last 6 months? _____

11.How many days have you stayed in bed, for health reasons, in?
the last 6 months?_____

12. Do you smoke? Yes____ No____ How many cigarettes a day?_____

13. Do you aspire the smoke? Yes____ No____

14. Have you smoked in the past? Yes____ No____ When did you stop smoking?_____

15. Are you frequently in places where there are others smoking Yes____ No____

16. Do you practice any sport? Yes____ No____
   Which one and how often?_____

17. Do you drink alcoholic beverages? Yes____ No____ If you answer is Yes, How many drinks do you have during a week approximately? 1 - 5____ 6 - 10____ 11 - 15____ More than 15____

18. Have you had sleep problems in the last 6 months (insomnia, nightmares, etc)?
Yes____ No____ What kind?_____

19. How many hours do you normally sleep? Less than 4____ 4-6____ 7-9____
More than 9____

20. Had you any relevant change during the last year in your:
Job Role No _____ Yes ____ Explain _____
Partner Role No _____ Yes ____ Explain _____
Parent Role No _____ Yes ____ Explain _____

PERSONAL VARIABLES

Here you will find a list of expressions that people used to describe themselves. Please make a circle around the number that best expresses how you feel now

1. I feel calm	1	2	3	4
2. I feel secure	1	2	3	4
3. I feel tense	1	2	3	4
4. I feel confused	1	2	3	4
5. I feel fine	1	2	3	4
6. I am worry about a possible problem	1	2	3	4
7. I feel rested	1	2	3	4
8. I feel anxious	1	2	3	4
9. I feel comfortable	1	2	3	4
10. I feel self-confident	1	2	3	4
11. I feel nervous	1	2	3	4
12. I feel stressed	1	2	3	4
13. I feel irritable	1	2	3	4
14. I feel relaxed	1	2	3	4
15. I feel satisfied	1	2	3	4

16. I am worried	1	2	3	4
17. I feel very excited and confused	1	2	3	4
18. I feel happy	1	2	3	4
19. I feel okay	1	2	3	4
20. I have little enthusiasm to undertake anything	1	2	3	4
21. I have poor appetite?	1	2	3	4
22. Felt lonely?	1	2	3	4
23. Felt bored or had very little interest to do things?	1	2	3	4
24. Had disturbances with sleeping or keeping to do things?	1	2	3	4
25. Have you found it easy to cry or felt like crying?	1	2	3	4
26. Felt depressed or restless?	1	2	3	4
27. Felt weak or without energy?	1	2	3	4
28. Felt hopeless about the future	1	2	3	4
29. I feel that I am a valuable person	1	2	3	4
30. I feel that I have many good qualities	1	2	3	4
31. I feel that I do not have much to be proud of	1	2	3	4
32. I have a positive attitude about myself	1	2	3	4
33. I am generally satisfied with myself	1	2	3	4
34. Most people that know me well think highly of me	1	2	3	4
35. Most people think I have a good sense of humor	1	2	3	4

¡¡¡¡THANKS FOR YOUR COLLABORATION!!!!

APPENDIX 8

Table 4.3. Intercorrelation between measures

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
1 Age	-																												
2 Education	-.077	-																											
3 N° Children	.308	-.251**	-																										
4 Children<7years	-.541**	.266*	.063	-																									
5 Partner Role	-.006	.198*	.324**	.227*	-																								
6 Mother Role	.294**	-.263**	.717**	-.134	.288**	-																							
7 Self-perception of Health	.148	-.091	-.106	.266*	-.033	-.037	-																						
8 Medical. Appointments	-.170	.114	-.109	-.022	.022	-0.83	-.374**	-																					
9 Psychological Appointments	.017	.158	.020	-.125	.084	.024	.035	.025	-																				
10 Hospitalizations	-.133	-.028	-.142	.147	.136	-.039	.000	.500**	.004	-																			
11 Work absenteeism	-.072	-.024	-.047	-.059	.135	.038	-.058	.296**	-.018	.514**	-																		
12 Stay in bed	-.197*	.024	-.011	.060	.161	.102	-.243**	.642**	-.032	.440**	.581**	-																	
13 Somatic	-.068	.066	.163	-.006	.223*	.061	-.533**	.415**	-.038	.107	.255*	.216*	-																
14 Anxiety	-.221*	.079	.026	.035	.177*	-.095	-.384**	.294**	-.030	.114	.230*	.273**	.635**	-															
15 Social cognitive	-.198*	.108	-.034	.207*	.088	-.156	-.424**	.299**	-.002	.079	.241*	.033	.622**	.554**	-														
16 Depression	-.177	.077	-.059	.121	-.003	-.171	-.282**	.383**	.230*	.127	.162	.111	.341**	.378**	.561**	-													
17 Total GHQ	-.199*	.098	.057	.211*	.182*	-.082	-.519**	.427**	.014	.131	.283**	.229*	.866**	.865**	.810**	.605**	-												
18 Family Support	.230*	.000	.007	.163	.040	.060	.292**	-.109	.011	.004	.101	-.052	-.293**	-.345**	-.341**	-.240*	-.383**	-											
19 Partner Support	.124	.069	-.074	-.249*	.229*	.004	.380**	-.149	.065	.025	-.039	-.118	-.261**	-.365**	-.228*	-.151	-.328**	.482**	-										
20 General Support	.056	.188*	.172	-.227	.217*	.194*	-.055	.041	.071	-.034	.077	.016	.140	.087	-.016	.030	.093	.126	.093	-									
21 Groups/Religious S.	.095	.095	-.032	.159	.128	-.026	.172	-.057	.146	-.113	-.107	-.005	-.132	-.136	-.250**	-.211*	-.205*	.329**	.160	.224*	-								
22 Job Support	.041	-.031	-.017	.013	.113	.131	.255**	-.187	.068	-.025	.010	-.239*	-.191*	-.302**	-.177	-.164	-.272**	.265**	.236*	.092	.099	-							
23 Total Social Support	-.036	.153	.134	-.051	.531**	.155	.263**	-.086	.133	.041	.066	-.007	-.089	-.199*	-.198*	-.147	-.191*	.651**	.646**	.406**	.470**	.325**	-						
24 Job Rewards	.032	-.098	.012	.071	.069	.006	.097	-.191*	-.301	-.036	.041	-.168	-.041	-.067	-.074	-.084	-.077	.042	.052	.114	.052	.144	.207*	-					
25 Job Concerns	-.110	.189*	.048	-.032	-.035	-.008	-.228*	.183	-.052	-.001	.016	.221*	.232*	.476**	.248**	.275**	.401**	-.299**	-.369**	.045	.000	-.487**	-.227*	-.161	-				
26 Partner Rewards	-.044	-.012	-.023	.053	-.027	.027	.188	-.203	-.237	-.235	-.197	-.120	-.177	-.208	-.104	-.037	-.193	.063	.471**	-.016	-.025	.087	.164	.235	.059	-			
27 Partner Concerns	-.122	0.162	.020	.273*	.121	-.061	-.248	.194	-.116	.124	.239	.213	.314*	.479**	.294*	.271*	.447**	-.252	-.646**	.092	-.083	-.386**	-.521**	.050	.446**	-.213	-		
28 Mother Rewards	.018	.210*	.089	.146	.050	.056	-.050	-.008	-.261**	-.174	-.049	.034	-.094	-.077	-.044	-.025	-.084	.081	.139	.217*	.162	.055	.255**	.375**	.154	.459**	.063	-	
29 Mother Concerns	.005	.053	.127	.062	-.137	.020	-.230*	.022	-.084	-.122	-.020	.113	.145	.336*	.133	.133	.248**	-.224*	-.414**	.003	-.075	-.499**	-.269**	-.033	.585**	-.111	.622**	.190*	-

* p< .05 ** p< .01

APPENDIX 9

5.6. : Intercorrelation of measures

BLES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
	-																																					
ıtion	.043	-																																				
children	.435**	-.388**	-																																			
en<7years	-.433**	-.084	.074	-																																		
r Role	.113*	.377	.188**	-.051	-																																	
r Role	.232**	-.151**	.447**	.354**	.186**	-																																
Role	-.341**	.207**	-.236**	.188**	-.208**	-.121*	-																															
Roles	.172***	-.063	.477**	.325**	.735**	.49**	.117*	-																														
ollar	-.147***	-.577**	.311**	.110*	-.087	.117*	.098*	.096	-																													
cal	-.072	-.388**	.021	.060	-.051	.056	.151**	.091	-.178**	-																												
ol teacher	-.197**	.032	-.181**	.001	-.068	-.163	.102*	-.143**	-.119*	-.185**	-																											
ssional	.100*	.776**	-.224**	-.035	.033	-.089	.284**	.014	-.333**	-.516**	-.331**	-																										
ewife	.341**	-.207**	.236**	-.118*	.208**	.121*	-1.00**	-.117*	-.098*	-.151**	-.102*	-.284**	-																									
erception of Health	-.100	.248**	-.142**	-.132*	-.042	-.156**	.093	-.159**	-.175**	-.075	.066	.197***	-.093	-																								
cal Appointments	-.032	-.011	-.012	-.122*	.052	-.024	-.010	-.001	.052	.009	-.011	-.033	.010	-.093	-																							
ıological	.010	.078	-.006	-.025	.008	-.002	.035	.022	-.050	-.049	.030	.071	-.035	.000	.096	-																						
ıents																																						
Absenteeism	.015	.013	.095	.014	.023	.023	-	.038	.025	.030	-.038	-.014	-	-.078	.142**	0.78	-																					
n bed	.029	.065	-.056	-.037	.022	.052	-.032	.026	-.069	-.004	-.007	.036	.032	-.137**	.178**	.152**	.381*	-																				
ty	.080	-.009	.135**	.002	.243**	.154**	.112*	.358**	.042	.018	-.080	.075	-.112*	-.165**	.080	.034	.065	104*	-																			
steem	-.043	.118*	-.098*	.015	-.023	-.104*	.148**	-.045	-.089	.031	.092	.046	-.148**	.230**	-.082	-.134**	-.009	-.027	.011	-																		
ssion	-.034	-.135**	.023	.125*	-.095	.073	-.014	.032	.098*	.054	-.130**	-.043	.014	-.387**	.121*	.123*	.033	.157**	.448**	-.295**	-																	
ol consumption	.047	.171**	-.056	-.025-	-.132**	-.078	.121*	-.092	-.176**	.048	.006	.122*	-.121*	.159**	-.054	.039	-.044	-.046	-.035	.077	-.022	-															
ing	-.016	-.084	.007	.040	-.066	.007	.101*	.014	.052	.078	-.021	-.036	-.101*	.034	-.012	.014	.030	.025	.032	.004	-.009	.004	-														
ing problems	.025	.027	-.075	-.038	-.083	.049	-.001	-.053	-.039	.018	-.119*	.068	.001	-.250**	.068	.079	-.017	.102*	.114*	-.089	.411*	.019	.050	-													
eing	.121*	.146**	.083	-.162**	.150**	-.033	-.024	.065	-.103*	-.070	.062	.067	.024	.286**	.050	-.056	.083	.043	-.074	.305**	-.407**	-.032	-.019	-.236**	-												
toms Report	-.062	-.024	-.035	-.015	-.023	.092	-.033	.019	.005	.000	-.029	-.015	.033	-.360**	.108	-.004	.031	.168**	.182**	-.149**	.444**	.109*	.006	.347**	-.271**	-											
Integration	.018	.294**	-.119*	-.059	.021	-.150**	.126**	-.051	.247**	-.107	.117*	.223**	.126**	.204**	-.002	-.014	.033	-.050	-.065	.225**	-.359**	.146**	.002	-.164**	.234**	-.173**	-										
onal Support	.067	.097*	-.053	-.127*	.058	-.086	-.061	-.050	-.038	-.124*	.024	.079	.061	.138**	-.006	-.035	.024	-.105	-.102*	.151**	-.359**	.026	.008	-.157**	.268**	-.218**	.334**	-									
responsibilities M	-.177**	.023	-.037	.146**	-.204**	.058	.595**	.117*	.089	.163**	.001	.130**	-.595**	.024	-.055	.050	-.022	-.007	.135**	-.005	.118*	.026	.080	.030	-.101*	.032	-.059	-.149**	-								
responsibilities T	-.181**	-.110*	-.102*	.131*	-.213**	-.004	.471**	.040	.085	.275**	.047	-.066	-.411**	-.072	-.003	-.006	-.056	-.001	.125*	.029	.142**	.022	.078	.026	-.071	-.001	-.093	-.129**	.649**	-							
actions	-.059	-.067	.035	.072	-.097*	.012	-.072	-.056	.013	.026	-.040	-.051	-	-.107*	-.015	-.021	-.045	.033	-.168**	-.267**	.139**	.004	.010	.099*	-.210**	.144**	-.235**	-.245**	.040	.008	-						
rences	-.042	.118*	.009	.083	-.020	-.010	-.024	.008	.065	-.208**	-.166**	.220**	-	-.140**	-.006	.060	-.082	.085	.058	-.162**	.389**	-.039	-.070	.225*	-.284**	.270**	-.196**	-.245**	.081	-.031	.194**	-					
wards	.183**	.385**	-.065	-.162**	.094	-.116*	-	-.047	-.418**	-.067	.135**	.242**	-	.261**	-.003	.104*	-.037	.014	.073	.373**	-.231**	.135**	.012	-.096	.346**	-.174**	.374**	.231**	-.100*	-.177**	-.419**	-.150**	-				
oncerns	-.173**	-.174**	.025	.084	-.085	.008	-	-.006	.301**	-.082	-.033	-.097	-	-.201**	-.009	-.070	.001	.001	.147**	-.044	.367**	-.040	.004	.204**	-.299**	.293**	-.208**	-.203**	.070	.057	.197**	.403**	-.505**	-			
r Rewards	-.076**	.266**	-.231**	-.074	.058	-.196**	.043	-.184**	-.202**	-.081	.118	.158**	-.043	-.192**	.031	-.040	.066	.048	.069	.287**	-.303**	-.083	-.085	-.139*	.361**	-.184**	.313**	.331**	-.184**	-.170**	-.332**	-.125*	.268**	-.043	-		
r Concerns	.060	-.119*	.18**	.084	-.041	.140*	.000	.173**	.033	.051	-.104	-.026	.000	-.241**	-.021	.019	-.047	-.039	.111	-.169**	.472**	.165**	.047	.266**	-.400**	.310**	-.249**	-.407**	.183**	.128*	.290**	.311**	-.158*	.24*7*	-.737**	-	
· Rewards	-.060	.160**	-.063	.056	.044	.029	.040	.069	-.100	-.095	.174**	.093	-.040	.079	-.052	-.008	.008	-.016	.119*	.344**	-.106	-.030	-.099	-.107	.235**	-.076	.150*	.207**	-.032	-.050	-.172**	-.085	.196	.047	.376**	-.276**	-
· Concerns	-.032	.026	.043	-.022	-.057	-.053	.092	.001	.043	-.035	-.122*	.131*	-.092	-.154**	.063	.047	.099	.151*	.219**	-.168**	.419**	.041	-.019	.212**	-.286**	.270**	-.236**	-.289**	.168	.106	.097	.400**	-.098	.252**	-.280**	.467**	-.351**	-

05 ** p< .01

APPENDIX 10

Table 6. 4. : Intercorrelation of measures

VARIABLES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51
1 Ages	-																																																		
2 Education	.305**	-																																																	
3 N° of children	.323**	-.283**	-																																																
4 Children >7 years	-.563**	-.194*	.026	-																																															
5 Blue collar	-.227**	-.747**	.326**	.071	-																																														
6 Clerical	-.160	-.160	-.041	.215*	-.327**	-																																													
7 Professional	.350**	.350**	-.235**	-.281**	-.563**	-.563**	-																																												
8 Job T1	-.60	-.060	.070	.078	.050	.050	-.089	-																																											
9 Job T2	.067	.067	-.065	-.014	-.210*	-.058	.218*	-.148	-																																										
10 Partner T1	-.043	-.043	.003	-.049.	-.161	.110	.056	-.059	-.004	-																																								
11 Partner T2	-.189*	-.189*	-.184*	-.001	-.151	.090	.060	-.152	.377**	.115	-																																							
12 Mother T1	.154	.154	.432**	.255**	.098	-.036	-.062	-.025	.093	-.192*	-.092	-																																						
13 Mother T2	-.103	-.103	-.098	.015	-.086	.061	.044	.053	.329**	.080	.523**	-.136	-																																				
14 Self-percept. Health T1	.128	.237**	-.005	-.094	-.181*	-.107	.240**	.039	.067	.067	-.60	-.110	.151	-																																			
15 Self-percept. Health T2	.021	.177*	.026	.020	-.141	.004	.091	.044	-.086	.085	.021	-.051	.107	.267**	-																																		
16 Med. Appointments T1	-.096	-.085	-.021	-.065	.065	-.018	-.083	-.122	-.088	-.054	-.076	-.069	-.106	-.192*	-.103	-																																	
17 Med. Appointments T2	-.215*	-.010	-.051	.058	.072	-.093	.025	-.002	.160	.130	.148	-.154	.238**	-.018	-.089	.213*	-																																	
18 Psych. Appointments T1	.127	.123	.049	-.072	-.098	-.006	.095	.015	-.058	-.114	-.076	-.025	-.048	-.031	-.041	.086	.081	-																																
19 Psy Appointments T2	-.044	.164	-.144	-.073	-.102	-.116	.189*	.021	.209*	.101	-.034	-.223*	.214*	-.028	-.080	.035	.295**	.113	-																															
20 Work absenteeism's T1	-.035	-.056	.091	-.010	.070	.116	-.168	.021	-.124	-.044	-.039	-.054	-.131	-.159	-.064	.393**	.046	.459**	-.063	-																													
21 Work Absenteeism s T2	-.118	-.121	.035	.035	.143	-.046	-.081	.018	-.012	.089	.137	.050	.138	-.159	.084	.069	.254**	-.049	-.050	.002	-																													
22 Stay in Bed T1	-.077	.061	-.094	.009	-.061	.032	.004	-.024	-.100	-.008	-.025	.016	-.095	-.121	-.037	.354**	.062	.642**	-.031	.598**	.014	-																											
23 Stay in Bed T2	-.033	.125	-.081	-.105	-.076	-.087	.152	.033	-.033	.116	.025	-.018	-.045	.002	-.157	-.077	.185*	-.052	-.055	-.019	.417**	.005	-																										
24 Anxiety T1	.103	.070	.021	-.148	-.035	-.089	.101	-.079	.037	.033	.133	.054	.055	-.005	.003	-.042	.064	.160	.086	-.092	.027	.058	.000	-																									
25 Anxiety T2	-.195*	.077	-.203	.058	.045	-.207	.166	-.279**	-.033	-.169	.065	-.033	.026	-.247	-.171	.135	.070	.113	.184*	-.024	.137	.086	.115	.202*	-																								
26 Self-esteem T1	.046	.088	-.025	-.076	-.155	.012	.106	.137	.042	.097	.202*	-.064	.036	.126	.125	-.046	-.050	-.038	-.105	-.010	.042	.000	.013	.282**	-.362**	-																							
27 Self-esteem T2	.080	.162	.047	-.180*	-.185	.013	.134	.010	.134	.1779	.179	-.020	-.016	.117	.125	-.014	-.118	.013	-.085	.000	-.116	.142	-.114	.192*	-.257**	.615**	-																					
28 Depression T1	-.121	-.113	-.125	.044	.164	-.102	-.029	-.078	-.007	-.357**	.053	-.014	-.005	-.309**	-.196*	.150	.116	.304**	.174	.116	.031	.203*	.054	.132	.618**	-.295**	-.304**	-																			
29 Depression T2	-.112	.071	-.112	-.009	.100	-.299	.179*	.023	.042	-.264**	.096	-.004	-.152	-.310**	-.394**	.050	.067	.183*	.121	.053	.038	.143	.138	.098	.471**	-.131	-.210*	.561**	-																		
30 Well-being T1	.239**	.128	.176*	-.166	-.096	-.052	.107	-.037	.048	.214*	-.094	.050	-.132	.222*	.096	.055	-.030	-.013	-.120	.131	-.219*	.117	-.053	.026	-.437**	.239**	.319**	-.396**	-.278**	-																		
31 Well-being T2	-.034	-.214*	.123	-.042	.271**	-.061	-.212*	.119	-.080	.078	-.090	-.085	.025	.124	.249**	.097	-.078	-.109	-.011	.057	-.017	.005	-.182*	-.078	-.155	.022	.124	-.050	-.379**	.199*	-																	
32 Symptoms Report T1	-.177*	.036	-.224*	-.022	-.080	.018	.092	-.064	.130	.084	.082	-.231**	.148	-.235**	-.104	.098	.092	.007	.163	.062	.161	.093	.166	.050	.389**	-.054	.006	.429**	.206*	-.353**	-.026	-																
33 Symptoms ReportT2	-.171	.043	-.203*	-.009	-.051	-.009	.070	-.050	.112	-.021	.164	-.128	.177	-.154	-.166	.031	.149	.133	.172	.142	.100	.168	.123	.131	.313**	-.063	-.227*	.349**	.414**	-.313**	-.272**	.513**	-																
34 Management T1	-.066	-.197*	-.062	.043	.245**	-.087	-.115	.004	-.028	-.544**	-.111	-.009	-.104	-.069	.024	-.055	-.070	.134	-.031	.079	.120	.021	.091	-.046	.222*	-.117	-.208*	.381**	.218*	-.322**	-.039	.004	.072	-															
35 Tasks T1	.001	.000	.046	.006	.088	-.202*	.107	-.076	.160	-.217*	.141	.055	.045	-.154	-.022	-.034	.034	.161	-.022	.066	.135	.086	.143	.084	.176*	.025	.033	.267**	.279**	-.225**	-.116	.147	.233*	.503**	-															
36 Satisfactions T1	-.066	.001	.023	.098	-.043	.055	.010	.012	.045	-.132*	-.006	.054	.101	-.070	-.130	-.010	-.019	.009	.031	-.080	-.074	.007	.038	-.028	.233**	-.121	-.041	.240**	.097	-.232**	-.173*	.115	.100	.221*	185*	-															
37 interferences T1	-.005	.204*	-.096	.036	-.084	-.270**	.309*	-.239**	.096	.001	.074	.002	-.018	-.001	-.029	-.029	-.095	-.037	.013	-.021	.021	.108	.074	.082	.399**	-.068	-.055	.270**	.203**	-.203*	-.003	.300**	.206*	.078	.181*	.152	-														
38 Job Rewards T1	.368**	.423**	.058	-.248**	-.457**	-.021	.398**	-.051	.236*	.180*	.084	-.078	-.004	.192*	.172	-.085	-.026	.142	.003	-.038	.014	.027	.022	.174*	-.266**	.409**	.447**	-.288**	-.155	.370**	.052	-.090	-.118	-.267**	-.104	-.424**	-.030	-													
39 Job Concerns T1	-.254**	-.200*	.094	.120	.385**	-.268	-.080	-.150	-.073	-.127	.017	.123	-.020	-.146	.019	.078	.082	-.037	.004	-.057	.203*	-.055	.043	.246**	.370**	-.094	-.132	.320**	.243**	-.330**	-.004	.269**	.177*	.245**	.254**	.198*	.378**	-.461**	-												
40 Partner Rewards T1	.006	.204*	-.153	-.052	-.188*	-.046	.178*	.120	.090	.021	-.026	-.067	-.014	.000	.107	-.020	.131	.024	.064	.021	.067	-.020	.014	.079	-.119	.120	-.028	-.200**	-.089	.183*	.049	-.014	.008	-.311**	-.314**	-.332**	-.024	.268**	-.124	-										
41.-Partner Concerns T1	.049	-.059	.149	.050	-.001	.048	-.019	-.030	.086	-.004	.010	.065	.065	-.042	-.098	-.011	-.054	-.048	.010	-.049	.036	-.071	.144	-.029	.173*	-.066	.015	.270**	.222*	-.242**	-.201*	.262**	.172	.181*	.302**	.276**	.258**	-.133	.179*	-.646**	-								
42.- Mother Rewards T1	-.093	.031	-.054	-.060	-.024	-.043	.035	.046	.008	.046	-.024	.001	-.039	-.106	-.022	.030	-.126	-.150	-.017	-.130	-.016	-.057	-.033	.155	.061	.197*	.201	-.165	.026	.089	.042	.040	-.004	-.053	-.131	-.082	.064	.105	.121	.334**	-.232**	-							
43.- Mother Concerns T1	.035	.081	.138	.101	-.023	-.095	.125	.117	-.123	.009	-.015	-.006	.080	.071	-.097	-.090	.049	.080	-.027	.015	.116	-.039	.200*	.084	.253**	-.084	-.093	.218*	.221*	-.221*	-.214*	.207*	.132	.056	.183*	.101	.349**	-.032	.175*	-.166	.367**	-.271**	-						
44.-Alcohol consumptionT1	.197*	.036	.036	-.150	-.339**	.068	.226*	-	.152	.041	.083	-.131	.198*	.264**	.103	-.034	.130	.029	.177*	-.061	-.067	-.057	.119	.074	-.021	.031	.087	-.007	-.118	.069	-.032	.204*	.229**	-.135	.003	.090	.056	.165*	-.080	.031	.095	-.101	.060	-					
45.-Alcohol consumptionT2	.153	-.015	-.015	-.066	-.326**	.266**	.076	-	.112	-.043	.014	-.138	.170	.231**	.071	-.046	.100	.033	.232**	.059	-.057	.062	.037	.120	-.034	.123	.108	.053	-.154	.107	.007	.150	.167	-.088	.003	.033	.040	.169	-.182*	.044	.077	-.160	.144	.587**	-				
46.- Smoking T1	-.090	.145	.145	.164	.154	.194*	-.280**	-	-.136	-.097	.042	.118	-.130	-.022	.008	-.026	-.079	.140	-.151	.195*	-.016	.178*	.062	-.011	-.078	-.027	.024	.050	-.108	.137	.016	-.069	-.094	.154	-.050	.040	-.115	-.039	.108	-.066	.017	.018	-.114	-.073	.047	-			
47.- Smoking T2	-.111	.132	.132	.180*	.148	.229**	-.306**	-	-.157	-.096	.023	.106	-.110	-.072	-.013	-.039	-.123	.153	-.142	.200*	-.072	.175*	-.098	-.089	-.110	-.085	.009	.040	-.106	.127	.051	-.123	-.078	.112	-.112	.049	-.149	-.066	.040	-.085	.019	-.016	-.173	-.142	.016	.866**	-		
48.- Sleeping problemsT1	.047	.047	-.140	-.096	-.151	.010	.148	-	.067	-.121	.200*	.076	.071	-.200*	-.101	.092	.092	.139	.135	-.018	-.031	.110	.054	.087	.304**	.005	.000	.411**	.331*	-.251**	-.176*	.359**	.189*	.084	.115	.147	.164	-.017	.153	-.044	.194*	-.002	.060	.069	.121	-.077	-.070	-		
49.- Sleeping problemsT2	.015	-.027	-.027	-.049	-.100	-.028	.138	-	.250**	-.026	.209*	.050	.124	-.088	-.057	.011	.011	.144	.100	-.016	-.036	.121	.077	.186*	.354**	-.019	-.075	.389**	.379**	-.226**	-.112	.144	.202*	.074	.206*	.163	.203*	-.062	.156	-.155	.198*	-.071	.120	.004	.107	-.032	-.094	.618**	-	
50.- Social Integration	.208*	.349**	-.066	-.125	-.376**	.020	.273**	.125	.177	.107	.028	-.058	-.035	.202*	.148	.051	-.071		-.118	.060	-.031	-.016	.033	-.098	-.246**	.098	.218*	-.311**	-.255**	.261**	.012	-.072	-.123	-.222*	-.091	-.135	-.017	.361**	-.196*	.125	-.063	.098	-.175*	.267**	.139	-.067	-.066	-.068	-.089	-	
51.- Emotional Support	.249**	.011	.102	-.237	.070	-.104	.052	.115	.139	.038	-.123	.010	.012	.116	.008	-.055	-.118		-.004	-.060	.022	-.141	.073	-.063	-.311**	.112	.083	-.322**	-.188*	.181*	.114	-.214*	-.177*	-.028	.016	-.240**	-.150	.233**	-.191*	.219*	-.178*	.159	-.229**	.001	-.012	.026	.052	-.121	-.162	.276**	-

APPENDIX 11

Table 6.5: One-way analysis of variance comparing health and psychosocial variables according to type of roles

	Employed Mother (n= 42)		Employed Partner (n= 10)		Employed Mother/Partner (n= 78)		
	Mean	SD	Mean	SD	Mean	SD	p
Self perception of physical health T1	3.26	0.72	3.50	0.79	3.32	0.72	NS
Self perception of physical health T2	3.26	0.79	3.50	0.79	3.40	0.70	NS
Anxiety T1	46.73	6.80	47.41	7.25	47.68	5.99	NS
Anxiety T2	40.52	9.22	43.50	12.13	37.52	10.09	NS
Depression T1	17.21	4.55	16.80	5.37	13.88	3.99	.001
Depression T2	19.58	4.28	18.50	3.23	17.25	3.75	NS
Symptoms report T1	17.76	2.14	20.08	2.87	18.07	2.57	.01
Symptoms report T2	17.60	2.59	18.66	3.31	17.38	2.39	NS
Self-esteem T1	22.69	3.89	23.09	5.12	23.26	3.93	NS
Self-esteem T2	22.55	3.43	23.25	4.15	23.77	2.95	NS
Well-being T1	6.60	1.91	6.41	2.46	7.56	1.96	.05
Well-being T2	7.18	1.75	8.41	1.08	7.58	2.01	NS
Job rewards T1	2.86	.45	3.12	.51	3.04	.46	NS
Jobs concerns T1	1.82	.41	1.54	.32	1.71	.38	NS
Partner rewards T1	-	-	3.18	.58	3.10	.58	NS
Partner concerns T1	-	-	1.49	.29	1.53	.41	NS
Mother rewards T1	3.30	.46	-	-	3.31	.45	NS
Mother concerns T1	1.78	.45	-	-	1.73	.35	NS
Emotional support	2.28	0.70	2.30	0.67	2.34	0.68	NS
Social Integration	16.52	4.68	17.08	5.90	17.60	4.69	NS
Management	35.68	7.58	30.83	5.54	24.58	8.30	.01
Tasks	95.89	12.53	89.33	8.02	88.33	18.72	NS
Satisfactions	10.18	1.53	9.50	1.24	9.62	2.27	NS
Interferences	15.50	1.91	15.58	0.90	15.53	5.24	NS

Table 6.6: One-way analysis of variance comparing health and psychosocial variables according to occupational status

	Blue-collar (n=32)		Clerical (n=34)		Professional (n=64)		
	Mean	SD	Mean	SD	Mean	SD	p
Self perception of physical health T1	3.09	0.85	3.18	0.59	3.50	0.69	NS
Self perception of physical health T2	3.18	0.73	3.37	0.70	3.43	0.75	NS
Anxiety T1	47.00	8.67	46.40	5.86	48.03	5.17	NS
Anxiety T2	39.75	10.59	35.28	8.56	40.65	10.30	NS
Depression T1	16.37	4.96	14.28	4.11	15.00	4.43	NS
Depression T2	18.71	3.70	15.96	4.06	18.77	3.80	NS
Symptoms report T1	17.81	3.17	18.25	2.60	18.40	2.12	NS
Symptoms report T2	17.34	2.62	17.53	3.10	17.75	2.23	NS
Self-esteem T1	22.03	5.25	23.17	3.44	23.51	3.47	NS
Self-esteem T2	22.34	3.52	23.45	3.03	23.82	3.15	NS
Well-being T1	6.81	2.84	6.96	2.22	7.37	1.36	NS
Well-being T2	8.43	1.93	7.34	1.85	7.14	1.74	NS
Job rewards T1	2.61	.43	2.98	.45	3.18	.38	.001
Job concerns T1	2.00	.44	1.54	.32	1.69	.32	NS
Partner rewards T1	2.78	.60	3.06	.61	3.26	.49	NS
Partner concerns T1	1.52	.39	1.57	.43	1.54	.39	NS
Mother rewards T1	3.32	.41	3.19	.60	3.37	.37	NS
Mother concerns T1	1.73	.36	1.65	.29	1.82	.44	NS
Emotional support	2.40	0.62	2.18	0.84	2.35	0.62	NS
Social Integration	14.09	4.17	17.40	4.42	18.56	4.40	.001
Management	32.38	8.13	26.99	9.40	27.32	9.42	.001
Tasks	93.18	12.93	84.78	17.71	92.43	17.20	.01
Satisfactions	9.62	1.45	9.96	1.84	9.79	2.33	NS
Interferences	14.90	4.53	13.53	3.38	16.85	4.12	NS

APPENDIX 12

CONTENT ANALYSIS FORMAT FOR THE INTERVIEWS

Code number_____

1.- The more important role

Mother _____
Partner _____
Worker _____
Combinations_____

2.- Role Quality:

2.1. Mother Rewards INDICATORS

2.2. Mother concerns

2.3. Partner rewards

2.4. Partner concerns

2.5. Worker rewards

2.6. Worker concerns

2.7 Other role:

Rewards
Concerns

3. Work-Family relationships

3.1.- Interferences

3.2. Satisfactions

4.- Household responsibilities

4.1. Household tasks

4.2. Household management

4.3. How do you perceived the distributions of household: Fair____
Unfair___
Others___

5.- Social support

5.1. Social integration

5.2. Emotional support

5.3. Sources of support

6.- Health habits

APPENDIX 13

Examples of the definition of the categories in Study 4

Categories	Definitions
Role Quality	All those demands, conflicts, tensions, worries or concerns as well as, benefits and satisfactions perceived for each role played by the women participating in this study.
Mother Satisfactions	Satisfactions or rewards women perceived in their mother role
Children's expressions of love	Any reference to attitudes & behaviours related to expressions of affection from the children to their mother.
Mother Concerns	Stress or concerns women perceived in their mother role
Insufficient time to dedicate to the children	Any comment making reference to how stressful it could be for them not to dedicate enough time to their children.
Partner Satisfactions	Satisfactions or rewards women perceived in their partner role
Partner support	Any comment indicating that they receive instrumental as well as emotional support from their partners
Partner concerns	Stress or concerns women perceived in their partner role
Lack of time and partner demands	Any expression indicating how worrying it is for them when they don't have enough time to cover their partner's demands o expectations, or little time to share with them.
Job satisfactions	Satisfactions or rewards women perceived in their job role
Co-workers support	Any comment indicating that they receive instrumental as well as emotional support from their co-workers
Job concerns	Stress or concerns women perceived in their job role
Work overload and demands	Any expression indicating perceived work overload or the excessive demands they have in their work.
Work-Family relationships	Personal valoration each participant made of the relationship from their family life to their work life or vice versa, bearing in mind interfering aspects as well as those that complement each other, and the satisfactions perceived by the individual when interacting in the family and work roles.
Job interferes with childcare and household activities	Any comment reflecting that work interferes with the care of their children and the proper functioning of the household.