

ABSTRACT

Title of Thesis: MARITAL RELATIONSHIP STATUS, SOCIAL SUPPORT
 AND PSYCHOLOGICAL WELL-BEING AMONG RURAL,
 LOW-INCOME MOTHERS

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This study examined the relationship between marriage, social support, and psychological health among impoverished, rural mothers. While research suggests marital status and social support are negatively correlated with depression, research investigating such relationships and effects on poor, rural mothers over time is scant.

To examine the roles of marital status, social support, and time on depression, mean comparison and analysis of variance were run for depression levels across time, categories of partnership, categories of social support, and categories of change in marital status over time. While findings revealed that marital status had little effect on depression levels, social support appeared to be negatively correlated with depression. Furthermore, mothers who maintained marital status and reported high social support reported the lowest depression levels. Findings contribute to the limited body of research focusing on health in rural areas and yield valuable knowledge about the experience of psychological health among impoverished, rural mothers.

MARITAL RELATIONSHIP STATUS, SOCIAL SUPPORT, AND
PSYCHOSOCIAL WELL-BEING AMONG RURAL,
LOW-INCOME MOTHERS

by

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CHAPTER I: Introduction

Psychological well-being is defined as possessing the capacity for good decision-making, effective stress management, good communication skills, effective parenting, and caring for oneself emotionally, according to Dr. Donald Franklin (2003). Others define psychological well-being as a general reference to feelings of happiness and hopefulness (Marks, 1996; Ross et al., 1990). As these definitions illustrate, psychological health affects many aspects of life.

While some research has specifically measured psychological health by examining happy and hopeful feelings, most research measures psychological distress or the absence of psychological well-being (Coiro, 2001; Dooley & Prause, 2002; Hoyt et al., 1997). Psychological distress most commonly consists of feelings of sadness, hopelessness, loneliness, abnormal eating and sleeping patterns, and irritability, which are symptoms that commonly occur when experiencing depression (Ross et al., 1990). Psychological distress is frequently characterized as depression. Much of the research on marital status and well-being uses scores on measures of depression as an indicator of psychological distress (Brown, Brody, & Stoneman, 2000; Brown, Abe-Kim, & Barrio, 2003; Kim & McKenry, 2002; Lamb, Lee, & DeMarris, 2003). Distress can also be identified by measures of anxiety, happiness, and self-esteem (Horwitz & White, 1991).

Although psychological well-being is an internal state, it is affected by external factors. Some influential external factors include: economic stability, interpersonal and intimate relationships, and perceived social support. Geographic location and race/ethnicity play significant roles in how economic status, marital status, and social support affect psychological health. Healthy psychological well-being is reflective of an

above poverty financial standing, the presence of intimate relationships, and the perception of social support.

In contrast, unhealthy, low psychological well-being reflects below poverty economic status, few or no intimate relationships, and little or no perceived social support. Research supports these impacts of economic, emotional and intimate support, and social support (Belle, 1990) on psychological well-being and raises questions for additional research: What makes these dimensions of life functioning influential? More importantly, what happens when any of these dimensions are diminished or absent? This study focuses on the impact of intimate and social support on psychological well-being measured by depression scores of impoverished, rural mothers.

Psychological Well-Being and Poverty

A substantial amount of research documents the relationship between psychological health and poverty (Amato & Zuo, 1992; Bruce, Takeuchi, & Leaf, 1991; Coiro, 2001; Dooley & Prause, 2002; Murry et al., 2002; Ross, 2000). Research suggests that continual economic hardships increase the risk for experiencing depression (Bruce et al., 1991; Hoyt et al., 1997; Human & Wasem, 1991; McGrath, Keita, Strickland, & Russo, 1990). Studies find poverty to be one of the life conditions associated with poor psychological health (McGrath et al., 1990; Rank, 2000). Webster (1995) defines poverty as a state, condition, or quality of being poor, having little or no money. According to the Economic Research Service of the United States Department of Agriculture, someone living in poverty has a total income less than an amount that is deemed to be sufficient to purchase basic needs of food, shelter, clothing, and other essential goods and services (2003). The 2000 Census revealed that poverty affected

34.6 million (12.1%) of the U.S. population (Proctor & Dalaker, 2002). Therefore, many people who experience the various disadvantages of low income are at risk for poor psychological well-being.

Poverty is a pathway to poor psychological health, especially for women, because compared to more financially fortunate women, poor women more frequently experience uncontrollable adverse life events (Mazure, Keita, & Blehar, 2002). Some of the disadvantages of poverty include: increased likelihood of stressful events exposure such as crime and illness; low self-esteem; a sense of no control over life; chronic economic hardships; few social resources; poor health; unstable employment; marital problems and/or divorce; and racism (Amato & Zuo, 1992; Belle, 1990; Brown et al., 2003; Coiro, 2001; McGrath et al., 1990; Ross, 2000).

Low-income women with young children are particularly at high risk for low psychological health. Mothers on welfare possess an increased risk for high psychological distress because they experience stressors such as persistent welfare dependence and inadequate social support. Research suggests that poverty weakens a mother's ability to cope with new problems and stressors, as well as her ability to use various types of social support (Coiro, 2001).

Psychological Well-Being and Geographic Location

Research finds that psychological health is related to regional economic conditions (Hoyt et al., 1997). Poverty occurs in both urban and rural environments; and has different effects for both settings. According to the 2000 Census, 16.7% of families living in central urban areas and 8.9% of families living outside urban areas fell below the poverty threshold (Proctor & Dalaker, 2002). Federal statistics show that poverty

rates and unemployment are higher for rural families than for their metro counterparts (U.S. Census, 2000). The poverty rate in rural communities remains high (U.S. Census, 2001b), and persistent. Long-term poverty is much more common for rural families than urban families (Deavers & Hoppe, 1992; Imig, Bokemeier, Keefe, Struthers, & Imig, 1997). According to U.S. Census data (2001a), between 1999 and 2000, median household income fell for those living outside of metropolitan areas.

Findings vary as to which environment is more conducive to poverty. Contrary to the common thought of rural America being a healthy place to live, rural Americans are disproportionately poor, thus making them at greater risk for psychological problems (Human & Wasem, 1991). In contrast, rural poverty can be seen as less harmful because perceived social support and interactions revolve more around family and religion, thus providing a sense of belonging and support (Amato & Zuo, 1992; Weinert & Long, 1987). Studies find that social interaction and support are often absent due to geographical isolation for those living in rural poverty (Amato & Zuo, 1992). Economic and social dislocations are major contributors to psychological distress (Hoyt et al., 1997). In addition to the geographic isolation, rural areas lack available and accessible mental health services. Mental health services are mostly concentrated in urban areas. (Human & Wasem, 1991) Of the few available services, distances requiring travel to obtain services and the lack of public transportation limit access (Human & Wasem, 1991).

Weinert & Long found that people living in rural areas report high levels of perceived social support (1987). Such social interaction is considered beneficial because it often serves as a barrier from the stress that is experienced due to poverty.

Additionally, some researchers hypothesize that rural living is advantageous to psychological health because rural people rarely mention mental health issues, ignore moderate distress, or deny psychological problems (Weinert & Long, 1987).

For racial minorities living in rural areas, the isolation and economic hardships and lack of services or access to support services, is especially problematic. In general, Latin Americans and especially African Americans, experience a great deal of distress due to low socioeconomic status because they are disproportionately represented among the poor (Brown et al., 2003; McGrath et al., 1990; Murry et al., 2002). In the 2000 Census, 24% of self identified African Americans and 21.8% of self identified Hispanics fell below the poverty threshold, compared to 8% of self identified whites (non-Hispanic) who reported living under the poverty threshold (Proctor & Dalaker, 2003).

Psychological Well-Being and Race/Ethnicity

Ethnic minority mothers are more likely to experience a number of risk factors for psychological distress such as ethnic/racial discrimination, lower education, lower income, sexism, single parenthood, and marital dissolution (Brown et al., 2000; McGrath et al. 1990). Additionally, African American women have a risk of living in poverty that is three times greater than the risk for Caucasian women (Brown et al., 2000). For minorities, a population already vulnerable to developing distress because of environmental and financial stress, a sense of demoralization increases the risk of psychological distress. Impoverished Latino women are particularly at risk for developing distress because of high levels of stress and lack of resources (Brown et al., 2003).

Current Marriage promotion legislation is based on the belief that poverty can be evaded by being married. Research supports the notion that marriage buffers economic instability and strain (Fox & Bartholomae, 2000). Through providing resources to escape financial hardship, marriage can prevent depression. However, much of the research is focused on more economically advantaged people.

Problem Statement

In 1996, legislation was passed establishing the Temporary Assistance For Needy Families program (TANF). This program had four “family formation” goals: “to provide assistance to needy families, to end dependence of needy parents on government benefits by promoting job preparation, work, and marriage, to prevent and reduce the incidence of out-of-wedlock pregnancies, and to encourage the formation and maintenance of two-parent families” (Ooms, 2002). A focus on marriage was introduced in the P.L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which introduced incentives for states to focus attention and funds on promoting marriage (Levin-Epstein, Ooms, Parke, Roberts, Turetsky, 2002; Ooms, 2002). This marriage promotion legislation is intended to lower the poverty rate and reduce dependence on federal assistance by increasing the number of marriages, enhancing existing marriages, and decreasing the divorce rate (Ooms, 2002). In 2002, the House of Representatives and the Senate Finance Committee each approved their version of a reauthorization bill, providing \$100 million annually for marriage promotion and family formation activities. However, as of April 2004, a final bill has yet to leave Congress.

Although this legislation has not been finalized and little is known about the effectiveness of marriage promotion among the welfare-reliant, it is being implemented

by states. Ooms (2002) suggested that the marriage promotion movements ignoring the needs and circumstances of the population group that is most in need of help, the low-income couples. Along with knowledge about the outcomes of marriage promotion for financially unstable and rural people, little is known about the link between marriage and the rural poor. Additional exploration of these demographic communities is important because these communities are influenced by a plethora of factors and stressors that are not experienced by the rest of the population (Ooms, 2002). This study examines the marital and social support status and psychological health of a sample of rural, low-income mothers.

CHAPTER II: Literature Review

Over the last four decades, much research has been conducted on marriage. The focus of previous research ranges from general findings on the effects of marriage to more specific findings comparing different relationship statuses. Previous research consistently shows the positive effects of marriage on men; however, findings vary in regards to women. Additionally, much of this research focuses on economically stable women living in suburban areas. The studies of economically unstable mothers and psychological well-being that were done consisted of mothers living in urban cities, suburban areas, farm towns, or unidentified areas and focused on psychological health with regard to socioeconomic status and geographic location (Amato & Zuo, 1992; Brown, Brody, & Stoneman, 2000; Dooley & Prause, 2002; Hoyt, Conger, Valde, & Weihs, 1997; Murry, Brody, Brown, Wisenbaker, Cutrona, & Simons, 2002). Little is known about the effects of marital status on psychological well-being of low-income, rural, non-farm mothers.

Research conducted to date reveals variant findings regarding marital status and psychological health. Many studies find that marriage is indeed extremely beneficial, however, only for men. Some studies find that married women are able to experience lower levels of psychological distress because of the benefits of marriage (Brown et al., 2000; Green & Rodgers, 2001; McGrath, Keita, Strickland, & Russo, 1990). Other studies show that married women possess higher levels of distress and that marriage can be a source of conflict (Cotton, 1999; Horwitz & White, 1991). Such findings give support to the notion that marital satisfaction rather than marital status affects psychological health. Studies suggest that marriage can be a source of stress with the

positive associations between marital status and psychological health related only to happy marriages (Fincham & Bradbury, 1990; Laakso & Paunonen-Illmonen, 2002). Marital satisfaction is a measure of comfort with disagreement and aspects of conflict resolution and communication. Marital satisfaction assesses the quality of spousal relationships.

These mixed findings regarding marriage and satisfaction lead to research questions: Is being married predictive of psychological health or are there benefits of marriage that could exist with relationships other than marriage? Does marriage enhance psychological well-being when the benefits of being married such as financial stability and social support are lacking or not present? Does economic status, location, or the existence of children affect the advantages of marriage?

Much of the research concerning marital status and psychological health focuses on economically stable men and women living in suburban areas. The few studies of women only, with regard to the influences of psychological health, consisted of women living in urban cities or farm towns, with no focus on the marital status variable. An abundance of studies examine the relationship between marital status and psychological health, marital status and gender, economic status and psychological well-being, economic status and women, and geographic location and psychological well-being. However, little is known about the effects of marital status on psychological health of low-income, rural, non-farm mothers. Additionally, research finds that life changes affect experience with poverty. More specifically, Rank (2000) found that divorce and separation was associated with approximately one-tenth of all periods of poverty. Of those below the poverty threshold, two-thirds escaped impoverishment because of

income increases and one-third escaped as a result of family structural changes such as marriage. Changes in income and family composition aid in the escape from or the induction into poverty (Rank, 2000). If poverty is affected by significant life changes, can life changes such as changes in marital status and social support also affect psychological health?

Marital Status and Psychological Well-being

Research suggests that marital status and psychological well-being are closely associated (McGrath et. al, 1990). Marital status refers to the various relationship configurations (married, separated, and cohabiting) or the lack there of (never married, divorced, and widowed). Over the last four decades, much research focused on marriage (Gove et al., 1983; Horwitz & White, 1991; Kessler & Essex, 1982; Lee et al., 1991; Lorenz, Simons, Conger, Elder, Jr., Johnson, & Chao, 1997; Pearlin & Johnson, 1977; Simon, 2002; Stack & Eshleman, 1998; Williams, 1988). The focus of previous research ranges from general findings on the effects of marriage to more specific findings of comparing different relationship statuses.

Marital Status and Race/Ethnicity

Race and ethnicity are important considerations when determining effects of marital status on psychological health. Studies show that Latin Americans value marriage as something that is essential for achieving a meaningful life. Despite economic disadvantage, high rates of marriage exist for Latin Americans (Tucker, 2000). Additionally, Latin Americans desire marriage more than whites and blacks. Studies find that in comparison to Caucasians and Latinos, African Americans desire marriage the

least (Oropesa & Gorman, 2000), are more likely to divorce, and are least likely to marry (Tucker & Mitchell-Kernan, 1998; Tucker, 2000).

Researchers find such low desire for marriage to be attributable to the belief by African Americans that marital success depends on economic security, which is perceived by African Americans as a factor that can be achieved by living together with someone (Tucker, 2000). Studies also suggest that the increased divorce rate and low marriage rate among African Americans is a result of a shortage of men, which is referred to as a sex-ratio imbalance (Tucker & Mitchell-Kernan, 1998). In addition to higher rates of divorce and separation, African Americans also possess a high rate of delayed marriage and unmarried cohabitation (Taylor, 2000).

As implied by high divorce and separation rates among African Americans, race has been found to be a significant risk factor to marriage dissolution (Kposowa, 1998). Kposowa (1998) found that almost half (47%) of unions among African American women were expected to dissolve by the end of 15 years of marriage, compared to an expected seventeen percent of unions among white women ending after 15 years of matrimony. Kposowa explained African American marital dissolution as an effect of socioeconomic status. The association between economic status and marital status is that low income suggests a lack of economic resources, which is a known source of stress (1998). With an income that is insufficient for meeting a family's needs, feelings of deprivation are more likely, which may create marital conflict and tension. Such problems within a marriage decrease the satisfaction and happiness experienced within the union, which can ultimately lead to separation and/or divorce. Such an explanation is

pertinent to African Americans because being black is strongly associated with low socioeconomic status (Kposowa, 1998).

Marital Status and Poverty

As stated above, through the presence or absence of essential resources, economic status affects marital status. Along with affecting the likelihood of marriage, poverty is also linked to increased separation and divorce rates (Rank, 2000). Rank (2000) concluded the lower likelihood of marriage among the impoverished to be attributable to a shortage of marriageable partners. Economically secure partners are desired and considered marriageable partners. However, poverty weakens the possibility of uniting with a financially stable person, thereby weakening the chance of marriage among the poor (Rank, 2000). Marital satisfaction is negatively affected by the financial stress experienced by impoverished married couples and often contributes to separation and divorce. Married couples in poverty often lack the resources that could be helpful in dealing with a strained marriage such as access to funds needed to alleviate the financial strains or to counseling/therapy to deal with the marital problems. With such limited resources, increased chances of divorce and separation exist for married couples with low socioeconomic status (Rank, 2000).

Married Persons and Psychological Well-Being

Research suggests that marriage contributes to an overall healthy well-being (Gove & Shin 1989; Lamb et al., 2003; Ross, Mirowsky, & Goldsteen, 1990). Married people enjoy the benefits of social support, immediate intimate emotional support, and economic support (Waite, 2000), as well as having lower morbidity and mortality rates (Coombs, 1991; Ross et al., 1990). Marriage is a legal, formalized relationship that

facilitates association in a network that could potentially provide social support and influences one's well-being (Cotton, 1999). Intimate emotional support, provided by a partner, is characterized as a sense of being cared about, loved, esteemed, valued as a person, along with having a confidante (Pierce, Sarason, Sarason, Joseph, & Henderson, 1996; Ross et al., 1990). Married people report higher degrees of intimate emotional support and also tend to report lower levels of depression (Stack & Eshleman, 1998). But is this true for all socioeconomic levels?

Marriage is assumed to be economically beneficial because it most often results in higher household incomes, which helps to potentially circumvent possible economic stresses and helps to provide for higher quality living, such as better housing, food, and services. The improved standard of living and lower risk of impoverishment contributes to a better overall psychological health (Gove & Shin, 1989; Stack & Eshleman, 1998).

While some studies show that married men and women experience improved holistic health (Waite, 2000), other studies find marriage to be emotionally disadvantageous for women and particularly beneficial to men (McGrath et al., 1990; Simon, 2002). Being married not only directly protects and improves men's physical and psychological health, but such a committed state also reduces risky behaviors (Ross et al., 1990; Waite, 2000; Wu & Hart, 2002). Men's lives are enhanced because they have someone who, by nature, is often nurturing and observant, thus directly paying service to his needs. For women, marriage is indirectly beneficial through the social assumptions of financial and emotional security and immediate social support. What happens when marriage does not provide these benefits?

Research further suggests that marriage, alone, is predictive of healthy psychological well-being (Acock & Demo, 1994; Kessler & Essex, 1982; Kim & McKenry, 2002). However, most research shows marriage to be beneficial in comparison to people who are not currently married (Gove, Hughes, Style, 1983; Horwitz & White, 1991; Kim & McKenry, 2002; Mastekaasa, 1994; Pearlin & Johnson, 1977; Stack & Eshleman, 1998; Williams 1988; Williams, Takeuchi, Adair, 1992), in terms of marital satisfaction (Waite, 2000), and with regards to what marriage provides.

Cohabitation

Cohabitation is a unique quasi-married status because the couple is not married; yet they experience many aspects of marriage. Persons living together experience the instant source of confiding intimacy, a degree of mastery and self-esteem, and often experience integration into the network provided by the live-in partner. Because of the existence of these factors, those who cohabit are often thought to be very similar to married people (Kim & McKenry, 2002).

Although cohabitants live with an intimate partner, they still possess higher levels of distress when compared to married people (Kim & McKenry, 2002). People who live together experience financial distress and lower psychological health (Stack & Eshleman, 1998). People who live together often differ in attitudes and behaviors from those who marry (Wu & Hart, 2002). It could be implied that because of prior psychological distress, those who cohabit are unable to attract partners who desire the commitment and responsibilities that accompany marriage.

Married vs. Non-Married Persons and Psychological Well-Being

Non-married persons are defined as persons who never married as well as persons who were formerly married (separated, divorced, widowed), and persons who are cohabitating. Studies find that when compared to married people, non-married persons report possessing higher levels of psychological distress (Ross et al., 1990). Although non-married individuals may report happiness, hopefulness, and a sense of social support, when compared married people, non-married people do not possess as high a level of psychological health (Williams, 1988)

Examined closely, studies reveal inconsistent findings when comparing married persons to each subgroup of non-married persons. Some research shows that married people are much happier and have lower depression levels, followed by those who never married, and finally by those who were formerly married (Gove et al., 1983; Marks, 1996). Other research found that widowed and never married individuals, especially women, experience more psychological distress than separated and divorced persons (Williams, 1988). Research also found that the divorced and never married were substantially more depressed than married women (Acock & Demo, 1994).

Additional support for the proposition that separated and divorced persons experience the highest depression levels also suggests that married persons experience the least distress, and the single and widowed experience an intermediate level of distress (Gove & Shin, 1989; Pearlin & Johnson, 1977; Williams et al., 1992). Other studies found that people who cohabit experience less psychological distress than other non-married individuals (Stack & Eshleman, 1998; Waite, 2000). In addition to the possible increase in happiness for the never married, studies suggest that a possible decrease in

happiness exists among the married (Lee et al., 1991). Thus the question arises, is marital status no longer suggestive of psychological well-being?

Previous studies reveal that compared with single people who are not in current relationships, married people are happier because of the idea that the married encounter higher levels of interaction with others (Stack & Eshleman, 1998). Many studies do not include persons living together in the non-married pool, but of those that do, people who cohabit were the happiest subset of non-married people. Cohabitation has many of the beneficial emotional characteristics of marriage such as an intimate relationship, a source of social support, regular sexual activity, and shared income, but also possesses the flexibility to end their relationship, an advantage of singlehood (Horwitz & White, 1998). People who cohabit are not considered to be equal to married people because cohabitation does not have the same legal status as marriage and has a negative association with financial satisfaction and health.

Past studies reveal that the idea that married persons are psychologically better off than never married persons who exhibit higher depression scores. Yet, more recent studies find this differential is no longer true or is losing validity. Some studies suggest that the state of marriage alone does not determine emotional health; rather the quality of the marriage determines emotional health (Haring-Hidore, Stock, Okun, & Witter, 1985; Waite, 2000; Kim & McKenry, 2002). Such inconsistent findings about the experience of depression and union statuses lend support for additional exploration of the relationship between marital status and psychological health especially among low-income and rural, low-income people and gives rise to questions. If the quality of the

relationship is what predicts psychological health, could quality non-marital relationships provide the same benefits of marriage?

Social Support and Psychological Well-being

Marriage makes each spouse a part of a larger social network that could potentially provide various social resources. Sanderson (2004) defines social support as the presence or amount of social relationships, the perception of available assistance, and the receipt of assistance. Social support is a care resource that can be received from family, friends, colleagues, and healthcare personnel (Laakso & Paunonen-Illmonen, 2002).

Social support can be divided into two categories: emotional support and instrumental support. As aforementioned, the conveyance of care and love is emotional support. Emotional support also includes appreciation for others, trust, and listening (Laakso & Paunonen-Illmonen, 2002). Instrumental support is behavior that provides tangible assistance (Pierce et al., 1996). Laakso and Paunonen-Illmonen (2002) also suggest two other categories of social support: appraisal support and informational support. While appraisal support means affirmation, feedback, and social equality, informational support refers to advice, suggestions, guidance, and information giving.

Perceived social support refers to the perceptions of the availability of others upon whom one can rely for support should support be needed (Pierce et al., 1996). Social support is recognized as a variable that moderates the negative effects of potential distress and the many causes of depression (Cotton, 1999; Cutrona, 1996, Laakso & Paunonen-Illmonen, 2002). Furthermore, research finds that people who report depressive symptomatology often report lower quality and levels of social support as well

(Davila, Bradbury, Cohan, & Tochluk, 1997). Social support is thought to enhance life by creating a sense of well-being, a sense of belonging, and a sense of hopefulness.

According to Green and Rogers (2001), social support is a stress reducer because it provides effective coping resources and helps people view events as less stressful than if they were handling the events in isolation. They found that the more social support a person perceives and/or receives, the less likely he or she is to perceive stress. They concluded that socially supportive relationships could promote psychological health because of a reciprocal association with mastery. Mastery is a resource that governs the use of other resources; that is, mastery influences the ability to get needed support and to determine when seeking help is appropriate. According to Green and Rogers, the role of mastery is not clear. One view is that greater perceptions of mastery are caused by effectively partaking in needed social support. The opposing view states that a sense of social support is important to the enhancement of mastery because it provides a secure base that increases one's confidence to explore and experiment (Green & Rodgers, 2001).

Social Support and Geographic Location

While studies find that the general rural population perceives high levels of social support (Weinert & Long, 1987), research shows that low-income persons living in rural areas do not possess strong social networks because low financial resources and geographical isolation limit opportunities (Amato & Zuo, 1992; Hoyt et al., 1997). However, studies found that rural families are more likely to live near extended family, which grants access to social support from family (Struthers & Bokemeier, 2000; Taylor, 2000). Although rural areas are less likely to have easily accessible support services and

resources, persons with a greater perception of social support are more willing to tap into the few present resources (Hoyt et al., 1997).

Social Support and Race/Ethnicity

Researchers find that ethnic minorities perceive higher levels of social support because cultural ties often reflect strong social/kin networks. For Latin Americans, the family offers security, a sense of belonging, and a source of strength and support (Becerra, 1998; Suarez, 1998). Helping out emotionally and instrumentally, kin social support serves as a resource in which one may turn to for help in times of stress or need. The support given consists of babysitting, giving personal advice, emotional support, and providing temporary housing (Becerra, 1998).

Similar to Latin Americans, McAdoo (1998) found that African Americans report frequently receiving extensive assistance from extended family members. Research shows that the marital relationship of parents is not what African Americans consider important. Rather, love, stability, and available resources within the family home are what are essential (McAdoo, 1998). Additionally, African Americans receive an abundance of social support from the church. The church is relied upon to provide solace, relief, support, employment, and financial assistance (McAdoo, 1998).

Social Support and Marital Status

Social support is one construct believed to play a protective role in buffering stress for the married and the non-married. However, Cotton (1999) found social support to be especially beneficial to non-married persons and people who are dissatisfied with their marriage because it helps to offset negative outcomes associated with singlehood and distressing unions. For widowed and never married persons, friend and relative

social support is strongly associated with psychological health (Cotton, 1999).

Regardless of marital status, if partner emotional support and/or social support from others are lacking, the married will experience higher depression levels. Most research provides evidence that the lower the level of social support, the higher the level of depression (Cotton, 1999).

Marriage as Social Support

Marriage can be a source of social support. Support by an intimate partner is distinctively helpful. Commonly, partners are most likely to be turned to for support in time of need (Beach, Fincham, Katz, & Bradbury, 1996). Research also found that available intimate emotional support is very beneficial in preventing distress from turning into depression (Cutrona, 1996). The presence of a supportive marital relationship is linked to reduced depression vulnerability in that marriage lessens one's susceptibility to experiencing distress (Davila et al., 1997).

Additionally, through the increased social network provided through marriage, partners may find psychological benefits (Cotton, 1999). Nonmarried individuals are isolated from important social ties, derived through marriage and usually centered on home and family, which often generates feelings of security and belonging (Gove et al., 1983; Cotton, 1999). Without those ties, nonmarried people are more likely to possess lower psychological health.

Based on these research findings, psychological health is greatly influenced by various factors that, in some way, are experienced by everyone. More specifically, everyone falls into some category of marital status, socioeconomic status, geographic location, and group of perceived social support. Over time, many researchers examined

the association between different relationship configurations (Cockrum & White, 1985; Gove & Shin, 1989; Lorenz et al., 1997; Marks, 1996); different geographic locations (Human & Wasem, 1991); and various perceptions of social support and psychological health (Green & Rodgers, 2001). Some studies even examined the combination effect of these variables, such as the affect of economic level and geographic location on psychological well-being (Amato & Zuo, 1992). However, the many studies on the influences on psychological well-being, research focused on the affects of marital status on psychological well-being, with mediating variables of poverty and rural, non-farm life, and the moderating variable of social support was not located. This study intends to fill this gap in the expansive literature on the relationship between psychological health and the many influential variables.

Theoretical Framework

This research is guided by elements of a social selection perspective and family stress theory. Many studies concerning influences of psychological health were conducted to understand the causal direction of psychological health and other external factors (Kessler & Essex, 1982; Lee et al., 1991; Marks, 1996; Mastekaasa, 1994; Wu & Hart, 2002). Proving to be difficult to determine causality, the intrinsic concept of social selection evolved. Some studies find evidence for this perspective (Mastekaasa, 1992), while many other researchers find evidence against this concept of social selection (Lee, Seccombe, & Shehan, 1991; Mastekaasa, 1994). Other researchers find the theory of family stress, a social causation perspective, to best explain the causal relationship between psychological well and marital status.

Social Selection Perspective

A social selection perspective views the connection between marital status and psychological health as a result of previous well-being. This perspective suggests that people with high levels of psychological well-being and low levels of psychological distress are more likely to be selected for marriage partners and actually stay married (Marks, 1996). The theory implies that those who never marry and those who separate or divorce have low levels of psychological well-being and high levels of distress prior to marriage, thus making more likely the dissolution of the marriage or absence of marriage (Mastekaasa, 1994). The social selection perspective suggests that some people are predetermined or predisposed to have high levels of distress, thus explaining why some people do not marry or their marriages do not last. Adherents to this theory argue that low levels of psychological well-being exist consistently over time (Lee et al., 1991; Mastekaasa, 1994).

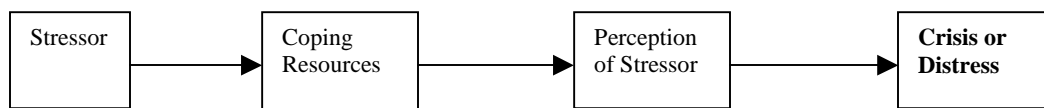
The social selection perspective holds that, based on psychological and temperamental health, persons with preexisting distress are less desirable partners and are less capable of obtaining and/or sustaining relationships (Kessler & Essex, 1982; Marks, 1996). For that reason, when non-married people are studied, they present with low levels of psychological well-being and high distress (Wu & Hart, 2002). According to the social selection perspective, happiness does not necessarily increase because of marriage; instead, people who are already happy and psychologically healthy are more likely to be selected for marriage; and in turn, report lower levels of distress compared to the non-married (Stack & Eshleman, 1998).

While many researchers study the uncontrollable condition of the Social Selection Theory to understand psychological health, many others focus on the external and internal factors that contribute to psychological distress. The roles of external and internal factors are accounted for in the Family Stress Theory.

Family Stress Theory

The family stress theory employs the ABC-X model, which identifies causal relationships that specify deterministic patterns. The X factor is caused or determined by the combination of the A, B, and C factors (Burr et al., 1994). The “A” is the stressor, “B” stands for the family’s resources, and “C” represents the family’s perception of the stressor. The “X” symbolizes the distress and crisis that occurs as a result of the stressor combined with the effects of the family’s resources and perception (Boss, Doherty, LaRossa, Schumm, & Seimetz, 1993; Boss, 2002). Family resources refer to the economic, psychological, emotional, and physical assets possessed by individual members and the whole family unit at the occurrence of the stressor (Burr et al., 1994).

Families experience stress when a disturbance in the steady state of the family occurs. These disturbances are caused by external and internal factors. According to Boss (2002), external factors consist of resources that are influenced by one’s environment, economic situation, and culture. The family does not control external factors. Internal factors refer to how one evaluates or defines the stressful event. One’s ability to utilize resources is contingent on how they perceive the stressor.



According to this model, the various disadvantages to not being married, along with the experience of a stressor, all combine to create distress. Exposure to life stress increases the chance of developing emotional problems (Dooley & Prause, 2002; Kessler & Essex, 1982). Researchers found that non-married people experienced or were more vulnerable to exposure to a variety of stressful events such as financial strain, social isolation, and increased parental responsibilities (Kessler & Essex, 1982; Marks, 1996; Pearlin & Johnson, 1977).

This social causation perspective suggests that because non-married people are less likely to be protected by the barriers of marriage, they are most likely to respond to the stress in an emotional way and less likely to cope with the issue in an effective way, thus resulting in higher levels of depression (Kessler & Essex, 1982). Unmarried people are less likely to possess internal resources (mastery and self-esteem) and somewhat less likely to have access to social resources (integration and intimacy). When compared to being in a married union, living as a single person is less satisfactory (Mastekaasa, 1994). With the family stress theory, low levels of psychological health are attributable to the occurrence of a stressor; therefore these high levels of distress are not consistent over time. Experience of distress at one moment is not predictive of marital outcomes or later experiences of distress because the distress is an effect of the stress (Lee et al., 1991, Mastekaasa, 1994). According to these researchers, psychological well-being is relative, changes over time, and is contingent upon the existence of stressful factors and one's ability to cope with the stress.

The ABC-X model suggests that higher levels of psychological well-being are results of marriage (Waite, 2000). Looking at the advantages of marriage, according to

this perspective, married people have the potential to experience a reduced level of stress and crisis because the union provides one with coping resources and realistic perspectives. Stressors will be experienced but because they theoretically have better resources, such as higher financial standing and sufficient social support system, married people are better equipped to handle the stressor, and hopefully evade a crisis. With adequate resources, a family has the potential to work together to prevail over the potential crisis and achieve an even higher level of functioning than its pre-stressor functioning (Boss et al., 1993).

Research shows that aspects of being married make marriage more advantageous to mental health. Men benefit mentally and physically, while women benefit mentally (Zu & Randy, 2002). Married people have lower levels of experienced psychological distress because they are exposed to fewer stressful experiences than single or previously married people (Kessler & Essex, 1982). Not only are married people less likely to become psychologically distressed, they are also less affected by the emotional damage caused by the strains and frustrations commonly experienced by unmarried persons, such as economic hardships and parental role problems (Kessler & Essex, 1982). These stressors affect married people to a lesser degree because they have a spouse to either prevent these strains from occurring or to share the stress with and protect them from the full effects (Stack & Eshleman, 1998). Additionally, married persons are able to tap into the various coping resources of mastery, self-esteem, integration, and intimacy (Kessler & Essex, 1982).

Marriage affects the way people view themselves and their abilities. Often marriage promotes feelings of mastery at being a spouse, taking care of others, along with

a higher self-esteem because the person feels desired and needed by his or her spouse. Self-esteem is an important psychological characteristic that improves psychological health by diminishing psychological despair and/or increasing motivation to cope better. Being married enhances mastery and self-esteem by providing a foundation for a sense of meaningfulness (Gove et al., 1983; Marks, 1996).

Through confiding, the existence of a spouse potentially provides the social resource of intimacy. Marriage is beneficial because it provides resources and relationships that promote psychological health. By providing emotional, social, and financial support, marriage maintains or enhances personal satisfaction and psychological health (Mastekaasa, 1994; Wu & Hart, 2002).

As mentioned previously, marriage has the potential to provide many types of support directly and indirectly. The direct support is the emotional support provided within the intimate relationship and the indirect support is the social support that is available through connections made through marriage. However, social support can come from people unassociated with the marriage. Any form of support is beneficial in buffering the effects of stress.

The definition of stress encompasses many aspects of life events. Sources of stress include a variety of frustrations, demands, and conflicts dealing with social relationships, partners and children, career, and significant events or changes (Lefrancois, 1993). According to the Social Readjustment Rating Scale created by T.H. Holmes and R.H. Rahe (1967), often stress is associated with positive and negative change in one's life. Some changes frequently linked to stress are changes in marital status such as marriage, divorce, and separation. According to Holmes and Rahe (1967), these changes

in marital status are ranked as some of the most distressing life changes. Other distressing life changes are changes in social support, including the gaining or loss of people or services that provide social support (Holmes & Rahe, 1967). Examples of social support changes are death of a close family member or friend, change in social activities, divorce, marriage, being fired at work, gaining a new family member, or child leaving home.

Purpose of the Study

The purpose of this study was to add to the body of knowledge about the relationship between marital status, social support, and psychological well-being among a sample of rural, low-income mothers. Findings have implications for both policy and programs. More specifically, this study tested the theories of Social Selection and Family Stress.

The exploratory research had 4 objectives: 1) to examine the relationship between marital status and depression, 2) to examine the relationship between social support and depression, 3) to examine changes in depression levels over a one-year period, and 4) to examine changes in marital status and social support of the rural, low-income mothers with regard to depression over time through a comparison of data collected at two points in time.

CHAPTER III: Methodology

Sample

The sample for this study was drawn from the multi-state, longitudinal study, NC-223: “Rural Low-Income Families: Tracking their Well-Being and Functioning in the Context of Welfare Reform.” The study involves researchers from land-grant universities in fourteen states, collectively examining how changes in welfare policies affect economically vulnerable families who live in rural areas of each included state. The fourteen states represent diverse regions of the United States, including the West Coast, the Midwest, the Northeast, and the South. The NC-223 sample is comprised of mothers of at least one child living in counties designated as “rural” based on Butler and Beale’s (1994) rural-urban continuum codes. Using this system of classification, counties are classified by population and proximity to a major metropolitan area, with a classification of zero being the most urban and a classification of nine being the most rural. All of the counties sampled in this study were classified as a six or higher on the continuum with the exception of California, Massachusetts, and New York, which did not have any counties meeting the Beale Code criteria of 6 through 8. In California, two counties were chosen from the central valley with no population center greater than 10,000 people. In New York and Massachusetts, counties coded as 4 were chosen, that is having an urban population of 20,000 to 50,000 but that had rural areas. Cognizant that participants would be “lost” during a longitudinal study, a minimum sample size of 15 participants per county was sought.

NC-223, funded in large part by the United States Department of Agriculture (USDA), began in October 1998. Starting in 2000, face-to-face interviews were

conducted once a year for three successive years with 414 participants from 24 different counties in the 14 participating states. Inclusion criteria were that participants had to be at least 18 years of age, mothers of at least one child younger than 13, and eligible for, or receiving, food stamps or the Supplemental Nutrition Program for Women, Infants, and Children (WIC). For this study, the sample for analysis consists of 307 participants who completed the interview protocols in both Wave 1 (2000) and Wave 2 (2001).

Procedures

The data used for analysis in this study were collected from 307 mothers who participated in both the first and second of three waves of interviews as part of the NC-223 study. Researchers in 24 rural counties in 14 states carried out the interviews using similar but not identical sampling and interviewing procedures. Each state was required to collect data from at least 20 participants in order to be included in the national study. Recruitment procedures varied from state to state, but in general, convenience sampling techniques, rather than random sampling techniques, were used. All participants had to meet the inclusion criteria. Families with preschool children were favored over families with older children in order for childcare arrangements to be studied.

The data collection teams from each state were made up of a combination of university faculty members from multiple disciplines (many of whom are Cooperative Extension appointees), graduate and undergraduate students, county Extension Educators, county social service employees, and when necessary, translators. One person at a time from each of these teams conducted the interviews with participants in person, guided by a semi-structured protocol, which included both standardized surveys and open-ended questions. Interviews yielded both quantitative and qualitative data about each

participant's current household composition, family well-being, family schedules, physical and mental health, life skills, community life, housing, household expenses, knowledge of community services, work history, current employment, sources of income, attitudes about and experiences with welfare reform, transportation, child care, family of origin, educational experiences, efforts to make ends meet, food security, parenting, and social support.

All interviews were audio-taped and later transcribed verbatim by individuals from each state's research team. The quantitative items were entered into a common SPSS data file by a central data entry team located at Oregon State University. Qualitative coding with the WinMax coding program was also conducted at Oregon State, using principles of grounded theory to code for thematic content. For this study, only quantitative data will be analyzed.

Measures

According to the Social Selection Perspective, this study is expected to reveal no evidence that marital status or social selection affect depression levels. Unchanged depressive symptomatology over the one-year period would provide further support for this finding. The maintenance of depression scores from Year 1 to Year 2 suggests that psychological well-being is not influenced by external factors such as marital status, social support, or significant life changes. Consistent with the Social Selection Perspective, this study predicted to find:

Hypothesis 1: No change in reported depression levels will be observed over the 1-year period.

Model 1

In contrast to the Social Selection Perspective, with adherence to the Family Stress Theory, this study was expected to reveal evidence that marital status affects depression levels. According to this theory, because marriage increases and enhances the available resources, being married would lower the experience of depression by reducing the level of perceived stress after encountering a stressor. This theory would also expect to find that social support received from persons other than the partner would affect depression levels. Similar to marital status, social support is considered a moderating factor that increases and enhances the available resources. Therefore, it is expected that the presence of high levels of social support would result in low depression scores and high depression scores would indicate low levels of social support.

A basic premise of this theory is the occurrence of a stressor, thus indicating a change of some sort. Therefore, according to this perspective, this study was expected to reveal changes in depression levels over a one-year period, and that change would be associated with the occurrence of stressors (changes in marital status and changes in social support). Figure 1 illustrates the Family Stress Theory in terms of marital status, social support, and psychological well-being.

In order to test the relationship between the occurrence of a stressor, marital status and social support (Family Stress Theory), this model used the following variables:

Predictor variable. The main independent variables for this study were changes in marital status and changes in social support from Year 1 to Year 2. For this analysis, marital status was divided into three groups: married, cohabiting, and not married (never married, divorced, separated). After preliminary analysis, marital status was divided into

2 groups: partnered (married and cohabiting) and not partnered (never married, divorced, separated). To analyze change in marital status, marital status was recoded to reflect marital status in Year 1 and Year 2 and the direction in which the change occurred. Such analysis created 4 new groups: remained partnered, remained not partnered, gained partner, and lost partner.

Participants were asked a variety of questions about their marital status including: Are you married?; Have you been married before?; What is your marital status?; Would you describe your marital status as single, married, divorced, separated?; And do you have a partner or boyfriend living with you right now? Has your marital status changed? What is your new marital status? Participants indicated their marital status based on the following categories: married, living with partner, divorced, separated, and single. The different levels of marital status resulted in a categorical variable.

Research provides evidence that marital status will affect the experience of psychological distress in the event of a stressor. Based on the existing research literature, it was hypothesized that the stress of changes in marital status would affect depression levels. More specifically, this study expected to find:

Hypothesis 2: If the mothers remain partnered from Wave 1 to Wave 2, no change in depression will be observed.

Hypothesis 3: If the mothers remain not partnered from Wave 1 to Wave 2, no change in depression will be observed.

Hypothesis 4: If the mothers gain a partner from Wave 1 to Wave 2, decreased depression levels will be observed.

Hypothesis 5: If the mothers lose a partner from Wave 1 to Wave 2, increased depression levels will be observed.

Hypothesis 6: Mothers who reported having a partner at Wave 1 and Wave 2 will report the lowest depression scores, followed by mothers who gain a partner, mothers who had no partner at Wave 1 and Wave 2, and mothers who lost a partner, respectively.

As an indicator of social support, the basic criterion variable in this analysis was perceived parental support, measured by the Parenting Ladder, a measure constructed by the Oregon State University Family Policy Program for utilization in a statewide evaluation of the Healthy Start Program (Richards, 1998). The original 10-item measure was modified by the Oregon State University Even Start Evaluation team in 1996/97 to include the addition of two items measuring stress that include, where would you put yourself on the Parenting Ladder in terms of: ...the amount of stress in your life right now? And... your ability of cope with the stress in your life? An additional modification made at the same time was the inclusion of one item measuring the amount of support in the respondent's life.

The measure is divided into two sections, one a self-assessment of parenting confidence and the other a self-perceived level of social support. The portion pertaining to perceived social support, consisting of six items asking participants to rate on a scale of zero to six, their level of agreement with a number of statements indicating the presence of various types of social support, including "someone to help you in an emergency," "someone for you to relax with," and "someone to offer helpful advice or moral support." The six items were summed, resulting in a total score of perceived level

of social support ranging from zero to 36. Cronbach's α based on the NC-223 sample for social support using all six items was .8368 (n=286) in Wave 1 and .8203 (n=298) for Wave 2. A copy of this measure is included in the appendix.

In order to divide the sample into two categories based on social support scores, the median score was used as a cutoff point, with participants receiving scores above the median designated as "high" on social support, and participants receiving scores below the median designated as "low" on social support. The categories were relative to each other, rather than a standardized social support score using this measure. For additional exploratory analysis, percentiles (25th, 50th, and 75th) were used to better examine the spread of social support scores.

Research provides evidence that social support will the effect the experience of psychological distress in the event of a stressor. It was hypothesized that the stress of changes in perceived social support would affect depression levels. More specifically, this study expected to find:

Hypothesis 7: If the mothers reported high levels of social support at Wave 1 and Wave 2, no change in depression scores will observed.

Hypothesis 8: If the mothers reported low levels of social support at Wave 1 and Wave 2, no change in depression scores will be observed.

Hypothesis 9: If the mothers reported changes in levels of social support from high to low from Wave 1 to Wave 2, increased depression scores will be observed.

Hypothesis 10: If the mothers reported changes in levels of social support from low to high from Wave 1 to Wave 2, decreased depression scores will be observed.

Hypothesis 11: Mothers who reported unchanged high levels of social support will report the lowest depression scores, followed by mothers who gain social support, mothers who report unchanged low levels of social support, and mothers who lost social support, respectively.

Race was examined as a possible covariate to marital status, social support, and depression scores. Race/Ethnicity was a subject variable reported by the mothers at the beginning of the Year 1 interview. Participants were asked to look at a card that listed the various categories for race and select which race she identified with most. The categories for race were as follows: Non-Hispanic White, Hispanic/Latina, African American, Native American, Multiracial, and Other. For the analysis, the Native American, Multiracial and Other categories were combined into one “Other” category.

Outcome variable. The main outcome variable was mother’s psychological well-being using a measure of depression as the dependent variable. The mothers in the study completed the original 20-item Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977). The CES-D is a self-report measure used to assess indicators of depression in the general population (Radloff & Locke, 1986). The CES-D scale has a high internal consistency, test-retest repeatability, content validity, concurrent validity, and discriminant validity (Radloff, 1977; Weissman, Sholomskas, Pottenger, Prusoff, & Locke, 1977).

The CES-D examines symptoms including depressed mood, feelings of worthlessness, feelings of helplessness, loss of appetite, and sleep disturbance (Radloff, 1977). The items ask how often in the past week the respondent felt (for example) “bother by things that don’t usually bother you,” “as good as other people,” “fearful,” “hopeful about the future,” “lonely,” “happy,” “sad,” “like people disliked me,” and “that everything I did was an effort.” Responses ranged from 0 to 3; the range of the summated scale is thus 0 to 60. Scores of 16 or more reflect the existence of at least six of the 20 symptoms, which is predictive of the experience of depression (Weissman et al., 1977). Cronbach’s α based on the NC-223 sample for depression using all twenty items was .8958 (n=286) for Wave 1 and .9042 (n=287) for Wave 2. A copy of this measure is included in the appendix.

Model 2

In order to test the general relationship between marital status, social support, and psychological well-being, this study used the following variables:

Predictor variable. The main independent variable for this study was marital status. For this analysis, marital status was divided into three groups: married, non-married (never married, divorced, and widowed), and cohabiting. Participants were asked a variety of questions about their marital status including: Are you married?; Have you been married before?; What is your marital status?; Would you describe your marital status as single, married, divorced, separated?; And do you have a partner or boyfriend living with you right now? Participants indicated their marital status based on the following categories: married, living with partner, divorced, separated, and single. The different levels of marital status resulted in a categorical variable.

Moderating variable. Social support was examined as a moderating variable, in order to determine whether or not mothers reporting different levels of social support were differentially impacted by the predictor variables. As an indicator of social support, the basic criterion variable in this analysis was perceived parental support, measured by the Parenting Ladder explained in the Model 1 description.

Again, in order to divide the sample into two categories based on social support scores, the median score was used as a cutoff point, with participants receiving scores above the median designated as “high” on social support, and participants receiving scores below the median designated as “low” on social support. The categories were relative to each other, rather than a standardized social support score using this measure. For additional exploratory analysis, percentiles (25th, 50th, and 75th) were used to better examine the spread of social support scores.

Outcome variable. The main outcome variable was mother’s psychological well-being using a measure of depression as the dependent variable. Again, the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977) described previously, was used.

Based upon the literature about marital status, marriage, social support, and psychological well-being, this study developed theses about the relationship between marital status, social support, and depression not addressed in either the Social Selection Perspective or the Family Stress Model. Figure 1 illustrates the directionality and influences of psychological well-being. Based on the existing research literature and consistent with the proposed model depicted in Figure 1, the following hypotheses were generated:

Hypothesis 12: Marital status will have an effect on the depression levels of the participating mothers with married mothers reporting lower levels of depression than non-married mothers. Additionally, partnered mothers (married and cohabiting) will have lower levels of depression than non-partnered mothers.

Hypothesis 13: No significant difference in depression levels between married and cohabiting mothers will be observed based on similarities in residential configuration and the benefits of an intimate partner.

Hypothesis 14: Levels of perceived social support will have an effect on reports of depressive symptoms. It is predicted that as the rate of perceived social support increases, psychological distress will decline, thus reflecting a negative correlation. Specifically, mothers reporting high levels of social support will have decreased levels of depression relative to mothers reporting low levels of social support.

Although it was predicted that the married mothers would report better psychological well-being, it was further hypothesized that the interaction effect of social support and marital status provide different reports of depression levels.

Hypothesis 15: This study expects to find that married mothers will be psychologically healthier; however, with high levels of social support, non-married mothers will also report low levels of depression. More specifically, married mothers, regardless of social support levels, will experience lower levels of depression, followed by unmarried mothers with high

levels of social support and unmarried mothers with low social support levels, respectively.

Based on literature about race and ethnicity, beliefs about marriage, marital practices, and marital status differed amongst the various races. Perceptions of social support differed as well.

Hypothesis 16: Minority mothers will report higher levels of social support than White mothers.

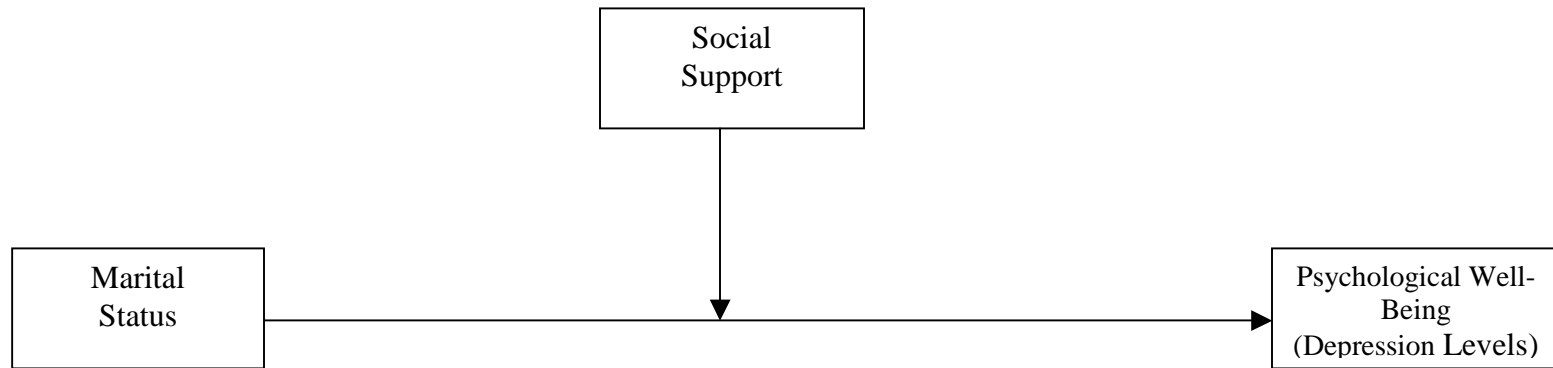


Figure 1. Model for psychological well-being (depressive symptomatology), marital status, and social support.

Data Analysis

Descriptive analyses were generated for all variables, as appropriate. Frequency and cross-tabulation statistics were run between marital status, social support, and depression, based on measures of the CES-D. To examine any changes in depression levels between when the mothers first completed the assessment in 2000 and their second assessment in 2001, cross-tabulations were run. *T*-tests were used to detect any significant differences between partnered mothers and not partnered mothers, and significant differences between high and low social support with respect to depression scores between Wave 1 and Wave 2. A Multivariate Analyses of Variance (MANOVA) was employed to further assess the effects of marital status and social support on the mean of reported levels of depression in addition to investigating the interaction effect of marital status and social support on depression levels.

CHAPTER IV: Results

Demographics Characteristics

Demographic characteristics of the study sample in Wave 1 and Wave 2 are presented in Table 1. Although the total sample for Wave 1 consisted of 414 rural mothers ranging in age from 16 to 72, only 307 of those mothers also participated in Wave 2. Of the 307 who participated in Wave 2, all reported marital status, however, only 304 reported her race/ethnicity and only 286 of those mothers responded to the measures for depression and social support.

The study sample for this investigation consisted of mothers ranging in age from 17 to 58. The mean age for mothers was 29.83 (SD=7.66). Over half (60%) of the mothers were partnered; 40% were not partnered. One hundred and thirty-five (44%) were married, forty-nine (16%) were living with a partner, sixty-eight (22.1%) were single/never married, thirty-five (11.4%) were divorced, and twenty (6.5%) were separated. The majority of mothers (64.2%) were Non-Hispanic White; 21.8% were Hispanic/Latina; 7.5% were African American; and 5.5% were of other ethnicities. The average income was \$15,997. The mean depression score for the entire sample was 17.67 (SD=11.50), which is above the CES-D cutoff for signs of depressive symptomatology. The mean social support score for this sample was 27.31 (SD=7.36).

Similar to Wave 1, of the 307 who participated in Wave 2, 306 reported marital status, 287 responded to the measures for depression, and 298 reported perceived social support. The Wave 2 sample consisted of mothers ranging in age from 18 to 59. Fifty-three mothers (17.3%) reported a change in marital status from Wave 1 to Wave 2; 82.4% reported no change in marital status. The study sample consisted of one hundred and

ninety-four (63.1) partnered mothers and 36.8% non-partnered mothers. One hundred and thirty-eight (45%) were married and 55 (17.9%) were living with a partner. The remainder of the sample consisted of 21.2% single/never married, 10.4% divorced, and 5.2% separated. One mother's information was coded as missing. The average income was \$22,805. The mean depression score for the entire sample was 14.52 (SD=11.05), which is above the CES-D cutoff for signs of depressive symptomatology. The mean social support score for this Wave 2 sample was 27.99 (SD=6.48). The measure for Race/ethnicity was measured in Wave 2.

Table 1
Characteristics of the Sample

Characteristic	Wave 1 (n=307)		Wave 2 (n=307)	
	<i>M</i>	<i>(SD)</i>	<i>M</i>	<i>(SD)</i>
Age in years	29.83	7.66		
Race				
White	.642		.642	
Hispanic/Latina	.218		.218	
African American	.075		.075	
Other	.055		.055	
Marital Status				
Partnered (married, living with partner)	.600		.631	
Not Partnered (single, divorced, separated)	.400		.368	
Depression Scores	17.67	11.50	14.52	11.05
Social Support Scores	27.31	7.36	27.99	6.48

Comparison of Mothers in Wave 1 only and those in Waves 1 and 2

This study focused on data from mothers who participated in both waves of data collection. However, to determine if any differences existed between the mothers who dropped out and those who continued, frequencies and comparative analyses were run.

Results showed that of mothers not participating in Wave 2, 68.3% were Non-Hispanic White, 13% were Hispanic/Latino, 13.8% were African American, and 3.3% were of other ethnicity, similar to the mothers participating in Wave 2. Of those not in Wave 2, 52.8% had a partner and 46.3% did not have a partner. The mean age of the mothers not in Wave 2 was 31 (SD=12.33). At Wave 1, the mean levels of depression and social support for mothers not in Wave 2 were 17.86 (SD=11.41) and 27.27 (SD=8.00), respectively. The independent samples test comparing the mean scores for depression scores and social support scores observed no significant difference between mothers in both waves and those in Wave 1 only.

Descriptive Data Analyses of Variables

Marital Status and Depression

Table 2 presents a matrix of mean depression scores based on marital status at Wave 1 and Wave 2. Wave 1 results revealed that on average, single mothers reported the least psychological distress with depression scores of 16.93 (SD=12.01), followed by married (M=17.14, SD=11.25), and cohabiting mothers (M=18.35, SD=9.95). Consistent with other findings, divorced and separated mothers reported the highest depression levels.

Analysis of the study sample at Wave 2 showed that on average, married mothers reported depression scores of 12.77 (SD=10.00). Divorced mothers reported the next lowest levels of depression (M=15.22, SD=12.34), followed by single mothers (M=15.43, SD=11.06), and then by cohabiting and separated mothers. Although married, divorced, and single mothers reported depression scores below the CES-D cutoff score (16), only

the married mothers reported scores that also fell below the mean score for the sample (14.52, SD=11.05).

Table 2
Depression Scores Based on Marital Status

Characteristic	Wave 1 (n=307)		Wave 2 (n=307)	
	<i>M</i>	(<i>SD</i>)	<i>M</i>	(<i>SD</i>)
Marital Status				
Married	17.14	11.25	12.77	10.00
Living with Partner	18.35	9.95	16.38	13.23
Single	16.93	12.01	15.43	11.06
Divorced	18.31	12.21	15.22	12.34
Separated	20.78	14.08	17.92	6.98

Social Support and Depression

Table 3 presents a matrix of means depression scores based on levels of social support. On average, high social support (scores above 27.99) reflected depression scores of 15.42 (SD=10.54). Low social support (scores below 27.99) reflected depression levels of 21.62 (SD=11.92). Analysis of the study sample at Wave 2 showed that on average, high social support (scores above 27.31) reflected depression scores of 12.02 (SD=9.01). Low social support (scores below 27.31) reflected depression levels of 18.70 (SD=12.78).

Table 3
Depression Scores Based on Perceptions of Social Support

Social Support	Wave 1 (n=307)		Wave 2 (n=307)	
	<i>M</i>	(<i>SD</i>)	<i>M</i>	(<i>SD</i>)
High	15.42	10.54	12.02	9.01
Low	21.62	11.92	18.70	12.78

Bivariate Relationships between Continuous Variables

Table 4 presents a correlational matrix of bivariate relationships between all continuous variables of interest. Results reveal several significant relationships between the variables examined in this study. In particular, depression scores at Wave 1 were positively correlated with Wave 2 depression scores ($r=.538, p<.001$) and negatively correlated with Wave 2 parental support scores ($r=-.317, p<.001$), indicating that as participants' Wave 1 depression scores got higher, their Wave 2 depression scores got higher and their Wave 2 parental support score lowered. Wave 1 parental support scores were positively correlated with Wave 2 parental support scores ($r=.513, p<.001$) and negatively correlated with Wave 1 depression scores ($r=-.384, p<.001$) and Wave 2 depression scores ($r=-.302, p=.001$), indicating that mothers reporting higher social support at Wave 1 reported higher social support scores at Wave 2 and had lower levels of depression at both waves. Additionally, Wave 2 depression scores were negatively correlated with Wave 2 parental support scores ($r=-.382, p<.001$), indicating that as Wave 2 social support levels got higher, Wave 2 depression scores lowered. Wave 1 marital status was also positively correlated to Wave 2 marital status ($r=.734, p<.001$).

Table 4
Bivariate Relationships Between Continuous Variables

Variable	1	2	3	4	5	6
1. Wave 1 Marital Status (partnered v. not partnered)	--			.734**	-.103``	
2. Wave 1 Depression Scores		--	-.384**			
3. Wave 1 Social Support Scores			--			
4. Wave 2 Marital Status (partnered v. not partnered)				--		
5. Wave 2 Depression Scores		.538**	-.306**		--	
6. Wave 2 Social Support Scores		-.317**	.513**		-.382**	--

* $p < .05$ ** $p < .01$ ``marginal (2-tailed)

Mean Comparison 1: Depression

Although descriptive data indicated that depression scores changed from Wave 1 to Wave 2, in order to further test the Social Selection theory, a series of *t*-tests were run, presented in Table 5. The first *t*-test, using paired samples test, focused solely on the extent to which reported depression scores differed over time. Depression scores at Wave 1 were compared with depression scores at Wave 2. Comparisons of depression levels showed statistically significant difference, $t(281) = .000$, $p < .001$, from Wave 1 to Wave 2. The second *t*-test, using one-sample test, focused solely on the extent to which the mean depression scores compared to the 25th, 50th, and 75th percentile depression scores. The results of this analysis indicated that when compared by various percentile

scores for depression for each, statistically significant differences existed. Comparisons of the Wave 1 mean depression score with the 25th, 50th, and 75th percentile, were significantly different, $t(285)=.000, p<.001$; $t(285)=.014, p<.05$; $t(285)=.000, p<.001$, respectively. Comparisons of the Wave 2 mean depression score with the percentiles, were significantly different, $t(286)=.000, p<.001$; $t(286)=.000, p<.001$; $t(286)=.000, p<.001$, respectively.

Table 5
Comparisons of Depression Scores

	Wave 1 (n=307)		Wave 2 (n=307)		<i>t</i> ¹
	Score	<i>t</i> ²	Score	<i>t</i> ²	
Comparison of Waves					.000***
Percentile					
25 th	9	.000***			
50 th	16	.014*			
75 th	23	.000***			
Percentile					
25 th			7	.000***	
50 th			12	.000***	
75 th			19	.000***	

¹Paired-samples *t*-tests compared means of Wave 1 with Wave 2 mothers.

²One-samples *t*-tests compared means of Wave 1 and Wave 2 with respective percentile scores.

* $p<.05$ ** $p<.01$ *** $p<.001$ (2-tailed)

Mean Comparison 2: Marital Status and Depression

In order to examine the relationships between marital status, partner status, change in marital status, and depression, a series of *t*-tests were run. The results of these analyses are presented in Table 6. The first *t*-test, using independent samples test, focused solely on the extent to which married mothers and mothers living with a partner differed for reported levels of depression. The results of this analysis indicate that when

compared by mean scores for depression, married mothers and cohabiting mothers did not differ significantly in either wave. Wave 1 showed no statistically significant difference $t(167)=.518$ for depression scores. Wave 2 showed marginal significance, $t(174)=.052$, was observed for depression scores. With no significant difference existing between married and cohabiting mothers, this study combined the two categories of married and cohabiting to form a category of partnered.

The second *t*-test, using an independent samples test, focused on the extent to which partnered and not partnered mothers differed for reported levels of depression. The results of this analysis indicated that when compared by mean scores for depression, partnered mothers and not partnered mothers did not differ significantly in either wave. Wave 1 showed no statistically significant difference, $t(284)=.746$, for depression scores. Wave 2 showed no significant difference $t(296)=.151$ was observed for depression scores.

The third *t*-test, using a paired samples test, examined comparisons in depression scores grouped by whether marital status had changed from Wave 1 to Wave 2. Compared to Wave 1, all mothers reported reductions in depression levels at Wave 2. The results of this analysis showed mothers who reported no marital status changes showed significantly lower depression levels in Wave 2 than in Wave 1, while mothers reporting marital status changes did not differ significantly. Mothers with no marital status changes showed statistically significant differences, $t(219)=.000$, $p<.001$, for levels of depression.

Additional examination of the relationship between change in marital status and depression over time employed another paired samples test. This test compared

depression scores grouped by the four subcategories of change in marital status (remained not partnered, remained partnered, gained a partner, and lost a partner) from Wave 1 to Wave 2. The descriptive data showed that all categories of partnership over time reported different depression scores over time. Of the subcategories for change in marital status only mothers who maintained her partnership experienced a significant reduction in depression levels, $t(142)=-.000, p<.001$.

Table 6
Comparisons of Depression Scores Grouped by Marital Status

	Wave 1 (n=307)		<i>t</i> ¹	Wave 2 (n=307)		<i>t</i> ¹	<i>t</i> ²
	<i>Mean</i>	<i>SD</i>		<i>Mean</i>	<i>SD</i>		
Married vs. Living with Partner			.518			.052 ^{``}	
Partnered vs. Not Partnered			.746			.151	
Change in Marital Status from Wave 1 to Wave 2							
No							.000***
Yes							.068
Remained Not Partnered	16.90	11.86		15.32	11.47		.163
Remained Partnered	17.44	11.00		13.17	10.20		.000***
Gained a Partnered	21.56	14.10		17.82	15.66		.232
Lost a Partner	20.71	11.14		18.57	7.40		.522

¹Independent-samples *t*-tests compared means of Wave 1 with Wave 2 mothers.

²Paired-samples *t*-tests compared means of Wave 1 and Wave 2.

* *p*<.05 ** *p*<.01 *** *p*<.001 ``marginal (2-tailed)

Mean Comparison 3: Perceived Social Support and Depression

A series of *t*-tests were run to examine the relationships between social support and depression at Wave 2. The first *t*-test, using independent samples test, analyzed comparisons in depression scores based on high and low levels of social support for the participating mothers. Table 7 presents results that revealed a statistically significant difference between reported depression levels of mothers with high and low levels of perceived social support, $t(280) = .000, p < .001$. Mothers with high levels of social support did experience better psychological health and less distress compared to mothers with low levels of social support.

Another *t*-test examined the difference in depression scores for partnered and not partnered mothers with high and low levels of social support. This test revealed significantly lower depression scores grouped by high and low social support for partnered and not partnered mothers, $t(106) = .003, p < .01$ and $t(172) = .000, p < .001$.

The third *t*-test, using independent samples test, was run to compare depression scores based on high and low levels of social support for mothers grouped by the variable for change in marital status. As presented in Table 7, descriptive data showed that depression scores varied based on level of social support. The *t*-test revealed that these differences in depression scores were significant for mothers who maintained marital status over time; $t(92) = .006, p < .01$ for mothers who remained not partnered and $t(148) = .000, p < .001$ for mothers who remained partnered. Although the greatest difference in depression scores, descriptively, was experienced by mothers who gained a partner, the analysis revealed that no significant statistical difference was observed for mothers who gained a partner $t(12) = .514$ or mothers who lost a partner $t(22) = .228$.

Table 7

Comparisons of Depression Scores Grouped by Change in Marital Status and Level of Social Support at Wave 2

	High Support (N=172)		Low Support (N=110)		<i>t</i> ¹
	<i>Mean</i>	<i>SD</i>	<i>Score</i>	<i>SD</i>	
Partner Status					
Partnered	11.25	8.54	18.12	13.45	.000***
Not Partnered	13.34	9.67	19.56	11.80	.003**
Change in Partner Status					
Remained Not Partnered	12.96	9.89	19.52	12.56	.006**
Remained Partnered	10.77	7.86	17.25	12.32	.000***
Gained a Partner	14.69	12.33	22.45	18.18	.228
Lost a Partner	17.00	6.72	19.75	8.11	.514
High Support vs. Low Support	12.02	9.01	18.70	12.78	.000***

¹Independent-samples *t*-tests compared means of Wave 1 with Wave 2 mothers.

p*<.05 *p*<.01 ****p*<.001 (2-tailed)

Multivariate Analysis of Variance 1: Marital Status and Social Support on Depression

In order to test the Family Stress Model, multivariate analysis of variance was used to determine the extent to which change in marital status and perceived social support affected depressive symptomatology. Descriptive data provided evidence

that scores for depression changed from Wave 1 to Wave 2 for all categories of change in marital status. Descriptive data showed that mothers who remained partnered reported the lowest depression levels (M=14.01, SD=.90). However, unlike predicted, the next lowest scores were reported by mothers who remained not partnered (M=16.24, SD=1.12), mothers who lost a partner (M=18.37, SD=2.87), and mothers who gained a partner (M=18.573, SD=2.17). Results of the MANOVA, shown in Table 8, revealed that no significant difference existed in depression scores for the four categories of change in marital status from Wave 1 to Wave 2, $t(3)=.108$; a significantly lower scores existed in depression for the two categories of social support, $t(1)=.003$, $p<.01$, and no significant difference existed in depression scores for the interaction effect of changes in marital status and social support.

Table 8
Multivariate Analysis of Variance of Marital Status and Social Support on Depression Scores at Wave 2

	Wave 2 (n=282)		<i>R</i> ²
	<i>Mean</i>	<i>SD</i>	
Change in Marital Status			<i>.108</i>
Remained Not Partnered	16.24	1.12	
Remained Partnered	14.01	.900	
Gained a Partner	18.37	2.87	
Lose a Partner	18.57	2.17	
Perceived Social Support			.003**
Change in Marital Status * Social Support			.917

* $p<.05$ ** $p<.01$ *** $p<.001$ (2-tailed)

Multivariate Analysis of Variance 2: Marital Status and Social Support on Change in Depression

A multivariate analysis of variance was used to determine the extent to which change in marital status and perceived social support at Wave 2 was related to change in depressive symptomatology from Wave 1 to Wave 2. As aforementioned descriptive data showed that scores for depression changed from over time. Frequency analyses revealed that 11 mothers (2.4%) reported the same depression scores from Wave 1 to Wave 2, 104 mothers (23.2%) reported higher depression scores at Wave 2, and 172 (38.3%) mothers reported lower scores at Wave 2. Results of the MANOVA, shown in Table 9, revealed that no significant difference existed in the changes in levels of depression for the four categories of change in marital status from Wave 1 to Wave 2, $t(3)=.687$ or for the two categories of social support, $t(1)=.358$, and no significant difference existed in the changes in levels of depression for the interaction effect of changes in marital status and social support $t(3)=.208$.

Table 9
Multivariate Analysis of Variance of Marital Status and Social Support on Change in Depression Scores at Wave 2

	Wave 2 ($n=282$)
	R^2
Change in Marital Status	.687
Perceived Social Support	.358
Change in Marital Status * Social Support	.208

* $p < .05$ ** $p < .01$ *** $p < .001$ (2-tailed)

Mean Comparison 4 and Multivariate Analysis of Variance 3: Race on Social Support and Depression

Although descriptive data indicated that depression scores changed from Wave 1 to Wave 2, a series of *t*-tests and an MANOVA were run, presented in Table 10. The first *t*-test, using paired samples test, focused solely on the extent to which reported depression scores differed over time amongst the races. Depression scores at Wave 1 were compared with depression scores at Wave 2. Comparisons of depression levels showed significantly lower levels for white mothers and mothers of other races, $t(184) = .000, p < .001$ and $t(16) = .023, p < .05$, respectively from Wave 1 to Wave 2. The second *t*-test, using one-sample test, focused solely on the extent to which the mean depression scores compared to the Wave 1 (17.67) and Wave 2 (14.52) sample mean depression score. The results of this analysis indicated that when compared by the sample mean depression score, no statistically significant difference existed. Marginal difference was observed for Hispanic mothers in Wave 1, $t(53) = .057$.

Although descriptive data indicated small changes in social support scores from Wave 1 to Wave 2, a series of *t*-tests were run, also presented in Table 10. The first *t*-test, using paired samples test, focused solely on the extent to which reported social support scores differed over time amongst the races. Comparisons of social support levels showed marginally different scores for Hispanic mothers, $t(51) = .053$, from Wave 1 to Wave 2. The second *t*-test, using one-sample test, focused solely on the extent to which the mean social support scores compared to the Wave 1 (27.99) and Wave 2 (27.31) sample mean social

support score. The results of this analysis indicated that when compared by the sample mean social support score, significantly lower scores existed for Hispanic mothers in Wave 2, $t(62)=-.000, p<.001$.

A MANOVA was used to determine the extent to which race/ethnicity affected depressive symptomatology and perceived social support at Wave 1 and Wave 2. Results of the analyses, shown in Table 10, revealed that no significant difference existed in depression scores for the four categories of race in Wave 1 or Wave 2, $t(4)=.239$ and $t(4)=.462$. While results revealed no significant difference for Wave 1 social support $t(4)=.196$, a significant difference existed in Wave 2 perceived social support, $t(4)=.018, p<.05$.

Table 10

Comparisons of Depression Scores and Social Support Scores Grouped by Race/Ethnicity

	Depression							Social Support						
	Wave 1			Wave 2				Wave 1			Wave 2			
	<i>M</i>	<i>SD</i>	<i>t</i> ²	<i>M</i>	<i>SD</i>	<i>t</i> ²	<i>t</i> ¹	<i>M</i>	<i>SD</i>	<i>t</i> ²	<i>M</i>	<i>SD</i>	<i>t</i> ²	<i>t</i> ¹
Non-Hispanic White	18.53	11.54	.302	15.34	11.71	.328	.000***	27.13	6.48	.350	26.80	7.42	.068	.410
Hispanic/Latino	15.03	9.95	.057``	12.44	9.81	.126	.088	30.55	5.45	.160	28.66	7.00	.000***	.053``
African-American	15.65	12.65	.453	13.71	8.06	.652	.213	29.80	6.66	.147	29.18	5.83	.226	.163
Other Race/Ethnicity	19.82	13.96	.534	13.35	10.28	.646	.023	25.94	7.41	.437	25.52	9.19	.271	.725
<i>R</i> ²	.239			.462				.196			.018**			

¹Paired-samples *t*-tests compared means of Wave 1 with Wave 2 mothers of each race.

²One-samples *t*-tests compared means of Wave 1 and Wave 2 mothers of each race to the sample mean.

p*<.05 *p*<.01 ****p*<.001 ``marginal (2-tailed)

CHAPTER V: Discussion

This study explored the relationships between marital status, social support, and levels of depression among rural, low-income mothers. Specifically, this study examined the way marital status and social support may aid or inhibit the experience of depression. This research built on previous research examining the way in which marriage affects the occurrence of depressive symptomatology. While research suggested that marital status and social support were important buffers to depression, there has been little research exploring these relationships within a rural, low-income population such as those included in this study.

Initial analyses rejected the hypothesis posed by the Social Selection perspective that no change in depression scores would be observed over time. Therefore, *t*-tests and multivariate analyses were employed to determine the extent to which depression levels were significant when compared by marital status, partner status, change in marital status, social support, and time. A measure of partnership was used to divide the sample into two categories of partnered and not partnered. Further analyses were employed for these subcategories to determine if marital status affected depression levels. A measure of change in marital status was used to divide the sample into four categories of remained not partnered, remained partnered, lost partner, and gained partner. These subcategories were then examined to determine whether or not change in marital status predicted change in psychological health. A measure of perceived social support was used to divide the sample into two categories of “high” and “low” social support. These subcategories were then further examined to determine whether or not social support served to moderate the link between marital status and levels of depression.

Characteristics of Rural Mothers

A number of differences between rural mothers in this sample are evident in demographic characteristics. A lower proportion than the general population of the mothers is of minority status, with roughly a third of the mothers being either Hispanic/Latina, African American, or of another racial/ethnic background. Of the mothers of minority status, less than a tenth of the mothers were African American. Slightly less than half of the mothers were married despite the barriers to marriage of poverty and race as suggested by the literature.

The Relationship between Marital Status and Depression

Consistent with the model proposed in this study depicted in Figure 1, it was hypothesized that marital status would affect depression levels with married mothers reporting lower levels of depression than non-married mothers. The current sample did not produce evidence in Wave 1 that married mothers were psychologically healthier than unmarried mothers. Surprisingly, single mothers had the lowest depression score, followed by married mothers, divorced mothers, mothers living with a partner, and separated mothers, respectively. Although the difference in depression scores for single and married mothers was not statistically significant, married mothers did not possess the lowest depression score as expected. Such findings are not completely consistent with previous research (Gove et al., 1983; Gove & Shin, 1989; Marks, 1996; Pearlin & Johnson, 1977; Stack & Eshleman, 1998; Waite, 2000; Williams et al., 1992). Although single mothers reported lower depression levels and the depression scores for single and married mothers were below the mean depression score (17.67) of the study sample, the scores were still above the CES-D cutoff score for determining depressive

symptomatology. This suggested that although these mothers reported lower depression scores relative to the other participating mothers, they still presented with some depressive symptoms. In Wave 1, single and married mothers presented to be psychologically healthier than cohabiting, divorced, and separated mothers. However, according to a clinical judgment regarding psychological well-being, they are not psychologically healthy.

Again, in Wave 2, depression scores were not as expected. Analysis of the study sample provided evidence that married mothers experienced the lowest levels of depression. Divorced mothers reported the next lowest levels followed by single mothers, mothers living with a partner, and separated mothers, respectively. Consistent with past research, Wave 2 analyses found that married mothers did report lower levels of depression (Gove et al., 1983; Marks, 1996) and separated mothers did report the highest levels of depression (Gove & Shin, 1989; Williams et al., 1992). However, variant from other studies, cohabiting mothers did not report the levels that fell between the married and those without partners (Stack & Eshleman, 1998; Waite, 2000). These findings imply that for this sample of rural, low-income mothers, marital status does not predict or affect psychological well-being.

Marital Status vs. Partner Status

In response to past literature about cohabiting and marriage, this study examined the similarities and differences between cohabiting mothers and married mothers. It was found that no significant difference existed for these mothers in terms of depression scores and perceptions of social support. Therefore, the categorical groups for marital status changed to partner status with two subcategories: partnered and not partnered.

Accordingly, it was further hypothesized that partnered mothers would report lower depression scores than not partnered mothers. The mean depression scores of the partnered and not partnered mothers were compared to find that no significant difference existed in Wave 1 or Wave 2. Such findings imply that when grouped by partner status, rural, low-income mothers' experiences of depression did not vary significantly.

The Relationship between Perceived Social Support and Depression

The proposed model also presented the thesis that levels of perceived social support would affect depression scores. This study predicted that mothers reporting high levels of social support would experience lower levels of depression compared to mothers reporting low levels of social support. Raw scores illustrated differences in reported levels of social support in both waves. Further analyses supported the hypothesis that this group of low-income, rural mothers with high levels of social support experienced lower levels of depression than mothers with low levels of social support.

The Relationship between Marital Status, Social Support, and Depression

Another hypothesis of this study was that married mothers would experience the lowest levels of depression regardless of reported levels of social support, followed by unmarried mothers with high levels of social support, and then unmarried mothers with low levels of social support. Results provided partial support for this hypothesis. Descriptive data showed that partnered mothers with high levels of social support did possess the lowest levels of depression. However, the not partnered mothers with high levels of social support had the next lowest levels of depression. The partnered mother with low levels of social support, and the not partnered mother with low levels of social support reported the highest levels of depression symptoms followed. Results revealed

that partnered mothers with high levels of social support were psychologically healthier. Not partnered mothers with low levels of social support experienced the greatest levels of psychological distress. This analysis did not provide support that marital status is more of a predictor of psychological health than levels of perceived social support.

Consistent with past research, this study found social support to be a possible reducer of stress and depression (Green & Rodgers, 2001). Similar to Cotton (1999), this study also found that regardless of marital status, the lack of social support results in higher depression levels. Comparable to previous research, this study found that the lower the levels of social support, the higher the level of depression (Cotton, 1999).

The Relationship between Life Changes and Depression

In order to test the Family Stress Theory, this research tested the effects of the significant life changes of change in marital status and change in social support on psychological health. Results did not provide evidence that the maintenance of marital status over time resulted in unchanged levels of depression. Analyses also failed to support the hypothesis that mothers who lose a partner will have an increase in depression levels. The descriptive data showed that all categories of partnership over time reported different depression scores. On average, every mother reported improved psychological health. Although change in depression scores was observed for all subcategories of change in marital status, none of the categories experienced significant differences in depression scores, except for mothers who remained partnered. Results provided partial evidence for the hypothesis that the order of psychological health would be: 1) mothers who were partnered at both waves; 2) mothers who gained a partner at Wave 2; 3) mothers who were not partnered at both waves; and 4) mothers who lost a

partner at Wave 2. This study found mothers who remained partnered experienced the least psychological distress and mothers who lost a partner at Wave 2 experienced the most psychological distress. However, mothers who remained not partnered experienced less depression than mothers who gained a partner. This suggested that although gaining a partner is often a positive experience, it is still more stressful than remaining not partnered. While this analysis revealed change in marital status over time, it also revealed that maintenance of a partnership over time reflected changes in depression scores. This suggested that these changes in depression levels were not related to change in marital status, but perhaps some other variable.

This study examined the depression scores based on levels of social support for the subcategories of change in marital status over time. Results found considerable difference for mothers who maintained partner status. Depression scores varied significantly for these mothers with high and low levels of social support. For mothers who remained partnered and not partnered, high social support resulted in low levels of depression. These levels were below the CES-D cutoff score for predicting depressive symptomatology, suggesting that when partner status does not change and with high levels of social support, rural, low-income mothers are psychologically healthy. For these mothers with unchanged partner status and low social support, they had high levels of depression. These levels were above the CES-D cutoff score, suggesting that even when partner status does not change, with low levels of social support, rural, low-income mothers present with depressive symptomatology. For all categories of change in partner status, high social support was associated with lower levels of depression. The only subcategory to experience depression scores above the cutoff score was those mothers

who lost a partner. Mothers who lost a partner between Wave 1 and Wave 2 and had high social support reported a mean depression score of 17, which is very slightly over the cutoff score of 16. Such a score is not a depression diagnosis, but does indicate some depressive symptoms. Additionally, all mothers with change in partner status who reported low levels of social support, also reported high levels of depression. This implies that change in partner status affects psychological health when levels of social support are low.

To further examine life changes and depression levels, a MANOVA was employed to determine the relationship between changes in marital status on depression, changes in social support on depression, and the interactive effect of changes in marital status and changes in social support on depression. Due to data coding and the means for calculating high and low social support, change in social support over time was not analyzed. Instead, this study assessed change in partner status from Wave 1 to Wave 2, perceived social support at Wave 2, and depression scores at Wave 2.

No significant difference was observed for solely change in marital status over time and reports of depressive symptoms. This suggested that the two variables are unrelated. Additionally, no significant difference was observed for the interaction of change in marital status and Wave 2 social support. However, Wave 2 reports of perceived social support did result in significantly different depression scores. When grouped by high and low levels of social support and change in marital status, depression scores were significantly lower for mothers with high support when marital status was maintained over time. Mothers who remained partnered and not partnered reported a negative correlation with social support and depression levels.

To further test the relationship between changes in marital status, social support, and depression, changes in depression over time were examined. Results revealed no significant difference in change in depression scores from Wave 1 to Wave 2 for the four categories of change in marital status, the two categories of social support at Wave 2, or the interaction of change in marital status and social support. This suggested that no relationship exists between marital status, social support, and depression.

Race/Ethnicity

In response to past literature about race, social support, and psychological health, this study examined the similarities and differences between the four categories of race. It was found that no significant differences existed between the races in terms of depression scores or when compared to the Wave 2 sample mean depression score. However, significant difference was observed for social support scores amongst the races. Such a finding suggested that different races experience variant levels of social support.

The comparison of mean scores of depression and social support at Wave 1 and Wave 2 showed that white mothers and mothers of other races experienced statistically significant changes in depression over time, and Hispanic mothers experienced statistically significant changes in perceived social support over time. At Wave 1, Hispanic and African American mothers experienced the lowest levels of depression that were lower than the sample mean and the CES-D cutoff score, while White mothers and mothers of other races reported depression scores higher than the sample mean and the CES-D cutoff score. This suggested that overall, Hispanic and African American mothers are psychologically healthier than White mothers and mothers of other races. At

Wave 2, all of the mothers experienced lower levels of depression and reported scores lower than the CES-D cutoff score. Only white mothers reported scores above the sample mean depression score at Wave 2. This suggested that over time, these mothers' psychological health improved.

Analyses provided partial evidence to accept the hypothesis that minority mothers would report higher levels of social support than white mothers. Descriptive analysis revealed that in both waves, Hispanic and African American mothers reported the highest levels of social support, which were also above the sample mean for social support thus categorizing them as mothers with high social support. White mothers and mothers of other races reported the lowest levels of social support which were also below the sample mean thus categorizing them as mothers with low social support.

Summary of Findings

This study found no evidence that the Social Selection Theory applied to this sample population. Instead, changes in depression levels occurred from Wave 1 to Wave 2. Although differences in depression levels were reported amongst the categories for marital status, these differences were not statistically significant. This suggested that marital status has no bearing on the experience of depression among this sample of rural, low-income mothers.

Analysis employed to test the Family Stress Theory found that while various categories of change in marital status did not produce significantly different reports of depressive symptomatology, the two subcategories for change in perceived social support did. When grouped by social support levels, those who remained married reported a negative correlation between social support and depression. Results indicated that

perceived social support, rather than marital status had the greater impact on psychological health. Such a finding is consistent with research on social support. As aforementioned, marriage can be a form of social support. While some researchers found that the presence of a partner is psychologically beneficial, others suggested that the resources provided by marriage such as social support and extended networks for support is what is advantageous.

Limitations

Although the current study provided an important contribution to literature in the area of rural marital relationships, social support, and psychological well-being, there are a number of limitations that need to be considered. First, it is important to note that this study involved the use of secondary data analysis. The study from which the sample was drawn was not explicitly designed to investigate the experiences of mothers with various classifications of marital status and social support; therefore only available variables could be used to examine the relationships between marital status, social support, and psychological health.

Specifically, the study did not include information about marital history, marital quality and satisfaction, or specific sources of social support, making it difficult to draw conclusions about how marital status and social support may have impacted depression levels. The failure to find a link between past, current, and change in marital status and psychological well-being may be due in part to the fact that current marital status gives no indication of when or for how long a participant has had a particular marital status or how satisfied a participant has been within her particular marital status. Furthermore, the lack of relationship data other than marital status, such as information about the quality of

the mothers' relationships and relationship satisfaction, made it difficult to truly understand the experience of the mothers. For example, it is possible that depression scores improved for mothers who lost a partner because the quality of the relationship was poor. A mother in a low quality relationship could possibly experience less stress and relief for leaving her relationship. Additionally, mothers may be more inclined to exhaust all sources of social support once she has lost her intimate support, thereby making her levels of social support increase, and subsequently improving her psychological health. Unfortunately, without this information, it is difficult to make such inferences.

The use of the parenting ladder as a measure of social support is another limitation for the current study, as it is not a standardized measure of support and thus makes findings difficult to generalize to other samples and populations. Additionally, the parenting ladder does not distinguish who provides the support, thereby making it difficult to determine if the social support measured in this study comes from the intimate partner or other people or places. Further, because the categories of "high" and "low" social support were assigned according to the sample median, they should only be interpreted in relation to each other, and not as absolute standards. Additionally, each wave had different values for the mean levels of social support as well as variant percentiles. When interpreting social support in relation to the means or percentiles, the results are only relative. Without knowing who changed her perception of social support, who did not, and to which subcategory change occurred, it was impossible to test the family stress model by analyzing the effect of change in social support on depression

scores or the true interaction effect of change in marital status and change in social support on depression levels.

Another limitation is the use of a depression scale to measure psychological distress. The use of a depression scale is limiting because it does not assess other aspects of psychological distress such as anxiety, psychosis, or schizophrenia. Additionally, using a depression scale is a measure of depression and not a measure of psychological health. Another limitation of this study was the use of change in marital status as a measurement of stressor. This variable did not directly measure stress, therefore the conclusions drawn about psychological health and stress may not be accurate.

A fourth limitation is the number and ratio of mothers grouped into each race category. With a disproportionate population of white mothers to minority mothers, this study did not provide an accurate report of how marital status and social support affect psychological health for all races. Additionally, results cannot be generalized for minority rural, low-income mothers, especially for the categories of African American and Other because the sample sizes were considerably small. However, such a disproportionate sample could serve as evidence to who actually comprise the rural poor.

Another limitation of this research was the lack of analysis of other changes occurring for this sample from Wave 1 to Wave 2. Because this study examined rural, low-income mothers, it would have been beneficial to consider socioeconomic indicators of change continually over time. This study found that depression scores lowered over time for this sample, however, it was not related to marital status. The study of other variables, such as change in income, addition of children, change in employment, and

change in expenses, could give more insight into what is influencing the improvement of psychological health.

A sixth limitation is the use of change in marital status as an indicator of stress. Although research shows that significant life changes are stress-inducing events (Holmes & Rahe, 1967), an instrument or question directly measuring the experience of stress could have provided a more accurate view of the mothers' experience. As previously mentioned, changes in marital status can be stress-inducing or stress-reducing. Such an indirect measurement of stress makes it difficult to clarify the connection between stress and psychological health, which is the focus of the Family Stress theory.

There were a number of potential threats to the external validity of this study. Findings cannot be generalized because the sample was not randomly selected. These mothers willingly participated in the lengthy interviews, and most likely had some type of contact pre-established with a local community or social services agency. This pre-existing relationship could have influenced their perceptions of social support. Finally, grouping rural mothers from 14 different states together and drawing conclusions about the group as a whole could potentially overlook economic and social influences that vary by region.

Future Research

The limitations and findings discussed here suggested a number of possible directions for future research. First, this study highlights the need for more research in the area of low-income, rural relationship status, social support, and psychological well-being. The lack of empirical studies pertaining to rural marital status and depression available in the course of this research leaves a great deal to be learned about the

experience of rural, low-income mothers. While this study focused on how marital status and social support affected psychological health within a rural sample, it would be helpful to conduct similar research comparing across rural and non-rural samples as well as with a randomized sample. Additionally, greater knowledge of the challenges and circumstances that are unique to rural areas is necessary to go beyond broad generalizations to more informed, region-specific findings. Even within rural regions, there is great variability, and thus it would be beneficial to conduct research comparing rural samples from different regions of the country in order to more fully account for unique economic and social influences.

Findings from this study also highlight the need for more research examining the causes of change in psychological health and how marital status and social support can be helpful or a hindrance. Specifically, consideration of other factors that may mediate the relationship between marital status and psychological outcomes could shed further light on the process. Other considerations include but are not limited to: marital satisfaction, marital quality, spousal support, social support other than parental support, social support from family and friends, social support from outside facilities and services, and other significant life changes such as change in employment, change in income, and change in household members.

The use of qualitative data could further illuminate the process and circumstances surrounding psychological well-being. Because of the uncertain causal direction of marriage and social support, further research is needed to determine if rural, low-income mothers are healthier because of social support provided by marriage or by social support provided beyond the institution of marriage. Additionally, a standardized measure of

social support that more precisely assesses the level and sources of mothers' social support is necessary to improve the reliability and validity of social support findings.

Program and Policy Implications

The current study has important implications for practitioners and policymakers concerned about marriage promotion for rural, low-income mothers. The lack of a relationship between marital status and depression suggested that efforts to promote marriage among these mothers could be fruitless because marriage appears to not be as helpful for the rural, low-income population as has been assumed by those supporting marriage among low-income mothers. In light of recent efforts to promote marriage as a means of reducing poor outcomes for single parents, this finding suggested that such policies will not necessarily impact mothers' depression levels, thus their psychological well-being. It is possible that marriage promotion programs in rural areas should not be implemented or supported until further research reveals that being married is beneficial to women's overall well-being.

For rural, low-income mothers who experienced depression, findings suggested that social support played an important role in helping these mothers cope with and buffer depression. While mothers in this study who reported having high social support clearly benefited from that support, filling the gap for mothers who do not have those built-in support systems is a challenge for program planners and policymakers. More emphasis should be placed on ways of strengthening rural mothers' support networks and reinforcing those networks that currently exist, in an effort to provide increased levels of social support in numerous arenas of social interaction. Emphasis on informal networks is especially important in rural areas, as rural mothers are more likely to be

geographically isolated and have fewer formal or community resources from which to draw.

Policymakers should seek to reinforce and strengthen informal support networks through policies that reward informal contacts for in-kind assistance, such as child care. Additionally, policymakers and program planners should consider ways to enhance social support in various spheres of rural mothers' lives, including the transportation system, the family, and the community. More specifically, rural, impoverished mothers could benefit from enhanced provisions for available, affordable, and accessible transportation services, childcare services, and medical and psychological services. Each of these areas of intervention provides possible opportunities to help mothers through the networks of which they are already a part and create networks for these mothers to become part. For example, providing working mothers with access to affordable transportation to and from work is one possible way to capitalize on occupational and community sources of social support. It is possible that greater access to others is one simple but meaningful way that mothers' perceptions of social support could be increased.

Conclusion

The major purpose of this study was to examine the relationship between marital status, social support, and psychological health among rural, low-income mothers. Findings indicated that marital status had little effect on the experience of psychological distress, while the perception of social support negatively affected psychological distress. Marital status had more of an effect when the status was maintained over time and when considering levels of social support. The more social support mothers' perceived, the less depressive symptomatology reported. These findings suggested that social support

can play an important role in helping rural, low-income mothers to overcome obstacles associated with poverty and a rural location. Because of a limited amount of research in the area of rural social support in relation to psychological outcomes, more research is needed to further clarify the link between these variables. However, these initial findings provide a meaningful starting point for focusing research on ways to assist rural mothers in difficult circumstances, and point to the importance of social support as a possible means by which to achieve that goal.

APPENDIX: Depression Measure
(Excerpted from “The CES-D Scale, A Self-Report Depression Scale for Research in the
General Population,” Radloff, 1977)

During the Past Week:

1. I was bothered by things that usually don't bother me.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

2. I did not feel like eating; my appetite was poor.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

3. I felt that I could not shake off the blues even with help from my family or friends.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

4. I felt that I was just as good as other people.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

5. I had trouble keeping my mind on what I was doing.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

6. I felt depressed.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

7. I felt that everything I did was an effort.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

8. I felt hopeful about the future.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

9. I thought my life had been a failure.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

10. I felt fearful.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

11. My sleep was restless.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

12. I was happy.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

13. I talked less than usual.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

14. I felt lonely.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

15. People were unfriendly.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

16. I enjoyed life.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

17. I had crying spells.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

18. I felt sad.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

19. I felt that people dislike me.
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

20. I could not get "going."
 - a. Rarely or None of the Time
 - b. Some or a Little of the Time
 - c. Occasionally or a Moderate Amount of Time
 - d. Most or All of the Time

APPENDIX: Social Support Measure
(Excerpted from “The Parenting Ladder,” Richards, 1998)

THE PARENTING LADDER

- 6 High
- 5
- 4
- 3
- 2
- 1
- 0 Low

Parenting is often smoother when others are there to help. Where would you put yourself on the Parenting Ladder in terms of:

- Other parents for you to talk to? _____
- Someone to help you in an emergency? _____
- Someone to offer helpful advice or moral support? _____
- Someone for you to relax with? _____
- Professional people to talk to when you have a question about your child? _____
- Your overall satisfaction with the amount of support in your life? _____

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