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**Multidomain engagement and self-reported psychosomatic symptoms in
middle-aged women and men**

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1 Running Head: MULTI-DOMAIN ENGAGEMENT AND PSYCHOSOMATIC
2 SYMPTOMS
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4 Multi-Domain Engagement and Self-Reported Psychosomatic Symptoms in Middle-
5 Aged Women and Men

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26 Abstract

27 *Background:* Multimorbidity can be operationalized as the presence of multiple
28 psychosomatic symptoms and has been shown to be detrimental to the quality of life
29 across the life span. Middle-aged adults are generally engaged in multiple life
30 domains simultaneously; this is one of the developmental challenges of middle
31 adulthood as it can lead to conflict between the demands of different domains and, in
32 turn, contribute to multiple psychosomatic symptoms, thereby diminishing the quality
33 of life. This may be particularly true for women. Facilitation between life domains
34 may serve to reduce the number of psychosomatic symptoms, but this subject has
35 been largely neglected in the literature.

36 *Objective:* We aimed to close this gap by investigating the influence of conflict and
37 facilitation between life domains (work, family, leisure) on the frequency of
38 psychosomatic symptoms in middle-aged women and men.

39 *Methods:* Life domain conflict/facilitation and psychosomatic symptoms were
40 assessed via self-report in a cross-sectional study with $N = 277$ adults aged 30 to 55
41 years ($M = 41.70$, $SD = 7.2$; 56.7% women) who all worked at least 30 hrs/week and
42 lived with their partner or family.

43 *Results:* In line with our hypothesis, women were found to experience more
44 psychosomatic symptoms when they experience conflict between life domains.
45 However, contrary to expectation, they did not profit more from facilitation than men
46 did and, at low levels of facilitation, women reported having more psychosomatic
47 symptoms than men. In men, there was no association between life domain
48 conflict/facilitation and psychosomatic symptoms. The results were robust when
49 statistically controlling for neuroticism.

50 *Conclusions:* Engagement in multiple life domains influences the frequency of
51 psychosomatic symptoms in women, but not in men. Thus, women suffer more and
52 profit less than men from combining work, family, and leisure.

53 *Key Words:* multimorbidity, quality of life, psychosomatic symptoms,
54 conflict, facilitation, sex differences

55

56 Multi-Domain Engagement and Self-Reported Psychosomatic Symptoms in Middle-
57 Aged Women and Men

58 *Multimorbidity* is defined as the co-existence of two or more chronic medical
59 conditions in an individual and has been linked to reduced quality of life (e.g., [1]). In
60 fact, there is widespread agreement in the literature that quality of life is a
61 multidimensional construct that includes physical well-being [2]. Psychosomatic
62 symptoms do not necessarily reflect medical conditions, but they constitute an
63 important, subjective aspect of physical well-being. Given that the “poorer physical
64 functioning that accompanies multimorbidity is persistent and may even increase over
65 time” [3, p. 211], adults who already subjectively experience poorer physical
66 functioning due to multiple psychosomatic symptoms in young or middle adulthood
67 might be at particular risk for disadvantageous trajectories in old age. In other words,
68 (un-)successful aging does not begin only in late adulthood but constitutes a lifelong
69 process that continues into very old age. Thus, because they have an impact on the
70 quality of life and are a precursor of (un-)successful aging, it is important to
71 understand the factors that contribute to the co-existence of multiple psychosomatic
72 symptoms in young and middle adulthood.

73 From a psychological perspective, the diagnosis of multiple “silent” medical
74 conditions (i.e., one without symptoms that are perceivable to the patient) might not
75 be the best operationalization of multimorbidity. Instead, one would expect the
76 number of symptoms perceived by the patient—regardless of whether they are linked
77 to one or multiple medical conditions—to affect psychological well-being. In fact, in
78 their review of the literature on multimorbidity and quality of life, Fortin and
79 colleagues [1] concluded that multimorbidity, operationalized as the presence of
80 multiple chronic medical conditions, appeared to affect the medical dimensions of

81 quality of life more strongly and the psychological dimensions of quality of life less
82 consistently. Thus, taking a psychological perspective, we investigated the
83 antecedents of self-reported psychosomatic symptoms. In the following, we will focus
84 on people's engagement in multiple life domains (i.e., conflict and facilitation in the
85 domains of work, family, and leisure) during the "rush hour" of life, that is, late
86 young and middle adulthood, as one of the factors that might contribute to the number
87 of psychosomatic symptoms. Moreover, we investigated whether there are sex
88 differences with respect to the impact of conflict/facilitation between life domains on
89 the number of reported psychosomatic symptoms.

90 **Young and middle adulthood as the rush hour of life**

91 Freund, Nikitin, and Ritter [4] have argued that young and middle adulthood
92 could be described as the "rush hour" of life [5] due to the prolonged phase of
93 "emerging adulthood" [6] in many Western societies combined with age-related
94 constraints on opportunity structures for the central developmental tasks of young
95 adulthood, namely, establishing a professional career and starting a family. It appears
96 that young adults postpone having children until they have finished the nowadays
97 rather prolonged education and role exploration phase. In addition, prescriptive social
98 norms regarding the timing of life-course transitions have weakened and the number
99 of options available to young adults in their search for a profession, partner, and
100 lifestyle has increased [7]. However, age-graded social opportunity structures (e.g.,
101 age-graded access to education and—often unofficial—age limitations for certain career
102 opportunities) as well as biological constraints (e.g., age-related decline in fertility)
103 increase the pressure to start a family and launch one's career in late young or middle
104 adulthood. As a result, the age group between 30 and 55 has to cope with the
105 simultaneous engagement in multiple, highly resource-demanding life domains.

106 The demands of being engaged in multiple life domains simultaneously can be
107 overwhelming and lead to conflicts. Regarding the pursuit of multiple goals, Riediger
108 and Freund [8, 9] found in several studies that young adults and early middle-aged
109 adults reported higher degrees of intergoal conflict than late middle-aged or older
110 adults. Conflict stemming from one's pursuit of multiple goals simultaneously occurs
111 when there are insufficient resources such as time or energy to pursue all of them
112 satisfactorily or when goal-related activities are incompatible (e.g., picking up one's
113 child from childcare and working long hours). In contrast, they found that facilitation
114 between goals increased across adulthood. *Facilitation* occurs when a single activity
115 serves goals in more than one domain (e.g., working out with one's partner serves
116 both family and leisure goals) or when one goal is instrumental in achieving another
117 goal (e.g., getting a well-paying job supports the family).

118 The research reported thus far focused on conflict and facilitation between
119 personal goals in various life domains and used goal pursuit or subjective indicators
120 of well-being as outcome variables. None of these studies investigated
121 conflict/facilitation between life domains in a broader sense or went beyond personal
122 goals, nor have they included psychosomatic symptoms as an outcome variable.

123 Taking a broader perspective and building on work by Greenhaus and Beutell [10],
124 we argue that conflict between life domains occurs when engagement in one life
125 domain hinders or precludes engagement in another. Similarly, facilitation occurs
126 when engagement in one life domain enables or enhances engagement in another.

127 There is first evidence concerning cross-domain conflicts and psychosomatic
128 symptoms: In a study with a large sample of female homecare nurses, Höge [11]
129 found that the experience of work–family conflicts partially mediates the relationship
130 between work-related time pressure and psychosomatic symptoms. However, Höge

131 only examined (a) two domains (viz., work and family) and (b) the experience of
132 conflict between domains. In contrast, the present study focused on three domains
133 (work, family, leisure) and on conflict as well as facilitation between domains.

134 **Multi-domain demands, stress, and psychosomatic symptoms**

135 Given that simultaneous engagement in multiple life domains places high
136 demands on resources, it is likely that young and middle-aged adults feel stressed
137 during the “rush hour” of life. In fact, according to Lazarus [12], stress occurs when
138 the demands of a given situation overtax a person’s resources. Stress, in turn, has been
139 shown to be related to psychosomatic symptoms. For instance, Frese [13] found that
140 subjective psychological and physical stress at work was significantly related to
141 psychosomatic symptoms across different samples of workers and that these
142 associations were robust when he controlled for potential third variables such as
143 income or SES. Moreover, the results of cross-lagged analyses of a longitudinal study
144 suggest that stress leads to an increase in psychosomatic symptoms (not vice versa).
145 There is increasing interest in the relationship between the stress caused by conflicts
146 resulting from simultaneous engagement in multiple life domains, particularly work
147 and family, and psychosomatic symptoms (e.g., [11]).

148 Most of the research on engagement in multiple life domains has focused on
149 the conflict and negative spillover between them. Research has only just begun to also
150 address the topic of facilitation between different life domains. However, work and
151 family not only conflict with each other, they can also facilitate each other. For
152 instance, positive experiences in the family domain can result in a positive mood that
153 spills over to the work domain (e.g., [14, 15]). Extending the concept of work–family
154 relationships to include facilitative relationships between the two domains, Wiese,
155 Seiger, Schmid, and Freund [16] found that positive outcomes (i.e., job or partnership

156 satisfaction) were primarily related to facilitation and not to conflict between work
157 and family.

158 In addition to the life domains of work and family, we also investigated that
159 of leisure in the present study because leisure has been found to play an important role
160 in coping with work-related stress and might help people to recover, to increase
161 productivity, and to prevent burnout (e.g., [17]). At the same time, however, leisure
162 activities draw on the time a person can spend with her/his family (at least when
163 family members cannot be included in leisure activities) or invest in work-related
164 tasks. Therefore, research on the effect of engagement in multiple life domains and
165 stress-related outcomes, such as psychosomatic symptoms, need to consider leisure as
166 well as work and family.

167 One of the problems encountered when assessing a person's psychosomatic
168 symptoms and/or perceived conflict/facilitation between life domains is that his/her
169 reports may be biased towards more positive or negative aspects of his/her situation
170 and well-being. In other words, correlations between perceived life-domain conflict
171 and psychosomatic symptoms might be spurious due to the fact that both are caused
172 by the person's generally negative perception of and report about psychological and
173 physiological experiences. A key candidate for a personality variable causing such a
174 spurious correlation is neuroticism. In fact, neuroticism has long been linked to
175 increased reports of psychosomatic symptoms (see, e.g., [18]). Moreover, there are
176 sex-related differences in neuroticism such that women score somewhat higher than
177 men (e.g., [19]). Thus, the present study controlled for the impact of neuroticism on
178 the associations between engagement in multiple life domains and reports of multiple
179 psychosomatic symptoms.

180 **Sex-related differences**

181 Previous research has consistently shown that women report more physical
182 and psychosomatic symptoms than men do. For instance, Kroenke and Spitzer [20]
183 investigated a sample of 1,000 primary care patients and found that most symptoms
184 (e.g., headache, back pain, fatigue, dizziness) were reported about 50% more
185 frequently by women than by men. Similarly, women report more pain symptoms (for
186 an overview, see [21]). Some experimental work suggests that the pain threshold as
187 well as pain tolerance may be lower in women than men (e.g., [22]). Interestingly,
188 Keogh and Birkby [22] found that anxiety sensitivity was associated with sensory
189 pain in women but not men. So, maybe women who are more sensitive to conflicts
190 between life domains are also more sensitive to physical symptoms and, hence, report
191 more psychosomatic symptoms. This would be in line with research showing that
192 stress leads to more psychosomatic symptoms in girls than boys and in women than
193 men (e.g., [23]). In their study of the effect of the burden of having to combine work
194 and family, Väänänen and colleagues [24] found that both men and women who
195 reported that their work-related roles and activities negatively affected their family
196 life had a significantly higher risk of experiencing psychological distress (i.e.,
197 discomfort or unpleasant emotions such as sadness or anxiety) and reported poorer
198 subjective health.¹ In addition, women (but not men) experienced more psychological
199 distress and poorer subjective health when their family-related goals were perceived
200 to have a negative impact on their work life. Thus, overall, women seem to suffer
201 more from conflicts emerging from their engagement in multiple life domains.
202 However, given that positive social relationships (social support) appear to counteract

¹ Different to psychosomatic symptoms, which are usually assessed using symptoms checklists (see Method section below), subjective health is typically assessed by an item calling for an overall evaluation of health: “Overall, how would you currently rate your health?”

203 work-related stress more in women than in men [25], we expect women also to profit
204 more than men from facilitation between life domains.

205 In summary, we hypothesize that women—but not men—will report more
206 psychosomatic symptoms when they experience conflict resulting from their
207 engagement in multiple life domains and fewer psychosomatic symptoms when they
208 experience facilitation between the different life domains.

209 **Method**

210 In this cross-sectional study, we investigated sex-related differences in the
211 relationship between conflict/facilitation arising from simultaneous engagement in
212 multiple life domains and self-reported psychosomatic symptoms in a sample of
213 young and middle-aged men and women. The data reported here were collected
214 online and constitute the first measurement occasion of a larger ongoing three-wave
215 longitudinal study.

216 **Sample**

217 We recruited participants through their workplace, newspaper articles, and
218 advertisements on Internet platforms and in newsletters. The criteria for participation
219 were age (30 -55 years), working ≥ 30 hrs/week, living with their partner or family.
220 The resulting sample consisted of $N = 277$ adults aged 30 to 55 years ($M = 41.70$, SD
221 $= 7.2$; 56.7% women). Most (78.7%) of the participants were Swiss; the remaining
222 participants reported other nationalities, but were fluent in German. The majority of
223 the sample (86.6%) reported being in a steady partnership; 30.8% had no children
224 19.2%, had one child, 33.7% had two, and 16.3% had three or more children.

225 **Procedure**

226 Adults interested in participating in the study followed a link to a webpage.
227 After providing informed consent, they completed a questionnaire that assessed

228 conflict and facilitation between the life domains of work, family, and leisure;
229 neuroticism; and psychosomatic symptoms. Participation was reimbursed with 60
230 Swiss francs (for the longitudinal questionnaire part of the study).

231 **Materials**

232 **Relations between life domains.** The relations with respect to conflict and
233 facilitation between the life domains of work, family, and leisure were assessed using
234 two separate scales.

235 **Conflict.** Conflict between life domains was measured using an adapted
236 questionnaire originally created by Carlson and Frone [26], which assesses conflicts
237 between work and family. We extended the original questionnaire to include the
238 leisure domain, shortened it to 36 items, and translated it into German. A sample item
239 for conflict spilling over from the family to the leisure domain is: “How often does
240 your family life or partnership keep you from spending the amount of time you want
241 on leisure?” Ratings ranged from 0 (*never*) to 5 (*always*), $\alpha = .90$, $M = 1.91$, $SD =$
242 0.60.

243 **Facilitation.** Facilitation between the life domains was measured using a
244 questionnaire by Wiese et al. [16] that assesses transfer of positive mood, transfer of
245 competencies, and compensation between work and family. We extended the original
246 questionnaire to include the leisure domain and shortened it to 58 items. A sample
247 item for the transfer of positive mood from the leisure to the work domain is: “If I am
248 in a good mood when undertaking my leisure activities, I am in a good mood at work,
249 too.” Ratings ranged from 0 (*not true at all*) to 5 (*completely true*), $\alpha = .94$, $M = 3.28$,
250 $SD = 0.64$.

251 **Self-reported psychosomatic symptoms.** The list of psychosomatic
252 symptoms was a slightly modified version of the Symptom Checklist-90-R (SCL-90-

253 R; German version [27]) to which we added one item about sleep disorders. The 12
254 items assessed psychosomatic symptoms such as headaches, back pain, dizziness, etc.,
255 over the past few days. The severity of psychosomatic symptom was rated on a scale
256 ranging from 0 (*not at all*) to 5 (*extremely*). We recoded the ratings so that 0 = no and
257 1 to 5 = yes. The reason for dichotomizing the scale was that the distribution was
258 better for the dichotomized than for the continuous score. Moreover, given that we
259 used reported psychosomatic symptoms as an indicator of multimorbidity, we were
260 interested in the number rather than the severity of perceived symptoms. Finally,
261 simply counting the number of self-reported diseases seems to result in almost as
262 good a predictor of most outcomes as complex measures of multimorbidity do [28].
263 Thus, a sum score of the number of psychosomatic symptoms was computed. This
264 score ranged from 0 to 13, $\alpha = .78$ $M = 4.58$, $SD = 3.1$. The continuous and the
265 dichotomized scores were highly correlated ($r = .88$, $p < .001$).²

266 **Neuroticism.** We assessed neuroticism using the four items of the German
267 version of the Big Five Inventory that showed the best correlations with the
268 neuroticism factor [29]. The rating scale ranged from 0 (*very uncharacteristic*) to 5
269 (*very characteristic*). Items were averaged to a mean score for the analyses (range: 0–
270 5, $\alpha = .75$, $M = 1.9$, $SD = 0.99$).

271 **Results**

272 Zero-order correlations between the study variables showed that the number of
273 psychosomatic symptoms reported was significantly (positively) associated with
274 cross-domain conflict ($r = .31$, $p < .001$) and neuroticism ($r = .41$, $p < .001$), but not
275 with facilitation ($r = -.11$, *ns*). The number of reported psychosomatic symptoms was
276 unrelated to age ($r = -.01$, *ns*). Conflict and facilitation did not correlate with each

² We also ran all of the analyses reported below with the score aggregating the continuous ratings and found no differences in the results.

277 other ($r = .06, ns$), but both correlated moderately with neuroticism ($r_{\text{conflict/neuroticism}} =$
 278 $.28, p < .01$; $r_{\text{facilitation/neuroticism}} = -.17, p < .01$).

279 Regarding sex differences, women reported having more psychosomatic
 280 symptoms than men did ($M_{\text{women}} = 5.05, SD = 3.34$; $M_{\text{men}} = 3.97, SD = 2.63$; $t(273) =$
 281 $2.86, p = .005$), scored higher on neuroticism ($M_{\text{women}} = 2.03, SD = 1.02$; $M_{\text{men}} = 1.77,$
 282 $SD = 0.93$; $t(273) = 2.15, p = .03$), reported more facilitation ($M_{\text{women}} = 3.34, SD =$
 283 0.68 ; $M_{\text{men}} = 3.19, SD = 0.57$; $t(275) = 1.93, p = .05$), but did not differ from men with
 284 respect to conflict ($M_{\text{women}} = 1.88, SD = 0.6$; $M_{\text{men}} = 1.95, SD = 0.58$; $t(275) = -0.97, p =$
 285 $.33$).

286 Multiple regression analyses were used to (1) assess whether the association
 287 between cross-domain conflict and self-reported psychosomatic symptoms was robust
 288 after controlling for neuroticism and (2) test the hypotheses that cross-domain
 289 relations interact with sex in predicting psychosomatic symptoms. Table 1
 290 summarizes the results of the multiple regression analyses. The number of
 291 psychosomatic symptoms was regressed separately on cross-domain conflict and
 292 facilitation. In Step 1, we entered neuroticism, sex, and age; in Step 2 cross-domain
 293 relationships (conflict or facilitation); and in Step 3 the interaction of cross-domain
 294 relations (conflict or facilitation) and sex. As hypothesized, there were significant
 295 interactions between cross-domain relations (conflict and facilitation) and sex in
 296 predicting self-reported psychosomatic symptoms.³ To better understand the nature of
 297 these interactions, we analyzed the simple slopes separately for male and female
 298 participants. Figure 1 (Panel A) shows that, as expected, there was a positive
 299 association between cross-domain conflict and the number of self-reported

³ Including the two- and three-way interactions Conflict/Facilitation x Neuroticism and Conflict/Facilitation x Sex x Neuroticism did not significantly improve the prediction of psychosomatic symptoms.

300 psychosomatic symptoms for women ($b = .44, p < .001$), but not for men. Analyses of
301 regions of significance show that this association differed significantly ($p \leq 0.05$) for
302 men and women for values of conflict ≥ 1.78 . Figure 1 (Panel B) displays the mirror
303 image of this pattern for goal facilitation: The more life domains facilitated each
304 other, the fewer psychosomatic symptoms women reported ($b = -.21, p < .01$).
305 Analyses of regions of significance showed that the slopes for men and women
306 differed significantly ($p \leq 0.05$) for values of facilitation ≤ 3.32 . As can be seen in
307 Figure 1, there was no association between cross-domain facilitation and
308 psychosomatic symptoms for men.

309 In a set of regression analyses, we also explored whether the relationship
310 between cross-domain facilitation and conflict, on the one hand, and self-reported
311 psychosomatic symptoms, on the other, was moderated by age, but did not find
312 significant interactions (all $ps > .10$). Similarly, the reported number of children
313 showed no main effect or interaction in predicting psychosomatic symptoms (all $ps >$
314 $.09$).

315 Discussion

316 How does engaging in multiple life domains affect the number of
317 psychosomatic symptoms one experiences in adulthood? The present study shows that
318 the relations between multi-domain engagement and self-reported psychosomatic
319 symptoms is not a simple one, but depends on (a) whether the engagement in multiple
320 domains is characterized by conflict or facilitation and (b) the sex of the person
321 engaged in multiple domains. Our results suggest that women suffer more than men
322 from engagement in multiple domains during middle adulthood: They report having
323 more psychosomatic symptoms when conflict between different life domains is high
324 and facilitation between them is low. In contrast, men's self-reported psychosomatic

325 symptoms seem unaffected by conflict or facilitation. Our finding that women suffer
326 more from conflict than men is in line with previously found sex differences in the
327 association between anxiety sensitivity and pain [22] or stress and psychosomatic
328 symptoms [23], as well as with the finding that negative spillover between work and
329 family is more strongly and pervasively related to health problems in women than
330 men [24].

331 However, women do not appear to be simply more sensitive to multi-domain
332 relationships than men are: Women do not profit more from facilitation than men do.
333 This result was unexpected based on the findings from the area of social relationships
334 showing that social support helps women more than men to counteract work-related
335 stress [25]. In our study, women and men with high levels of facilitation reported the
336 same number of psychosomatic symptoms, but women with low levels of facilitation
337 reported more psychosomatic symptoms than their counterparts did. Thus, they appear
338 to be doubly at risk—they report more psychosomatic symptoms when there are strong
339 (compared to low) conflicts between their life domains and when there is little
340 (compared to high) facilitation between domains.

341 Interestingly, number of psychosomatic symptoms was unrelated to age,
342 although this study covered an age range of 25 years. It appears that, at least in middle
343 adulthood, chronological age is less important than how people cope with engagement
344 in multiple life domains. Juggling the many demands of work, family, and leisure
345 during the “rush hour” of life might constitute one of the main developmental tasks of
346 this age group, particularly for women.

347 One of the strengths of this study is that we were able to control for
348 neuroticism, a personality trait that has been associated with psychosomatic
349 symptoms as well as with whether one experiences intrapsychic conflict or harmony.

350 In fact, neuroticism was associated with reports of more psychosomatic symptoms as
351 well as more conflict and less facilitation. Importantly, then, we controlled for
352 neuroticism in our analyses to ensure that the associations between cross-domain
353 relations and psychosomatic symptoms were not driven by any negatively biased view
354 of oneself and the world.

355 **Limitations.** One of the limitations of the present study was the cross-
356 sectional design, which did not allow us to test time-lagged associations. In other
357 words, this study did not allow us to test whether cross-domain relationships result in
358 more psychosomatic symptoms or whether psychosomatic symptoms result in more
359 conflict and less facilitation between life domains. We assume that more conflict and
360 less facilitation result in greater stress and, thereby, more psychosomatic symptoms in
361 women. However, the opposite direction of causality is also plausible: Experiencing
362 psychosomatic symptoms might constrain the resources necessary for engaging in
363 multiple life domains, thereby contributing to high cross-domain conflict and low
364 facilitation. In fact, we assume that there is a reciprocal relationship between cross-
365 domain conflict/facilitation and psychosomatic symptoms. A test of this hypothesis
366 requires multiple assessments of cross-domain relations and psychosomatic symptoms
367 over time.

368 **Conclusion.** Psychosomatic symptoms in earlier phases of adulthood likely
369 contribute to poorer physical functioning later in life [3]. Thus, understanding which
370 factors contribute to multiple psychosomatic symptoms in middle adulthood seems
371 key for identifying risk factors that may lead to psychological and physical problems
372 in old age. Our results suggest that the ability to cope with engaging in multiple life
373 domains might be such a key factor in women. High conflict and low facilitation
374 between multiple life domains are related to reports of more psychosomatic symptoms

375 in women. In contrast, there is no association of conflict or facilitation between life
376 domains and reported psychosomatic symptoms for men. This may imply that the
377 social and cultural context is less supportive for women than for men when it comes
378 to their attempt to cope with the many demands of work, family, and leisure. In fact,
379 research shows that work-related demands are at least as high for women as for men
380 and that women still bear the brunt of family-related and household chores [30]. Thus,
381 we are hesitant to suggest that women need better coping skills, particularly in light of
382 the fact that we statistically controlled for neuroticism in our study. Women, then,
383 seem to be in need of more support from their environment for the many demands
384 they are asked to meet during young and middle adulthood; this support would serve
385 to promote their successful development across adulthood.
386

387

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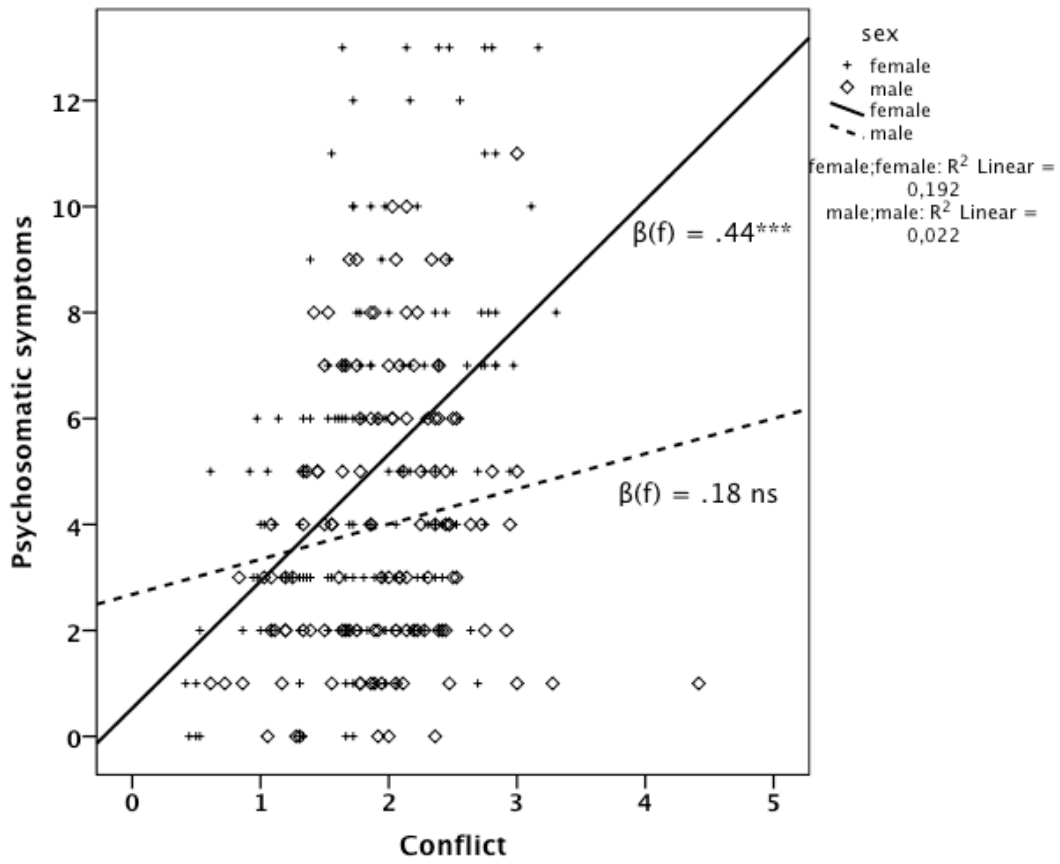
476 **Table 1.** Results from Multiple Regression Analysis Predicting Psychosomatic
 477 Symptoms From Relations Between Life Domains (Conflict, Facilitation), Sex, Age,
 478 and Neuroticism
 479

Relations Between Life Domains: Predictor	Relations Between Life Domains As Predictors of Psychosomatic Symptoms			
	Conflict		Facilitation	
	ΔR^2	β	ΔR^2	β
<i>Step 1</i>	.180***		.180**	
Neuroticism		.395***		.395***
Gender		-.120 *		-.120 *
Age		.038		.038
<i>Step 2</i>	.054***		.004	
Domain Relationships (Conflict / Facilitation)		.249***		-.066
<i>Step 3</i>	.023**		.019*	
Domain Relationships x Sex		-.462**		.413*
Total R ²	.258		.203	

480 *Note.* N = 277; * $p < .05$. ** $p < .01$. *** $p < .001$.

481

482 *Figure 1.* Interaction between multi-domain engagement (Panel A: conflict; Panel B:
 483 facilitation) and sex in predicting self-reported psychosomatic symptoms.



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