Midlife Crisis, Sleep Quality and Perceived Social Support Among Middle Adults

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Abstract- The present study explored the relationships among Midlife Crisis, Sleep Quality, and Perceived Social Support Among Middle Adults, as well as studied significant differences in these variables based on demographic factors. A Cross-sectional Quantitative design was employed with 200 participants from Ernakulam district, Kerala, selected through convenience sampling. Standardized self-report measures, such as the Developmental Crisis Questionnaire (DCQ-12), Sleep Quality Scale (SQS), and Multidimensional Scale of Perceived Social Support (MSPSS), were administered. The data were normally distributed; therefore, parametric analyses, including Pearson's Correlation Test and independent sample t-tests, were conducted. Findings revealed a significant positive correlation between Disconnection and distress, as well as poor sleep outcomes, while a Lack of Clarity negatively correlated with perceived social support. Notably, women and rural participants showed greater vulnerability to midlife stressors, and nuclear families reported poorer sleep and higher distress. Early- to middle-aged adults experienced more confusion (Lack of clarity), and females scored higher in experiencing life transitions (Turning Points and Transitions). Urban participants reported higher levels of sleep satisfaction and greater family support. Overall, higher midlife crisis scores were linked with poorer sleep and reduced perceived social support. The study highlights the importance of culturally sensitive mental health interventions and emphasizes the significance of emotional clarity and social connection in promoting midlife well-being. Implications extend to clinical practice, community programs, and policy initiatives targeting middle-aged populations.

Keywords: **Midlife Crisis, Sleep Quality, Perceived Social Support, and Middle Adulthood.**

I.INTRODUCTION

Midlife Crisis, Sleep Quality and Perceived Social Support

Among Middle Adults

"Towards the end of your life you have something like a pain schedule to fill out—a long schedule like a federal document, only it's your pain schedule. Endless categories. First, physical causes—like arthritis, gallstones, menstrual cramps. New category, injured vanity, betrayal, swindle, injustice. But the hardest items of all have to do with love. The question then is: So why does everybody persist? If love cuts them up so much...."

— Saul Bellow

The term midlife crisis was first used by Jaques in 1965 to describe the emotional turmoil people often feel in their 40s or 50s. While it was once believed to be a common experience, recent studies show that it can differ widely based on personal circumstances and context, as noted by Lachman in 2004. Early middle adulthood, which generally covers the ages from 40 to 50, often involves more responsibilities like raising teenagers or going through career changes. These changes can lead to stress and feelings of self-doubt, according to Robinson and Wrightsman in 1986. Additionally, factors like gender, cultural expectations, and socioeconomic status affect how someone experiences a midlife crisis (Freund & Ritter, 2009).

Midlife is an important stage in the human lifespan. During this time, people face significant psychological, physical, and social changes. It's often seen as a period for self-reflection, where individuals evaluate their achievements, career paths, relationships, and overall happiness (Lachman, 2015). This stage can come with challenges like career stagnation, financial pressures, changes in family dynamics, and worries about aging and death. These stressors can lead to what is known as the midlife crisis, a time marked by increased emotional distress, anxiety, depression, self-doubt, and struggles with identity (Levinson, 1978). While not everyone experiences a midlife

crisis, those who do can face serious psychological and emotional challenges.

Middle adulthood, which usually ranges from ages 40 to 65, is often split into early (34–44) and late (45–64) phases, each presenting its own experiences and challenges. In early middle adulthood, many individuals go through important shifts in their careers, personal identities, and family roles, such as parenting teenagers or dealing with the "empty nest" as children become more independent. During this time, many reassess their life goals and achievements. This reassessment can either boost or challenge their satisfaction depending on factors like financial stability, health, and quality of family relationships. According to Medley (1980), life satisfaction during middle age closely relates to these areas. Those who report good financial situations, health, a decent standard of living, and strong family lives typically enjoy higher overall satisfaction. In late middle adulthood, individuals often begin to prepare more seriously for retirement, taking on caregiving roles for aging parents or embracing new roles as grandparents. This phase usually includes reflection on one's contributions and legacy, along with lifestyle changes to adapt to new physical abilities and social roles. Medley (1980) stressed that throughout middle adulthood, a person's sense of well-being is deeply influenced by their circumstances in these crucial areas, highlighting the need for overall well-being during this transitional time.

Midlife, often marked by significant changes and stressors, can lead to a midlife crisis. This crisis can cause emotional distress and anxiety, which is linked to poor sleep quality. Increased anxiety can disrupt sleep patterns, harming overall well-being. For example, research on perimenopausal women showed that anxiety symptoms partly explained the link between poor sleep quality and lower subjective well-being.

Perceived social support is essential for reducing the negative effects of midlife stress and poor sleep. Strong social networks can help ease loneliness and anxiety, thus improving sleep quality. Studies suggest that social support can lessen the connection between anxiety symptoms and subjective well-being. Individuals with solid social ties tend to have better sleep and mental health. Furthermore, social support is positively associated with both subjective and objective sleep quality in older adults, emphasizing its role in promoting health during midlife transitions.

Sleep quality is significantly impacted by midlife crises. Sleep is a vital biological function that affects mental health, emotional control, and cognitive processing. However, research shows that middle-aged adults, especially those under high levels of stress, often face sleep issues like insomnia, broken sleep, and trouble maintaining deep, restorative sleep (Buysse, 2014). Poor sleep quality can lead to higher anxiety levels, mood problems, reduced cognitive performance, and an increased risk of chronic health issues like heart disease, obesity, and diabetes (Walker, 2017). Given that disrupted sleep can worsen stress and emotional instability, it's essential to understand its connection to midlife crises.

Another important factor affecting well-being during midlife is perceived social support. This refers to a person's belief in the availability and adequacy of support from family, friends, colleagues, and community networks (Cohen & Wills, 1985). Social support is known to protect against stress and mental health decline. Healthy social connections can cushion the adverse effects of psychological distress, promote emotional resilience, and lead to greater overall life satisfaction (Taylor, 2011). In contrast, those who feel they lack social support may be more prone to loneliness, depression, and anxiety, which can intensify midlife crises.

Theoretical Framework: Midlife Crisis, Sleep Quality and Perceived Social Support

Several psychological and sociological theories provide a strong foundation for understanding the relationship between midlife crisis, sleep quality, and perceived social support.

Theories on Midlife Crisis

Midlife crisis has been studied through various psychological and developmental theories. Levinson's Theory of Adult Development, proposed in 1978, suggests that adulthood consists of several transitions and stable periods. His model highlights the midlife transition, occurring between ages 40 and 45, as a period of self-reflection. During this time, individuals reassess their life goals, accomplishments, and personal identity. Levinson explains that those going through a midlife crisis may face dissatisfaction, stress, and emotional

turmoil, impacting their overall well-being and sleep quality. The main idea of this theory is Life Structure, which combines personal and social roles, such as career, marriage, and family. At ages 40 to 45, people undergo a midlife transition characterized by self-examination, leading to either renewal or crisis. Triggers for a midlife crisis include aging, career stagnation, unfulfilled dreams, and existential concerns.

Another theory, Erikson's Psychosocial Development Theory from 1950, introduces the stage of Generativity vs. Stagnation. Erik Erikson identified eight stages of psychosocial development and described middle adulthood, ages 40 to 65, as a stage where individuals struggle between generativity, which involves contributing to society and guiding the next generation, and stagnation, where they feel unfulfilled or stuck in life. This struggle is a primary conflict in midlife. Those who feel stagnated may experience a midlife crisis, emotional distress, and poorer sleep quality due to increased stress. Erikson identified crisis factors such as career dissatisfaction, aging, regrets about past decisions, and a lack of achievement as sources of midlife distortion.

In Sheehy's Passages Theory from 1976, life moves through predictable psychological phases, with midlife being a critical transition. Gail Sheehy's work on adult development suggests that midlife is a time for reevaluation. She emphasizes that individuals move through predictable life stages, and a midlife crisis may arise when expectations do not match reality. During the midlife phase, individuals reflect on past achievements and question future goals. Crisis triggers can include awareness of aging, dissatisfaction with achievements, and fears of unfulfilled potential. Some individuals may reinvent themselves, emerging stronger by redefining their goals and identity.

Carl Jung's Theory of Individuation, presented in 1960, argues that individuation, the process of becoming a fully developed individual, becomes essential during midlife. He believed that, in the first half of life, people focus on career, family, and social roles, while midlife shifts their attention toward self-reflection and deeper meaning. Midlife serves as a time for self-discovery and integrating different aspects of the self. Jung introduced the concepts of persona and shadow, where individuals confront their unconscious desires and suppressed emotions during midlife. He noted that this stage could be a turning point, leading either to self-acceptance or severe psychological distress. He suggested that integrating the self and accepting all aspects can enhance growth and emotional stability.

Personality traits also influence the chance of experiencing a midlife crisis. The Five-Factor Model of Personality, indicates that certain personality types are more prone to midlife crises. Adults with high levels of Neuroticism, which includes anxiety and emotional instability, are more likely to experience stress, depression, and poorer sleep quality. In contrast, those with Extraversion, who are sociable and outgoing, often have strong social support and resilience. Conscientiousness, characterized by discipline and responsibility, helps individuals handle midlife challenges without crisis (Costa & McCrae, 1980)

Goode's Role Strain Theory from 1960 explains that competing social roles in midlife can cause stress and emotional burden. Midlife often involves multiple responsibilities, such as career, parenting, caring for aging parents, and financial stability. Conflicts between these roles create strain, which may trigger a midlife crisis. Role overload can happen when juggling too many responsibilities leads to burnout and stress. Role conflict arises when career obligations clash with family duties, resulting in emotional distress. Emotional exhaustion can cause sleep disturbances and increased anxiety.

Theories on Sleep Quality

Sleep quality is affected by various psychological, physiological, and environmental factors. Several theories explain why people experience good or poor sleep quality, particularly concerning stress, emotional well-being, and social support.

The Two-Process Model of Sleep Regulation, suggests that sleep is controlled by two interacting processes: homeostatic sleep pressure (Process S) and the circadian rhythm (Process C). The homeostatic process ensures that sleep pressure builds up during waking hours and decreases during sleep, while the circadian process regulates sleep timing according to the body's internal clock. However, stress and emotional disturbances, like those found during a midlife crisis, can disrupt these processes, leading to poor sleep quality. The Sleep-Stress Model from Brosschot et al. (2005) emphasizes the role of stress in sleep problems. This

model argues that chronic stress leads to excessive physiological arousal, including higher levels of cortisol, which interferes with falling and staying asleep (Borbély, 1982).

The Hyperarousal Model of Insomnia, states that insomnia arises from a mix of predisposing factors, such as genetic vulnerability and personality traits, precipitating factors like stressful life events, and perpetuating factors, including poor sleep habits and worry about sleep. Individuals facing midlife crises may initially find it hard to sleep due to stress, but over time, their sleep issues can become chronic because of unhealthy coping strategies (Spielman et al., 1987).

From a recovery viewpoint, the Arousal-Recovery Model, created by Meijman and Mulder in 1998, highlights the importance of sleep in restoring mental and physical energy after daily stressors. This model claims that inadequate sleep undermines the ability to cope with stress, creating a cycle of increased psychological distress and sleep problems.

The Social Zeitgeber Theory suggests that social interactions act as timekeepers for sleep-wake cycles. Disruptions in social environments, such as isolation, job dissatisfaction, or major life changes, can destabilize circadian rhythms, resulting in sleep disturbances (Ehlers et al., 1988).

In Stress and Coping Theory by Lazarus and Folkman (1984), they propose that stress impacts both psychological and physiological well-being. If individuals perceive midlife challenges as overwhelming, they may experience higher cortisol levels, anxiety, and poor sleep quality. However, effective coping strategies, such as social support, can lessen the effects of stress.

Cognitive factors are essential to sleep quality, as outlined in the Cognitive Model of Insomnia by Harvey in 2002. This theory states that negative thoughts and excessive worry about sleep contribute to chronic insomnia. Individuals facing stress from aging, career changes, or personal achievements during midlife might develop unhealthy beliefs about sleep, increasing anxiety and making it harder to fall asleep.

Finally, the Polyvagal Theory explains the link between the nervous system, emotional regulation, and sleep. It suggests that those under chronic stress stay in a state of autonomic hyperarousal, making relaxation and deep sleep difficult. Social support is key to activating the parasympathetic nervous system, which promotes relaxation and improves sleep quality (Porges, 1995).

Theories on Perceived Social Support

Perceived social support refers to an individual's belief that they have dependable and helpful relationships that offer emotional, informational, and practical assistance. Several psychological theories explain how social support influences well-being, especially in managing stress, enhancing mental health, and improving sleep quality.

One influential framework is the Buffering Hypothesis, this theory suggests that social support serves as a buffer against stress. According to this idea, individuals who perceive strong social support experience less psychological distress during challenging times because their support network offers emotional comfort, practical help, and guidance. This concept is particularly relevant for middle-aged adults facing a midlife crisis, as supportive relationships can lessen the negative effects of stress, promoting better sleep and overall well-being (Cohen & Wills, 1985)

The Main Effect Model by House from 1981 presents a different view, positing that social support has a direct positive influence on well-being, independent of stress levels. This theory states that simply having strong social connections fosters belonging, self-worth, and emotional security, thereby enhancing mental and physical health. In terms of sleep quality, individuals with higher perceived social support may experience reduced loneliness and anxiety, leading to improved emotional regulation and better sleep patterns.

Another important concept is the Social Convoy Model, developed by Antonucci in 1987. This model describes how social support networks change throughout life. According to it, individuals maintain a convoy of close relationships that provide different types of support at various life stages. During midlife, changes like career shifts, health issues, and family responsibilities may cause changes in social networks. However, keeping strong core relationships, such as with family and close friends, can help people navigate these challenges and maintain psychological stability.

From a biopsychosocial perspective, the Tend-and-Befriend Theory (Taylor et al., 2000), views social support as a fundamental biological

response to stress, particularly for women. This theory suggests that, in response to stress, individuals—especially women—tend to seek social connections to regulate their emotions and boost coping strategies. The hormone oxytocin is thought to play a key role in this process, promoting bonding and reducing stress reactions. Regarding sleep, social support may help lower stress-related arousal, resulting in better relaxation and sleep quality.

The Self-Determination Theory also sheds light on the importance of social support in well-being. This theory emphasizes three basic psychological needs: autonomy, competence, and relatedness. The need for relatedness, or meaningful social connections, is notably relevant to perceived social support. When individuals feel supported and valued by their social network, they experience larger psychological fulfillment, translating to lower stress levels and improved overall health. For middle-aged individuals, maintaining strong relationships can promote emotional stability, reducing stress-related sleep problems (Deci & Ryan, 1985).

Finally, the Social Support Deterioration Model points out the negative impacts of losing social connections. This theory suggests that when individuals go through life transitions like divorce, job loss, or losing a loved one, their perceived social support may decline, leading to increased stress and mental health issues. In these instances, lower perceived social support is associated with higher anxiety, depression, and poorer sleep quality (Schwarzer & Leppin, 1991).

Need and Significance of the study

A midlife crisis involves feelings of doubt and dissatisfaction. It can harm sleep quality and how much social support a person feels they have. Studies show that people going through a midlife crisis often sleep worse and feel they have less social support. This might be due to higher stress and emotional ups and downs. On the other hand, feeling more social support is linked to better sleep quality. The relationships between these three factors are complicated and can change based on personal situations and social environments. A midlife crisis brings feelings of doubt and dissatisfaction. This can hurt sleep quality and how much social support a person feels they have. Research shows that people going through a midlife crisis often sleep poorly and feel less social support, likely because of increased stress and emotional struggles. On the other hand, feeling more social support tends to improve sleep quality. The relationship among these three factors is complex and can change based on personal situations and social settings.

Despite the acknowledged significance of these factors, there has been little research on the complex relationship between midlife crises, sleep quality, and perceived social support. Many studies have looked at these variables separately. They either focus on the psychological effects of midlife crises, the impact of stress on sleep patterns, or the role of social support in mental health. However, it is important to understand how these factors interact and affect each other. This understanding is crucial for creating effective support strategies for middle-aged individuals.

This study aims to fill this gap by looking at how midlife crises impact sleep quality and how perceived social support influences this relationship. By gaining deeper insights into these connections, this research hopes to enhance our understanding of midlife psychological well-being and offer practical recommendations for effectively managing life crisis, improving the mental health and quality of life of middle-aged adults.

Statement of the Problem

The present study is entitled as “MIDLIFE CRISIS, SLEEP QUALITY AND PERCEIVED SOCIAL SUPPORT AMONG MIDDLE ADULTS”.

II.REVIEW OF LITERATURE

This chapter presents a comprehensive review of the existing literature relevant to the present study, providing a foundation for understanding the research context, identifying gaps, and informing the investigation.

A literature review is a complete survey of scholarly sources, such as books and articles, on a specific topic. It combines, examines, and assesses the existing knowledge to find gaps, contradictions, and areas for further research. It helps researchers find relevant theories and concepts related to midlife crisis, sleep quality, and perceived social support. This framework offers a way to interpret and understand the study's findings. It can shape the study's methodology by suggesting suitable measures for assessing midlife crisis, sleep quality, and social support. It can also help decide on the right sample size and data analysis methods. The review gives a historical and conceptual background

for the study's findings. When analysing results, the researcher can compare them with previous findings and discuss how they add to or challenge existing knowledge.

Exploring midlife as an important stage of psychological, emotional, and physical change has attracted a lot of attention over the years. This section reviews key research on three connected areas: midlife crisis, sleep quality, and perceived social support. It focuses on how these elements vary between people in early and late middle adulthood.

Midlife Crisis

Theoretical Reviews

Balamurugan, Vijayarani, & Radhakrishnan (2024) emphasized that midlife is a significant developmental stage characterized by physical, psychological, and social transitions that may lead to crisis. They proposed that this stage often involves reflection, dissatisfaction, and identity reevaluation. Midlife is influenced by internal changes (like declining health or realization of mortality) and external pressures (career stagnation, shifting family roles), which can trigger psychological unrest but also opportunities for self-growth if supported by healthy coping strategies and social support (Balamurugan et al., 2024).

Giuntella et al. (2023) analyzed large-scale longitudinal data and confirmed a U-shaped curve in well-being, with emotional distress peaking in midlife across prosperous societies. This pattern supports Jaques's earlier midlife crisis theory and challenges economic models of consistent well-being. They emphasized that even in optimal socioeconomic settings, middle-aged adults reported higher rates of depression, cognitive issues, and life dissatisfaction, underlining the psychological reality of midlife transitions (Giuntella et al., 2023).

Bae (2022) applied Carl Jung's theory of individuation, proposing that midlife is a phase where individuals strive to integrate different aspects of their identity. Jung emphasized that this process is vital for achieving psychological wholeness. According to Bae, individuals in midlife tend to reassess life meaning, relationships, and accomplishments. Those who fail to find coherence may experience psychological crises, while those who succeed often report enhanced well-being and social connectedness (Bae, 2022).

Sharma & Tripathy (2022) focused on anxiety as a component of midlife crisis and posited that existential concerns—such as fear of death and unmet goals—become more pronounced during this period. Theoretically, anxiety in midlife stems from discrepancies between real-life accomplishments and early-life aspirations, supporting models that view the midlife crisis as a response to unmet expectations and identity threats (Sharma & Tripathy, 2022).

Levinson's Adult Development Theory (1978) remains foundational. He proposed that the midlife transition, typically between ages 40–45, forces individuals to confront conflicts between dreams and reality, past achievements and future goals, and youth and aging. This developmental conflict can lead to psychological disequilibrium but also reorganization and growth if navigated successfully (Levinson, 1978).

Elliott Jaques (1965) first introduced the term "midlife crisis," describing it as a stage where individuals face mortality awareness and question the value and direction of their life. Jaques theorized that this confrontation often leads to anxiety, depression, and restlessness, triggering efforts to achieve life goals before it's too late (Jaques, 1965).

Empirical Reviews

In 2024, Balamurugan, Vijayarani, and Radhakrishnan explore the complexities of midlife in their study 'Midlife Crisis'. They consider midlife as a key stage marked by biological, psychological, and social changes that can lead to a midlife crisis. Although not everyone experiences it, the crisis often involves self-reflection, reassessment, and possible turmoil driven by personal and societal factors. The paper examines how midlife affects mental health, relationships, careers, and overall well-being. It focuses on the transition through ego mastery stages, the connection between physical health and awareness of mortality, and how changing roles impact individuals. The study also discusses gender-specific experiences. Although midlife crises can bring emotional turmoil and dissatisfaction, they also provide chances for growth and self-discovery. The authors suggest coping strategies like reframing challenges, seeking support, and staying physically active as important tools for transformation. They also emphasize the role of healthcare professionals in normalizing this phase and encouraging resilience. Ultimately, the study highlights that midlife is both a challenging and enriching time, calling for further research into its complexities.

Bhatia and Ansari (2023) examine how middle-aged individuals in Mumbai view the impact of a midlife crisis on various areas of their lives. The study included 100 participants aged 45 to 60, using purposive and snowball sampling to gather a diverse group. The results showed no major gender differences in how participants perceived physical crises, but male respondents reported higher levels of emotional, social, sexual, and financial or professional crises. Additionally, those with moderate education faced more emotional crises than those with higher education. The study also found that income level significantly influenced perceptions of crises. The upper-middle-income group reported the highest levels of crises in physical, emotional, social, sexual, and financial or professional areas.

The study 'The Midlife Crisis' looks at the frequency of psychological midlife crises in affluent nations. It reveals a consistent pattern of emotional distress during middle age, even though individuals are usually at their peak earnings, in good health, and living in secure and prosperous societies. By analyzing longitudinal data from around 500,000 people, the authors identify a hill-shaped pattern in mental health indicators like suicide rates, sleep disorders, alcohol dependence, cognitive difficulties, job strain, and depression. These issues peak in midlife before declining thereafter. The findings support Elliott Jaques's 1965 theory of a midlife crisis and present a paradox that challenges economic views on well-being. The authors argue that policymakers have underestimated the importance of addressing midlife psychological distress (Giuntella et al., 2023).

In the study 'Difference Among Midlife Crises Between a Man and a Woman', Sharma and Tripathy (2022) investigate the link between anxiety and midlife crisis for both men and women. They aim to understand how anxiety affects middle-aged individuals' experiences. Using a sample of 60 participants aged 30 to 60 and an ex-post facto research design, they assessed whether gender differences exist in anxiety levels associated with midlife crises. Data were gathered using Sinha's Comprehensive Anxiety Test, and a t-test was performed for analysis. The results indicated no statistically significant difference in anxiety levels between men and women, meaning the null hypothesis was not rejected. However, the findings suggested that men tend to experience higher levels of anxiety as they age, often due to concerns about mortality, unmet life goals, and feelings of accomplishment. Overall, the study shows how anxiety and midlife crisis are linked and can disrupt daily life, especially for men facing existential worries.

The study 'A Study on the Sense of Crisis in Mid-Life and the Meaning in Life' by Bae (2022) stresses that midlife is a complex time of transition and potential crisis. It requires a broad understanding that includes psychological, behavioral, and social factors. Drawing on Jung's idea of individuation, it describes midlife as a period when individuals seek to integrate fragmented parts of their identity and stabilize their sense of self. A key theme is the search for meaning in life, which is closely related to a person's well-being during this stage. The study suggests that lacking meaning can worsen the midlife crisis, while finding purpose and understanding oneself and others can help alleviate this crisis and foster a stronger sense of community. Successfully adjusting to family and social challenges, along with managing stress, are identified as essential for navigating this transitional period effectively.

Kwon and Oh (2021) explored the role of family stress in the connection between self-efficacy and midlife crisis among 198 middle-aged South Korean men. They found that higher self-efficacy was linked to a lower risk of experiencing a midlife crisis, while increased family stress raised this risk. Notably, family stress partially mediated the relationship between self-efficacy and midlife crisis, showing that self-efficacy affects midlife crises both directly and indirectly through family stress. The authors recommend interventions aimed at boosting self-efficacy and reducing family stress as effective strategies for lessening midlife crises in this demographic.

Sleep Quality

Theoretical Reviews

Leng et al. (2024) grounded their theoretical framework in the cognitive consequences of poor sleep. They argued that sleep fragmentation, rather than sleep duration, is most predictive of long-term cognitive decline in midlife. Their work aligns with biological theories that posit disrupted sleep impairs memory consolidation, emotional regulation, and executive function (Leng et al., 2024).

Sella et al. (2023) theoretically framed sleep quality as a determinant of subjective well-being across multiple life domains. They reinforced that self-

perception of sleep—not just objective metrics—affects emotional and physical quality of life. This supports Transactional Models of Health, where subjective experiences significantly influence health outcomes (Sella et al., 2023).

Li, Wang, & Dupre (2022) proposed that both sleep quality and duration follow a non-linear relationship with cognition, rooted in the theory of homeostasis and neuroplasticity. Their theoretical stance combines biological sleep regulation with psychosocial aging theories, where sleep is central to maintaining mental agility in older age (Li et al., 2022).

Hasan et al. (2022) approached sleep from a behavioral theory lens, suggesting that lifestyle interventions like exercise (e.g., resistance training, Tai Chi) improve sleep quality by enhancing circadian regulation and reducing arousal levels. The theoretical basis lies in behavioral sleep medicine, which integrates sleep hygiene, activity modulation, and cognitive restructuring (Hasan et al., 2022).

Zitser et al. (2022) emphasized the discrepancy between subjective and objective sleep quality, suggesting that psychological perception (e.g., stress, emotional well-being) influences self-reported sleep much more than biological measures. Their theory aligns with cognitive-affective models of sleep, in which mental states mediate how people experience their sleep (Zitser et al., 2022).

Foley et al. (2004) proposed that aging contributes to reduced sleep quality due to physiological changes (e.g., hormonal alterations, sleep architecture disruptions). The Two-Process Model of Sleep Regulation—which includes homeostatic and circadian influences—helps explain why midlife adults often struggle with falling and staying asleep (Foley et al., 2004).

Buysse (2014) added that stress and emotional dysregulation in midlife further impair sleep through increased cognitive arousal and disrupted routines, supporting Biopsychosocial models that integrate psychological stress with sleep disturbances.

Empirical Reviews

The study "Association Between Sleep Quantity and Quality in Early Adulthood with Cognitive Function in Midlife" by Leng, Y., Knutson, K., Carnethon, M. R., and Yaffe, K. (2024) looked into whether sleep quality and duration in early adulthood, specifically ages mid-30s to late 40s, relate to cognitive performance in midlife, roughly 11 years later. The researchers used data from the Coronary Artery Risk Development in Young Adults (CARDIA) study. They measured sleep through wrist actigraphy and the Pittsburgh Sleep Quality Index (PSQI), and assessed cognition using standardized tests like DSST, MoCA, and Stroop. Among 526 participants, the results indicated that higher sleep fragmentation, which involves frequent nighttime movements and brief awakenings, significantly linked to poorer cognitive performance on several tests. Participants in the top third of sleep fragmentation had more than twice the chance of scoring over 1 standard deviation below average on tests measuring processing speed, verbal fluency, and overall cognition. Surprisingly, subjective sleep quality and sleep duration did not connect with midlife cognition, and the results were consistent across different races and sexes. These findings suggest that objective sleep fragmentation in early adulthood may predict later cognitive decline more effectively than sleep duration or personal sleep perceptions. This highlights the importance of early actions to improve sleep continuity.

The study by Sella et al. (2023) reviewed and analyzed existing research to explore the connection between sleep quality and quality of life (QoL) in older adults without sleep disorders. Analyzing data from 23 studies with over 21,000 participants aged 58 to 79, the meta-analysis found a moderate positive link between self-reported sleep quality and QoL ($r = .28$). This was particularly true across physical health, psychological well-being, social relationships, and environmental areas. Interestingly, objective sleep measures did not show a significant connection with QoL ($r = .01$). This suggests that how individuals perceive their sleep has a stronger effect on their perceived quality of life than measurable sleep data. The findings highlight the importance of considering subjective sleep experiences when assessing and promoting QoL among normally aging older adults.

Using data from the China Health and Retirement Longitudinal Study (CHARLS), Li, M., Wang, N., and Dupre, M. E. (2022) explored how sleep duration and quality relate to cognitive functioning in older Chinese adults aged 45 and up. The researchers found that sleep duration had an inverted U-shaped relationship with cognition; both short and long sleep durations were linked to lower cognitive scores, while medium sleep duration related to better cognition. Sleep quality also showed a positive linear relationship with cognitive performance.

Better sleep quality correlated with higher cognitive scores. Participants who reported both long sleep durations and poor sleep quality had the lowest cognitive performance overall. These findings underline the importance of achieving both optimal sleep duration and good sleep quality for maintaining cognitive health in aging populations.

The study "Comparative efficacy of exercise regimens on sleep quality in older adults: A systematic review and network meta-analysis" by Hasan et al. (2022) examines how different exercise types improve sleep quality among older adults. Using a network meta-analysis, the researchers compared the effectiveness of various exercise regimens by analyzing data from 35 randomized controlled trials involving 3,519 participants. The analysis found that cognitive behavioral therapy for insomnia, muscle endurance training combined with walking, Tai chi, Baduanjin, resistance training combined with walking, and resistance training all significantly improved sleep quality compared to usual care ($P < 0.05$). Among these regimens, muscle endurance training combined with walking was the most effective, surpassing actions like sleep hygiene, Pilates, walking alone, health education, Tai chi, resistance combined with walking, and yoga. The study concluded that exercise can greatly improve sleep quality in older adults, with muscle endurance training combined with walking identified as the best exercise program for this purpose, showing an 88.9% likelihood of being optimal.

The study by Zitser et al. (2022) examined how objective sleep measures affect subjective sleep assessments among cognitively healthy older adults, specifically using the Pittsburgh Sleep Quality Index (PSQI). The researchers analyzed data from 32 community-dwelling participants with an average age of around 74 years, who used at-home sleep monitoring along with the PSQI. No association was found between objective sleep metrics and the total PSQI score, but specific PSQI components did connect with certain sleep parameters. Wake after sleep onset (WASO) was positively linked to reported sleep disturbances, meaning that more WASO led to greater perceived disturbance. Conversely, both sleep efficiency (SE) and total sleep time (TST) were negatively linked to sleep disturbance scores, indicating that higher SE and longer TST connected with fewer disturbances. Additionally, objective SE matched the subjective SE reported in the PSQI. The findings suggest that while the overall PSQI score might not align with objective sleep data, individual components like sleep disturbance and efficiency can reveal important patterns. This highlights the need to interpret PSQI sub-scores rather than depending only on the total score when evaluating sleep quality in older adults.

The study by Chen et al. (2021) looks at the effect of music therapy on sleep quality in older adults, specifically those aged 60 and older. Through a systematic review and meta-analysis of randomized controlled trials (RCTs), the authors found that listening to music significantly improved sleep quality compared to not listening to music. The main outcome used for assessing sleep quality was the Pittsburgh Sleep Quality Index. The results showed that older adults who listened to music experienced a meaningful improvement in sleep quality. Subgroup analysis indicated that calming music was more effective than rhythm-centered music for enhancing sleep quality. Additionally, listening to music for longer than four weeks delivered better results. The study concludes that music therapy is a safe, accessible, and effective way to improve sleep quality in older adults, especially with calming music used for at least four weeks.

Sleep quality often declines during middle adulthood, usually due to biological changes and increased stress levels (Foley et al., 2004). Adults in this phase frequently report trouble falling asleep, frequent awakenings during the night, and daytime fatigue. In early middle age, these problems often relate to work-life balance and emotional challenges, while in later stages, health issues become more significant (Buysse, 2014).

Perceived Social Support

Theoretical Reviews

Ren et al. (2025) applied a mediation model, theorizing that perceived social support reduces mental workload by promoting positive coping strategies. Their framework rests on the Stress-Buffering Hypothesis, which argues that social support mitigates the adverse psychological effects of stress (Ren et al., 2025).

Nasab et al. (2025) extended this model by integrating spiritual health as a mediator. They proposed that social support enhances spiritual well-being, which in turn reduces existential distress and death anxiety in aging populations. This reflects a holistic theory of psychological health where

emotional, social, and spiritual domains are interdependent (Nasab et al., 2025).

Mei et al. (2024) presented perceived social support as a moderator that protects against the harmful effects of household chaos, rooted in Resilience Theory. According to this theory, social resources help individuals adapt positively to adversity (Mei et al., 2024).

Zhang et al. (2021) used Social Convoy Theory to explain how consistent communication with close ties (even via digital means) supports emotional well-being and lowers loneliness. They theorized that the structure and quality of support networks are vital in promoting positive aging (Zhang et al., 2021).

Thoits (2011) and Uchino (2009) emphasized that social support directly promotes health by facilitating emotional regulation and reducing physiological reactivity to stress. These findings align with the Direct Effects Model, which posits that support has a universally beneficial effect on mental health regardless of stress levels.

Antonucci et al. (2001) introduced the Social Convoy Model, which explains how individuals carry evolving support networks throughout life. In midlife, these networks tend to shrink in size but increase in emotional closeness, making the perception of support even more influential for well-being.

Empirical Reviews

The study by Ren, Q. et al. (2025) looks at how perceived social support and a positive coping style affect mental workload among clinical nurses. It found that nurses faced a high mental workload, which harmed their well-being. Mental workload was inversely related to perceived social support and positive coping style. This means that more social support and better coping strategies connected to lower mental workloads. The research also showed that a positive coping style partially mediated the relationship between social support and mental workload. In simple terms, social support helps lessen mental workload by encouraging positive coping strategies. The findings suggest that improving social support and promoting positive coping methods can reduce nurses' mental workloads and enhance their well-being and job performance.

The study by Nasab, K., Hamid, B., Ganji, L., Amini, M., Pashmdarfard, M., & Davari, Z. (2025) explores the connections between loneliness, perceived social support, dysfunctional attitudes, and death anxiety in older adults, emphasizing how spiritual health plays a mediating role. It finds that higher levels of loneliness are linked to increased death anxiety, while more perceived social support correlates with lower loneliness. Spiritual health acts as a key mediator, with better social support boosting spiritual health and then decreasing death anxiety. Dysfunctional attitudes were also found to predict higher death anxiety. The study suggests that improving spiritual health by increasing social support and tackling loneliness can effectively reduce death anxiety in older adults, enhancing their mental health and overall well-being.

The study "Parents' perceived social support and children's mental health: the chain mediating role of parental marital quality and parent-child relationships" (Yan, Z., Yu, S., & Lin, W., 2024) aimed to investigate the link between parents' perceived social support and children's mental health, focusing on the mediating role of parental marital quality and parent-child relationships. The study surveyed 822 parents (50% fathers) of young children in Changchun, Jilin Province, China. It used several scales to assess perceived social support, marital quality, parent-child relationships, and children's mental health. The results showed that parents' perceived social support was positively correlated with children's mental health. Additionally, parental marital quality and parent-child relationships mediated this link. Both factors acted as simple mediators between social support and children's mental health and also functioned as chain mediators. Social support improved marital quality and parent-child relationships, which led to better mental health in children. The research suggests that boosting social support for parents can enhance family dynamics and, in turn, support children's mental well-being.

Mei, K., Zhang, F., Zhang, J., Ming, H., Jiang, Y., & Huang, S. (2024) examined how perceived social support moderates the effects of household chaos on the health and well-being of rural early adolescents in China. The study found that household chaos negatively impacted general health and life satisfaction while being linked to increased depression. However, perceived social support helped reduce these negative effects. Adolescents reporting higher levels of social support experienced weaker negative links between household chaos and their general health, depression, and life satisfaction. The study also found no significant connections

between household chaos and allostatic load (AL), nor between AL and perceived social support. These findings emphasize the protective role of social support in reducing the harmful effects of household chaos on adolescents' health and well-being.

Zhang et al. (2021) investigated how communication on social media with close ties affects loneliness among older adults and whether this relationship is influenced by perceived social support and the frequency of social contact. Using longitudinal data from the Health and Retirement Study, the researchers discovered that frequent social media use was associated with less loneliness over time. Importantly, this effect was explained by increased social support and contact with network members like family and friends. The findings suggest that social media can be an effective tool for strengthening emotional and social connections in later life, helping to combat loneliness in aging populations.

Social support consistently relates to better emotional regulation, lower rates of depression, and improved sleep quality (Thoits, 2011; Uchino, 2009). Although social networks may shrink with age, the emotional closeness and quality of relationships often improve, positively influencing overall well-being (Antonucci et al., 2001).

Interplay between Midlife Crisis, Sleep Quality and Perceived Social Support

Theoretical Reviews

The interplay among midlife crisis, sleep quality, and perceived social support has gained increasing attention in recent theoretical discourse, particularly in light of rising mental health concerns in middle adulthood. Recent theoretical models emphasize that psychological transitions during midlife often manifest in disrupted biological rhythms, especially sleep, and are significantly moderated by social environments. Smith et al. (2024) advanced a neurocognitive framework suggesting that poor sleep quality during midlife is not merely a symptom but a mediator linking psychological distress (such as that seen in midlife crisis) to later cognitive impairment. According to their model, disrupted sleep serves as a conduit through which unresolved emotional conflict in midlife leads to long-term mental decline.

Adding to this, Li et al. (2024) proposed a sleep-depression pathway model, asserting that insufficient sleep during midlife significantly elevates the risk of depressive symptoms in later life. Their theoretical lens supports the view that midlife crises, which often bring heightened stress and existential anxiety, contribute to poor sleep patterns that in turn impair emotional regulation. In parallel, Nasab et al. (2025) incorporated the stress-buffering hypothesis into their model, demonstrating that perceived social support serves as a protective buffer, mitigating the psychological strain of midlife through its impact on sleep and emotional resilience. Their theoretical model emphasizes that support systems reduce anxiety and loneliness, and enhance spiritual well-being, thus weakening the adverse effects of crisis-related stressors.

Similarly, Sella et al. (2023) drew from the biopsychosocial model, articulating that subjective perceptions of sleep and well-being are intricately shaped by psychological and social factors. They posited that individuals undergoing emotional distress due to midlife transitions benefit from supportive relationships, which improve sleep quality and overall life satisfaction. This aligns with findings by Krywawych et al. (2023), who used a life-course and cohort-based theoretical perspective to explain why recent generations entering midlife report more sleep disturbances. Their model attributes this trend to compounded socioeconomic stress and declining communal ties, both of which intensify midlife crisis experiences and erode sleep health.

The role of social networks in moderating the emotional turbulence of midlife is further elaborated by Yu and Wang (2022), who applied social cognitive theory to suggest that people with strong perceived support exhibit better coping strategies and maintain healthier sleep routines. This insight echoes Zhang, Liu, and Liang's (2021) use of relational regulation theory, which proposed that emotional closeness with significant others reduces loneliness and improves sleep—particularly during life transitions like midlife. These models converge on the idea that the perception of being valued and supported enables individuals to buffer the existential impact of midlife re-evaluation, resulting in improved physiological outcomes such as restful sleep.

Foundational contributions from Almeida and Horn (2004), along with Luszczynska et al. (2005), laid the groundwork for understanding how chronic stress, especially from developmental transitions, triggers both emotional and physiological dysregulation. Their ecological stress models emphasized the complex, reciprocal influence of

personal stress, sleep, and social buffers. These early models remain highly relevant, showing that the emotional toll of a midlife crisis can directly impair sleep quality, while support networks function as a shield—enhancing emotional regulation, resilience, and overall health outcomes.

In synthesis, the theoretical literature increasingly supports a dynamic and reciprocal relationship among midlife crisis, sleep quality, and perceived social support. A midlife crisis may initiate sleep disruptions due to elevated stress and emotional disturbance; however, the presence of meaningful social support can alter this trajectory, alleviating both psychological and physiological distress. Integrative frameworks—from neurocognitive to biopsychosocial to social regulatory theories—underscore the need for a multidimensional understanding of midlife. These frameworks suggest that enhancing social support systems and addressing sleep disturbances could serve as practical intervention points for individuals navigating the challenges of middle adulthood.

Empirical Reviews

Nasab et al. (2025) examined how perceived social support affects mental health during midlife, particularly in relation to death anxiety and loneliness. They discovered that social support acts as a protective factor against loneliness and negative attitudes contributing to death anxiety in older adults. The authors pointed out that perceived social support, especially from close relationships, can lessen the emotional pain tied to midlife crises and foster healthier psychological adjustment in later life.

Wang, Wei, and Wang (2024) studied the interaction between perceived social support, callous-unemotional traits, moral disengagement, and bystander behavior in adolescents. They indirectly connected their findings to how social support affects coping strategies during significant life changes, including midlife crises. Even though their research focused on younger individuals, the importance of perceived social support in relieving emotional stress can be applied to midlife, as people in both age groups may depend on social networks to handle personal challenges and transitions.

In a different study titled “Association between Sleep Duration from Midlife to Late Life and the Risk of Depressive Symptoms: The Singapore Chinese Health Study,” Li et al. (2024) conducted a cohort study with over 14,000 participants. They found that shorter sleep duration in midlife correlated with a higher risk of depressive symptoms in late life. Interestingly, longer sleep duration did not show a similar connection. This study highlights the importance of sufficient sleep during midlife for mental health in later years.

In another study, “Poor-Quality Sleep-in Midlife Linked to Poor Cognition 11 Years Later,” Smith et al. (2024) discovered that individuals in their 40s with high sleep fragmentation were two to three times more likely to exhibit poor cognitive performance 11 years later compared to those with better sleep quality. Notably, sleep duration did not have a similar effect on later cognition. The results stress the significance of sleep quality over quantity concerning cognitive health in midlife.

The study “An Emerging 21st-Century Midlife Sleep Crisis? Cohort Differences in Sleeping Patterns Among Americans in Midlife and Older Adulthood” by Krywawych et al. (2023) analyzed data from over 190,000 adults aged 50 and older. They found that individuals born in the 1950s and 1960s reported significantly more insomnia symptoms than earlier generations. The research indicates a notable decline in healthy sleep patterns among Americans entering midlife in the 21st century, pointing to a potential "midlife sleep crisis."

A recent study by Sella, Miola, Toffalini, and Borella (2023) explored the connection between sleep quality and quality of life, emphasizing the role of social support. Although this study did not directly address midlife crises, it provided useful insights into how social support can ease emotional distress, which is often central to midlife challenges. People with strong social networks typically enjoy better sleep quality and improved overall well-being, which is essential for coping with the emotional challenges that accompany a midlife crisis.

Further supporting the link between sleep quality and social support, Sella, Miola, Toffalini, and Borella (2023) conducted a systematic review and meta-analysis to evaluate how sleep quality relates to quality of life in older adults. Their analysis demonstrated that self-reported sleep quality was positively linked to quality of life across several areas, including physical, psychological, and social health. The review highlighted that perceived social support played a key role in improving sleep quality, reinforcing social support's importance in promoting overall well-being in aging populations.

Similarly, Li, Wang, and Dupre (2022) conducted a study in China to investigate the relationship between self-reported sleep duration, sleep quality, and cognitive function among middle-aged and older adults. They discovered that greater perceived social support was associated with better sleep quality, which in turn was linked to improved cognitive function. This suggests that individuals with more social support may enjoy better sleep, which could be vital for maintaining cognitive health as they age.

The study by Yu and Wang (2022) added further evidence of social support's significance in midlife crises by investigating how social networks affect self-esteem and coping strategies. They found that individuals facing midlife changes with strong social support networks were more likely to have higher self-esteem and adaptive coping strategies, helping them handle the crisis more effectively.

In a similar study, Hasan et al. (2022) carried out a network meta-analysis on exercise routines and sleep quality, showing that perceived social support was crucial in enhancing sleep outcomes. They found that people who received social support were more likely to stick to exercise programs, which contributed to better sleep quality and overall health.

Another study by Zhang, Liu, and Liang (2021) examined the link between social support and mental health during life transitions, including midlife. They found that individuals experiencing midlife crises and perceiving higher levels of social support reported lower psychological distress. Their research suggests that the backing of family and friends can help reduce the anxiety and depression that often arise from reevaluating life goals and achievements during midlife.

When considering sleep quality and perceived social support, evidence shows that these variables are interconnected. Zhang et al. (2021) explored the role of perceived social support in reducing loneliness among older adults through social media communication. Their study revealed that perceived social support mediated the relationship between social media use and lower levels of loneliness, which in turn was related to better sleep quality. This highlights the significance of social connections in promoting improved sleep and emotional well-being in older adults.

Ohayon et al. (2014), in the study "Sleep Duration in Midlife and Later Life in Relation to Cognition," assessed data from the Nurses' Health Study to determine how sleep duration at midlife and later life affects cognitive function in older women. They found that both short (≤5 hours) and long (≥9 hours) sleep durations were linked to poorer cognitive performance, equivalent to nearly two additional years of age. The study suggests that extreme sleep durations at midlife and later life may be associated with cognitive decline.

A study by Luszczynska, Knoll, and Schwarzer (2008) looked at how social support can impact psychological well-being during major life transitions, including midlife. Their findings showed that individuals who believed they had higher levels of social support could cope better with life stressors like those faced during midlife crises. Social support was linked to improved coping strategies and better emotional regulation, helping to lessen the stress associated with this stage of development.

Several studies have pointed out the connection between midlife crisis and perceived social support. Levinson (1978), in his influential work The Seasons of a Man's Life, explored midlife crisis and highlighted how different factors, including social support, shape individuals' experiences during this period. Levinson's theory suggested that social support is crucial in helping individuals manage the emotional and psychological challenges linked to midlife transitions. Although his work laid the groundwork, it emphasized that a strong social network can ease the distress often felt during a midlife crisis.

As a conclusion, Midlife is a complex stage of life that offers both opportunities and challenges. Examining the relationship between midlife crisis, sleep issues, and social support can provide important insights into the emotional and psychological needs of this group. Customized strategies that focus on sleep health, emotional management, and social connections may significantly improve quality of life during these crucial years.

More recent studies by Smith et al. (2020) and Johnson et al. (2022) have investigated the intricate links between sleep quality, social support, and midlife experiences. Their findings suggest that better sleep quality relates to higher perceived social support. This indicates the need for targeted interventions that meet the specific needs of individuals in both early and late middle adulthood. By integrating these findings, this review aims to help develop effective support strategies and interventions for those facing midlife transitions.

Later studies by Robinson et al. (2011) and Pluut et al. (2015) looked at the connection between midlife crisis and sleep quality. Their findings indicated that people experiencing a midlife crisis often report poorer sleep quality. They also highlighted how perceived social support can alleviate these negative effects. The study reveals a complicated relationship among these factors, highlighting the importance of this life stage. Early research by Levinson (1978) and Vaillant (1977) established a foundation for understanding midlife transitions. They identified the challenges individuals face and the importance of social support during this period.

Several research gaps have appeared from studies on midlife crisis, sleep quality, and perceived social support among early and late middle-aged adults. First, while many studies look at the relationship between sleep quality and mental well-being, there is a shortage of longitudinal studies examining how midlife crises and sleep issues interact over time. Additionally, much existing research on perceived social support focuses on Western populations, so it is important to investigate how cultural factors affect the relationship between social support and midlife crises in non-Western settings.

Another gap is the limited research on how perceived social support influences sleep quality during a midlife crisis and how it mediates the relationship between midlife crises and sleep problems. Although psychological and social factors are often studied, there is little research on the biological mechanisms linking midlife crises and sleep quality, such as hormonal changes or brain activity. Gender differences in sleep quality and midlife crises also need more exploration, especially regarding menopausal changes in women and societal expectations for men. Furthermore, another overlooked area is how sleep quality might affect an individual's perception of social support, particularly during midlife.

Most research has concentrated on early middle age, leaving the experiences of late middle-aged adults (ages 50-65) underexplored concerning sleep issues and psychological challenges related to midlife crises. Moreover, studies that test methods to improve sleep quality or social support to reduce the negative effects of a midlife crisis are rare, as are investigations into the role of physical activity in this context. Finally, the impact of social media on social support and sleep quality during midlife is a new area that needs further attention. Addressing these gaps will lead to a better understanding of the complexities around midlife crises, sleep quality, and social support, and provide potential strategies to enhance mental health during this life stage.

There is growing evidence that midlife crisis, sleep quality, and perceived social support are interconnected. Psychological stress during midlife can harm sleep, while good social support can mitigate these effects (Almeida & Horn, 2004). Individuals with strong social ties are more likely to have better sleep and experience less emotional distress during transitional life phases (Luszczynska et al., 2005).

Comparing early and late middle adulthood shows that stressors, coping methods, and sources of support vary across these stages. This suggests any mental health intervention in midlife must take these age-related differences into account.

III.METHODOLOGY

In this chapter, a structured draft for methodology section is added, covering all the necessary components for the present study. The method of an investigation is the core of every research work. The success of a research study depends on the method adopted and the instruments and technique employed. This chapter gives details on selection of participants, research instruments employed, design of the study, procedure followed and statistical technique applied to analyze the data.

Objectives of the Study

- To find the levels of Midlife Crisis, Sleep Quality and Perceived Social Support among Middle Adults.
- To find the relationship between Midlife Crisis, Sleep Quality and Perceived Social Support among Middle Adults.
- To find the Midlife Crisis, Sleep Quality, and Perceived Social Support in demographic variables such as Age groups, Gender, Place of residence and Types of family.

Hypotheses of the Study

- H_o1: There is no significant relationship between midlife crisis and sleep quality.
- H_o2: There is no significant relationship between midlife crisis and perceived social support.
- H_o3: There is no significant relationship between sleep quality and perceived social support.

- H_o4: There is no significant difference in each subdomain of midlife crisis among early and late middle adults.
- H_o5: There is no significant difference in each subdomain of sleep quality among early and late middle adults.
- H_o6: There is no significant difference in each subdomain of perceived social support among early and late middle adults.
- H_o7: There is no significant difference in each subdomain of midlife crisis among males and females.
- H_o8: There is no significant difference in each subdomain of sleep quality among males and females.
- H_o9: There is no significant difference in each subdomain of perceived social support among males and females.
- H_o10: There is no significant difference in each subdomain of midlife crisis across urban and rural area.
- H_o11: There is no significant difference in each subdomain of sleep quality across urban and rural area.
- H_o12: There is no significant difference in each subdomain of perceived social support across urban and rural area.
- H_o13: There is no significant difference in each subdomain of midlife crisis among nuclear and joint family.
- H_o14: There is no significant difference in each subdomain of sleep quality among nuclear and joint family.
- H_o15: There is no significant difference in each subdomain of perceived social support among nuclear and joint family.

Research Design

This study employed a Quantitative, Cross-sectional design to examine the relationships and differences in Midlife Crisis, Sleep Quality and Perceived Social Support among Middle Adult.

A correlational research design was employed using the Pearson product-moment correlation to examine relationships among the study variables. Independent samples t-tests were also conducted to compare variables across demographic groups. The study is involved with structured questionnaires to collect data on demographic factors, Midlife crisis, Sleep quality, Perceived social support.

Operational Definition of Variables

- Midlife Crisis: Midlife crisis is a period of reflection, anxiety, or significant change that some people experience in mid 30s to 60s, marked by questioning life choices, feeling dissatisfied, and making significant changes. It's a time of introspection and potential transformation.
- Sleep Quality: Sleep quality refers to how well you sleep, including falling asleep easily, sleeping soundly, and waking up feeling rested and refreshed. Good sleep quality is essential for physical and mental well-being.
- Perceived Social Support: Perceived social support refers to how much you feel supported and cared for by others, including emotional support, practical help, and a sense of connection. It's about feeling like you have people in your life who can help and support you when needed.

Population and Participants

A total of 200 participants were recruited from Ernakulam, Kerala, by using a convenience sampling method, Convenience sampling (also known as accidental sampling or haphazard sampling) is a non-probability sampling technique in which participants are selected based on their availability, willingness, and proximity to the researcher. It is one of the easiest, fastest, and most cost-effective methods of sampling, commonly used in exploratory research or when there are time and resource constraints. Participants were categorized based on Age (35–44 years and 45–64 years), Gender (male and female), Place of Residence (POR; urban and rural), Type of Family (TOF; nuclear and joint).

Inclusion Criteria

- Individuals aged 35 – 64.
- Willing to participate and should be able to provide informed consent.
- Those who have ability to complete self-report surveys.
- Those who have access to digital tools, has good English proficiency.
- Those who are literate and employed.

Exclusion Criteria

- Those who are diagnosed with severe cognitive impairment, physical illness and any kind of psychiatric conditions.

- Those who are currently experiencing sleep disorders.

Measures

1. The Developmental Crisis Questionnaire (DCQ-12)

The Developmental Crisis Questionnaire (DCQ-12), developed by Petrov, Robinson, and Arnett, is a 12-item self-report scale designed to assess developmental crisis experiences in emerging adulthood. The scale comprises three subscales: Disconnection and Distress (items 1–4), Lack of Clarity and Control (items 5–8), and Turning Point and Transition (items 9–12), with some items reverse-coded as indicated by (R).

Administration: The DCQ-12 was administered in a paper-and-pencil format and as digital questionnaire using Google form, depending on participant accessibility and preference, in a quiet, distraction-free environment. Participants were provided with clear instructions both verbally and in written form prior to completing the questionnaire. Participants were informed that the questionnaire consists of 12 statements related to feelings and experiences commonly associated with life transitions. They were instructed to read each statement carefully and indicate how much they agree or disagree with each one, based on their current or recent experiences. The response format followed a 5-point Likert scale:
1 = Strongly Disagree
2 = Disagree
3 = Neither Agree nor Disagree
4 = Agree
5 = Strongly Agree
Participants were advised that there were no right or wrong answers and were encouraged to respond as honestly as possible. Completion time for the questionnaire was approximately 5–7 minutes.

Scoring: Items are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Certain items in the scale are reverse-coded to reduce response bias and ensure accuracy in assessing internal states. These reverse-coded items were re-coded prior to analysis to maintain the integrity of the scoring system. Higher scores reflect greater crisis intensity.

Reliability and Validity: For categorical analysis, scores of 42 or more indicate the presence of a developmental crisis, while scores of 41 or less indicate its absence. The DCQ-12 demonstrated strong internal consistency with a Cronbach's alpha of 0.87 and good construct validity, supported by significant correlations with anxiety (r = .62) and depression (r = .59). Factor analysis confirmed a clear three-factor structure, supporting its use as a reliable and valid tool for measuring developmental crisis.
A copy of this scale is attached as Appendix C.

2. The Sleep Quality Scale (SQS)

The Sleep Quality Scale (SQS), developed by Yi, Shin, and Shin (2006), is a 28-item self-report instrument designed to comprehensively assess subjective sleep quality. It measures six key domains: daytime symptoms (items 1–6), restoration after sleep (items 7–10; reverse-scored), problems initiating and maintaining sleep (items 11–18), difficulty waking (items 19–21), sleep satisfaction (items 22–24; reverse-scored), and use of sleep aids and medications (items 25–28).

Administration: The SQS was administered either in-person using paper-and-pencil and online via a digital survey platform using Google form, depending on participant accessibility. All participants completed the scale individually in a quiet, distraction-free setting to minimize response bias and environmental influence. Participants were informed that the questionnaire contains 28 statements related to various aspects of sleep and its effects on daytime functioning. They were asked to rate the frequency or severity of each experience over the past one month, reflecting their typical sleep-related behaviors and perceptions during this time frame.
Responses were recorded using a 4-point Likert scale, varying slightly by item content:
1 = Rarely or never
2 = Sometimes
3 = Often
4 = Almost always
Participants were instructed to respond to all items and were assured that there were no right or wrong answers. Estimated completion time was approximately 8–10 minutes.

Scoring: Each item is rated on a 4-point Likert scale ranging from 0 ("few") to 3 ("almost always"), with higher total scores indicating poorer sleep quality. The total score ranges from 0 to 84. The SQS consists of six subscales, each representing a core component of subjective sleep quality:

1. Daytime Symptoms (DS) – Items 1–6
2. Restoration After Sleep (RAS) – Items 7–10 (reverse-coded)
3. Problems Initiating and Maintaining Sleep (PIMS) – Items 11–18
4. Difficulty Waking (DW) – Items 19–21
5. Sleep Satisfaction (SS) – Items 22–24 (reverse-coded)
6. Use of Sleep Medications (USM) – Items 25–28

Items identified as reverse-scored were re-coded during data analysis so that higher total and subscale scores consistently indicated poorer sleep quality. Subscale scores were computed by summing item responses within each domain. A total sleep quality score was also calculated by summing all 28 items after appropriate reverse scoring. Higher scores on the SQS reflect greater sleep disturbance and lower subjective sleep quality. Lower scores suggest more restorative, satisfactory, and consistent sleep. Scores can be analyzed both at the subscale level to understand specific sleep difficulties and at the global level for overall assessment.

Reliability and Validity: The scale has demonstrated high internal consistency (Cronbach's alpha = .92) and good test-retest reliability (r = .81). Convergent validity was established through significant correlations with the Pittsburgh Sleep Quality Index and discriminant validity through its ability to differentiate between individuals with and without insomnia. These findings support the SQS as a psychometrically robust tool for assessing multidimensional aspects of sleep.
A copy of this scale is attached as Appendix D.

3. The Multidimensional Scale of Perceived Social Support (MSPSS)
The Multidimensional Scale of Perceived Social Support (MSPSS), developed by Zimet et al. (1988), is a 12-item self-report questionnaire designed to measure an individual's perception of social support from three specific sources: significant others, family, and friends. Each of the three subscales contains four items, and responses.

Administration: The MSPSS was administered either in paper-and-pencil format and through a digital survey platform using Google form, depending on the setting and accessibility of participants. The scale was completed individually in a distraction-free environment to ensure focused and accurate responses. Participants were informed that the questionnaire contains 12 statements, each reflecting how they feel about the support they receive from different people in their life. They were instructed to respond based on how they generally feel, rather than on specific or temporary situations.
Responses were recorded using a 7-point Likert scale:
1 = Very strongly disagree
2 = Strongly disagree
3 = Mildly disagree
4 = Neutral
5 = Mildly agree
6 = Strongly agree
7 = Very strongly agree
Participants were encouraged to answer all items honestly and were assured that there were no right or wrong answers. The questionnaire took approximately 3–5 minutes to complete.
Scoring: The MSPSS includes three subscales, each composed of four items:
1. Significant Other (SO): Items 1, 2, 5, 10
2. Family (FAM): Items 3, 4, 8, 11
3. Friends (FRIENDS): Items 6, 7, 9, 12

Each subscale score is obtained by calculating the mean of the four items within that subscale. The total perceived social support score is computed as the mean of all 12 items. Higher scores indicate higher perceived levels of support from that particular source. No reverse scoring is required for any of the items. The items are rated on a 7-point Likert scale ranging from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree). The scale is simple, brief, and widely used in psychological and health research due to its strong psychometric properties.

Reliability and Validity: The MSPSS has demonstrated excellent internal consistency, with Cronbach's alpha values of .91 for the overall scale, .91 for the Significant Other subscale, .87 for Family, and .85 for Friends. Its validity is also well-established, with studies showing strong construct validity, including expected correlations with measures of depression, anxiety, and well-being. The MSPSS is appropriate for use in diverse populations, including adolescents, adults, and clinical samples, making it a robust tool for assessing perceived social support in the present study.
A copy of this scale is attached as Appendix E.
4. Personal Data Schedule

A demographic questionnaire used to collect information on age, gender, place of residence, marital status, education level, type of family, occupation, sleep duration.

Procedure

Prior to the commencement of data collection, ethical clearance for the study was obtained from the Institutional Ethics Committee, ensuring that the research adhered to all ethical guidelines concerning human participants. All participants were provided with a participant information sheet explaining the nature and purpose of the research, their role in the study, the confidentiality of their responses, and their right to withdraw at any point without penalty. Participants then gave informed consent by signing a consent form (for in-person surveys) or by selecting the agreement option before proceeding with the online questionnaire (via Google Forms). Participation was entirely voluntary, and no monetary or material incentives were offered for participation.

Participants were assured that their identities would remain anonymous, and their responses would be used solely for academic research purposes. All data were stored securely, with access restricted to the principal investigator and research supervisor. Data were collected using a structured set of standardized self-report questionnaires, including the Developmental Crisis Questionnaire (DCQ-12), the Sleep Quality Scale (SQS), and the Multidimensional Scale of Perceived Social Support (MSPSS). The questionnaires were available in both paper-based format and digital format via Google Forms, providing flexibility for participants based on their location and access to digital resources.

The paper-based questionnaires were administered in community settings, such as residential neighbourhoods, local clubs, and educational institutions, with prior permission obtained from the concerned authorities. For the digital format, a Google Form link was distributed via email, social media, and messaging platforms (e.g., WhatsApp, Telegram, Instagram, LinkedIn) to reach a diverse participant pool, including those in urban and rural locations.

Participants were instructed to complete the questionnaires individually, without discussion or consultation with others. A brief set of clear, standardized instructions was provided at the beginning of the questionnaire, outlining how to respond to Likert-scale items and complete each section. For online participants, automated field validations and progress indicators were embedded in the Google Form to minimize missing data and improve completeness.

The average time taken to complete all three questionnaires was approximately 20 to 30 minutes. Participants were encouraged to respond at their own pace and were informed that there was no time limit. To ensure the validity and integrity of the data, responses were reviewed for completeness. Any paper-based forms with substantial missing data (e.g., more than 20% unanswered items) were excluded from analysis. In the case of digital submissions, Google Forms automatically flagged incomplete entries for review.

Collected data were entered into a statistical software package for data analysis. To maintain confidentiality, all data were coded and stored using participant identification numbers rather than names or personal details. Digital data were stored in password-protected files on a secure computer, while physical forms were kept in locked storage accessible only to the research team.

Data Analysis

Data were analysed using SPSS 20.0 and Jamovi software. Descriptive statistics, including mean, standard deviation, skewness, and kurtosis, were computed. Normality of the data was assessed using the Kolmogorov–Smirnov and Shapiro–Wilk tests. As the data satisfied the assumptions of normality, parametric tests namely, independent samples *t*-tests and Pearson product-moment correlations were conducted to examine group differences based on age, gender, place of residence, and type of family, as well as to assess the interrelationships among the study variables.

Independent Sample t Test

The independent samples *t*-test is a parametric statistical test used to determine whether there is a significant difference between the means of two independent groups on a continuous variable. T tests were employed to examine significant differences in midlife crisis, sleep quality, and perceived social support across various demographic variables, including age group (early vs. late middle adulthood), gender (male vs. female), place of residence (urban vs. rural), and type of family (nuclear vs. joint). This analysis helped determine whether demographic factors were associated with

significant differences in the variables under investigation.

Pearson Product-Moment Correlation

The Pearson product-moment correlation is a statistical method used to examine the strength and direction of the linear relationship between two continuous variables. It produces a correlation coefficient, denoted as r, which ranges from -1 to +1. A positive value indicates a direct relationship, a negative value indicates an inverse relationship, and a value close to zero suggests no linear relationship between the variables. This test assumes that the variables are measured on interval or ratio scales, the relationship between them is linear, and the data are normally distributed with no significant outliers. In the present study, Pearson correlation was used to analyze the interrelationship between midlife crisis, sleep quality, and perceived social support.

IV.RESULTS AND DISCUSSION

This chapter provides the details of the results reached by the investigator through statistical analysis of the data collected. Analysis is the key aspects of any research work as well as it is the way to test the hypotheses formulated by the investigator. The different statistical designs used in the study to find out the results and their procedures are discoursed below.

The present study examined the relationships among Midlife Crisis, Sleep Quality, and Perceived Social Support in Early and Late Middle Adulthood, while also assessing demographic differences across these variables. A total of 200 participants, aged 35 to 64 years, were selected using convenience sampling from Ernakulam, Kerala. Data were collected using three standardized self-report instruments: the Developmental Crisis Questionnaire (DCQ-12), the Sleep Quality Scale (SQS), and the Multidimensional Scale of Perceived Social Support (MSPSS). As the data met the assumptions of normality, parametric statistical analyses including Pearson product-moment correlation and independent samples t-tests were conducted.

Descriptive Statistics

Preliminary analysis entails fundamental descriptive statistics like arithmetic mean, median, mode, standard deviation, skewness, and kurtosis of the variables under study. Descriptive statistics are used to know whether the variables are normally distributed. The main purpose of this analysis is to get a general idea about the nature of variables. Preliminary statistics of variables midlife crisis, sleep quality and perceived social support among early and late middle adults are presented in the table 4.1.

Table 4.1 *Mean, Median, Standard Deviation, Skewness, Kurtosis and Shapiro-Wilk value of Midlife Crisis, Sleep Quality and Perceived Social Support (N = 200)*

Variables	Mean	Median	Mode	SD	Skewness	Kurtosis	Shapiro-Wilk W
DD	9.58	9.0	8.00	2.84	0.48	-0.0	0.962
LOC	10.3	10.0	12.00	2.78	0.38	0.05	0.966
TT	12.6	13.0	14.00	3.34	-0.14	-0.09	0.973
MCT	32.5	32.0	31.00	5.84	-0.24	0.0	0.982
DS	6.3	6.0	7.00	2.97	0.94	1.34	0.938
RAS	7.28	7.0	8.00	2.1	-0.45	0.54	0.958
PIMS	9.13	9.0	8.00	4.26	0.21	0.86	0.975
DW	3.13	3.0	3.00	1.58	0.15	0.09	0.95
SS	6.14	6.0	6.00	1.83	-0.59	0.83	0.932
USM	5.7	6.0	7.00	2.15	-0.09	0.46	0.965
SQT	37.7	37.0	35.00	6.74	0.56	0.69	0.975
SO	5.3	6.0	6.00	1.35	-0.8	0.05	0.92
FAM	5.37	5.5	7.00	1.34	-0.9	0.24	0.912
FRNDS	4.84	5.0	6.00	1.29	-0.69	-0.08	0.944
PSST	5.14	5.25	5.16	1.17	-1.04	1.16	0.928

Note. DD = Disconnection and Distress; LOC = Lack of Clarity; TT = Turning Point and Transition; MCT = Midlife Crisis Total Score; DS = Daytime Symptoms; RAS = Restoration After Sleep; PIMS = Problems Initiating

and Maintaining Sleep; DW = Difficulty Waking; SS = Sleep Satisfaction; USM = Use of Sleep Medications; SQT = Sleep Quality Total Score; SO = Significant Other; FAM = Family; FRNDS = Friends; PSST = Perceived Social Support Total Score.

Table 4.1 indicates the Mean, Median, Mode, Standard Deviation, Skewness, Kurtosis and Shapiro Wilk value for each variable under study. Descriptive statistics and Shapiro-Wilk tests were conducted to examine the normality and distribution characteristics of the variables in the dataset. For each variable, comparisons were made between the Mean, Median, and Mode, along with interpretations of Skewness, Kurtosis, and Shapiro-Wilk W values. In variable Midlife Crisis, for Disconnection and Distress (DD), the Mean (M = 9.58), Median (Mdn = 9.00), and Mode (Mo = 8.00) are closely aligned, with a slight positive Skewness (0.48) and near-zero Kurtosis (-0.0), indicating an approximately normal distribution. The Shapiro-Wilk test (W = 0.962) supports this assumption. In Lack of Clarity (LOC), the Mean (10.3), Median (10.0), and Mode (12.0) are relatively similar, although the mode is slightly higher. Skewness is low (0.38), and Kurtosis is close to zero (0.05), indicating a near-normal shape. Shapiro-Wilk W = 0.966 suggests no significant deviation from normality. For Turning point and Transition (TT), the values Mean = 12.6, Median = 13.0, Mode = 14.0 are closely clustered, and Skewness (-0.14) and Kurtosis (-0.09) are minimal, supporting symmetry in distribution. The Shapiro-Wilk statistic (W = 0.973) also indicates normality. The total score for Midlife Crisis (MCT) shows a Mean (32.5), Median (32.0), and Mode (31.0) that are quite close, with low Skewness (-0.24) and zero Kurtosis, further supported by Shapiro-Wilk W = 0.982, indicating a normal distribution.

When Sleep quality domains were analysed, Daytime symptoms (DS) have a Mean (6.3), Median (6.0), and Mode (7.0), which are close in range, though Skewness is moderately positive (0.94) and Kurtosis (1.34) is slightly elevated, suggesting normality. The Shapiro-Wilk test (W = 0.938) remains within acceptable limits, permitting parametric analysis with caution. Restoration After Sleep (RAS) presents a Mean of 7.28, Median of 7.0, and Mode of 8.0, with slight negative Skewness (-0.45) and moderate positive Kurtosis (0.54). The Shapiro-Wilk W = 0.958 confirms approximate normality. For Problems Initiating and Maintaining Sleep (PIMS), the Mean (9.13), Median (9.0), and Mode (8.0) are close, Skewness is low (0.21), and Kurtosis is 0.86. With Shapiro Wilk W = 0.975, distribution is approximately normal. In the case of Difficulty Walking (DW), the Mean, Median, and Mode is 3.13, 3.0, and 3.0 respectively and aligned well, with low Skewness (0.15) and minimal Kurtosis (0.09). The Shapiro-Wilk value (W = 0.950) supports a normal distribution. For Sleep Satisfaction (SS) has a Mean (6.14), Median (6.0), and Mode (6.0), with slight negative Skewness (-0.59) and Kurtosis (0.83). The normality assumption is justified with Shapiro-Wilk W = 0.932. Use of Sleep Aids and Medication (USM) shows consistency between Mean (5.7), Median (6.0), and Mode (7.0). Skewness is minimal (-0.09) and Kurtosis is low (0.46), with a Shapiro-Wilk W = 0.965 indicating a reasonably normal distribution. For Sleep Quality Total (SQT), the Mean (37.7), Median (37.0), and Mode (35.0) are fairly close. Skewness (0.56) and Kurtosis (0.69) are slightly positive, but the Shapiro-Wilk value (W = 0.975) suggests the data are approximately normally distributed.

When subscales of Perceived Social Support were analysed, Significant Others (SO) displays a Mean of 5.3, Median of 6.0, and Mode of 6.0. Although Skewness (-0.8) and the Shapiro-Wilk value (W = 0.920) suggest mild normality, the deviation is not extreme, making parametric testing acceptable with caution. Family (FAM) has a Mean (5.37), Median (5.5), and Mode (7.0), with more notable negative Skewness (-0.9) and moderate Kurtosis (0.24). Shapiro-Wilk W = 0.912 indicates some deviation from normality, but still within reasonable limits for parametric testing in larger samples. The subscale Friends (FRNDS) exhibits a Mean of 4.84, Median of 5.0, and Mode of 6.0. Skewness (-0.69) and near-zero Kurtosis (-0.08) along with W = 0.944 support near-normality. Lastly, total score of Perceived Social Support (PSST) has a Mean (5.14), Median (5.25), and Mode (5.16) that are very close, with slight negative skewness (-1.04) and moderate kurtosis (1.16). Despite W = 0.928 indicating normal distribution.

Across all variables, the Mean, Median, and Mode were found to be approximately equal, with Skewness and Kurtosis values generally within acceptable ranges (±1). The Shapiro-Wilk test values were all above 0.90, indicating that the assumption of normality was not severely violated.

Therefore, the further analysis is carried out with Parametric test.

Relationship of the variables

To examine the relationships among midlife crisis, sleep quality, and perceived social support, Pearson product-moment correlation coefficients were computed.

Relationship between Midlife Crisis and Sleep Quality

To verify the hypothesis $H_0 1$: There is no significant relationship between Midlife Crisis and Sleep Quality. Pearson product-moment correlation was used and details are given in the table 4.2.

Table 4.2- *Pearson's Correlation Matrix of Midlife crisis and sleep quality (N = 200)*

Variables	DS	RAS	PIMS	DW	SS	USM	SQT
DD	0.288***	-0.101	0.204**	0.182**	-0.067	0.133	0.292***
LOC	-0.042	0.154*	-0.069	0.032	-0.203**	-0.065	-0.082
TT	-0.052	0.082	0.062	-0.067	0.101	0.109	0.088
MCT	0.091	0.071	0.102	0.066	-0.072	0.096	0.153*

*Correlation is significant at 0.05, **Correlation is significant at 0.01, ***Correlation is significant at 0.001

Note. DD = Disconnection and Distress; LOC = Lack of Clarity; TT = Turning Point and Transition; MCT = Midlife Crisis Total Score; DS = Daytime Symptoms; RAS = Restoration After Sleep; PIMS = Problems Initiating and Maintaining Sleep; DW = Difficulty Waking; SS = Sleep Satisfaction; USM = Use of Sleep Medications; SQT = Sleep Quality Total Score.

Table 4.2 indicates the Correlation coefficients for Midlife Crisis and Sleep Quality.

The dimensions of Midlife Crisis included Disconnection and Distress, Lack of Clarity, Turning Point and Transition, and the total score of Midlife Crisis. These were examined in relation to seven aspects of sleep quality: Daytime Symptoms, Restoration After Sleep, Problems Initiating and Maintaining Sleep, Difficulty Waking, Sleep Satisfaction, Use of Sleep Medications, and the Sleep Quality Total Score.

The findings revealed that Disconnection and Distress had statistically significant positive correlations with multiple dimensions of sleep quality. Specifically, Disconnection and Distress was positively correlated with Daytime Symptoms ($r = 0.288$, $p < .001$), indicating that individuals experiencing greater disconnection and emotional distress during midlife reported more daytime fatigue and dysfunction. It was also positively associated with Problems Initiating and Maintaining Sleep ($r = 0.204$, $p < .01$), suggesting difficulties in falling asleep or staying asleep. Additionally, Disconnection and Distress was significantly correlated with Difficulty Waking ($r = 0.182$, $p < .01$) and the Sleep Quality Total Score ($r = 0.292$, $p < .001$), pointing to an overall poorer sleep experience. However, there were no significant associations between Disconnection and Distress and the dimensions of Restoration After Sleep, Sleep Satisfaction, or Use of Sleep Medications. This suggests that individuals experiencing feelings of emotional disconnection or psychological distress may not differ significantly in these specific aspects of sleep quality.

The dimension of Lack of Clarity showed a significant negative correlation with Sleep Satisfaction ($r = -0.203$, $p < .01$), indicating that individuals who felt uncertain or confused about their life direction were more likely to experience dissatisfaction with their sleep. A weak but statistically significant positive correlation was also observed between Lack of Clarity and Restoration After Sleep ($r = 0.154$, $p < .05$). This means that people who reported feeling more unclear or confused in their thoughts (lack of clarity) also reported slightly higher levels of feeling refreshed or restored after sleeping. No significant relationships were found between Lack of Clarity and the remaining sleep dimensions.

The dimension Turning Point and Transition did not show any statistically significant relationships with any of the sleep quality dimensions. This suggests that experiencing transitions or turning points during midlife, without accompanying distress or confusion, may not necessarily affect sleep quality.

The Midlife Crisis Total Score was found to have a significant positive correlation with the Sleep Quality Total Score ($r = 0.153$, $p < .05$), indicating that a higher overall experience of midlife crisis was

associated with poorer overall sleep quality, although this relationship was relatively weak.

The present findings highlight a significant relationship between Midlife Crisis experiences and Sleep Quality, particularly emphasizing the role of emotional distress in sleep disruption. The strong positive correlations observed between the Disconnection and Distress dimension of Midlife Crisis and multiple facets of poor sleep namely, increased daytime symptoms, more problems initiating and maintaining sleep, difficulty waking, and higher total sleep disturbance underscore the detrimental impact of psychological distress on sleep health.

This aligns with previous research that has identified emotional turmoil, existential distress, and social disconnection during midlife as key contributors to poor sleep outcomes. For instance, Wang, Qiao, and Lin (2023) conducted a systematic review and concluded that psychological stress and emotional dysregulation are major factors affecting sleep quality in middle-aged adults.

Similarly, Li, Zhang, and Wu (2022) found that emotional rumination and cognitive overactivity were significantly associated with insomnia and poor sleep continuity, reinforcing the notion that unresolved emotional issues such as those present in Disconnection and Distress can severely impair one's ability to fall and stay asleep.

The negative association between Lack of Clarity and Sleep Satisfaction observed in this study further supports existing theories linking purpose in life and psychological coherence to restful sleep. Schlarb, Brandhorst, and Hautzinger (2021) found that individuals with greater clarity about their life direction experienced higher satisfaction with sleep. The present study mirrors this finding, suggesting that midlife uncertainty may erode sleep satisfaction, possibly through increased worry and nighttime rumination.

Interestingly, the dimension Turning Point and Transition showed no significant correlations with any sleep variables. This may suggest that experiencing major life changes, such as a new career, lifestyle shift, or altered family roles, does not necessarily lead to poorer sleep unless it is accompanied by emotional or existential distress. This is consistent with the conclusions of Kim and Cho (2022), who noted that role transitions during midlife only significantly impact sleep when accompanied by role strain or unresolved personal conflict.

The positive relationship between the total score of Midlife Crisis and the Sleep Quality Total Score, while statistically significant, was relatively weak. However, it still implies that the overall experience of a midlife crisis is linked with some degree of sleep disruption. This supports the biopsychosocial model proposed by Harvey, Hein, Dong, and Kalmbach (2020), who emphasized the role of emotional and cognitive regulation in sleep quality. Individuals undergoing a midlife crisis may experience heightened emotional arousal, negative self-reflection, and increased stress—all of which can interfere with the physiological processes required for healthy sleep.

In conclusion, the results of this study reinforce the critical role of emotional well-being during midlife in determining sleep quality. Midlife crises characterized by disconnection, distress, and a lack of life clarity appear to be especially detrimental to sleep. Hence the hypothesis $H_0 1$ is rejected. There is a statistically significant relationship between Midlife Crisis and Sleep Quality among the participants.

Relationship Between Midlife Crisis and Perceived Social Support

To verify the hypothesis $H_0 2$: There is no significant relationship between Midlife Crisis and Perceived Social Support. Pearson product moment correlation was used and details are given in the table 4.3.

Table 4.3- *Pearson's Correlation Matrix of Midlife Crisis and Perceived Social Support (N = 200)*

Variables	SO	FAM	FRNDS	PSST
DD	-0.219**	-0.316***	-0.133	-0.279***
LOC	-0.508***	-0.549***	-0.392***	-0.567***
TT	0.143*	0.142*	0.189**	0.192**
MCT	-0.267***	-0.334***	-0.144*	-0.296***

*Correlation is significant at 0.05, **Correlation is significant at 0.01, ***Correlation is significant at 0.001

Note. DD = Disconnection and Distress; LOC = Lack of Clarity; TT = Turning Point and Transition; MCT = Midlife Crisis Total Score; SO = Significant Other; FAM = Family; FRNDS = Friends; PSST = Perceived Social Support Total Score.

Table 4.3 indicates the Pearson's Correlation for Midlife Crisis and Perceived Social Support. The dimensions of Midlife Crisis and its total score were correlated with the three dimensions of Perceived Social Support: support from Significant Other, Family, and Friends, along with the Perceived Social Support total score.

The results demonstrated that Disconnection and Distress had a statistically significant negative correlation with support from Significant Other ($r = -0.219$, $p < .01$), Family ($r = -0.316$, $p < .001$), and the Perceived social support total score ($r = -0.279$, $p < .001$). However, the correlation between Disconnection and Distress and support from Friends was not statistically significant ($r = -0.133$, $p > .05$), implying that perceived support from friends may not have a strong or consistent impact on feelings of emotional distress in midlife.

The dimension Lack of Clarity revealed strong negative correlations with all aspects of Perceived social support. It was significantly and negatively correlated with support from Significant Other ($r = -0.508$, $p < .001$), Family ($r = -0.549$, $p < .001$), Friends ($r = -0.392$, $p < .001$), and the Perceived Social Support total score ($r = -0.567$, $p < .001$). These results indicate that individuals who experience greater confusion and lack of direction in Midlife tend to perceive lower levels of Social Support.

In contrast, the dimension Turning Point and Transition showed statistically significant positive correlations with all dimensions of Perceived Social Support. It was positively correlated with support from Significant Other ($r = 0.143$, $p < .05$), Family ($r = 0.142$, $p < .05$), Friends ($r = 0.189$, $p < .01$), and the Perceived Social Support total score ($r = 0.192$, $p < .01$). These findings suggest that individuals who perceive midlife as a period of growth and transition may also experience greater perceived support.

Finally, the Midlife Crisis total score showed significant negative correlations with support from Significant Other ($r = -0.267$, $p < .001$), Family ($r = -0.334$, $p < .001$), Friends ($r = -0.144$, $p < .05$), and the Perceived social support total score ($r = -0.296$, $p < .001$). These findings confirm that individuals with higher overall levels of Midlife Crisis tend to have lower levels of Perceived Social Support.

The results highlight a significant relationship between Midlife Crisis and Perceived Social Support. Specifically, individuals experiencing higher levels of Midlife psychological distress and identity confusion tend to report lower levels of Perceived Support from significant others, family, and friends. The negative correlations found between Disconnection and Distress and Perceived Social Support suggest that emotional withdrawal and feelings of alienation during Midlife can impair one's perception of social connectedness and available support. This finding is consistent with Yang and Zhou (2023), who found that psychological distress in middle-aged individuals contributes to emotional isolation and reduced access to social resources.

The dimension Lack of Clarity showed the strongest negative relationships with all dimensions of Perceived Social Support. Individuals who lack direction and purpose during midlife may experience social disconnection, possibly because they are less likely to reach out for help or may misinterpret available support as insufficient. This is supported by Petry, Fuchs, and Weber (2021), who reported that low self-concept clarity negatively affects interpersonal communication and perceptions of Social Support, particularly during psychologically vulnerable periods like Midlife.

Interestingly, the dimension Turning Point and Transition was positively associated with Perceived Social Support. This finding suggests that when midlife changes are interpreted as opportunities for growth and transformation, individuals may become more open to engaging with their support systems. Mahoney and Cavanaugh (2022) emphasized that viewing midlife transitions positively can foster stronger relational bonds and greater emotional support, enhancing resilience during this life stage.

The negative correlations between the Midlife Crisis total score and all aspects of Perceived Social Support further reinforce the idea that a more intense and negative Midlife experience is associated with diminished feelings of being supported. Individuals undergoing a severe Midlife Crisis may experience emotional exhaustion, cognitive distortions, and social withdrawal, which together undermine their perceptions of being understood or cared for by others. This aligns with the theoretical model

proposed by Harvey, Hein, Dong, and Kalmbach (2020), who suggest that emotional dysregulation and psychological stress impair social functioning and the capacity to seek or accept support. Hence the hypothesis H_o2 is rejected. There is a statistically significant relationship between Midlife Crisis and Perceived Social Support among the participants.

Relationship between Sleep Quality and Perceived Social Support

To verify the hypothesis H_o3: There is no significant relationship between Sleep Quality and Perceived Social Support. Pearson's Correlation was used and details are given in the table 4.4.

Table 4.4- *Pearson's Correlation Matrix of Sleep Quality and Perceived Social Support (N = 200)*

Variables	SO	FAM	FRNDS	PSST
DS	-0.206**	-0.102	-0.074	-0.145*
RAS	0.107	-0.007	-0.132	0.003
PIMS	-0.000	-0.012	0.156*	0.018
DW	-0.009	-0.008	-0.092	-0.054
SS	0.180*	0.115	0.193**	0.187**
USM	-0.017	-0.039	-0.043	-0.012
SQT	-0.016	-0.038	0.042	-0.018

*Correlation is significant at 0.05, **Correlation is significant at 0.01, ***Correlation is significant at 0.001

Note. DS = Daytime Symptoms; RAS = Restoration After Sleep; PIMS = Problems Initiating and Maintaining Sleep; DW = Difficulty Waking; SS = Sleep Satisfaction; USM = Use of Sleep Medications; SQT = Sleep Quality Total Score; SO = Significant Other; FAM = Family; FRNDS = Friends; PSST = Perceived Social Support Total Score.

Table 4.4 indicates the Correlation coefficient for Sleep Quality and Perceived Social Support. The dimensions of Sleep Quality included Daytime Symptoms, Restoration After Sleep, Problems Initiating and Maintaining Sleep, Difficulty Waking, Sleep Satisfaction, Use of Sleep Medications, and the Sleep Quality Total Score. These were correlated with the dimensions of Perceived Social Support, namely support from Significant Other, Family, Friends, and the Perceived social support total score. The results revealed several statistically significant relationships. Daytime Symptoms had a significant negative correlation with support from Significant Other ($r = -0.206$, $p < .01$) and the Perceived social support total score ($r = -0.145$, $p < .05$), indicating that individuals who perceived less social support tended to report more daytime dysfunction related to poor sleep.

Problems Initiating and Maintaining Sleep showed a significant positive correlation with support from Friends ($r = 0.156$, $p < .05$), suggesting a somewhat counterintuitive finding where greater support from friends was associated with more sleep initiation and maintenance problems.

Sleep Satisfaction showed significant positive correlations with support from Significant Other ($r = 0.180$, $p < .05$), Friends ($r = 0.193$, $p < .01$), and the Perceived social support total score ($r = 0.187$, $p < .01$). This implies that individuals who felt more supported in their relationships reported greater satisfaction with their sleep, even if other sleep issues persisted. No statistically significant relationships were found between the dimensions of Perceived social support and Restoration After Sleep, Difficulty Waking, Use of Sleep Medications, or the overall Sleep Quality Total Score.

The findings reveal a modest yet meaningful pattern of associations between these two constructs. The significant negative relationship between Daytime Symptoms and support from both Significant Other and overall Perceived social support suggests that individuals who feel emotionally and socially supported tend to experience fewer daytime consequences of poor sleep. This finding is supported by prior research, such as that of Kent de Grey et al. (2018), who found that social support serves as a protective factor against the physiological and emotional impairments associated with poor sleep.

Sleep Satisfaction emerged as the most consistently correlated component of Sleep quality, positively associated with social support from Significant Other, Friends, and overall support. This suggests that the subjective feeling of being satisfied with one's sleep is closely linked to the perception of being emotionally supported, especially by close

interpersonal relationships. These results align with the findings of Troxel et al. (2015), who emphasized that higher relationship quality and social closeness contribute to better subjective sleep outcomes.

Interestingly, the positive correlation between Problems Initiating and Maintaining Sleep and support from Friends suggests a more complex dynamic. One possible explanation is that individuals who are struggling with sleep may reach out more to their friends or receive more attention from them, temporarily increasing the perception of support while still experiencing sleep issues. Alternatively, social activities with friends that extend into the night may indirectly contribute to sleep initiation challenges.

The absence of significant correlations with the Sleep Quality Total Score and most sleep dimensions indicates that the overall relationship between Sleep quality and Perceived social support is limited to specific dimensions such as Daytime Symptoms and Sleep Satisfaction, rather than global sleep functioning. This highlights the importance of using multidimensional assessments of both sleep and social support in research, rather than relying solely on total scores. Hence the hypothesis H_o3 is rejected. There is a statistically significant relationship between Sleep Quality and Perceived Social Support among the participants.

Differences in subdomains of Midlife Crisis, sleep quality and perceived social support among Early (35-44) and Late (45-64) Middle Adults

To verify the hypothesis H_o4: There is no significant difference in each subdomain of Midlife Crisis among Early and Late Middle adults, H_o5: There is no significant difference in each sub domains of Sleep Quality among Early and Late Middle adults and H_o6: There is no significant difference in each subdomain of Perceived social support among Early and Late middle adults. Independent Sample t Test was used and details are given in table 4.5.

Table 4.5- *Independent Sample t Test used to compare variables with Early (35-44) and Late Middle Adulthood (45-64).*

Variables	Age	N	Mean	SD	t- value	p
DD	35-44	100	9.60	2.72	0.0994	0.921
	45-64	100	9.56	2.97		
LOC	35-44	100	10.69	2.83	2.0768	0.039*
	45-64	100	9.88	2.69		
TT	35-44	100	12.31	3.45	-1.3810	0.169
	45-64	100	12.96	3.20		
MCT	35-44	100	32.60	6.16	0.2417	0.809
	45-64	100	32.40	5.52		
DS	35-44	100	6.41	3.09	0.4989	0.618
	45-64	100	6.20	2.86		
RAS	35-44	100	7.20	2.22	-0.5388	0.591
	45-64	100	7.36	1.97		
PIMS	35-44	100	9.35	4.44	0.7135	0.476
	45-64	100	8.92	4.08		
DW	35-44	100	3.20	1.63	0.5805	0.562
	45-64	100	3.07	1.54		
SS	35-44	100	6.03	1.84	-0.8497	0.397
	45-64	100	6.25	1.82		
USM	35-44	100	5.96	2.15	1.7516	0.081
	45-64	100	5.43	2.13		
SQT	35-44	100	38.15	7.26	0.9650	0.336
	45-64	100	37.23	6.17		
SO	35-44	100	5.31	1.35	0.1310	0.896
	45-64	100	5.29	1.35		
FAM	35-44	100	5.28	1.42	-0.9065[a]	0.366
	45-64	100	5.46	1.27		
FRNDS	35-44	100	5.00	1.31	1.7735	0.078
	45-64	100	4.68	1.26		
PSST	35-44	100	5.22	1.15	0.9778	0.329
	45-64	100	5.06	1.19		

P<0.05

Note. DD = Disconnection and Distress; LOC = Lack of Clarity; TT = Turning Point and Transition; MCT = Midlife Crisis Total Score; DS = Daytime Symptoms; RAS = Restoration After Sleep; PIMS = Problems Initiating and Maintaining Sleep; DW = Difficulty Waking; SS = Sleep Satisfaction; USM = Use of Sleep Medications;

SQT = Sleep Quality Total Score; SO = Significant Other; FAM = Family; FRNDS = Friends; PSST = Perceived Social Support Total Score.

Table 4.5 indicates the Independent Sample t Test done to compare differences between Early Middle Adulthood (35-44) and Late Middle Adulthood (45-64) regarding Midlife Crisis, Sleep Quality, and Perceived Social Support.

The analysis of midlife crisis subdomains included Disconnection and Distress (DD), Lack of Clarity (LOC), Turning Point and Transition (TT), and Midlife Crisis Total (MCT). For DD, the t-value was 0.0994 ($p = 0.921$), indicating no significant difference. Similarly, TT showed a t-value of -1.3810 ($p = 0.169$), and MCT yielded a t-value of 0.2417 ($p = 0.809$), both non-significant. However, LOC presented a statistically significant difference with a t-value of 2.0768 and $p = 0.039$ ($p < 0.05$), suggesting that individuals in early middle adulthood reported higher levels of confusion and lack of direction compared to their late middle adulthood counterparts. This aligns with Lachman et al. (2015), who noted that the early 40s may be a peak period of self-reflection and identity struggles, often perceived as a psychological turning point. Additionally, Willis & Martin (2020) found that early middle-aged adults face intensified role conflicts, potentially explaining the higher LOC scores. Therefore, H_o4 is rejected, as a significant difference was found in one subdomain (LOC), but not in the others.

In terms of sleep quality, there is no significant differences in any subdomain between the two age groups. For instance, Daytime Symptoms (DS) had a t-value of 0.4989 ($p = 0.618$), Restoration After Sleep (RAS) $t = -0.5388$ ($p = 0.591$), Problems Initiating and Maintaining Sleep (PIMS) $t = 0.7135$ ($p = 0.476$), Difficulty Waking (DW) $t = 0.5805$ ($p = 0.562$), Sleep Satisfaction (SS) $t = -0.8497$ ($p = 0.397$), and Use of Sleep Medications (USM) $t = 1.7516$ ($p = 0.081$). Although USM approached significance, it did not meet the 0.05 threshold. The total sleep quality score (SQT) also showed no significant difference ($t = 0.9650$, $p = 0.336$). These findings support those by Ohayon et al. (2017), who found that sleep quality declines gradually with age but not significantly across adjacent midlife stages. Moreover, Krystal (2020) emphasized that psychosocial stress, rather than age alone, contributes more prominently to variations in sleep quality. Thus, H_o5 is accepted, as no significant age-related differences were found in sleep quality.

The subdomains of perceived social support (Significant Other [SO], Family [FAM], Friends [FRNDS]) and the total score (PSST) also showed no statistically significant differences between early and late middle adulthood. For SO, the t-value was 0.1310 ($p = 0.896$), for FAM it was -0.9065 ($p = 0.366$), for FRNDS it was 1.7735 ($p = 0.078$), and for PSST the t-value was 0.9778 ($p = 0.329$). Although, the friends subdomain in Perceived social support approached a significance, but, the difference did not meet the required alpha level. These results can be aligned with Antonucci et al. (2019), who noted that social networks remain relatively stable during midlife, and the quality of perceived support tends to remain consistent unless disrupted by major life events. Furthermore, Carstensen's Socioemotional Selectivity Theory (1992; updated 2019) supports the idea that with age, individuals become more selective but emotionally closer to their social ties, which may contribute to the stability in perceived support. Hence, H_o6 is accepted, as no significant difference was found across the perceived social support domains.

In summary, the results show that among the three hypotheses tested, H_o4 is rejected due to a significant difference in the Lack of Clarity subdomain of midlife crisis, while H_o5 and H_o6 are accepted, indicating no significant differences in sleep quality and perceived social support across early and late middle adulthood.

Gender Differences in Subdomain of Midlife Crisis, Sleep Quality and Perceived Social Support

To verify the hypothesis H_o7: There is no significant difference in each subdomain of midlife crisis among males and females, H_o8: There is no significant difference in each subdomain of sleep quality among males and females and H_o9: There is no significant difference in each subdomain of perceived social support among males and females. Independent Sample t Test was used and details are given in table 4.6.

Table 4.6- *Independent Sample t Test used to compare variables with Gender.*

Variables	Gender	N	Mean	SD	t value	P

DD	Male	100	9.49	2.94	-0.4476	0.655
	Female	100	9.67	2.74		
LOC	Male	100	10.45	3.20	0.8385[a]	0.403
	Female	100	10.12	2.29		
TT	Male	100	12.04	3.64	-2.5574[a]	0.011*
	Female	100	13.23	2.90		
MCT	Male	100	31.98	6.59	-1.2618[a]	0.209
	Female	100	33.02	4.95		
DS	Male	100	6.52	2.76	1.0236	0.307
	Female	100	6.09	3.17		
RAS	Male	100	7.20	1.98	-0.5388	0.591
	Female	100	7.36	2.21		
PIMS	Male	100	9.28	4.11	0.4808	0.631
	Female	100	8.99	4.42		
DW	Male	100	3.04	1.51	-0.8492	0.397
	Female	100	3.23	1.65		
SS	Male	100	6.17	1.80	0.2313	0.817
	Female	100	6.11	1.86		
USM	Male	100	5.68	2.23	-0.0984	0.922
	Female	100	5.71	2.08		
SQT	Male	100	37.89	6.70	0.4188	0.676
	Female	100	37.49	6.81		
SO	Male	100	5.12	1.33	-1.8760	0.062
	Female	100	5.47	1.35		
FAM	Male	100	5.19	1.41	-1.8916[a]	0.060
	Female	100	5.55	1.26		
FRNDS	Male	100	4.88	1.24	0.3750	0.708
	Female	100	4.81	1.34		
PSST	Male	100	5.04	1.19	-1.1755	0.241
	Female	100	5.24	1.15		

P<0.05

Note. DD = Disconnection and Distress; LOC = Lack of Clarity; TT = Turning Point and Transition; MCT = Midlife Crisis Total Score; DS = Daytime Symptoms; RAS = Restoration After Sleep; PIMS = Problems Initiating and Maintaining Sleep; DW = Difficulty Waking; SS = Sleep Satisfaction; USM = Use of Sleep Medications; SQT = Sleep Quality Total Score; SO = Significant Other; FAM = Family; FRNDS = Friends; PSST = Perceived Social Support Total Score.

Table 4.6 indicates the Independent Sample t Test conducted to find the differences between Male and Female participants in areas related to Midlife Crisis, Sleep Quality, and Perceived Social Support. The subdomains analyzed under midlife crisis include Disconnection and Distress (DD), Lack of Clarity (LOC), Turning Point and Transition (TT), and the Midlife Crisis Total Score (MCT). The t-test results show that DD (t = -0.4476, p = 0.655), LOC (t = 0.8385, p = 0.403), and MCT (t = -1.2618, p = 0.209) are all statistically non-significant, suggesting that there is no gender differences in these aspects. However, a significant difference (at 0.05 level of significance) was found in the TT subdomain (t = -2.5574, p = 0.011), indicating that females reported a greater sense of transition and turning points in midlife compared to males. This is consistent with findings by Robinson et al. (2020), who reported that women tend to experience midlife as a more emotionally charged period due to intersecting roles (e.g., caregiving, career re-evaluation), often leading to increased self-reflection and transitional experiences. Therefore, $H_0 7$ is rejected.

For sleep quality, the subdomains Daytime Symptoms (DS), Restoration After Sleep (RAS), Problems Initiating and Maintaining Sleep (PIMS), Difficulty Waking (DW), Sleep Satisfaction (SS), and Use of Sleep Medications (USM) along with the Sleep Quality Total Score (SQT), all showed no significant differences between males and females. Specifically, DS (t = 1.0236, p = 0.307), RAS (t = -0.5388, p = 0.591), PIMS (t = 0.4808, p = 0.631), DW (t = -0.8492, p = 0.397), SS (t = 0.2313, p = 0.817), USM (t = -0.0984, p = 0.922), and SQT (t = 0.4188, p = 0.676) were all statistically non-significant. These findings are aligned with research by Zhang & Wing (2020), who found that although women generally report higher sleep disturbances, the difference is often not statistically significant in non-clinical midlife populations. Similarly, a study conducted by Mallampalli and Carter (2014) suggested that biological and social factors can have an impact on sleep differently across genders, but

these do not always translate into large quantitative differences. Hence, H_o8 is accepted, as there is no significant gender-based differences were observed in any subdomains of sleep quality.

Regarding perceived social support, the subdomains assessed were Significant Other (SO), Family (FAM), Friends (FRNDS), and the Total Perceived Social Support Score (PSST). The t-values and p-values for SO ($t = -1.8760$, $p = 0.062$) and FAM ($t = -1.8916$, $p = 0.060$) approached statistical significance but did not cross the 0.05 threshold. FRNDS ($t = 0.3750$, $p = 0.708$) and PSST ($t = -1.1755$, $p = 0.241$) were clearly non-significant. These trends suggest a possible tendency for females to report slightly higher support from family and significant others, although not conclusively significant in this sample. This trend aligns with Taylor et al. (2000), who highlighted that women generally maintain closer social ties and are more likely to seek and perceive emotional support. However, based on statistical evidence, H_o9 is accepted, as none of the subdomains reached significance.

In conclusion, the results of the Independent Sample T Tests reveal that among the three hypotheses, H_o7 is rejected due to a significant gender difference in the Turning Point and Transition domain of midlife crisis, H_o8 is accepted, with no significant differences in sleep quality between genders, and H_o9 is accepted, as no significant gender differences were observed in perceived social support.

Difference in Each Subdomain of Midlife Crisis, Sleep Quality and Perceived Social Support Across Urban and Rural Area

To verify the hypothesis H_o10: There is no significant difference in each subdomain of midlife crisis across urban and rural area, H_o11: There is no significant difference in each subdomain of sleep quality across urban and rural area and H_o12: There is no significant difference in each subdomain of perceived social support across urban and rural area. Independent Sample t Test was used and details are given in table 4.7.

Table 4.7- *Independent Sample t Test used to compare variables with Place of Residence.*

Variables	Gender	N	Mean	SD	t value	P
DD	Urban	100	9.65	3.02	0.348	0.728
	Rural	100	9.51	2.65		
LOC	Urban	100	9.77	2.45	-2.659	0.008**
	Rural	100	10.80	3.00		
TT	Urban	100	13.42	3.13	3.416	<.001***
	Rural	100	11.85	3.36		
MCT	Urban	100	32.84	5.57	0.823	0.411
	Rural	100	32.16	6.10		
DS	Urban	100	6.21	3.31	-0.451	0.652
	Rural	100	6.40	2.60		
RAS	Urban	100	7.25	2.21	-0.202	0.840
	Rural	100	7.31	1.99		
PIMS	Urban	100	9.20	4.44	0.215	0.830
	Rural	100	9.07	4.09		
DW	Urban	100	3.02	1.68	-1.029	0.305
	Rural	100	3.25	1.47		
SS	Urban	100	6.44	1.87	2.345	0.020*
	Rural	100	5.84	1.75		
USM	Urban	100	5.64	2.19	-0.361	0.719
	Rural	100	5.75	2.12		
SQT	Urban	100	37.76	6.95	0.147	0.884
	Rural	100	37.62	6.55		
SO	Urban	100	5.44	1.29	1.501	0.135
	Rural	100	5.16	1.40		
FAM	Urban	100	5.57	1.24	2.135	0.034*
	Rural	100	5.17	1.42		
FRNDS	Urban	100	5.01	1.25	1.841	0.067
	Rural	100	4.68	1.31		
PSST	Urban	100	5.30	1.06	1.974	0.050*
	Rural	100	4.98	1.26		

****P<0.001, **P<0.01, *P<0.05*

Note. DD = Disconnection and Distress; LOC = Lack of Clarity; TT = Turning Point and Transition; MCT = Midlife Crisis Total Score; DS = Daytime Symptoms; RAS = Restoration After Sleep; PIMS = Problems Initiating and Maintaining Sleep; DW = Difficulty Waking; SS = Sleep Satisfaction; USM = Use of Sleep Medications;

SQT = Sleep Quality Total Score; SO = Significant Other; FAM = Family; FRNDS = Friends; PSST = Perceived Social Support Total Score.

Table 4.7 indicates Independent Sample t Test used to find the differences in Midlife Crisis, Sleep Quality, and Perceived Social Support based on Place of Residence.

Among the midlife crisis subdomains, Disconnection and Distress (DD) and Midlife Crisis Total Score (MCT) did not show significant differences between urban and rural residents, with DD ($t = 0.348$, $p = 0.728$) and MCT ($t = 0.823$, $p = 0.411$) yielding non-significant results. However, significant differences were found in Lack of Clarity (LOC) ($t = -2.659$, $p = 0.008$) and Turning Point and Transition (TT) ($t = 3.416$, $p < .001$, significant at 0.001 level). Specifically, rural participants reported higher LOC scores, indicating greater confusion and indecision during midlife, whereas urban participants reported higher TT scores, suggesting more pronounced perceptions of life transitions. This may be due to differing life contexts—rural individuals often face limited opportunities and social mobility, contributing to identity struggles (Srinivasan & Subrahmanyam, 2020), while urban individuals may experience dynamic environments that promote self-reflection and transitions (Ghosh & Singh, 2022). Therefore, H_o10 is rejected, as significant differences were observed in two subdomains.

In the domain of sleep quality, most subdomains did not show significant differences between urban and rural residents. These include Daytime Symptoms (DS) ($t = -0.451$, $p = 0.652$), Restoration After Sleep (RAS) ($t = -0.202$, $p = 0.840$), Problems Initiating and Maintaining Sleep (PIMS) ($t = 0.215$, $p = 0.830$), Difficulty Waking (DW) ($t = -1.029$, $p = 0.305$), Use of Sleep Medications (USM) ($t = -0.361$, $p = 0.719$), and the Sleep Quality Total Score (SQT) ($t = 0.147$, $p = 0.884$). However, Sleep Satisfaction (SS) showed a significant difference ($t = 2.345$, $p = 0.020$, significant at 0.05 level), with urban participants reporting higher satisfaction. This may be linked to better healthcare access, sleep environments, and stress management in urban settings (Patel et al., 2019). Despite this, the lack of significant difference in most subdomains supports the notion that sleep quality is influenced more by individual lifestyle and stress levels than geography alone (Gulia & Kumar, 2018). Therefore, H_o11 is rejected due to the significance observed in the SS subdomain.

The analysis of perceived social support revealed mixed results. Support from Significant Other (SO) ($t = 1.501$, $p = 0.135$) and Friends (FRNDS) ($t = 1.841$, $p = 0.067$) showed non-significant trends, although the latter approached significance. In contrast, Family Support (FAM) ($t = 2.135$, $p = 0.034$, significant at 0.05 level) and the Perceived Social Support Total Score (PSST) ($t = 1.974$, $p = 0.050$, significant at 0.05 level)) showed statistically significant differences, with urban residents reporting higher support. This contrasts traditional assumptions that rural communities are more collectivistic; however, shifting family structures, urban migration, and changing lifestyles may contribute to decreased perceived support in rural settings (Yadav & Misra, 2021). Thus, H_o12 is rejected, based on significant differences in family support and total support perception.

In conclusion, the results of the Independent Sample T Tests reveal that among the three hypotheses, H_o10 is rejected, with significant differences in LOC and TT subdomains of midlife crisis, H_o11 is rejected, with significant difference found only in sleep satisfaction and H_o12 is rejected, due to significant differences in family support and total perceived support.

Difference in Each Subdomain of Midlife Crisis, Sleep Quality and Perceived Social Support Among Nuclear and Joint Family

To verify the hypothesis H_o13: There is no significant difference in each subdomain of midlife crisis among nuclear and joint family, H_o14: There is no significant difference in each subdomain of sleep quality among nuclear and joint family and H_o15: There is no significant difference in each subdomain of perceived social support among nuclear and joint family. Independent Sample t Test was used and details are given in table 4.8.

Table 4.8

Independent Sample t Test used to compare variables with Family Types.

Variables	Family type	N	Mean	SD	t value	P
DD	Nuclear	100	10.13	2.98	2.787	0.006**
	Joint	100	9.03	2.59		

LOC	Nuclear	100	10.14	2.68	-0.737	0.462
	Joint	100	10.43	2.89		
TT	Nuclear	100	13.06	3.47	1.812	0.071
	Joint	100	12.21	3.16		
MCT	Nuclear	100	33.33	6.06	2.027	0.044*
	Joint	100	31.67	5.51		
DS	Nuclear	100	6.79	3.11	2.334	0.021*
	Joint	100	5.82	2.75		
RAS	Nuclear	100	7.19	2.14	-0.606	0.545
	Joint	100	7.37	2.05		
PIMS	Nuclear	100	9.50	4.26	1.214	0.226
	Joint	100	8.77	4.24		
DW	Nuclear	100	3.51	1.48	3.445	<.001***
	Joint	100	2.76	1.60		
SS	Nuclear	100	6.05	2.00	-0.695	0.488
	Joint	100	6.23	1.64		
USM	Nuclear	100	5.73	2.33	0.230	0.819
	Joint	100	5.66	1.96		
SQT	Nuclear	100	38.77	6.59	2.290	0.023*
	Joint	100	36.61	6.75		
SO	Nuclear	100	5.19	1.40	-1.103	0.271
	Joint	100	5.40	1.29		
FAM	Nuclear	100	5.34	1.38	-0.328	0.743
	Joint	100	5.40	1.31		
FRNDS	Nuclear	100	4.74	1.26	-1.173	0.242
	Joint	100	4.95	1.32		
PSST	Nuclear	100	5.12	1.16	-0.269	0.788
	Joint	100	5.16	1.19		

****P<0.001,**P<0.01,*P<0.05*

Note. DD = Disconnection and Distress; LOC = Lack of Clarity; TT = Turning Point and Transition; MCT = Midlife Crisis Total Score; DS = Daytime Symptoms; RAS = Restoration After Sleep; PIMS = Problems Initiating and Maintaining Sleep; DW = Difficulty Waking; SS = Sleep Satisfaction; USM = Use of Sleep Medications; SQT = Sleep Quality Total Score; SO = Significant Other; FAM = Family; FRNDS = Friends; PSST = Perceived Social Support Total Score.

Table 4.8 indicates the Independent Sample t Test to compare individuals from Joint and Nuclear Families.The subdomains of midlife crisis examined were Disconnection and Distress (DD), Lack of Clarity (LOC), Turning Point and Transition (TT), and the Midlife Crisis Total Score (MCT). Results revealed a significant difference in DD (t = 2.787, p = 0.006, significant at 0.01 level), with individuals from nuclear families reporting higher distress levels than those from joint families. The MCT also showed a significant difference (t = 2.027, p = 0.044, significant at 0.05 level), again higher in nuclear families, suggesting a greater overall experience of midlife crisis symptoms.

Although the TT subdomain approached significance (t = 1.812, p = 0.071), it did not meet the conventional threshold. LOC (t = -0.737, p = 0.462) showed no significant difference.

These findings are in line with Chadda and Deb (2013), who emphasized the psychological buffering role of joint family systems in India. Joint families often provide more emotional and instrumental support, which helps individuals cope better with identity transitions and emotional turmoil during midlife. In contrast, nuclear families may experience more isolation and less shared responsibility, leading to increased stress.

Thus, $H_0$13 is rejected there are significant differences in Distress and Disconnection and Midlife Crisis Total Score, suggesting that family type does influence how midlife crises are experienced.

Analysis of the sleep quality domains showed significant differences in Daytime Symptoms (DS) (t = 2.334, p = 0.021, significant at 0.05 level), Difficulty Waking (DW) (t = 3.445, p < .001), and the Sleep Quality Total Score (SQT) (t = 2.290, p = 0.023, significant at 0.05 level), with nuclear family participants reporting poorer sleep quality in these areas. Other domains Restoration After Sleep (RAS) (t = -0.606, p = 0.545), Problems Initiating and Maintaining Sleep (PIMS) (t = 1.214, p = 0.226), Sleep Satisfaction (SS) (t = -0.695, p = 0.488), and Use of Sleep Medications (USM) (t = 0.230, p = 0.819) did not show significant differences.

These results align with Bharathi & Dhanalakshmi (2017), who found that individuals in joint families report better sleep hygiene and fewer disruptions due to shared responsibilities and stronger emotional networks. The joint family structure can offer routine, companionship, and lower levels of loneliness, all of which contribute to improved sleep quality. On the other hand, nuclear family members especially those managing caregiving and employment without additional support may experience heightened stress and sleep disturbances (Suri & Mahapatra, 2020).

Therefore, $H_0$14 is rejected, as significant differences were observed in three key sleep-related subdomains.

For perceived social support, none of the subdomains—Significant Other (SO) ($t = -1.103$, $p = 0.271$), Family (FAM) ($t = -0.328$, $p = 0.743$), Friends (FRNDS) ($t = -1.173$, $p = 0.242$), and the Total Score (PSST) ($t = -0.269$, $p = 0.788$)—showed statistically significant differences between family types.

Although joint families are traditionally thought to offer greater support, changing social dynamics in India may have narrowed this gap. For instance, Singh & Joshi (2019) noted that nuclear families increasingly rely on strong spousal and friendship bonds, often substituting for extended family support. Moreover, urbanization and the rise of digital communication may help nuclear family members stay socially connected even without co-residing with relatives.

Consequently, $H_0$15 is accepted, indicating that family structure did not significantly influence perceived levels of social support in this sample.

In summary, $H_0$13 is rejected: Significant differences were found in Disconnection and Distress and total midlife crisis scores, with nuclear families reporting higher levels. $H_0$14 is rejected: Significant differences in Daytime Symptoms, Difficulty Waking, and Total Sleep Quality suggest poorer sleep in nuclear families. $H_0$15 is accepted: No significant differences were found in perceived social support between nuclear and joint families.

The findings of the present study, supported by psychological theories and recent literature, highlight the complex interplay between age, gender, type of family, and place of residence in shaping midlife crisis, sleep quality, and perceived social support. Significant positive correlations were observed between midlife crisis and poor sleep quality, aligning with Lachman et al. (2015) who emphasized that psychological distress during midlife often disrupts sleep. Differences based on age revealed that individuals in early middle adulthood experienced greater lack of clarity, while gender differences indicated that women were more likely to perceive life as a period of transition and turning points, supporting the views of Robinson et al. (2020).

Significant differences across place of residence showed that urban individuals reported more pronounced transitions and better sleep satisfaction, while rural participants reported higher confusion (LOC), possibly due to limited access to opportunities and support, consistent with Srinivasan & Subrahmanyam (2020). Likewise, family structure influenced experiences, with nuclear family members reporting significantly higher levels of disconnection and distress, more daytime symptoms, and poorer overall sleep quality compared to those in joint families. This supports Chadda & Deb's (2013) assertion that joint families offer emotional buffering and shared responsibilities that ease midlife stress. However, perceived social support did not significantly differ across gender, family type, or residence, echoing Carstensen's Socioemotional Selectivity Theory, which posits that individuals prioritize emotionally meaningful relationships regardless of context.

Overall, the study affirms that midlife adjustment is multifaceted, influenced by demographic and contextual factors, and significantly tied to psychological well-being and sleep health, as reinforced by Bharathi & Dhanalakshmi (2017) and Yadav & Misra (2021).

V.SUMMARY AND CONCLUSION

In this chapter, an overview of the important aspects of the investigation, the major findings, implications, limitations and suggestions for the further research are presented.

Summary of the Study

The current study entitled *"Midlife Crisis, Sleep Quality and Perceived Social Support Among Middle Adults"* aimed to investigate how psychological distress during midlife correlates with sleep health and perceptions of social support. The study employed a quantitative, cross-sectional design involving 200 participants aged 35 to 64 years from Ernakulam district, Kerala, using convenience sampling. Participants were evenly distributed across gender, age groups (early middle

adulthood: 35–44; late middle adulthood: 45–64), family types (nuclear and joint), and places of residence (urban and rural).

Three standardized tools were used:

- The Developmental Crisis Questionnaire (DCQ-12) measured subdomains of midlife crisis: Disconnection and Distress (DD), Lack of Clarity (LOC), and Turning Point and Transition (TT).
- The Sleep Quality Scale (SQS) assessed sleep problems, including Daytime Symptoms (DS), Restoration After Sleep (RAS), Problems Initiating and Maintaining Sleep (PIMS), Difficulty Walking (DW), Sleep Satisfaction (SS) and Use of Sleep Aids and Medications.
- The Multidimensional Scale of Perceived Social Support (MSPSS) evaluated support from significant others, family, and friends.

Descriptive and inferential analyses were conducted, including Pearson's correlation and Independent Sample t-tests. The results highlighted complex interrelationships among the core variables and showed how psychological and social factors influence midlife well-being.

VI.MAJOR FINDINGS

Relationship between Midlife Crisis and Sleep Quality shows statistically significant positive correlations, especially between Disconnection and Distress and poorer sleep quality. Participants with more distress experienced increased sleep disruptions such as daytime dysfunction, difficulty falling or staying asleep, and poor overall sleep quality. In Midlife Crisis and Perceived Social Support, negative correlations were observed. Individuals reporting higher levels of Lack of Clarity and Disconnection and Distress perceived significantly lower support, especially from family and significant others. In Sleep Quality and Social Support, Poor sleep, particularly daytime dysfunction and dissatisfaction, was related to lower levels of social support. Interestingly, support from friends was positively associated with sleep initiation problems, possibly due to late-night social activities or reverse causality.

When variables were compared it is found that, early middle-aged adults reported significantly more Lack of Clarity, aligning with the idea that this phase involves identity exploration and role revaluation. Women scored significantly higher in the Turning Point and Transition subdomain, reflecting a greater sense of change and revaluation during midlife. Rural participants had more Lack of Clarity, whereas urban participants showed higher Turning Point and Transition and Sleep Satisfaction. Urban participants also reported better family support. Participants from nuclear families experienced significantly higher Disconnection and Distress, total midlife crisis scores, and poorer sleep quality (specifically daytime symptoms, difficulty waking, and overall sleep score). No significant differences were found in perceived social support.

VII.IMPLICATIONS OF THE STUDY

1. Clinical Implications

- The study underscores the need for psychological interventions tailored to middle-aged adults, especially for those showing signs of disconnection and distress. Counselling and psychotherapy can address emotional upheavals and promote healthier coping strategies.
- The clear link between emotional distress and sleep issues suggests that sleep hygiene interventions may be more effective if paired with stress management and emotion regulation training.

2. Public Health and Policy

- These findings have implications for community mental health programs. Policymakers and NGOs should prioritize mental health outreach in rural areas and for nuclear families, where stress and lack of clarity are higher.
- Workplace wellness initiatives could be developed for middle-aged employees, offering support groups, wellness education, and counselling as preventive mental health strategies.

3. Social and Family Interventions

- The buffering effect of joint families highlights the importance of social connectedness and emotional safety. Programs fostering intergenerational bonding and communal caregiving may mitigate midlife distress.
- Family education programs may improve awareness of midlife transitions and the support needed to navigate them effectively.

VIII.LIMITATIONS OF THE STUDY

- The findings may not generalize to other Indian states or cultural settings with different socio-economic structures.
- The cross-sectional design limits causal interpretation; longitudinal studies are needed to examine changes in midlife crisis and its long-term effects.
- All data were collected using self-report questionnaires, which are subject to social desirability and response bias, especially in culturally sensitive topics like emotional distress.
- Other potentially influential variables such as employment status, chronic health conditions, marital satisfaction, and caregiving responsibilities were not controlled.
- While methodologically convenient, the equal distribution of participants across demographic groups (age, gender, residence, family type) may not reflect the actual population proportions.

IX.SUGGESTION FOR FURTHER RESEARCH

- Tracking participants over several years could offer insights into how midlife crises, sleep patterns, and support networks develop or change.
- Interviews or focus groups can uncover personal narratives and deeper meanings that go beyond numerical data.
- Including participants from various regions, socio-economic backgrounds, and religions would provide more representative data.
- A combination of quantitative and qualitative tools could offer a comprehensive picture of the midlife experience.
- Future studies should explore the effectiveness of targeted psychological, social, and lifestyle interventions to improve midlife well-being.
- Variables like marital satisfaction, occupational stress, health status, and lifestyle behaviors could provide a richer understanding of midlife adjustment.

X.CONCLUSION

The study sheds light on the intricate web of psychological, behavioral, and social factors that influence the experience of midlife. Emotional turmoil, particularly feelings of disconnection and lack of clarity, were found to significantly disrupt sleep and reduce perceptions of being supported. Women, early middle-aged adults, and individuals living in nuclear families or rural areas appeared especially vulnerable to midlife stressors.

These findings reinforce psychological models like the Biopsychosocial Model and Socioemotional Selectivity Theory, which emphasize that mental health and social bonds are key determinants of subjective well-being. The role of context family structure, living environment, and life stage cannot be ignored in understanding and managing midlife crises.

Ultimately, this research contributes valuable insights to the field of lifespan psychology, suggesting that midlife is not merely a time of decline or crisis, but a complex phase influenced by internal struggles and external supports. It calls for the development of preventive, therapeutic, and community-based strategies to help individuals transition through this life stage with resilience and a renewed sense of purpose.

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APPENDICES

APPENDIX A

Informed consent form

I, the undersigned, have been informed about the study titled "Midlife Crisis, Sleep Quality and Perceived Social Support Among Early and Late Middle Adulthood" conducted by Diya Sana K N, a Second-year MSc Psychology student at MES TO Abdulla Memorial College, Kunnukara, Aluva. I understand that my participation is voluntary, and I have the right to withdraw from the study at any time without penalty. I am aware that my responses will remain confidential and used only for educational purposes. I have been informed that there are no foreseeable risks involved and that the study will take approximately 15-20 minutes to complete. By

signing below, I give my consent to participate in this research.

Participant's Signature:
Date:
Researcher's Signature:

APPENDIX B
PERSONAL DETAILS

Please tick and fill the details for the following.

Age
- 35 – 44
- 45 – 64

Gender

- Male
- Female

Place of Residence
- Urban
- Rural

Marital Status
- Single
- Married
- Divorced
- Widower

Education …….

Occupation ……

Employment Status
- Full – time
- Part – time
- Self – employed
- Unemployed
- Retired

Past Job, If any? …….

Income level
- High
- Medium
- Low

Type of family
- Joint family
- Nuclear family
- Staying alone

Number of family members
Health status
- Excellent
- Good
- Fair
- Poor

Physical activity (Exercise, walk, run, etc.)
- Yes
- No

Taking any diet
- Yes
- No

Substance use (Alcohol, drugs, smoking, etc.)
- Yes
- No

At which time do you usually sleep?

At which time do you usually wake up?

How much hours of sleep you get?

Are you facing any sleep disturbances?

How is your relationship with family members?
- Excellent
- Good
- Fair
- Poor

How is your relationship with friends group?
- Excellent
- Good
- Fair
- Poor

How is your relationship with work colleagues?
- Excellent
- Good
- Fair
- Poor

APPENDIX C
THE DEVELOPMENT CRISIS QUESTIONNAIRE (DCQ-12)

Please indicate using a tick mark whether the following statements describe your life in general over the past six months or so. Read each statement and choose the correct options.

STATEMENTS	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. I have been questioning myself and my life more than I normally do.					
2. I feel like my life has lost direction.					
3. I have been experiencing stronger negative emotions than normal.					
4. I have been thinking that life is meaningless.					
5. I have been confident about what I need to do to make it in life.					
6. I have been feeling in control of my life.					
7. My life feels stable and predictable.					
8. I have felt that I have had the resources to deal with any challenges that life throws at me.					
9. I am experiencing a time of transition in my life.					
10. I am passing through a major turning point in my life.					
11. I feel like I may be in the process of leaving the 'old me' behind and am developing a 'new me'.					
12. I have noticed that the way I have thought about my life has changed.					

APPENDIX D

SLEEP QUALITY SCALE (SQS)

The following survey is to know the quality of sleep you had for the last one month. Read each statement and check the closest answer.

STATEMENTS	*Rarely*	*Sometimes*	*Often*	*Almost Always*
1. I have difficulty falling asleep.				
2. I fall into a deep sleep.				
3. I wake up while sleeping.				
4. I have difficulty getting back to sleep once I wake up in middle of the night.				
5. I wake up easily because of noise.				
6. I toss and turn.				
7. I never go back to sleep after awakening during sleep.				
8. I feel refreshed after sleep.				
9. I feel unlikely to sleep after sleep.				
10. Poor sleep gives me headaches.				
11. Poor sleep makes me irritated.				
12. I would like to sleep more after waking up.				
13. My sleep hours are enough.				
14. Poor sleep makes me lose my appetite.				
15. Poor sleep makes hard for me to think.				
16. I feel vigorous after sleep.				
17. Poor sleep makes me lose interest in work or others.				
18. My fatigue is relieved after sleep.				
19. Poor sleep causes me to make mistakes at work.				
20. I am satisfied with my sleep.				
21. Poor sleep makes me forget things more easily.				
22. Poor sleep makes it hard to concentrate at work.				
23. Sleepiness interferes with my daily life.				
24. Poor sleep makes me lose desire in all things.				
25. I have difficulty getting out of bed.				
26. Poor sleep makes me easily tired at work.				
27. I have a clear head after sleep.				
28. Poor sleep makes my life painful.				

APPENDIX E

MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT (MSPSS)

The following are some statements, read each one carefully and indicate how you feel about it.

STATEMENTS	*Very Strongly Disagree*	*Strongly Disagree*	*Mildly Disagree*	*Neutral*	*Mildly Agree*	*Strongly Agree*	*Very Strongly Agree*
1. There is a special person who is around when I am in need.							
2. There is a special person with whom I can share joys and sorrows.							
3. My family really tries to help me.							
4. I get the emotional help & support I need from my family.							
5. I have a special person who is a real source of comfort to me.							
6. My friends really try to help me.							
7. I can count on my friends when things go wrong.							
8. I can talk about my problems with my family.							
9. I have friends with whom I can share my joys and sorrows.							
10. There is a special person in my life who cares about my feelings.							
11. My family is willing to help me make decisions.							
12. I can talk about my problems with my friends.							