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GENDER AND MENTAL HEALTH: AN ANALYSIS AND REINTERPRETATION (DEMORALIZATION, SOCIAL CLASS, FAMILY)

GERALD THOMAS HOTALING

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GENDER AND MENTAL HEALTH: AN ANALYSIS AND REINTERPRETATION (DEMORALIZATION, SOCIAL CLASS, FAMILY)

Abstract

Two research findings on sex roles and mental disorder have become a firm part of the knowledge base in the sociology of mental health and illness. The first of these is that, since around 1950, females consistently report higher overall rates of mental disorder than males. A second, related finding is that higher rates of female illness are due to the differential impact of family based statuses on the mental health of men and women.

It is the contention of this research that asking which sex is more mentally ill is the wrong question. Further, it is suggested that the tenacity of beliefs about "greater female mental illness" and the "vulnerability of married women" is due to both a series of methodological and conceptual problems, and the fit between these beliefs and the prevailing values of a number of interested parties.

Data used in this research is from a number of sources. First, epidemiological studies of mental illness from the United States and Canada, 1955 and 1983; second, National Institute of Mental Health treatment data, 1960-1981; third, historical evidence on the expanding view of mental illness since World War II; and, fourth, data on demoralization from a sample of 373 users and non-users of mental health agencies.

The major findings are as follows: the overrepresentation of women as "mentally ill" is due to a massive expansion in the concept of mental illness since around 1950. Second, a higher rate of mental health problems among married women shows up only in treatment populations. Studies using treatment samples fail to consider the confounding of true effects on mental health from the effects of help-seeking behavior. In both epidemiological and sample data examined in this research, there was no evidence for a sex-marital status interaction effect on mental health among non-treatment populations.

Lastly, social role explanations of sex differences in mental health are not useful when controlling for the effects of economic variables. The best predictor of sex differences in mental health in this sample data is a sex-social class interaction effect. Low socioeconomic women report the lowest morale regardless of marital status or the family roles performed.

Keywords

Sociology, General

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GENDER AND MENTAL HEALTH:
AN ANALYSIS AND REINTERPRETATION

BY
GERALD T. HOTALING

B.A., University of Delaware, 1971
M.A., University of New Hampshire, 1975

A DISSERTATION

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ABSTRACT

GENDER AND MENTAL HEALTH: 
AN ANALYSIS AND REINTERPRETATION

by

GERALD T. HOTALING

UNIVERSITY OF NEW HAMPSHIRE May, 1984

Two research findings on sex roles and mental disorder have become a firm part of the knowledge base in the sociology of mental health and illness. The first of these is that, since around 1950, females consistently report higher overall rates of mental disorder than males. A second, related finding is that higher rates of female illness are due to the differential impact of family based statuses on the mental health of men and women.

It is the contention of this research that asking which sex is more mentally ill is the wrong question. Further, it is suggested that the tenacity of beliefs about "greater female mental illness" and the "vulnerability of married women" is due to both a series of methodological and conceptual problems, and the fit between these beliefs and the prevailing values of a number of interested parties.

Data used in this research is from a number of sources. First, epidemiological studies of mental illness from the United States and Canada, 1955 and 1983; second, National Institute of Mental Health treatment data, 1960 - 1981; third, historical evidence on the expanding view of mental illness since World War II; and, fourth, data
on demoralization from a sample of 373 users and non-users of mental health agencies.

The major findings are as follows: the overrepresentation of women as "mentally ill" is due to a massive expansion in the concept of mental illness since around 1950. Second, a higher rate of mental health problems among married women shows up only in treatment populations. Studies using treatment samples fail to consider the confounding of true effects on mental health from the effects of help-seeking behavior. In both epidemiological and sample data examined in this research, there was no evidence for a sex-marital status interaction effect on mental health among non-treatment populations.

Lastly, social role explanations of sex differences in mental health are not useful when controlling for the effects of economic variables. The best predictor of sex differences in mental health in this sample data is a sex-social class interaction effect. Low socioeconomic women report the lowest morale regardless of marital status or the family roles performed.
"Has there really been a dramatic decline in female mental health relative to male mental health since 1950?"

"Is this decline magnified among married women and due to the social roles they perform in marriage and family?"

A majority of authors of scientific articles on gender and mental illness and writers of textbooks on Social Problems and the Sociology of Mental Illness would answer these questions in the affirmative. Evidence for a "yes" answer to the first question seems conclusive. Epidemiological reports from the United States and abroad and treatment statistics from North America indicate females to be overrepresented among the ranks of the mentally disordered. Review studies of such data indicate that the deterioration in female mental health began shortly after World War II and continues today. For example, all nineteen of the U.S. and foreign studies of the prevalence of mental illness conducted between 1950 and 1972 reviewed by Gove and Tudor (1973) show a higher percentage of mentally ill females than males. Of the fourteen U.S. and foreign studies on depression investigated by Weissman and Klerman (1976), all except one report higher rates of depressive disorder among women. Goldman and Ravid (1980) reviewed twenty-two studies of mental illness conducted since 1950. Eighteen compare the overall male and female prevalence rates for some type of mental
illness. Sixteen studies point to higher rates for women; two report no sex differences. Not one of these studies finds the overall rate of mental illness to be higher for males.

Not only have women been characterized as more mentally ill than men, but married women are seen as the group primarily responsible for the higher overall rate of disorder among women. Proponents of a specific sex role theory see female mental illness as a response to the frustration and conflict in women's roles since World War II. It is among married women that the role stress and strain is most severe (Bernard, 1972; Gove and Tudor, 1973; Nathanson, 1975).

It is the contention of this dissertation research that asking which sex is more mentally ill is the wrong question. Further, I will argue that males and their mental illness pose a greater threat to the social order and is more costly both financially and symbolically. Finally, I suggest that the tenacity of beliefs surrounding "greater female mental illness" and the "vulnerability of married women" is due to the fit between these beliefs and the prevailing values of a number of interested and influential parties.

The reinterpretation offered here will be based on a number of sources of evidence. These will include the following. First, a review of epidemiological studies of mental illness conducted in the United States and Canada between the years 1955 and 1983. These studies focus on sex differences in a variety of forms of mental disorder in normal populations. Second, a review of data issued by the National Institute of Mental Health between the years 1960 and 1981 on sex differences in the utilization of a number of types of treatment facilities for mental disorder. Third, a review of historical evidence concerning the
expanding view of mental illness since World War II. Fourth, an analysis of data on demoralization from a sample of 373 users and non-users of mental health agencies residing in the same geographical area and administered the same measurement instruments.

Assumptions in the Belief in Greater Female Mental Illness

The beliefs in the "greater decline in female mental health since 1950" and the "greater vulnerability of married women to mental illness" are based on the acceptance of a number of assumptions. Existing empirical evidence from both psychiatry and sociology casts serious doubt on the validity of these assumptions. A discussion of these assumptions follows.

The Assumption that the Absence of Mental Health Equals the Presence of Mental Illness

Any attempt to define mental illness should consider the comments of Aubrey Lewis in his 1953 article "Health as a Social Concept." He argues that asking "what is mental illness?" is not a productive question. He feels the reasonable question to ask is whether it is useful or not useful to define mental illness in a particular way and what are the costs and gains of doing so.

The literature on mental illness contains at least three ways to define mental illness. All three agree that mental illness refers to serious problems in the mental functioning of individuals, but would disagree about the manner by which it can be recognized and measured. To extend the definition somewhat, all three perspectives would agree that there are at least three general categories of problems in mental
functioning. They are: 1) severe distress, manifested by symptoms of dysphoria, severe worry and agitation, resulting in some degree of immobilization and interference in the performance of normal social roles; 2) mental disorganization, manifested by such symptoms as hallucinations, delusions, flights of ideas, and gross confusion; and 3) serious disruptive acts, referring to overt acts that create obvious problems for self and others. These acts usually involve threatened or actual violent behavior (Gove and Howell, 1974). Three perspectives on the question "what is mental illness" follow.

The Psychiatric Orientation. Psychiatry defines mental illness on the basis of a disease model that looks for independent evidence of pathological mental functioning. Psychiatry attempts to classify signs and symptoms of individual behavior into diagnostic categories roughly corresponding to the classification of neuroses, psychoses, and personality disorders. Psychiatry sees mental illness as real illness. Based on an extensive body of knowledge and diagnostic criteria, psychiatry searches for evidence of definite illness. The reliability of psychiatric diagnoses is low. A review article of studies of psychiatric diagnostic reliability concludes:

Reliability appears to be only satisfactory for three categories: mental deficiency, organic brain syndrome and alcoholism. The level of reliability is no better than fair for psychoses and schizophrenia and is poor for the remaining categories" (Spitzer and Fleiss, 1974).

The Public's Orientation. The general public defines mental illness by reference to involvement in mental health treatment. To the question "who are the mentally ill?", the answer is "those who are in treatment for mental illness," Cumming and Cumming (1957) and Phillips
(1963) have found support for this treatment based definition of mental illness. In fact, Phillips (1963) finds that people make discriminations in the degree of severity of mental illness based on the type of help source a person is involved with. For example, a person who sees a physician for psychological problems is deemed less mentally ill than someone who sees a private therapist than someone who is in or has spent time in a mental hospital.

The Social Constructionist Orientation. This perspective takes a broad view of mental illness centering about the notion of "problems in living" (Szasz, 1970), or "psychological well-being" (Bradburn, 1969). In this perspective, mental illness is seen as the absence of mental health. The definition of health used by the World Health Organization sets the standard in the search for mental illness. The opening passage of the international charter of the WHO (1948) states that "health is a state of complete physical, mental, and social well-being".

As will be reviewed in Chapter II, the majority of epidemiological research conducted in the United States since World War II takes a social constructionist view of mental illness. Symptom checklist scales composed of items denoting mild psychological distress are used to measure mental illness in these reports. Items used in these scales show little, if no. relationship to clinical psychiatric disorder (Murphy, 1974; Dohrenwend, 1979; 1980) and are ineffective in predicting subsequent seeking of mental health treatment (Murphy, 1974).

The use of symptom checklist scales in mental health research since World War II has greatly expanded our view of what constitutes mental illness. Murphy (1974) has summarized the social
constructionist's search for mental illness in this way:

Over the years, mental health surveys have become decreasingly clinical and increasingly sociological in aim, seeking less to identify the sick than to assess the prevalence of psycho-social stress (1974: 67).

Chapter II will examine the nature of epidemiological research and problems in the measurement of mental illness. The importance of this issue for this dissertation research is paramount. The belief in "greater female mental illness" is based almost exclusively on the ideas of social constructionism and the results of epidemiological research using symptom checklist scales.

The Assumption of the Unidimensionality of Mental Illness

There is not, at this point in time, any known common denominator of all functional psychiatric disorder (Murphy, 1974; Dohrenwend et al., 1979; 1980). There is no known measure of symptomology that is frequently present in most if not all functional disorders. At the very least then, psychiatric research must proceed on the assumption that there are different types of psychopathology, with no underlying common dimension, and that these types differ by symptom and severity. When mental illness is not conceived of in such monolithic ways, the evidence for a consistent sex difference softens. Dohrenwend and Dohrenwend (1974) in a review of U.S. and foreign studies report that for overall psychiatric disorder, eighteen studies find higher rates for women and twelve find higher rates for men. The lack of a clear-cut sex difference is magnified when studies are broken down by type of mental illness. No sex differences are evident for the psychoses.
Females have higher rates in seventeen of twenty-one studies on neuroses, while males have higher rates in thirteen of seventeen studies on personality disorders. Higher rates of female mental illness in recent times, according to the Dohrenwends, reflect a concentration of studies on neuroses rather than on types of mental illness in which males predominate.

The Assumption of Sample Comparability

Often, studies of gender differences in mental illness make no distinction between the types of samples being examined. The major problem here concerns the use of samples of persons in treatment for mental illness. Do higher female rates in these samples reflect true prevalence or the greater willingness of women to seek help for emotional distress? The reviews of studies mentioned earlier differ in their handling of treatment and general community samples. Those of Gove and Tudor (1973) and Weissman and Klerman (1977) consistently find higher female rates, but fail to differentiate treatment from general community samples. The reviews of Dohrenwend and Dohrenwend (1976) and Goldman and Ravid (1980) make note of this distinction and also find less clear-cut gender differences in rates of mental disorder.

Interpreting Female Vulnerability to Mental Illness

The distinction between treatment and general community samples becomes very important when examining gender differences in mental illness in interaction with other demographic variables. The variable that has been the most influential in sex difference studies has been marital status. Based largely on the work of Bernard, 1972; Gove and
Tudor, 1973; and Gove, 1972, women's mental health is seen as having been in decline since after World War II and the decline reflects a worsening of conditions for women in the United States, especially among married women. Higher rates of female disorder primarily reflect a large gap between married men and married women. These authors hold that married women have been experiencing increased frustration and conflict in modern roles; most notably, family and marital roles. The sex difference in mental illness is due largely to a sex by marital status interaction effect with married women being a most vulnerable group. It must be kept in mind, however, that most of the evidence supporting this view is based on data from treatment samples and may not be applicable to general community samples.

**Initial Objectives**

Chapters II, III, and IV of this research will examine epidemiological data on gender and mental illness during the time period 1955-1983, and recent treatment statistics on mental illness for men and women. It will be argued that the belief in higher rates of mental illness among women is due to the changing measurement of mental illness over the past thirty years. It will also be argued that the current state of evidence in epidemiological and treatment data does not allow for a clear test of greater female or male vulnerability to mental illness.

Given the tentative and ambiguous findings on gender and mental illness, another purpose of the early chapters of this research is to explore why we promote the belief in the greater female propensity to mental illness. It is suggested that the belief in greater female
mental illness is highly compatible with the values of a number of interested parties and wider cultural values.

Another objective of the review of epidemiological and treatment statistics on gender and mental illness is to pay particular attention to the variable marital status. I suggest that the sex-marital interaction effect that underlies theories of sex differences may only be applicable to treatment samples and not necessarily to general community samples.

**Gender and Demoralization: Family and Non-Family Roles**

Large scale epidemiological surveys and data on the treatment of mental illness allow researchers to identify groups "at-risk" to emotional distress. Rarely do they allow for a more specific analysis of factors that may underlie certain forms of disorder. For example, epidemiological data is sparse which would allow for an in-depth analysis of the quantity and quality of family and non-family roles of men and women and their relation to mental health.

A second major purpose of this research is to explore, in a sample of 373 families, how the nature of social roles might account for the observed sex difference in one kind of emotional distress: demoralization.

**Why Demoralization?**

Recent evidence suggests that the notion of demoralization may be the construct that best describes what has been measured by symptom checklist scales since their inception thirty years ago. During the last two decades, checklist scales have come under attack for not being
able to validly distinguish between types of known psychiatric disorders and for being too vague as a global measure of mental illness (Frank, 1973; Seiler, 1973; Murphy, 1974; 1978; Dohrenwend et al., 1979; 1980).

Evidence which has accrued since the middle of the 1970's suggests that what these scales are actually measuring is demoralization. Jerome Frank (1973) was the first to suggest the construct demoralization. To Frank, a person becomes demoralized when he/she finds "he cannot meet the demands placed on him by the environment and cannot extricate himself from his predicament" (p.316). Demoralization is seen as a psychological state brought on by situations of marked interpersonal stress. Again, according to Frank:

To demoralize is to deprive a person of spirit, courage, to dishearten, bewilder, to throw him into disorder or confusion (p.314).

Dohrenwend and his colleagues (1980) note that the construct of demoralization best fits the facts about what symptom checklist scales measure. They present evidence from a series of validation studies that several of the most used checklist scales correlate highly with measures of self-esteem, helplessness, hopelessness, sadness, and anxiety, all of which are major facets of what Frank (1973) means by demoralization. High scorers on checklist scales are likely to be those who are powerless to control their environments, and whose lives are marked by social marginality and whose social positions block them from mainstream strivings.

While demoralization does not always occur in conjunction with clinical psychiatric disorder, Dohrenwend et al., (1980) feel it is a
condition of distress important in its own right. Based on results of a number of community studies and two nationwide epidemiological surveys, Dohrenwend et al., (1980) estimate that the rate of demoralization in the United States approaches one-quarter of the population.

**Sex Differences in Demoralization**

One of the clearest findings from the last thirty years of epidemiological research is the higher rate of demoralization among women (Gurin et al., 1960; Phillips, 1966; U.S.P.H.S., 1970; Engelsmann et al., 1972; Warheit et al., 1976). Attempts to further discriminate high risk women from those with high morale has emphasized the peculiar position of married women. Of all gender-marital status comparisons, the gap between married men and married women in rates of demoralization is consistently high. As mentioned earlier, the major interpretation for the vulnerability of married women centers on the stressful nature of their social roles. Their major responsibility for the care of children, the maintainence of the household as well as the discrimination they face in the economic sphere are seen as critical in discussions of their morale. While this line of reasoning seems logical and is the preeminent thinking on the matter of sex differences in mental health, there are some ambiguities underlying the evidence that supports this view.

Primary among these problems is the generalizability of the evidence for a sex-marital status interaction effect. A review of studies (see Chapter II) indicates this interaction effect is most likely to be found in samples of treatment populations and rarely in untreated general population samples. It is plausible that married
women are more likely than other groups to be in treatment for problems. Their willingness to seek help is interpreted as evidence of a greater mental health problem.

A related problem is statistical in nature. A consistent problem in mental health research is the absence of appropriate control variables. Rarely do studies control for the effects of age, family income, social class, employment status, and the nature of non-family roles on mental health. Even in treatment samples, the sex-marital status interaction effect could be spurious without allowing for the impact of other variables on the relationship.

It is hypothesized that there will be no evidence for the existence of a sex-marital status interaction effect to explain higher rates of female demoralization, at least among an untreated general community sample. What then might be a plausible explanation of higher female rates? There appear to be at least two possible explanations. The first holds that marital status is no longer a good indicator of the family roles people perform. The second argues that higher rates of demoralization among women are due to a sex-social class interaction effect with lower SES women the most vulnerable group to demoralization.

Marital Status Versus Family Role

The first explanation holds that the absence of evidence for a sex-marital status interaction effect is due to the increasing unreliability of the concept marital status. Marital status is becoming increasingly descriptive of the actual family roles men and women perform. The distinction is an important one since those who argue that
married women are more vulnerable to mental health problems make their argument not on the basis of her status as married, but on the basis of the stressful family roles she performs.

Census data throughout the 1970's has pointed to the increasing lack of correspondence between marital status and family role. In many cases the concept marital status does not tell us anything about actual adult living arrangements, the presence or absence of parenting roles, or the extensiveness of other family role obligations. One plausible hypothesis to account for the often observed sex difference in demoralization is the extensiveness of family role obligations. Regardless of marital status, as family role obligations increase, the sex difference in demoralization increases.

Social Class and Family and Non-Family Roles

One certainty from thirty-five years of epidemiological research is the relationship between psychological distress with sex and social class. In the most comprehensive review of community studies on mental illness to date, the authors of MENTAL ILLNESS IN THE UNITED STATES (Dohrenwend et al., 1980) conclude that being female or a member of the lower social classes places one at-risk to mental distress. Based on the stability of these findings over an extended period of time, it is curious that attempts to explain sex differences have, for the most part, ignored the variable social class. If both variables sex and social class separately account for excess rates of distress, in combination they should be a good predictor of higher rates of female demoralization.

Many facets of family and non-family roles indicated as accounting
for sex differences in mental health seem more characteristic of working and lower-class families than higher socioeconomic families. Life in lower and working class families may be more stressful for men and women, but especially so for women. Meile et al., (1976) using education as a measure of social class finds, in a sample of women, large differences by educational level in mental health functioning. There would seem to be a number of reasons for this. The lower and working class woman is less likely to receive emotional and instrumental support from her spouse (Bell, 1971:54). Single mothers are more likely to fall into lower SES groups and not have the emotional and instrumental advantages of a spouse present. Parenthood is likely to be viewed by working-class mothers as as source of dissatisfaction and problems. Langner and Micheal (1963), for example, argue that working-class housewives are more likely than middle-class housewives to view their children as causing trouble.

Meile et al., (1976) have chronicled several social class differences among women in families. Lower-class married women have more children than middle-class women, increasing their confinement to the household (Westoff and Westoff, 1971). Additionally, the lower-class husband relative to his middle-class counterpart helps less with the socialization and care of the children, and performs fewer household tasks. The opportunities for gratification outside the family also increase with socioeconomic status. Booth (1972) finds that middle-class women are more likely to find employment that provides interesting and challenging career opportunities. Women in the working class may find additional barriers when it comes to outside employment. Rubin (1976) has elaborated the complexities involved in the
working-class wife's decision to work. She argues that the decision about working involves a different psychology in working-class families.

It is harder because, historically, it has been a source of status in working-class communities for a woman to be able to say 'I don't have to work.' Many men and women still feel keenly that it's his job to support the family, hers to stay home and care for it (p.171).

Restrictions in social activity also occur in the area of support networks. Social class is related to differences in friendship patterns for women. A consistent finding is that higher status women have more friends and more close friends than working-class women (Booth, 1972; Graham, 1980; Bell, 1981). Lower SES women meet greater proportions of their friends in the neighborhood, while middle-class women recruit friends from wider social circles (Rubin, 1976; Bell, 1981).

For these reasons, it is plausible that the sex difference in demoralization is partly explained by the existence of a sex-social class interaction effect.

The Nature of the Sample to be Analyzed

Data to be analyzed in this study is composed of respondents from both a treatment sample and a general random community sample. Thus, the existence of a sex-marital status interaction effect can be tested for in each of the two types of samples discussed in epidemiological research.

The data to be analyzed are drawn from the first phase of a longitudinal study carried out in 1973 and 1976. The 1973 sample with
an N of 373 contained two sub-samples. One sub-sample was comprised of individuals who were known to be clients at community guidance and counselling centers. Four clinics provided clients. The other sub-sample was composed of a random sample of persons living in areas served by those agencies, but not known to be involved with any helping agency. A more detailed description of the sample and variables used in this study appears in Chapter VI.

Social Class Versus Family Roles

The preceding section centered on the question of sex differences in demoralization. Specifically, what particular characteristics of men and/or women account for the often observed sex difference in demoralization. It was hypothesized that there would be a sex by marital status interaction effect to explain the female excess in demoralization with married women reporting significantly higher rates of distress than married men. Most important, however, it is hypothesized that the importance of marital status as an explanatory variable would only apply to those in the treatment sample but not to men and women in the general community sample. In the random community sample it is hypothesized that women of lower SES standing compared to low SES men will account for the gender gap in demoralization. This difference is posited to hold regardless of marital status.

If these hypotheses are born out by the data it would support the notion that the sex by marital status interaction effect is an artifact of sample type; more applicable to persons who have initiated help for emotional problems. It would also indicate that sex differences in demoralization in the general population may be due to some set of
factors more general than the extensiveness or stressfulness of family based roles.

What is at issue is the priority of family or non-family roles in explaining the demoralization of men and women in the two different samples. According to the major interpretive scheme for sex differences in demoralization, it is the family based roles of men and women that explain most of the sex difference in demoralization (Gove, 1972; Bernard, 1972; Gove and Tudor, 1973). To these authors, it is the overinvolvement and responsibility of women in family based roles that lead to stress overload and consequent demoralization. But these notions may be applicable only to women who have already sought out help for emotional difficulties. Research based on treatment samples may be tapping into a group of persons who are seeking help for a variety of family based complaints. Because married women show up in clinics in great numbers bearing problems of family stress, it is assumed that family stress is the primary cause of demoralization.

Two dimensions of family roles are the most cited as responsible for higher rates of demoralization among women: 1) the extensiveness of family roles; and 2) the stressfulness of family roles in the sense of family problems and conflicts. Two other dimensions of family roles have been cited in the literature as important in discussions of sex differences in demoralization. One is the extensiveness or restrictiveness of non-family roles such as work roles or friendship roles, and the second is the extensiveness or restrictiveness of adult social support. It may be that these two dimensions of social roles have more to do with sex differences in demoralization in random community samples than an exclusive focus on family based role stress.
This would seem to be the case if a sex by social class interaction effect is indeed found in the community sample.

Chapter V discusses each of these dimensions of social roles and their relationship to demoralization as discussed in the mental health literature. Chapter VII presents analyses of the variable effects of a sex-marital status versus a sex-social class interaction effect on demoralization in the treatment and non-treatment samples. Chapter VIII presents separate analyses for men and women of the effects of family and non-family roles on demoralization among persons in the treatment sample. Chapter IX presents analyses of the extensiveness and restrictiveness of family and non-family roles on the mental health of those in the random community sample. It is predicted that among this group, the effects of economic variables will be more important than an exclusive focus on family roles.
CHAPTER II

THE COMMUNITY STUDY OF GENDER AND MENTAL ILLNESS

This chapter has three objectives. The first is to review a number of community studies on the relationship between gender and mental illness conducted in the U.S. between 1955-1983. The second purpose is to examine these studies for sex differences in mental illness across marital statuses. Marital status is often used as a key explanatory variable in interpretations of the relationship between gender and mental distress, so it is important to understand its relationship to mental health functioning. The community studies to be reviewed span a period of time that has witnessed a great expansion in what constitutes mental illness. Understanding this broadening conceptual domain is a third purpose and starting point of this chapter.

The Epidemiological Survey

Most data on the extent and distribution of problems of mental illness in the United States and elsewhere consist of records of patients admitted to mental hospitals and other care facilities. For a long time, however, researchers have known that these cases are biased by a number of selective factors. Who, among those suffering from a psychiatric disorder, actually gets into treatment? Massive epidemiological studies of mental illness over the past thirty years
have repeatedly confirmed that there are many people in the community who appear, from a psychiatric point of view, every bit as symptomatic as people who arrive in treatment, yet they are not in treatment and are not in search of treatment (Srole et al., 1962; Langner et al., 1963; Gurin et al., 1960).

The epidemiological survey attempts to find out about the "true" prevalence of mental illness in a defined area independent of treatment statistics. These studies identify psychiatric cases in the community in one of three ways. First, through psychiatrist's evaluations of the records of various community agencies; second, through data provided by community informants, or through interviews of community members by psychiatrists or other mental health workers or; lastly, through self-reports of psychiatric symptoms or related distress indicators by community members (Dohrenwend and Dohrenwend, 1969; 1976). Self-report studies have been an especially popular methodology for estimating prevalence since World War II. Whatever form they take, the intent of the epidemiological survey is to randomly select a non-institutionalized sample from a community. As Goldman and Ravid (1981) postulate:

Theoretically, the epidemiological survey canvasses both the mentally ill who have received professional help and those who have not (p.31).

THE PROBLEM OF "CASENESS"

Once treatment status is abandoned as the major criterion for determining who is mentally ill, research is confronted with the problem of determining the constitution of a countable psychiatric case. At present, there is no clear consensus as to what exactly constitutes "mental illness" or "psychiatric disorder" and how such
terms should be measured. As Dohrenwend and Dohrenwend (1974; 1980) have reported in their review of large scale epidemiological studies:

"...although over 60 different investigators since the turn of the century have attempted to count not only treated "cases" but also untreated "cases" in over 80 communities in different parts of the world, the rates reported fluctuate wildly—not as a function of differences in the persons and places studied, but rather as a consequence of differences in the concepts and methods used to define disorder (p.3)."

One could easily conclude from a review of epidemiological studies of mental illness that the most important predictor of mental health is where one happens to be living at the time a psychiatric survey is conducted. In their review of 80 community studies mentioned above, Dohrenwend and Dohrenwend (1974) find the prevalence of mental illness reported in various settings ranges from 1% to 64% of the population. Plunkett and Gordon (1960) in a review of eleven community studies find rates of psychiatric impairment ranging from 16.7 to 333.0 per 1000 persons. The elastic range in the reported prevalence rates reflects several things; most notably, a number of methodological problems. In the studies reviewed by the Dohrenwends (1969; 1974), "clinical judgement was the tool relied upon for case identification in almost all studies" (p.170). These studies did not report in detail "the information available to the judge nor the criteria on which the diagnosis were based" (p.99). Validity was not independently measured, but "was assumed to be implicit in the diagnostic process" (p.170).

Inconsistency in defining "mental illness" is compounded by variations in the professional orientation of the judge. Professionals as diverse as psychiatrists, psychologists, general practitioners,
nurses, and social workers have been used to evaluate the presence or absence of mental illness in these studies (Goldman and Ravid, 1980:32). The problem of validity is as important in community studies using symptom checklist questionnaire as it is in those that rely upon clinical evaluation. Symptom checklist scales were first developed during World War II as screening instruments for identifying those armed forces recruits most in need of psychiatric evaluation (Stouffer et al., 1949; Star, 1950). From a large pool of items, the final scale used by the armed forces consisted of fifteen items concerning physical and psychological complaints such as hands trembling, cold sweats, upset stomach, nervousness, headaches, and nightmares. Criterion validity was established by the ability of the scale to discriminate between 3,501 soldiers on active duty and 563 soldiers hospitalized as neurotic (Dohrenwend et al., 1980). The success of this instrument during World War II led to the development of a number of very similar brief screening scales during the 1950's and 1960's. The best known and most frequently used screening devices are the Cornell Medical Index (Brodman et al., 1952), the 24-item Health Opinion Survey Scale (Macmillan, 1957), and the Langner 22-item scale (Langner, 1962). These scales and equivalent measures are highly similar in content and structure, correlate very well with one another (Dohrenwend et al., 1979) and have been used in at least forty community studies since World War II.

Given the extent of their use, it is important to remember that their validity has been widely challenged. Dohrenwend et al., (1980) posits that none of the screening scales reflect a clearly defined conceptual domain. There is no ready correspondence between the content
of the items and major dimensions of psychopathology such as depression, mania, or personality disorder. According to Dohrenwend et al., (1980):

The items in this scale are generally associated with affective distress but are not specific to any psychiatric disorder p.1229-1230

In addition to confusion over what exactly these scales measure there is no evidence of their ability to predict subsequent mental health problems. Murphy (1974) administered a screening scale to over 1100 freshmen at the University of Singapore and then followed them for over two years for evidence of abnormal behavior, the seeking of psychiatric aid, or greater than average use of health services. He concluded on the basis of his follow-up that the symptom checklist failed to identify vulnerable individuals (p.260). Seiler critiques the heavy reliance upon "known groups" techniques for validation of these scales.

It appears that use of this technique has resulted from not fully differentiating two theoretical questions. The first question, the one upon which the 22-item scale's validity rests, is: Are respondents with some high number of symptoms, as represented in the 22-item scale, mentally ill? The second, which is tangential to the first is: Do the mentally ill evidence some unusually high number of the 22-item scale symptoms? If the answer to the second is affirmative, that is, that mental patients evidence a statistically abnormal number of such symptoms, this does not imply that the answer to the first question is also affirmative, that those residing in the community who evidence a statistically abnormal number of symptoms are also mentally ill (1973:255).

Veroff et al., (1981) have also criticized the symptom checklist scales because of the possible confounding of psychological and
physiological symptoms. They contend that a substantial number of items in checklist scales are tapping symptoms of ill health.

Perhaps the greatest difficulty in the use of brief screening scales is the determination of cut-off points to differentiate between the sick and well. This issue has produced difficulties in comparability across studies using checklist scales. Community studies since World War II have used cut-off points of four, five, seven, or ten symptoms as evidence of psychopathology. Manis et al., (1964) recognized this problem in their reexamination of three large epidemiological studies; the Midtown Manhattan Study, the Baltimore Commission on Chronic Illness, and the Kalamazoo, Michigan Studies. These authors report that rates of pathology cited by each study were fairly similar under one condition: if only severe cases were included in estimating prevalence, i.e., only cases above a high cut-off point. When cases of mild or moderate disorder are included, the difference in rates becomes quite pronounced. When strict cut-off points are used the reported rates of mental disorder for the three communities are between 7 and 37 per 1,000 persons. When liberal cut-off points are used, the range between the three studies is 109 and 815 per 1,000 persons. In the Midtown Manhattan Study, for example, Srole et al., 1962 found 32.2 per cent of their sample impaired when 4+ symptoms were used as the cut-off point, but when 7+ symptoms were used as the cut-off, the percentage of impaired dropped to 11.2 per cent.

This effect is readily seen in studies using more than one cut-off point within the same study. Dohrenwend et al., (1980) find considerable variation in studies using 4+ or 7+ symptoms on the Langner 22-item symptom scale. Table 2.1 presents Dohrenwend's summary
This effect is more pronounced in studies reporting cut-off points of 4+, 7+, and 10+ symptoms. Summers et al. (1971) found 16.6% of their sample impaired when using 4+ symptoms, 5.9% at 7+ symptoms, and 2.3% of the sample impaired when 10+ symptoms were used as the cut-off. Langner’s (1962) results show the same pattern. 31.2% of his sample were deemed impaired at 4+ symptoms, 11.2% at 7+ symptoms, and 3.7% at 10+ symptoms. Obviously, in such studies, the prevalence of impaired cases in the community is a function of the cut-off point. Such decisions have had a profound impact on estimates of mental illness rates since World War II.

**THE EXPANSION OF THE PSYCHIATRIC CASE**

Leaving aside the significant problems in the measurement of a psychiatric case, there is considerable evidence that over the past thirty years we are willing to consider many more behaviors as indicative of psychiatric illness. In the words of the mental health movement historian Finkel (1976):

In historical perspective, the realm of disorders has indeed expanded, and the expansion has had a clear direction. The focus has moved from the severe, to the mild, to the general malaise; ironically this distinction makes the word disorder a misnomer. In the realm of disorders, mental illness has gone from the diseased to the dis-eased, and from the paranoid to the para-annoyed (p. 40).

This expansion has accelerated since World War II and one of the major reasons for the broadening definition of mental illness comes directly from the war experience. The institution of psychiatric screening of inductees marked the first massive screening of "normal"
### Table 2.1: Rates of Demoralization Estimated With Different Cutoff Points on the Langner Scale

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a D. Mueller, personal communication

b NORC data were made available by the study director Eleanor Singer, and analyzed by Bruce Link

Source: Compiled by the authors.

population groups for symptoms of psychological distress. Over 16 million men received psychiatric examinations (Session Hearings on HR 4512, the National Mental Health Act, 1945, pps. 58-63). The evaluation of the emotional stability of the nation's male fighting force was quite disturbing. The number of men rejected for psychiatric reasons was about 1,850,000 (Rennie, 1948). This represented 12% of the 16 million men examined and 37% of the approximately 5 million men rejected for unfitness (Session Hearings, S. 1160, 1945). Additionally, 39% of medical discharges given during World War II were for mental disorders. This totaled 530,000 men (Bell, 1958). Criteria were not clear-cut for excluding men from service because of psychological reasons. One's chances of rejection depended as much on the manpower needs of the Army as on the presence of symptoms.

While the induction into and discharge from the Army of psychoneurotics in practice varied with the availability of manpower, nonetheless, in policy, at least, psychoneurosis was never considered to be grounds for rejection or discharge unless it rendered a man incapable of performing a 'reasonable day's work for the Army' in some capacity (Stouffer, 1950, V.4, 490).

More to the point, military psychiatrists found in their evaluations that existing categories of psychiatric classification covered only about 10% of the patients they saw. War-time psychiatry found itself "operating within the limits of a nomenclature specifically not designed for 90% of the cases handled (Raines, 1952, p.vi). This quandry led to the development of two new classification systems. The first, developed by the Army in 1945, and the second by the American Psychiatric Association (the DSM-I in 1952) expanded the realm of abnormality. Subclassifications were added to existing categories
relating to combat disorders, and new categories such as transient and minor personality disorders were included.

The expansion of the conceptual domain did not end in 1952. The trend toward expansion of psychiatric disorder continued in the next decade with the development of DSM-II (1968) which added new categories of neuroses: depersonalization neuroses, neurasthenic neuroses, and hypochondriacal neuroses, for example. DSM-II also added several major categories such as "Behavior Disorders of Childhood and Adolescence" with subtypes including hyperkinetic, withdrawn, overanxious, runaway, aggressive, unsocialized, and group delinquent children. DSM-II also includes a chapter on "Conditions Without Manifest Psychiatric Disorder and Nonspecific Conditions". It largely describes problems of maladjustment in social, marital, and occupational spheres. Finkel (1976) finds this last condition somewhat ironic:

This category is most paradoxical, and deserves special attention. This label, in effect, indicates that the psychiatric manual is focusing on a disorder that is not manifestly "psychiatric". It also indicates that people are asking for psychiatric services for certain nonpsychiatric conditions" (p.39).

A new edition of the Diagnostic and Statistical Manual (DSM-III, 1980) continues the trend of the first two manuals by "including considerably more categories than earlier editions" (Eitzen, 1980: 434). The newest manual adds behaviors previously considered human problems, not psychiatric symptoms. The human problems of people, regardless of severity can qualify as disorder in DSM-III if the problem causes subjective distress or disability.

The increasing breadth of what constitutes a psychiatric case is
reflected in epidemiological estimates of the extent of disorder over the past thirty years. This seems clear from evidence presented by Dohrenwend and Dohrenwend (1976) in their review of eighty community studies of mental illness conducted before and after 1950. They identified thirty-three carried out in North America and Europe, nine of them conducted before 1950 and twenty-four since 1950. These studies clearly show that rates of mental illness have risen substantially since 1950, and in all major psychiatric subclassifications. This trend accelerates after 1950. In other words, studies done before 1950 report rates of about 2% of the population impaired; studies conducted between 1950 and 1959 report rates of about 13%, and studies after 1960, a rate of over 20%. The authors attribute this rise not to a general deterioration of Western civilization, but primarily to a changing methodology that taps a broader array of symptoms in later studies. Specifically, prior to 1950, most studies relied upon key informants and official records to identify psychiatric cases. Such procedures typically tapped the more severe cases of impairment, and more importantly, only visible or recognized cases. Investigations published in 1950 or later tended to rely on direct interviews of respondents by mental health personnel for data collection. By 1960, a growing number of epidemiologists had adopted symptom checklist scales to identify psychiatric cases.

**Contributing Factors to an Expanded View of Mental Illness**

The need for an wider classification system of mental disorder that developed during World War II and the development and accelerated use of symptom checklist scales to assess the extent of mental health
problems in general populations represented the mechanics for a broadened conception of mental illness. But this new methodology and conception did not arise from a vacuum. There were several factors, many with roots in the 1920's and 1930's, taking shape after the second World War, that contributed to a broader domain of mental health problems.

The Expanded Role of the Federal Government

Prior to World War II, mental illness was considered a medical problem to be dealt with by state governments and the medical profession. The experiences of World War II, especially the high rate of rejection for psychoneurosis, the large number of men discharged for "combat disorders", and experiences of draft boards with problems of malingering led to new and expanded concerns with mental health treatment. The psychiatric community made it quite clear that these events had large scale social and political implications. Articles in psychiatric journals following the war were quite explicit. Titles such as "Psychiatry Speaks to Democracy" (Strecker, 1945), and "The Interdependence of Democracy and Mental Health" (Schreiber, 1945) echoed the sentiments of Lawrence Frank, then President of the American Association for the Advancement of Science:

Whatever fosters and promotes mental health will guard and advance democracy (1939:284-285).

The Director of the Neuropsychiatric Division, U.S. Army, Colonel William C. Menninger also drew the link between mental illness and larger social issues. The high rejection rate of inductees was seen as having implications for all societal institutions:
This finding (the high incidence of psychoneuroses among men rejected by Selective Service) does have an important sociological significance which should not be ignored, and has ramifications into our democratic way of living, our determination to be individualists, and our resentment of authority. It concerns our family life and educational system (1945:615).

The Federal government did not ignore the sociological implications of mental illness. The passage of the National Mental Health Act of 1946 marked the start of an era of federal involvement in the control of mental illness. Mental illness became a focus and responsibility of the Federal government because it was now proclaimed to be not only a public health issue, but a national defense issue.

The 1946 National Mental Health Act led to the establishment of the National Institute of Mental Health whose charge was to "prevent and treat mental disease in order to preserve and strengthen our national defense" (Coleman, reported in Borgman, 1978). The institute began with an annual budget of 4.5 million dollars to administer funds for research, training, and education. Testimony from House and Senate hearings on the establishment of NIMH (H.R. 4512) make it clear that the primary intent of the bill was to upgrade the conditions of state and county mental hospitals for the care of the severely disturbed and the training of personnel to meet this challenge. According to Marx et al., 1974, in spite of Federal intentions, between 1946 and 1955 the conditions in state hospitals actually worsened to such a degree that Congress passed the Mental Health Study Act of 1955 (pp. 22). This bill established the Joint Commission on Mental Health and Illness whose purpose was to survey resources for mental illness and provide
recommendations for combating mental illness in the United States. The Joint Commission concluded that the original intent of the Federal role in mental illness begun in 1946 had been lost. Those least in need of professional help were the largest recipients of Federal monies. As Marx et al., (197) summarize:

The Joint Commission...focused its attention on the fact that adult psychiatric and child guidance clinics were absorbing large monetary and personnel commitments but, for the most part, were not reaching the most severely mentally ill, those in state hospitals (p.23).

In the words of the Joint Commission (1961):

Major mental illness is the core problem and unfinished business of the mental health movement and...the intensive treatment of the patients with prolonged mental breakdowns should have first call on fully trained members of the mental health professions (p.xiv).

The basis of this report gives a little discomfort to some...who have a strong commitment toward practices of programs aimed at the promotion of positive mental health in children and adults...We have assumed that the mental hygiene movement has diverted attention from the core problem of major mental illness (p. 242).

The Mental Health Movement

It is clear from these writings that a great deal of money and professional effort was being directed toward mental health not mental illness. The infusion of federal funding into the area of mental illness led to a proliferation of training programs for mental health professionals and research monies for education and prevention. Rather than a primary concern with conditions of mental hospitals, much effort and funding went toward research into prevention through mental health
education programs, and, relatedly, toward studies dealing with changing attitudes toward mental illness on the part of the general public (Marx et al., 1974; Dohrenwend and Dohrenwend, 1976). The concept of prevention was, of course, not a new one. Mental Health associations had been developing prevention programs and talking in terms of positive mental health since the early 1900's (Sicherman, 1967; Ridenour, 1961), but much of the early effort was directed to the improvement of conditions in mental institutions. This changed in the 1940's and early 1950's. The mental health historian Nina Ridenour (1961) explains the shift of mental hygiene societies from illness to health in this way:

Exhausted by their fruitless struggle against public apathy about the welfare of the mentally ill and seeing how much easier it was to catch public attention with the 'mental health angle', the boards and staff of mental hygiene societies could scarcely be blamed for shifting their programs away from mental illness and in the direction of mental health, especially when could so easily be rationalized as the more important direction because they felt it implied prevention (p. 126).

In the late 1940's there was increasing pressure from state associations of the National Association of Mental Hygiene to become more deeply involved in public relations work. In addition to a change in names to the National Association of Mental Health, proponents of an aggressive use of public relations techniques:

......insisted that the mental health movement must become a true mass movement and that only through public relations techniques is it possible to carry the message to all the people (Ridenour, 1961:120).

Part of the "mental health angle" was to construct and disseminate a
programmatic statement about the achievement of happiness and well-being. The mental health movement proposed a set of values and tenets for a healthy mental life. According to a widely distributed pamphlet published by the National Association for Mental Health in 1951 called "Mental Health Is...1,2,3", the characteristics of mentally healthy people are described in this way: "They feel comfortable about themselves; they feel right about other people; they are able to meet the demands of life" (in Ridenour, p.139). Again, according to Ridenour (1961):

The field of mental health strives to bring to bear scientific information on the age old problems of love and hate, fear and tension and anxiety; human aspirations and failures; man's relations to his fellow man including his inhumanity; his war with himself-in short, the entire gamut of human behavior (p.140)

During the late 1940's and early 1950's, the mental health movement was working to broaden the definition of mental illness to encompass all "problems in living", not just severe instances of psychopathology. New principles of mental health were being spread through the helping professions. Physicians, nurses, schoolteachers, clergy, law enforcement personnel, and others were learning the principles of mental health:

It is of course impossible to assign a date to any specific period when mental health ideas began to take hold in the professions. The process was gradual but by no means slow. As psychiatrically oriented workers began to realize how many problems might be prevented if more people had more understanding of what the workers regarded as 'mental health principles', they became eager to spread their knowledge (Ridenour, 1961:81).
The principles of mental health were becoming increasingly integrated into child guidance work as well as parent education. Brim (1959) in his history of parent education in America sees the mental health movement as responsible for the growth and spread of parent education in the middle of the century:

The growth of parent education from 1950 on undoubtedly has been aided by the substantial sums available for work in the area of "mental health" (p.338).

Conversely, mental health professionals looked to parent education activities as a particularly useful vehicle for the transmission of mental health principles.

The major growth of activity during the decade (the 1950's) came from the greater use of parent education by workers in the field of mental health in order to prevent mental illness (Brim, 1959).

Changing Theoretical Notions of Mental Illness

The mental health movement's efforts to conceptualize mental illness as a much broader category of behaviors and symptoms than in the past found increasing support for its views from both academic disciplines and other professional groups during the 1950's. The growth of social psychiatry, community psychiatry, and community mental health promoted a view of individual behavior as closely intertwined with the social milieu. The second world war was instrumental in developing this view. It provided solid proof that severe social stresses could cause mental disorder in almost anyone. Abundant evidence of socially induced disorders came from cases of prisoners of war, battle-weary soldiers, and survivors of concentration camps. Such evidence promoted
a coalition between psychiatry and the social sciences and led to a
number of new conceptions of mental illness. According to
Marx et al., (1974) in their appraisal of the concept of mental illness
during this period:

The 1950's saw the emergence and acceptance of
several competing conceptual formulations (such as
Regorian client-centered counselling and existential
psychology) which were not based on or associated
with the medical model, the increasing involvement
of other professional treatment specialties (such as
clinical psychology) in the mental health field, and
a growing recognition of the importance of
sociocultural factors in the etiology, nature, and
consequences of mental disorder (p.19-20).

Reformulations of the concept of mental illness in the 1950's stressed
the breakdown of social relationships. The concept was broadening to
include "maladaptive interpersonal behaviors involving subjective
discomfort due to unsatisfying human relationships, or more general
problems in living" (Marx et al., 1974:20). Taber et al., (1969) argues
that after World War II, a common theme in mental illness research
emerged. It saw mental illness as:

.....behavior on which a social judgement is
passed. Recognition depends not upon expert
diagnosis, but on social evaluations of specific
behaviors. A second theme is that the phenomena is
clearly a property not of the individual but of the
interaction situation (p.354).

The Sociocultural Climate

These progressive changes in the definition of mental illness did
not occur in a vacuum. The second world war marked a period of great
upheaval in domestic American life. The experiences of the war itself,
advances in industrial technology, communications and transportation, the movement of large numbers of women into and out of the labor market, and the war's effect on family life made the 1940's a time of great social change. The most outstanding of these changes was the increasing affluence of the American public. At the start of the 1940's, one third of the country remained ill-housed, ill-fed, and ill-clothed. Millions of Americans faced long-term unemployment. World War II ended the depression and started a boom that lasted well into the 1960's. According to Skolnick (1978):

The war put an end to hard times for many families. During the war years, the proportion of families living on less than $2,000 dollars a year dropped from three-quarters to one-quarter of the population. Family income more than doubled between 1939 and 1969. For the first time a majority of Americans no longer had to worry about being able to obtain the basic necessities of food, clothing, and shelter (p.13).

This increasing affluence had an undeniable effect on the inner life of Americans. Following World War II, a growing number of Americans, starting with the upper middle classes and filtering throughout the social structure were developing a new basis for evaluating themselves and other people. This basis was psychological adjustment (Veroff et al., 1981:5). As Reisman (1961), Ehrenreich and English (1979), and others have argued: the fulfilled life began to depend on internal psychological states such as contentment, peace of mind, inner control, rather than only on external goals such as success and achievement. Veroff et al., (1981) emphasize the connection, emerging in the 1950's, between affluence and self-evaluation:

When people struggle to survive, they have little time or energy for a search for fulfillment and
peace of mind. External reality—the struggle to wrest a livelihood from a difficult environment—compels attention and absorbs consciousness. Self-consciousness and self-development are luxuries to people whose whole effort and attention are designed for survival (p.6).

The Expansion of the Psychiatric Case: A Summary

The foregoing sections were not intended as an exhaustive history of the mental health movement since World War II. The complexity of this issue could fill several volumes. The intent was to argue that the exponential growth in estimates of mental illness over the past forty years in American society is due, in large part, to a number of fiscal, ideological, methodological, and organizational processes that have redefined and broadened our society's conception of mental illness.

Of course, there is an alternative explanation of the rise in estimates of mental illness during this century. The increase could be real. One could easily draw the conclusion from both epidemiological and treatment data over the past forty years that more Americans are mentally ill. There is a substantial difference in estimates between studies published before 1950 and those published in 1950 or later. In fact, the later time period shows a prevalence rate over seven times greater than results from before 1950 (Dohrenwend and Dohrenwend, 1976). The increase has occurred across all the major subclassifications of psychoses, neuroses, and personality disorders. The bulk of the increase, however, has occurred among the non-psychotic, or mild, neurotic disorders. Changing methodologies over the century make comparisons difficult from one decade to another. Symptom checklist scales, for example, were not in use forty years ago. But these scales, which tap very mild psychiatric symptoms, or no
psychiatric symptoms at all, are used as a major source of evidence that we have become more mentally ill. Solely on methodological grounds, any estimate of the true prevalence of mental disorders over time is probably highly unreliable. Dohrenwend and Dohrenwend (1974) find that in most instances of case identification, epidemiological studies using clinical judgment present little evidence of content, criterion, or construct validity. Likewise, symptom checklist scales are being increasingly criticized as tapping symptomology that is only weakly and indirectly related to clinical psychiatric disorder (Murphy, 1978; Dohrenwend et al., 1980, 1981).

Still, some authors have attempted to uncover an historical increase in mental illness on the basis of treatment statistics. Goldhammer and Marshall (1953) tested the hypothesis that modern civilization has brought with it an increase in the incidence of psychosis. They examined data on rates of hospitalized insanity for the state of Massachusetts from 1840 to 1930. They concluded that "there has been no long-term increase during the last century of the incidence of psychoses of early and middle life" (1953:92).

Contemporary analyses of treatment statistics becomes more difficult because of the tremendous growth of treatment facilities since World War II. Between the years 1945 and 1973 there has been a large overall increase in the psychiatric episode rate in the United States from 629.1 per 100,000 persons to 2,508.5 per 100,000 persons. The psychiatric episode rate refers to the number of contacts between people and recognized professionals in the mental health system per 100,000 population during any year (Kramer, 1977). The vast majority of this increase is due to the great expansion of outpatient services
following World War II. These services deal primarily with less severe and nonpsychiatric disorders. The increase in use of services that deal with the psychoses and more severe disorders, inpatient facilities, has been slight. But again, this could be due to the increase in inpatient facilities in the last thirty years, especially general hospital inpatient facilities. There has been, for example, an increase in the psychiatric episode rate in inpatient facilities from 1945-1973 of about 14% from 629.1 per 100,000 persons to 701.0 per 100,000 persons (Kramer, in Eaton, 1980:177). Most of this 14% increase is due to the proliferation of general hospital inpatient units. In fact, the rate at public mental hospitals has decreased during this time period from 424.6 per 100,000 in 1945 to 313.3 per 100,000 persons in 1973.

It is difficult to demonstrate a real increase in mental illness over the past forty years. Changing conceptions of mental illness, the inclusion of non-severe, mild symptoms in statistics on mental illness, changing methodologies that measure symptoms not recorded in earlier periods, and the great expansion in services since World War II, makes comparisons difficult. Perhaps the most important reason for the expansion in our thinking in about mental illness has been the willingness of the American public to think in psychological ways. The years following the war were a time of great social change and people sought answers in terms of a psychological orientation to behavior. John Seeley, in a 1953 article on the value components of mental health argues that the message of the mental health movement was perfectly suited for large-scale acceptance in the middle 1940's. He saw four major reasons for the growth of this movement during these years:
1) it filled the power vacuum created by the bankruptcy of other institutions.
2) in times of widespread and radical change people turn sustained attention and effort not only to the life without, but also the life within.
3) such a time will tend to call out a spate of new social inventions—ways of dealing with human problems, and these, if they appear at a sufficiently rapid rate will in time call out mediators of the new ideas. And this is precisely where the mental health movement operates—between the scientific pen and the lay eye.
4) whether or not there has been a net increase in misery of a psychological nature, the existence of a movement directed to its remedy or alleviation will tend to focus concern upon the problem—that is, in effect, to expand the market which it is equipped to supply (p.23).

To Seeley, psychological distress, our conceptions about it, and our treatment of it are, to a large degree, a function of changes in the social structure and an index of our collective anxiety.

GENDER AND THE PREVALENCE OF MENTAL DISORDER

The expansion in the conceptualization of mental illness has affected the estimated rates of mental disorder for men and women quite differently. Since 1950, the most consistent finding from epidemiologic research has been that women are more mentally disordered than men. Curiously, before 1950, just the reverse was considered true: men were consistently reported to be more mentally ill than women. In their 1969 review of U.S. and foreign epidemiological studies, Dohrenwend and Dohrenwend report that prior to 1950, studies reveal a higher rate of mental illness for men in seven of nine studies. Since 1950, studies show a higher rate for women in eighteen of nineteen studies. These findings are more understandable when type of mental disorder is taken into account. Overall, both before and after 1950, the Dohrenwends
report no sex differences in studies examining the psychoses. Females have higher rates of neurosis in seventeen of twenty-one studies, while men show higher rates of personality disorder in thirteen of seventeen studies. But why the radical increase in overall rates of mental disorder among women since 1950? The Dohrenwends (1976) attribute this increase to the type of methodology employed in later studies. Symptom checklist scales such as the Langner 22-item scale (Langner, 1962), the Health Opinion Survey (Macmillan, 1957), and the Cornell Medical Index (Brodman et al., 1952) have been the most frequently used scales in epidemiological research since the early 1950's. More to the point, these scales do not pretend to measure forms of psychoses, aspects of personality disorder, or symptoms of anti-social behavior. They measure neurotic-like psychophysiological symptoms that women consistently report to a greater extent than men.

Gove and Tudor (1973), for example, reviewed nineteen U.S. and foreign studies conducted since 1950. All show a higher percentage of mentally ill females than males. The nature of mental disorder varies from study to study in their review, but almost all center on symptoms of neuroses, especially psychophysiological complaints. Weissman and Klerman (1976) reviewed fourteen U.S. and foreign studies of depression and found in all but one that women were more depressed than men. In a third review article, Goldman and Ravid (1980) support previous findings that women are more mentally ill than men. In their investigation of twenty-two U.S. studies, all but two find higher rates of disorder among women. Two studies find no sex differences. No study reviewed found higher male rates of disorder. Not one study in their review focused on personality disorders.
While such reviews support the notion that women experience more mental illness than men, they neglect to point out that symptoms of distress typically experienced by males are rarely the focus of epidemiological research. Instead, a great deal of effort is devoted to asking why women are overrepresented among the mentally disordered. Gove and Tudor (1973), again, contend that the shift from higher male rates of mental illness to higher female rates around 1950 is a real change. According to these authors, the disturbing decline in female mental health reflects a worsening of conditions for women in the United States. Women report more symptoms of both physical and psychiatric conditions than men and are also overrepresented in medical and psychiatric facilities because of true differences in physical and mental illness (Gove and Tudor, 1973; Nathanson, 1975; Gove and Hughes, 1979). This real difference in illness, as Foss (1979) has summarized the position of true prevalence theorists, is typically explained through a stress model that views mental illness as a response to the frustration and conflict in modern women's roles (Bernard, 1972; Gove and Tudor, 1973; Nathanson, 1975). Among the problems encountered by women in modern industrial societies, at least since World War II are: contradictory or ambiguous expectations (Komarovsky, 1947; 1950); confinement to the realm of domesticity which precludes alternative sources of gratification (Bernard, 1972; Gove and Tudor, 1973); in comparison to men's work, housework is unskilled and of low prestige (Gove and Tudor, 1973); women's extrafamilial jobs are typically of low esteem and unrewarding. Compounding these sources of stress among some women are the dual responsibilities of two full-time jobs for women who work outside the home, and a lack of control over one's future because
of dependence on the husband's occupational movements.

A central contention of this perspective is that most of the difference in rates of mental illness between men and women is accounted for by an interaction between gender and marital status. Married women are seen as more at-risk relative to married men, while nonmarried men and women show more comparable rates.

**A REVIEW OF EPIDEMIOLOGIC STUDIES**

There are, then, at least two interpretations of why women's rates of mental illness increased dramatically following World War II. One position sees the rise as an artifact of measurement. High rates of mental disorder among women are due to the changing conceptualization and measurement of mental illness since the early 1950's. These measures tap symptomology typical of women and do not use instruments that would tap male responses to distress. The true prevalence perspective, on the other hand, holds that the increase in mental disorder among women is quite real and due to the stressful role of married women since World War II. A critical difference between these positions is the effect of marital status on mental illness rates. If it could be demonstrated that married women consistently report higher rates of disorder relative to married men, partial support would be generated for the "real" difference approach. If married women show the same sex difference relative to men as women in other marital statuses, a central tenet of the "true prevalence" perspective will not be supported.

This section will review thirty-six epidemiological studies that focus on sex differences in mental illness. Within this review is a
subset of studies that report data on sex-marital status interactions. The survey will review studies using a variety of measurement instruments and conducted during the period 1955-1983 in the United States and Canada. Although foreign studies compose the bulk of studies reviewed by Dohrenwend and Dohrenwend (1976) they are excluded here to avoid problems of cross-cultural psychiatric evaluation. All studies attempt to determine prevalence rates of overall and/or specific forms of mental disorder independent of treatment rates. In these studies, samples were drawn on residents of particular communities or the entire United States. Unless otherwise noted, respondents in these community studies were 18 years or older.

Consistent with the findings of other reviews of studies of sex differences in mental illness (Gove and Tudor, 1973; Weissman and Klerman, 1976; Dohrenwend and Dohrenwend, 1976; and Goldman and Ravid, 1980), my review also finds women predominating in the symptoms of distress that have been the subject of epidemiological distress. As indicated in Table 2.2, in thirty of the thirty-six studies under review, rates of the mental illness were higher for women than men. As Goldman and Ravid (1980) also report, not one study finds males to have higher overall rates of mental illness than women. The five studies in which females did not predominate in symptoms of mental illness are those that measured mental illness multidimensionally. In line with the Dohrenwend's review of U.S. and foreign studies of gender and mental illness, the greater vulnerability of women to mental illness does not hold up when a variety of types of disorder are examined. In my review, of the four studies that measured symptoms of personality disorder or symptoms of anti-social behavior, men always scored higher than women.
Table 2.2.-Community Studies of Sex and Marital Status Differences in Mental Disorders, United States and Canada, 1955-1983.

<table>
<thead>
<tr>
<th>Author</th>
<th>Type of Disorder Measured/ Instrument Used</th>
<th>Summary of Sex Differences</th>
<th>Summary of Sex-Marital Status Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aneshensel, Frerichs, and Clark (1981)</td>
<td>CES-D 20-item Depression Scale</td>
<td>Female-Male Ratio 1.8:1 on CES-D. 23.3% of women and 12.9% of men scored above cut-off point of 16+ symptoms.</td>
<td>Women report higher mean depression scores in every marital status category except widowed.</td>
</tr>
<tr>
<td>Beilin and Hurd (1958)</td>
<td>Overall Mental Health Inventory of 37 signs and symptoms. Protocol evaluated by mental health personnel who rated respondents on 8-point scale of impairment.</td>
<td>24% of females and 22% of males judged to have poor mental health</td>
<td>No significant differences between men and women among married, never married, and widowed. More males rated as impaired among the divorced and separated</td>
</tr>
<tr>
<td>Benfarl, Belser, Leighton, and Mertons (1972)</td>
<td>Symptoms of Neurotic Behavior- (checklist scale)</td>
<td>Women scored higher than men on measures of anxiety; psychological symptoms, and mixed anxiety-depression. No sex differences on cognitive depression</td>
<td>No analysis of sex-marital status interactions</td>
</tr>
<tr>
<td>Bradburn (1969)</td>
<td>Measures of Psychological Well-Being and Happiness</td>
<td>Women scored lower on well-being. No sex differences in reported happiness</td>
<td>Married men and never married men more likely to report unhappiness. Separated, divorced, and widowed women more likely to report unhappiness</td>
</tr>
<tr>
<td>Bradburn and Caplowitz (1965)</td>
<td>Measures of Anxiety and Happiness</td>
<td>54% of the women and 31% of the men report symptoms of anxiety. 17% of the men and 16% of the women report being &quot;not too happy&quot;</td>
<td>Across all marital statuses, a higher proportion of men than women report &quot;not being very happy&quot;</td>
</tr>
<tr>
<td>Cleary and Mechanic (1983)</td>
<td>PERI (Psychiatric Epidemiology Research Interview)</td>
<td>Women score consistently higher than men on PERI</td>
<td>Women have higher mean scores than men in every marital status.</td>
</tr>
<tr>
<td>Author</td>
<td>Date of Publication</td>
<td>Sample Size</td>
<td>Date of Data Collection</td>
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<tr>
<td>Commission on Chronic Illness (1957)</td>
<td>N=11,574</td>
<td>1952-1956 data collected in Baltimore, MD</td>
<td>Overall Mental Disorder (checklist scales and clinical evaluation)</td>
</tr>
<tr>
<td>Eaton and Weil (1955)</td>
<td>N=8542</td>
<td>1950-1951 data collected in Hutterite communities in Canada and the United States</td>
<td>Lifetime prevalence of mental disorder (psychiatric evaluation)</td>
</tr>
<tr>
<td>Engelsmann, Murphy, Prince, Leduc, and Deners (1972)</td>
<td>N=875</td>
<td>Three samples from Montreal, Canada and surrounding area</td>
<td>Langner 22-item Symptom Scale (Psychophysiological symptoms)</td>
</tr>
<tr>
<td>Fox (1980)</td>
<td>Reanalysis of three data sets: Gurin et al., 1960 (N=2460) U.S. Public Health Service, 1970 (N=6672) HANES study, USPHS, 1973 (N=6907)</td>
<td>Symptoms of Psychological Distress (Gurin et al); Langner 22-item symptom scale (USPHS); General Well-Being Schedule (HANES)</td>
<td>In all three reanalyses, women report higher impairment on symptoms under study</td>
</tr>
<tr>
<td>Gove, Hughes, and Style (1983)</td>
<td>N=2,248</td>
<td>1974-1975 data from national probability sample (48 contiguous states)</td>
<td>Composite scale of 12 Gurin-like psychological symptom items, five positive affect items (Bradburn, 1969) and 8 self-esteem items</td>
</tr>
<tr>
<td>Author</td>
<td>Type of Mental Disorder/Instrument Used</td>
<td>Summary of Sex Differences</td>
<td>Summary of Sex-Marital Status Differences</td>
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<td>------------------------------------------</td>
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<tr>
<td>Gurin, Veroff, and Feld (1960)</td>
<td>Measures of Mental Adjustment; Happiness</td>
<td>No sex differences in reported happiness. Women report higher scores on anxiety measures</td>
<td>Women report more anxiety than men in all marital statuses. Never married men less happy than never married women on measures of &quot;happiness&quot;. No difference on happiness reported by men and women in other marital statuses</td>
</tr>
<tr>
<td>Haberman (1970)</td>
<td>Langner 22-item Symptom Scale (Psychophysiological symptoms)</td>
<td>Women report higher rates of impairment. 25.3% of women and 18.2% of men in Wash. Heights score 4+ symptoms. 33.3% of women and 14.5% of men in N.Y.C. score 4+ symptoms</td>
<td>No analysis of sex-marital status interactions</td>
</tr>
<tr>
<td>Hogarty and Katz (1971)</td>
<td>Katz Adjustment Scale (Adjustment and social behavior)</td>
<td>Higher rates of impairment for women on measures of anxiety, nervousness and helplessness</td>
<td>No analysis of sex-marital status interactions</td>
</tr>
<tr>
<td>Kessler, Brown, and Broman (1981)</td>
<td>General Well-Being; CES-D 20-item Depression scale; Serious life Problems</td>
<td>In all four samples, women are between 33% and 82% more likely to report symptoms under study during past week</td>
<td>No analysis of sex-marital status interactions</td>
</tr>
<tr>
<td>Knupper, Clark, and Room (1966)</td>
<td>Symptoms of Depression, Anxiety, Anti-Social Tendencies, and Severe Neuroses</td>
<td>Overall, women report more symptoms of anxiety and worry. Men report more anti-social behaviors and severe neurotic symptoms</td>
<td>Married women report more symptoms of depression and anxiety than married men or single women. Married men report more symptoms than married women of anti-social behaviors and severe neuroses. Same pattern holds for single men and women</td>
</tr>
<tr>
<td>Author</td>
<td>Date of Publication</td>
<td>Sample Size</td>
<td>Date of Data Collection</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------</td>
<td>-------------</td>
<td>-------------------------</td>
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<tr>
<td>Leighton, Harding, Macklin, Macmillan, and Leighton (1963)</td>
<td>N=1010</td>
<td>1950’s data from Stirling County</td>
<td>Psychiatric evaluation of interview data on a variety of symptoms</td>
</tr>
<tr>
<td>Markush and Favero (1974)</td>
<td>N=2129</td>
<td>2 samples: Washington Co., MD and Kansas City, MO 1972 data</td>
<td>CES-D Depression Scale and Langner 22-item Symptom Scale</td>
</tr>
<tr>
<td>Meile and Haese (1969)</td>
<td>N=6018</td>
<td>Plains States-3 communities 1960’s data</td>
<td>Langner 22-item Symptom Scale</td>
</tr>
<tr>
<td>Mechanic and Greenley (1976)</td>
<td>N=1502</td>
<td>Mid 1970’s data from Midwestern College Campus</td>
<td>Langner 22-item Symptom Scale</td>
</tr>
<tr>
<td>Pasamanick, Roberts, Lenkau, and Krueger (1957)</td>
<td>N=809</td>
<td>1952 data collected in Baltimore, Md.</td>
<td>Clinical evaluation of interview data on a number of symptoms of distress</td>
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<tr>
<td>Pearlin (1975)</td>
<td>N=2300 (cluster sample)</td>
<td>1972 data from Chicago, IL</td>
<td>BSI Symptom Depression Scale. Measures of Psychophysiologic symptoms, anxiety, and cognitive disturbance</td>
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<tr>
<td>Author</td>
<td>Date of Publication</td>
<td>Sample Size</td>
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<td>-------------------------</td>
</tr>
<tr>
<td>Phillips (1966)</td>
<td>N=600 early 1960's data from State of New Hampshire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phillips and Segal (1969)</td>
<td>N=302 1964-1965 data from Lebanon, HI</td>
<td></td>
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<tr>
<td>Radloff (1975)</td>
<td>2 samples; N=1159 in Kansas City, MO; N=1670 in Washington County, MD 1971-1973 data</td>
<td></td>
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<tr>
<td>Roberts and O'Keefe (1981)</td>
<td>N=752 married couples 1974 data from Alameda County, CA</td>
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<td></td>
</tr>
<tr>
<td>Gaitz and Scott (1972)</td>
<td>N=1441 1969 data from stratified sample in Houston, TX</td>
<td></td>
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<tr>
<td>Siassi, Crocetti, and Spiro (1974)</td>
<td>N=888 1968 data from Baltimore, MD</td>
<td></td>
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<tr>
<td>Srole, Langner, Michael, Rennie, and Opler (1962)</td>
<td>N=1660 early 1950's data from Midtown Manhattan, N.Y.C.</td>
<td></td>
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<tr>
<td>Author, Date of Publication</td>
<td>Type of Mental Disorder/ Instrument Used</td>
<td>Summary of Sex Differences</td>
<td>Summary of Sex-Marital Status Interactions</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------------</td>
<td>----------------------------</td>
<td>-------------------------------------------</td>
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<tr>
<td>Summers, Seiler, and Bough (1971)</td>
<td>Langner 22-item Symptom Scale</td>
<td>Women report a higher mean number of symptoms, 2.79 for females; 1.78 for males</td>
<td>No analysis of sex-marital status interactions</td>
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<tr>
<td>N=1096</td>
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<tr>
<td>1966 data from Hennepin, IL</td>
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<td></td>
<td></td>
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<tr>
<td>United States Public Health Service (1970)</td>
<td>Langner 22-item Symptom Scale</td>
<td>Overall Female/Male ratio of 2.1/1 on 4+ symptoms of distress</td>
<td>In all marital statuses, women report higher mean distress scores than men</td>
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<tr>
<td>N=6672</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1970 data from entire U.S.</td>
<td></td>
<td></td>
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<tr>
<td>Veroff, Kulka, and Douvan (1981)</td>
<td>Measures of Happiness, Anxiety, Worry, and Well-Being</td>
<td>Women more than men report difficulties in their lives. Women have more anxiety and worry than men</td>
<td>No significant sex-marital status interactions. Men report greater well-being than women among the married. Married women report greater well-being than single women</td>
</tr>
<tr>
<td>N=2267</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1975 data from entire U.S.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warheit, Holzer, Bell, and Arey (1976)</td>
<td>Health Opinion Survey (Symptoms of Psychological and Psychophysiological distress)</td>
<td>Women report higher mean distress scores than men</td>
<td>Women in all marital statuses report higher mean symptom scores than men</td>
</tr>
<tr>
<td>N=3674</td>
<td></td>
<td></td>
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<tr>
<td>early 1970's data from area probability sample in Southeastern U.S.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yancey, Rigsby, and McCarthy (1972)</td>
<td>Langner 22-item Symptom Scale</td>
<td>Women report higher symptom scores than men</td>
<td>No analysis of sex-marital status interactions</td>
</tr>
<tr>
<td>N=1,172</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1969 data from Philadelphia, PA and Nashville, TN</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Women report a higher mean number of symptoms, 2.79 for females; 1.78 for males.
In studies designed to tap symptoms of psychoses, one study reported no sex differences (Leighton et al., 1963), one reports higher male rates (Passamanick et al., 1957), and one finds higher female rates (Eaton and Weil, 1955). Remarkably, symptom checklist scales such as the CES-D depression scale and the Langner 22-item scale are found to be used in over 80 per cent of studies conducted during this time period. As expected, on these measures, women score consistently higher than men.

One further aspect of this review is the extent to which symptoms of distress, such as anxiety, lack of well-being, unhappiness, tension, worry, and the presence of life problems are used as direct measures of mental illness. The authors of these studies do not intend these indicators to represent clinical diagnoses, but these items routinely appear in the literature on mental illness and are used as evidence that women are more mentally ill than men. While women consistently score higher on these vague symptoms, their relationship to clinical psychiatric disorder remains unknown.

Because of the extensive use of measures that seem to tap rather mild forms of disorder, or no disorder at all, it is impossible to argue that women are, indeed, more vulnerable to mental illness than men. Further, those studies in my review that have examined a variety of types of disorder present a rather mixed picture in terms of overall gender differences in mental disorder. Leighton et al., (1963) report no difference between rates of psychoses for men and women, but finds women more likely to be psychoneurotic, and men more likely to display symptoms of anti-social behavior. Mazur (1974), on the basis of a five year psychiatric register reports women to be more likely to experience symptoms of emotional distress and men to be in predicaments of an
anti-social nature. Passmanick et al., (1957) reports that women have more psychoneurotic, and physiologic autonomic and visceral disorders, while men predominate in psychotic symptomology. Knuffer, Clark and Room (1966) report that men experience more severe neurotic and anti-social symptoms than women, whereas women reveal more symptoms of anxiety and worry than men. The Commission on Chronic Illness Study (1957) find psychoneurotic symptoms and psychophysiological symptoms higher in women and problems of alcoholism and personality disorder higher in men. Benfari et al., (1972) find women score higher on measures of anxiety, psychophysiological symptoms, and mixed anxiety-depression, while there are no sex differences on cognitive depression. These findings are in broad agreement.

In my review, three different scales measuring depression found the same results. Pearlin (1971) using the 11-item depression scale developed by Lipman et al., (1969) and by Derogatis et al., (1971), Roberts and O'Keefe (1981) using the California Human Population Laboratory 18-item depression scale, and Radloff (1975) using the 20-item Center for Epidemiologic Studies depression index, all find women reporting more symptoms than men. Some studies using symptom checklist scales such as the Langner scale present their results broken down by factors. Gurin et al., (1960) finds four factors or subindices comprising the Gurin 20-item symptom scale and reports that women scored higher than men on all four indices, physical anxiety, immobilization, psychological anxiety, and physical health. Engelsmann et al., (1972) also finds women scoring higher on the four factors comprising the Langner scale, but Philips and Segal (1969) report that women score higher than men on psychological and psychophysiological
subscale and men score higher on ambiguous items and items of a purely physical health dimension.

**Sex-Marital Status Interaction Effects on Mental Illness Rates**

My review of thirty-six community studies goes beyond previous reviews by focusing on the interaction between sex and marital status on mental illness rates. Of the thirty-six studies included here, fifteen breakdown their data by sex and marital status. All of these fifteen studies measure neurotic behavior and symptoms of anxiety, nervousness, unhappiness, and worry. None of the studies examining a sex and marital status focus on symptoms of psychosis and only one study includes symptoms of personality disorder.

It will be remembered that a central tenet of the "true prevalence" perspective is that the deterioration of female mental health since World War II is due to worsening conditions in the lives of females, especially among married women. This effect should show up in epidemiological research in the form of a sex-marital status interaction effect indicating higher rates of the symptoms under study for married females. Remarkably, the studies in my review provide little evidence of a sex-marital status interaction in rates of mental illness. Overall, the majority of studies find women to have higher rates of the symptoms under study in all or most marital statuses. The vulnerability of women relative to men among the married also seems to be characteristic of women among the divorced, the separated, the widowed, and the never married. Hogarty and Katz (1971) report women have higher rates of disorder than men within the same marital status across all marital status categories on measures of anxiety,
nervousness, and helplessness. Warheit et al., (1976) report the same
findings on measures of psychophysiological measures of distress. The
most extensive evidence against a sex-marital status interaction is
from the work of Fox (1980). He reanalyzed data from three large data
sets: the 1960 Gurin et al., study, the 1970 U.S. Public Health Service
Study, and the 1973 HANES study by the U.S. Public Health Service. In
each data set (all used checklist measures of psychological distress)
women report higher overall rates of impairment, and, more importantly,
within each marital status, women report higher rates of distress than
men. The degree of difference between men and women varies by marital
status, with the largest differences occurring among the widowed,
divorced, and separated. The smallest difference occurs among the
married and never married.

Of the studies reviewed here there is little evidence of a
sex-marital status interaction effect. The female excess on symptoms
of psychological distress is not due to an excess of symptoms only
among married women, but to an excess among women in all marital status
categories. Regardless of marital status, women in these studies report
higher rates of impairment than their male counterparts. But this type
of comparison does not tell us about the main effect of marital status
on rates of mental illness. It is to this issue we now turn.

**Main Effect of Marital Status**

For both sexes there are large differences in vulnerability to forms of
mental distress according to marital status. Among women, the divorced,
separated, and widowed seem particularly at-risk. Compared to these
women, married women receive a large protective effect, and never
married women are more protected still. Among men, the same result appears. Married men are protected compared to the widowed, the divorced and separated. Never married men, on some measures, seem more protected than married men. These results may be due to age effects, but the existing literature emphasizes the peculiar conditions of each marital status.

The Separated and Divorced

In this review of fifteen studies of sex, marital status, and mental illness, persons who are divorced or separated have been repeatedly found to be overrepresented among the ranks of the mentally impaired. As Srole et al., (1962) report in their Midtown Manhattan Study:

.....the Midtown divorced of both sexes have the highest mental morbidity rates of all four marital status categories (p.185)

These authors report that among women, 19.9% of the married and 42.1% of the divorced are impaired. Among males, 19.3% of the married compared to 40% of the divorced are psychiatrically impaired. Warheit et al., (1976) also find both males and females who are divorced significantly more impaired than married males and females. Phillips (1966) does not provide data on marital status by sex, but reports that 27.3% of the married compared to 42.1% of the separated/divorced report 4+ symptoms on the Langner scale. Pearlin and Johnson (1977) report more depressive symptomology among the maritally disrupted than the married. Bloom et al., (1978) in a review article on marital disruption summarizes that separation and divorce are significant stressors in the
lives of both men and women. In their review, they find the divorced and separated to be more vulnerable to mental illness, mental hospitalization, motor vehicle accidents, physical illnesses, disability, suicide, and to have higher age-specific death rates due to tuberculosis and cirrhosis of the liver.

According to Veroff et al., (1981) the status of divorced or separated is subjectively bad for both sexes:

Divorced/Separated men and women are not very happy....nor are they as hopeful about the future as married people. They worry more than other groups, more often say they have felt as if they might have a nervous breakdown, and more often report feelings of inadequacy as parents (p. 403).

The Never Married

In this review, there are less than clear-cut results in comparisons between never married men and women as well as overall comparisons between the never married and those of other marital statuses. In most discussions of the never married status, however, it is assumed that never married women are mentally healthier than never married men. Ravid (1980), for example, in their review of gender and mental illness studies conclude:

The most consistent finding is that single men are more 'maladjusted', 'mentally impaired', or 'depressed' than single women....In no study are single women shown as more prone to mental illness than single men (p. 47).

Gove (1972) in a review of fifteen studies of sex differences among the never married concluded that single women have lower rates of mental illness than single men. In eleven of the fifteen studies he reviewed, this finding
lives of both men and women. In their review, they find the divorced and separated to be more vulnerable to mental illness, mental hospitalization, motor vehicle accidents, physical illnesses, disability, suicide, and to have higher age-specific death rates due to tuberculosis and cirrhosis of the liver.

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Gove (1972) in a review of fifteen studies of sex differences among the never married concluded that single women have lower rates of mental illness than single men. In eleven of the fifteen studies he reviewed, this finding
emerged. In the Goldman and Ravid (1980) review, the studies by Bradburn (1969), Bradburn and Caplowitz (1965), Gurn et al., (1960) and Knupfer et al., (1966) are cited in support of the advantage single women have over single men. The studies have something in common and it may be the reason for the difference in findings between the Goldman and Ravid review and the one here. All of these studies measure the difference in rates of mental illness between single men and single women using global measures of "happiness". All find single men reporting themselves to be "not too happy" compared to single women.

As we will see below, when other measures of mental distress are used, gender differences between the never married become more complex. The Gove (1972) review also has some difficulties in estimating gender differences among the never married. Many of the studies in his review are not epidemiological studies, but, rather, treatment studies of those who sought help for difficulties. In fact, nine of the eleven studies cited in support of a greater vulnerability to disorder among single men are based on treatt statistics, not on data from more general populations.

In my review of fifteen studies, the results for the never married are mixed. It seems to depend upon the type of distress under examination. Single men are more likely than single women to report being "not too happy". On measures of anxiety, psychophysiologic symptoms, and other indicators of neurotic-like symptomology, results are more ambiguous. Srole et al., (1962) found more single men than women disordered based on clinical evaluations of structured interview data. Warheit et al., (1976) on the basis of results from the HOS psychophysiologica symptom scale finds almost identical proportions of
single men and women to be impaired. Bradburn (1969) also finds single men and women equally likely to report negative psychological well-being. Hogarty and Katz (1971) find single women slightly more likely than single men to report symptoms of anxiety, nervousness, and helplessness. Radloff (1975) breaks down the status of the never married into those who are heads of household and those who are not. On the basis of the 20-item CES Depression scale she reports a higher mean depression score among single females than males who are not heads of household, but just the opposite is true among those singles who are heads of household. In three large epidemiological studies reviewed by Fox (1980), his reanalysis finds that in all three, single women are more impaired than single men. Compared to men and women in other marital statuses, the amount of difference between men and women in the never married category is smallest. All that can be concluded from my review is that outside of indicators of "happiness", single men and single women report very similar rates of impairment, especially in studies conducted since 1970. This may reflect dramatic changes in the make up of the single population compared to earlier times.

The Widowed

Overall, the widowed as a group seem better off than the divorced and separated, but not as well off as the married and never married. Several authors have found that the rates of impairment among the widowed are similar to those of the divorced and separated (Gove, 1972; Srole et al., 1962; and Bradburn, 1969). Veroff et al., (1981) equates the mental health status of the widowed with that of other maritally disrupted groups:
The widowed status is also an unhappy one. Widows are as likely as divorced men and women to report not being very happy and having low future morale (p.403).

Fox (1980) in his reanalysis of three large data sets finds the widowed to have better mental health than the divorced and separated in two of three studies he reexamined. In the third data set the widowed had almost identical rates of impairment as the separated.

There is also some controversy as to rates of impairment by sex among the widowed. Srole et al., (1962) finds no significant sex differences among the widowed. Clayton et al., (1972) report no sex differences in depression rates among the widowed. Again, Fox (1980) reports that in the three data sets he reexamined, females had higher rates of distress than males among the widowed.

The Married Versus the Never Married

Direct comparison of rates of impairment between the married and never married are very important. Sex role interpretations of differences in mental health have typically emphasized marital status as an important social fact in accounting for observed sex differences. In simplified form, it has been argued that marriage is good for men and bad for women, and conversely, singlehood promotes mental health for women, but handicaps men. A review of the literature in the last section did not find clear evidence of a female advantage among the never married. However, this is not direct evidence that never married women are better off than their married counterparts.

It was decided to gather together measures of mental health from studies that examined differences between at least four sex-marital
status groups: married men, married women, never married men and never married women. Seventeen measures of psychological status were found in eleven epidemiologic studies from the original review of thirty-six studies. Measures vary widely from "overall psychological impairment" to "symptoms of depression" to indicators such as "not being too happy". All are symptoms of mild psychiatric disorder. As a crude measure of differences between the four groups in terms of level of mental health, groups were ranked within each study as to their relative level of mental health functioning. For example, if married men reported the lowest scores on measures of depression, they received a rank of 1 indicating the "best" mental health of the four groups. The group reporting the most symptoms depression within the study would be ranked fourth. The other two groups received intermediate scores. Mean rank scores were computed from the results of seventeen separate measures of psychological status.

Table 2.3 reports the actual data and rank of each of the four sex-marital status groups under study. Overall, there are three results worth noting. One is the clear advantage of married men compared to the other three groups. On ten of the seventeen measures married men rank highest. The second finding of note is that there is a complete absence of differentiation between married women, never married men, and never married women. All three groups have almost identical mean rank scores. These three groups also rank very differently within studies on particular measures of mental impairment. As can be seen in Table 2.3, measures of psychological status vary between general malaise --"overall level of impairment" (Srole et al., 1962; Leighton et al., 1963) to the rather mild "reported happiness" (Gurin et al., 1960;
<table>
<thead>
<tr>
<th>Author</th>
<th>Measure of Distress</th>
<th>N</th>
<th>Married Men</th>
<th>Married Women</th>
<th>Never Married Men</th>
<th>Never Married Women</th>
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<td>Bradburn (1962)</td>
<td>Per cent reporting &quot;not too happy&quot;</td>
<td>14</td>
<td>11</td>
<td>31</td>
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<tr>
<td></td>
<td>N</td>
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<td>824</td>
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<tr>
<td>Bradburn (1969)</td>
<td>Per cent reporting &quot;not too happy&quot;</td>
<td>9</td>
<td>7</td>
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<tr>
<td></td>
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<td>4th</td>
<td>3rd</td>
<td></td>
</tr>
<tr>
<td>Bradburn (1969)</td>
<td>Ridit scores of negative well-being (high score= low well-being)</td>
<td>.45</td>
<td>.53</td>
<td>.54</td>
<td>.54</td>
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<tr>
<td></td>
<td>N</td>
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<td>1180</td>
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<td>2nd</td>
<td>3rd</td>
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<td></td>
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<tr>
<td>Fox (1980)</td>
<td>Per cent reporting 5+ symptoms on scale of psychological anxiety</td>
<td>22.6</td>
<td>37.8</td>
<td>19.8</td>
<td>31.6</td>
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<tr>
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<td>956</td>
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Table 2.3.

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<th>Author</th>
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<th>Married Women</th>
<th>Never Married Men</th>
<th>Never Married Women</th>
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<tbody>
<tr>
<td>Fox (1980) Re-analysis of USPHS data (1973)</td>
<td>Per cent reporting low scores on General Well-Being Schedule</td>
<td>19.9</td>
<td>30.4</td>
<td>25.5</td>
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<td>3rd</td>
<td>2nd</td>
<td>4th</td>
</tr>
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<td>Gurin, Veroff, and Feld (1960)</td>
<td>Per cent reporting &quot;not too happy&quot;</td>
<td>8</td>
<td>7</td>
<td>13</td>
<td>11</td>
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<td>963</td>
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<td>1st</td>
<td>4th</td>
<td>3rd</td>
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<tr>
<td>Knupfer, Clark, and Room (1966)</td>
<td>Per cent reporting &quot;not too happy&quot;</td>
<td>7</td>
<td>10</td>
<td>21</td>
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<tr>
<td></td>
<td>N</td>
<td>374</td>
<td>375</td>
<td>101</td>
<td>109</td>
</tr>
<tr>
<td></td>
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<td>2nd</td>
<td>4th</td>
<td>3rd</td>
</tr>
<tr>
<td>Knupfer, Clark, and Room (1966)</td>
<td>Per cent reporting &quot;Bothered by feelings of depression&quot; (&quot;often&quot; or &quot;sometimes&quot;)</td>
<td>27</td>
<td>50</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>337</td>
<td>349</td>
<td>46</td>
<td>53</td>
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<td>2nd</td>
</tr>
<tr>
<td>Author</td>
<td>Measure</td>
<td>Per cent reporting &quot;bothered by feeling tense or nervous&quot; (&quot;some&quot; or &quot;a lot&quot;)</td>
<td>N</td>
<td>Rank</td>
<td>Per cent reporting &quot;bothered by feeling tense or nervous&quot; (&quot;some&quot; or &quot;a lot&quot;)</td>
</tr>
<tr>
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<td>------</td>
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</tr>
<tr>
<td>Knupfer, Clark, and Room (1966)</td>
<td>Distress</td>
<td>36</td>
<td>57</td>
<td>41</td>
<td>56</td>
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<tr>
<td>Leighton, Harding, Macklin, MacMillan, and Leighton (1963)</td>
<td>Ridit score overall impairment (High score = higher impairment)</td>
<td>.436</td>
<td>.579</td>
<td>.483</td>
<td>.595</td>
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<td>Radloff (1980)</td>
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<td>Mean depression score (CES-D)</td>
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<td>9.84</td>
</tr>
<tr>
<td>Radloff (1980)</td>
<td>(Singles not Head of Household)</td>
<td>Mean depression score (CES-D)</td>
<td>7.33</td>
<td>9.53</td>
<td>10.27</td>
</tr>
<tr>
<td>Author</td>
<td>Measure</td>
<td>Per cent reporting &quot;bothered by feeling tense or nervous&quot; (&quot;some&quot; or &quot;a lot&quot;)</td>
<td>N</td>
<td>Rank</td>
<td>Per cent reporting &quot;bothered by feeling tense or nervous&quot; (&quot;some&quot; or &quot;a lot&quot;)</td>
</tr>
<tr>
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<tr>
<td>Knupfer, Clark, and Room (1966)</td>
<td>Distress</td>
<td>36</td>
<td>57</td>
<td>41</td>
<td>56</td>
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<tr>
<td>Leighton, Harding, Macklin, MacMillan, and Leighton (1963)</td>
<td>Ridit score overall impairment (High score = higher impairment)</td>
<td>.436</td>
<td>.579</td>
<td>.483</td>
<td>.595</td>
</tr>
<tr>
<td>Radloff (1980)</td>
<td>(Singles are Head of Household)</td>
<td>Mean depression score (CES-D)</td>
<td>7.33</td>
<td>9.53</td>
<td>9.84</td>
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<tr>
<td>Radloff (1980)</td>
<td>(Singles not Head of Household)</td>
<td>Mean depression score (CES-D)</td>
<td>7.33</td>
<td>9.53</td>
<td>10.27</td>
</tr>
</tbody>
</table>
Table 2.3.

<table>
<thead>
<tr>
<th>Author</th>
<th>Measure of Distress</th>
<th>N</th>
<th>Per cent judged impaired from evaluation of responses Langner symptom scale</th>
<th>N</th>
<th>Per cent reporting &quot;being happy&quot;</th>
<th>N</th>
<th>Per cent reporting positive self-esteem</th>
<th>N</th>
<th>Mean Score on Health Opinion Survey (High Score = More Impaired) (Whites Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Srole, Langner, Michael, and Rennie (1962)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>26.0 26.9 26.1 26.7</td>
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<tr>
<td></td>
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<td>20</td>
<td>537</td>
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<td></td>
<td></td>
<td>697</td>
<td>53</td>
<td>738</td>
<td>55</td>
<td>130</td>
<td>56</td>
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<tr>
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<td>4th</td>
<td>3rd</td>
<td>2nd</td>
<td>1st</td>
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<td>970</td>
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<td>1093</td>
<td>26.9</td>
<td>233</td>
<td>26.1</td>
<td>162</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Rank</td>
<td>1st</td>
<td>4th</td>
<td>2nd</td>
<td>3rd</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 2.3.

<table>
<thead>
<tr>
<th>Author</th>
<th>Measure of Distress N Rank</th>
<th>Married Men</th>
<th>Married Women</th>
<th>Never Married Men</th>
<th>Never Married Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL MEAN RANKING</td>
<td></td>
<td>1.52 (1st) 2.64 (2nd) 2.70 (3rd) 2.70 (3rd)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OVERALL MEAN RANKING (EXCLUDING &quot;HAPPINESS&quot; STUDIES)</td>
<td></td>
<td>1.25 (1st) 3.08 (4th) 2.33 (2nd) 2.75 (3rd)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*1st ranking denotes best mental health of four groups; 4th rank denotes poorest mental health*
Bradburn, 1969, 1962; Knupfer et al. 1966). The measures of happiness, in particular have probably the weakest relationship to mental illness, although they are widely used as reflective of level of mental health.

Secondly, if happiness measures are removed from the analysis in Table 2.3, results change considerably. The exclusion of these measures solidifies the impression that married men have an advantage in mental health. Without these measures, the remaining three groups become somewhat more differentiated, but in an unexpected way. Never married men now move into a position right behind married men in overall rank. Never married married women follow and married women are now ranked as the group with the worst mental health of all four four groups.

An anomalous finding of both calculations of overall mean rank is that the standing of never married men fare much better in this review than is indicated by previous research. Their rank is as good or better than the position of both groups of women and they are only ranked lower than married men. As was mentioned in a previous section, the presumed advantage of never married women relative to never married men is largely based on studies of happiness. When these are excluded from analysis, the advantage of single women not only disappears, but reverses in favor of single men.

Third, the advantage of never married men to never married women is a recent trend. In Table 2.3, if only studies conducted since 1970 are considered, never married women report worse mental health than never married men in every study except one (Radloff depression data for never married men and women who are heads of households). Prior to 1970, single women seem to hold a clear advantage over single men. This recent decline in the mental health of single women is surely due to a
number of factors. As will be discussed in a later chapter, it may be
due to more never married women taking on the stresses and strains of
parenting roles without a corresponding change in marital status.

Methodological Problems in Community Studies

My review of thirty-six community studies conducted in the United
States and Canada between 1955 and 1983 presents several difficulties
for the estimation of the true prevalence of mental illness. Chief
among these difficulties is the limited range of types of mental
illnesses that have been the subject of epidemiological investigations.
There is a paucity of studies focusing on the psychoses and personality
disorders. While women report more of the symptoms under study in my
review, an overall gender differential is impossible to determine
because of the omission of symptomology characteristic of a male
response to stress and strain. In addition to the problem of selective
measurement, there are a number of problems in these community studies
that should be briefly mentioned.

Data Gathering and Reporting Problems.

The majority of epidemiological studies are conducted in local
communities. Usually no information is given about the community in
terms of its ethnic/racial mix, income, age, or economic structure.
Refusal or non-response rates are mentioned in only a few of the
studies. Refusal rates in the range of 30-40 per cent are common and it
is unusual for a study to report the implications of non-response on
results. Exceptions include the Baltimore Study on Chronic Illness
(1957) and Bradburn’s study of psychological well being (1969). In
studies using symptom checklist scales, little information is given about administration and studies relying on clinical evaluation typically leave out information concerning validity. In several studies, vague symptoms of distress are presented as separate items without reference to how they are put together and what dimension of pathology is being measured. Knupfer et al., (1962) present data, for example, on twenty-five symptom items with no information on their scalability, reliability or validity. Other studies of this type include Bellin and Hardt (1958), Hogarty and Katz (1971), and Siassi et al., (1974).

Statistical Analysis Problems

Many studies reported in my review analyze one variable at a time. Rarely are gender differences examined for interactions with other variables or tested in a multivariate format. Authors such as Phillips (1966), Dohrenwend (1973), and Engelsmann et al., (1972) analyze the relationship between gender and mental illness without further specifying the relationship with other demographic information. Goldman and Ravid (1980) in their review of community studies point out that many do not test for statistical significance. Even when statistical significance is reported, many studies fail to consider the substantive significance of their findings. For example, Hogarty and Katz (1972) and Bradburn (1969) report very small gender differences on their impairment measures, but because of large sample sizes find statistical significance.

Lastly, rarely do community studies examine within group differences for men and women on measures of mental illness.
Exceptions include Radloff (1975) and Pearlin (1975) who examine gender differences across a number of important variables, and Meile et al., (1976) who examine marital role and education differences within groups of women.

**Conceptual Problems**

In many of the studies in my review there does not seem to be an overriding concern with designing or ordering analyses according to any theoretical perspective. Rarely are studies explicitly designed to test competing explanations. This is especially obvious concerning the issue of social selection versus social causation. One cannot determine from existing epidemiological evidence whether mentally ill individuals are selected in and out of different marital statuses because of pre-existing psychiatric conditions or become impaired because of the life style associated with different marital statuses.

There is also little attention paid to the problem of the measurement of mental illness. The exact relationship of measures of "unhappiness", "tension", "nervousness", and "lack of well being" to mental illness is rarely examined. A notable exception is Veroff et al., (1981) who devote a lengthy discussion to the meaning of the symptoms they utilize in their study. Recently, Dohrenwend et al., (1980a; 1980b) has contended that most symptom checklist screening scales used in community studies measure a dimension of psychological distress with little relationship to clinical psychiatric disorder. These authors contend that what is being measured is a subclinical dimension similar to Jerome Frank's construct of demoralization.
Conclusion

My review of community studies of gender differences in mental illness both supports and fails to support the results of earlier reviews by Gove and Tudor (1973), Weissman and Klerman (1977), and Goldman and Ravid (1980). All previous reviews agree that rates of mental illness are higher for women. However, Goldman and Ravid (1980) and my review support the contention of Dohrenwend and Dohrenwend (1976) that sex differences depend upon the type of disorder under investigation. Since there are very few U.S. community studies of psychoses and personality disorders, men are underrepresented in estimates of the true overall rate of mental illness. In fact, a major conclusion of my review is that mental illness is not "one thing". At this time, one can only conclude that women report more of the symptoms that have been the focus of mental health investigations since the early 1950's.

Two additional conclusions from my review bear on the issue whether there has been a disturbing decline in female mental health since around 1950. First, in over eighty per cent of the studies reviewed here, the measure of mental illness was based on responses to items in symptom checklist scales. These scales have shown little relationship to clinical psychiatric conceptions of mental illness. They are held to measure very mild forms of psychological distress with no known relationship to recognized psychiatric disorder (Dohrenwend et al., 1980). In a review of several studies that used both screening scales and clinical judgements to identify psychiatric cases in the same samples of respondents from the general population, there is clearly an imperfect relationship between the two procedures. Link and
Dohrenwend (1980) report in this review that in these studies the proportion of cases identified by both procedures is less than half of all cases identified by one or both. Relatedly, many of the studies examined in my review do not use symptom checklist scales, but rather, singular or small sets of items whose relationship to mental illness is not known. Women consistently report more symptoms of "unhappiness", "tension", "nervousness", and "lack of well being", but how these states relate to clinical psychiatric disorder is rarely examined. In spite of this evidence, the belief in greater overall rates of mental disorder among women contributes unnecessarily to stereotyped images of women as "helpless, dependent, unreasonable, or crazy" (Chesler, 1972: 35).

A second additional conclusion of my review of epidemiological studies is the absence of evidence for a sex-marital status interaction effect in accounting for variations in rates of psychological distress among men and women. Proponents of a "true prevalence" approach to mental disorder argue there has been a real decline in the mental health of women since World War II. The decline is seen as due to the role stress of women trying to meet the conflicting demands of family and non-family roles. Compared to married men, married women are especially vulnerable to role conflict and subsequent distress while never married women compared to never married men are predicted to fare quite well. In my review of fifteen studies of mental health that break down their data by sex and marital status the predicted pattern of results of the true prevalence perspective is not supported. Sex differences in mental health indicators is not greatly affected by marital status. On most indicators of psychological distress, women
report higher numbers of symptoms regardless of marital status.

The purpose of this chapter was to examine two central contentions about the relationship of gender and mental illness. The first contention states that women have higher overall rates of mental illness than men. The second states that married women contribute most to the female overrepresentation in mental illness.

A historical review of changing conceptions of mental illness and of thirty-six epidemiological studies conducted in the United States and Canada since 1955 find little support for either of these tenets. The next chapter will review data from United States' and Canadian mental illness treatment facilities in an attempt to find support for these two beliefs about the relationship of gender and mental illness.
CHAPTER III

GENDER DIFFERENCES IN THE USE OF MENTAL HEALTH FACILITIES

The previous chapter analyzed the results of community studies to estimate which sex is more in need of treatment, not the extent of treatment. Data on the utilization rates of various mental health facilities can tell us which demographic groups are more likely to be involved with mental health treatment. While the use of mental health services in general is not a definitive indication of mental illness, rates of use of mental hospitals for severe disorders are a fairly accurate barometer of the extent of serious mental health problems in the population. At the very least, rates of use of mental health facilities in general can serve as a sign that certain groups are more or less "at risk".

This chapter will examine gender and marital status differences in the use of a variety of mental health treatment facilities throughout the United States and Canada during the 1970's. It will also explore gender differences in the use of informal help sources including family, friends, and co-workers for problems of emotional and psychological distress.

The Importance of Specifying Type of Treatment

In Chapter II one of the most important findings was the fact that discussions of gender differences in mental illness should specify the
type of disorder under discussion. Men seem to be more vulnerable to certain types of disorder, and women other types. The same seems to be true concerning the use of mental health facilities. However, the literature often reports generalizations and unsupported assertions concerning gender differences in utilization. For example, quite recently, Russo and Sobel (1981) report:

One of the most striking characteristics of women's utilization of mental health services is their overrepresentation in most mental health facilities (p.7)

As will be reported below, such a conclusion is not warranted by existing data notwithstanding the claims of a number of reports. Several writers conclude from their examination of treatment statistics that women are more likely than men to be mentally hospitalized. One of the most extensive reviews of empirical evidence and theoretical work on gender and the use of mental health facilities, the REPORT OF THE SPECIAL POPULATIONS SUBPANEL ON MENTAL HEALTH OF WOMEN OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH (1978) declared that:

It is tempting to conclude that in a man's world, women's place is in our mental institutions (p.1038).

This conclusion is shared by writers of articles and recent texts on Social Problems and the Sociology of Mental Health and Illness. For example:

Women, more than men, are subjected to psychotherapeutic treatment. Females are incarcerated in mental institutions for 'disturbed' behavior more often than males (Text on deviant behavior, Balkan et al., (1980): p.303-304.
Age standardized first admissions (to State, County, and Private Hospitals) are consistently higher for women than for men (Article on Sex Roles and Mental Illness, Tudor and Gove, 1977).

Analyses of hospitalization records support the 'greater illness among females' hypothesis; for example, in the United States 125,351 more females than males were hospitalized in the period from 1964 to 1968 alone (Text on Sociology of Mental Illness, Gallagher, 1980, p.196).

Women are also more likely to be admitted to mental hospitals......(Social Problems text, Robertson, 1980, p.357).

Overall, according to Phyllis Chesler, there is a higher rate of admission to mental hospitals for women than men (Social Problems text, Smith and Fontana, 1981, p.129).

The belief that women outnumber men in mental institutions is widely shared and accepted. However, the data on this issue does not support this claim.

State and County Mental Hospital Admission Data

Two beliefs seem prominent in the literature on mental hospitalization. The first is that women are mentally hospitalized to a greater extent than men and the second is that the number of females in mental institutions has been rising since the early 1960's. Neither belief is supported by official treatment data in the United States or Canada. Belle (1981) reports age-adjusted rates of admission per 100,000 to State and County mental hospitals from the National Institute of Mental Health, for 1972. She reports a rate of 253.4 per 100,000 for men and a rate of 143.3 per 100,000 for women, a male rate 70% higher. Broken down by both race and gender, the age-adjusted rate is 228.5 for white males, 425.2 for non-white males, 136.5 for white
females, and 190.1 for non-white females.

National Institute of Mental Health data on first admissions to State and County Mental Hospitals for three years later, 1975, compiled by Rosenstein and Milazzo-Sayre (1981) show females accounting for only 35% of all first admissions to State and County mental hospitals. This is corroborated by data presented in the Alcohol, Drug Abuse, and Mental Health National Data Book (1980). Using 1975 data, males are found to constitute 65% of all first admissions to State and County mental hospitals. This same pattern emerges in Canadian mental health data. In a 1975 review of STATISTICS CANADA, Smith reports that first admissions to public mental hospitals in 1970 in Canadian provinces find women to constitute 39% of all admissions during that year.

Not only do men represent the vast majority of patients in State and County mental hospitals, their numbers relative to women have been increasing since the mid-1960's. Over the decade 1965-1975, the proportion of male first admissions to State and County mental hospitals has risen from 57% to 67% (National Data Book, 1980).

As mentioned in Chapter II, a prevailing belief associated with greater female mental illness is that the female excess is due to a large differential between married men and married women. Data in Table 3.1 on gender and marital status differences on rates of first admissions to State and County mental hospitals does not support this idea.

Mental Hospitalization and Marital Status

Men, in every marital status, have higher rates of admission to State and County mental hospitals. Admission rates are substantially
higher for both men and women with disrupted marriages as well as among
the never married than they are for married persons. It is worth noting
that of all gender-marital status groups, married women report the
lowest rate, a rate twenty-one times lower than the rate for
separated/divorced males. The largest within marital status gender
difference occurs among the divorced/separated with men being about
three times as likely as women to be institutionalized.

State and County Mental Hospitals: a Summary

Despite the overall decline in the number of State and County
mental hospitals since 1950, they still account for more than 50% of
all psychiatric beds in the country, at least since 1974 (Belle, 1974).
Throughout the 1960's and 1970's, the overrepresentation of males in
these facilities has been increasing. As mentioned, during this period,
males first admissions have risen from 57% to 67% of the total. The same
is true as regards residence statistics. In 1968, for example, the
proportion of year-end residents in State and County mental hospitals
was split evenly between men and women. However, in 1975, there were
117 males for every 100 females (NIMH, 1978). The State and County
mental hospital is the facility that deals with the most severe mental
disorders. Commitment is often involuntary and the median length of
stay in such facilities is longer than any other, 25.5 days (Rosenstein

Research on the utilization of State and County mental hospitals
indicates it is the socially powerless who are overrepresented in such
facilities. Persons from lower socioeconomic groups are more likely to
be referred for hospitalization (Hollingshead and Redlich, 1958; Shader
et al., 1969). Gibbs (1962) presents data that finds persons from the lowest income groups and non-whites are at the highest risk of institutionalization. Age-adjusted admission rates at State and County mental hospitals in 1975 reveal that whites had a rate of 159.7 per 100,000 compared to a non-white rate of 340.4, a rate twice as great (Russo and Sobel, 1981). Affiliated individuals seem less likely to enter the ranks of the hospitalized. Separated and divorced persons show the highest rates of mental hospitalization, and married persons, the lowest. In fact, analyses of the ratio of involuntary to voluntary admissions show that the married are less likely to be involuntarily committed than are people in other marital categories (Rushing and Esco, 1977).

In light of the relationship between power and mental hospitalization, it would be expected that women have higher rates of mental hospitalization than men. However, data presented in this section offer clear support for the greater vulnerability of men to mental hospitalization.

**General Hospital Inpatient Psychiatric Units and Private Hospitals**

It is possible that women are overrepresented in these types of inpatient facilities. Women might appear in large numbers in private and public general hospital psychiatric units, while men predominate in State and County mental hospitals. Inpatient psychiatric units are found within both public and private general hospitals and in Veteran's Administration hospitals. According to Belle (1981), these types of units have grown rapidly since World War II because of Medicare, Medicaid, and the increased coverage of mental illness costs by health
### Table 3.1. Admission Rates Per 100,000 Population to State and County Psychiatric Hospitals in the United States by Sex and Marital Status, 1975

<table>
<thead>
<tr>
<th></th>
<th>Never Married</th>
<th>Married</th>
<th>Separated/Divorced</th>
<th>Widowed</th>
<th>Total</th>
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<tr>
<td>Males</td>
<td>501.1</td>
<td>122.1</td>
<td>1712.4</td>
<td>335.6</td>
<td>318.5</td>
</tr>
<tr>
<td>Females</td>
<td>216.3</td>
<td>81.7</td>
<td>595.1</td>
<td>152.6</td>
<td>159.7</td>
</tr>
</tbody>
</table>


### Table 3.2. Discharge Rates from General Hospital Inpatient Units and Veteran's Administration Hospitals, by Sex, 1975

<table>
<thead>
<tr>
<th></th>
<th>Public and Non-Public General Hospitals</th>
<th>V.A. Hospitals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate per 100,000</td>
<td>Number</td>
</tr>
<tr>
<td>Males</td>
<td>211,569</td>
<td>207.1</td>
<td>215,640</td>
</tr>
<tr>
<td>Females</td>
<td>303,968</td>
<td>278.1</td>
<td>3,121</td>
</tr>
</tbody>
</table>

insurance. Also, the passage of the Federal Community Mental Health Centers Construction Act in 1963 spurred the creation of general hospital inpatient units to service the inpatient needs of community mental health centers.

In terms of gender differences in the use of general hospital inpatient units, age-adjusted rates of discharge per 100,000 show a male rate of 320.1 compared to a female rate of 261.8 at general hospital inpatient units for 1970-1971 (Belle, 1971). By race, white males had a rate of 297.0; non-white males 481.8; white females, 265.5; and non-white females a rate of 236.2.

General hospital inpatient statistics are usually comprised of data from both public and non-public general hospitals as well as from Veteran's Administration general hospital inpatient units. Some authors choose not to include VA data in overall statistical summaries of gender and inpatient use because VA facilities serve men almost exclusively. This is a tenuous argument since if these men were not treated at VA hospitals, they would be treated elsewhere. VA clientele comprise a sizable number of severely disturbed mental hospital patients and should not be excluded from calculations because of administrative decisions.

Table 3.2 shows male and female discharge rates per 100,000 as well as the actual number of inpatients for both general hospital and VA inpatient facilities. Here again, men outnumber women by a sizable margin as inpatients at general hospital inpatient units.

By marital status, discharge data from 1970-1971 for general hospital inpatient units (Bachrach, 1973) show a different picture than data on state and county mental hospitals. Table 3.3 shows that married
Table 3.3.—Admission Rates per 100,000 Population to General Hospital Inpatient Units in the United States by Sex and Marital Status, 1970-1971

<table>
<thead>
<tr>
<th></th>
<th>Never Married</th>
<th>Married</th>
<th>Separated/ Divorced</th>
<th>Widowed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>927.4</td>
<td>271.8</td>
<td>1904.9</td>
<td>416.1</td>
<td>422.5</td>
</tr>
<tr>
<td>Females</td>
<td>524.6</td>
<td>300.8</td>
<td>907.6</td>
<td>543.1</td>
<td>357.7</td>
</tr>
</tbody>
</table>


Table 3.4.—Admission Rates per 100,000 Population to Private Mental Hospitals in the United States by Sex and Marital Status, 1975

<table>
<thead>
<tr>
<th></th>
<th>Never Married</th>
<th>Married</th>
<th>Separated/ Divorced</th>
<th>Widowed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>93.9</td>
<td>50.2</td>
<td>186.8</td>
<td>99.0</td>
<td>71.1</td>
</tr>
<tr>
<td>Females</td>
<td>93.7</td>
<td>79.6</td>
<td>139.3</td>
<td>76.7</td>
<td>87.0</td>
</tr>
</tbody>
</table>

and widowed females have higher rates of use than males in these positions, whereas never married and divorced/separated men have higher utilization rates than comparable women. Overall, the married have the lowest rates of involvement with these facilities of any marital status.

**Private Mental Hospital Data**

Private mental hospitals, either profit or non-profit, provide inpatient services to a much smaller segment of the population than the other facilities discussed thus far. According to Belle (1981), in 1970 there were 149 private mental hospitals reporting data to the National Institute of Mental Health. Women are overrepresented at this type of facility. Age-adjusted rates of admission per 100,000 show a female rate of 47.1 to a male rate of 34.6. By race, non-white men and women have similar rates; 14.1 for males and 16.1 for females. Among whites, males have a rate of 39.1 and females a rate of 53.5. Table 3.4 presents admission rates per 100,000 to private mental hospitals for 1975 by sex and marital status.

**Summary of Gender Differences in the Use of Inpatient Facilities**

There are several ways to conceptualize treatment data. The above statistics are primarily based on first admissions data which have been age-adjusted per 100,000 population. Several sources of information present their data in raw form. For example, the National Data Book on Alcohol, Drug Abuse, and Mental Health (1980) present data unadjusted for age typically in percentage form. Such data presents a somewhat different picture of sex differences in inpatient facilities.

In Table 3.5, the percentage of males and females who were
Table 3.5.—Percentage of Males Receiving Treatment in Selected U. S. Inpatient Mental Health Facilities, 1975 (Part A) and Canadian Inpatient Facilities, 1970 (Part B)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number All Patients</th>
<th>Percent Male</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A United States Inpatient Facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State and County Mental Hospitals (^b)</td>
<td>376,733</td>
<td>65</td>
</tr>
<tr>
<td>General Hospital Psychiatric Inpatient Units (Public and Non-Public) (^c)</td>
<td>509,392</td>
<td>41</td>
</tr>
<tr>
<td>Private Mental Hospitals (^b)</td>
<td>126,944</td>
<td>43</td>
</tr>
<tr>
<td>Veteran's Administration Inpatient Facilities (^c)</td>
<td>218,761</td>
<td>99</td>
</tr>
<tr>
<td>Total U.S. Inpatient</td>
<td>1,231,830</td>
<td>59</td>
</tr>
<tr>
<td><strong>Part B Canadian Inpatient Facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Mental Hospitals</td>
<td>11,831</td>
<td>61</td>
</tr>
<tr>
<td>Public Psychiatric Units</td>
<td>19,769</td>
<td>40</td>
</tr>
<tr>
<td>Psychiatric Hospitals</td>
<td>5,237</td>
<td>53</td>
</tr>
<tr>
<td>Federal Psychiatric Hospitals</td>
<td>728</td>
<td>99.7</td>
</tr>
<tr>
<td>Hospitals for Addicts</td>
<td>4,010</td>
<td>79</td>
</tr>
<tr>
<td>Total Canadian Inpatient</td>
<td>41,569</td>
<td>52</td>
</tr>
</tbody>
</table>

\(^a\) Includes persons age 14 and older  
\(^b\) Refers to first admission data  
\(^c\) Refers to discharge data  
\(^d\) Includes persons 15-59

inpatients in 1975 in U.S. and Canadian inpatient facilities in 1970 is presented. Overall, the U.S. data indicate that 59% of those in inpatient facilities are male, a male-female ratio of 1.43. The corresponding percentage of males in Canadian inpatient facilities is 52%.

Taking all inpatients into consideration in the United States in 1975, the male-female ratio looks a little different when presented in age-adjusted rates per 100,000. Table 3.6 presents the age-adjusted rates for men and women at the four inpatient facilities under examination. First admission and discharge data indicate that males had a rate of inpatient use of 715.4 per 100,000, and females a rate of 473.5 per 100,000; a male-female ratio of 1.51. Whatever the measurement procedure, data from Canadian provinces and from the United States indicates that males are overrepresented in inpatient mental health facilities.

In addition to gender differences in the utilization of inpatient facilities, there are substantial marital status differences as well. Table 3.7 presents an overall breakdown of marital status differences in rates of use of inpatient facilities. It can readily be seen that the married enjoy a high protective effect relative to men and women in other marital statuses. Those whose marriages have been disrupted through divorce or separation seem especially vulnerable to hospitalization. In fact, they are over five times more likely to be hospitalized than are the married.

In terms of a sex-marital status interaction, married men and married women have roughly equal rates of mental hospitalization across all facilities. Men, in other marital statuses predominate in inpatient
Table 3.6.—Male-Female Rates Per 100,000 of First Admissions and Discharge Data From Four Inpatient Facilities, 1975

<table>
<thead>
<tr>
<th>Facility</th>
<th>Males</th>
<th>Rates</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>State and County Mental Hospitals(^a)</td>
<td>242.7</td>
<td></td>
<td>124.7</td>
</tr>
<tr>
<td>General Hospital Inpatient Units(^b)</td>
<td>207.1</td>
<td></td>
<td>278.1</td>
</tr>
<tr>
<td>Private Mental Hospitals(^a)</td>
<td>54.5</td>
<td></td>
<td>67.8</td>
</tr>
<tr>
<td>Veteran's Administration Facilities(^b)</td>
<td>211.1</td>
<td></td>
<td>2.9</td>
</tr>
<tr>
<td>Total Inpatient</td>
<td>715.4</td>
<td></td>
<td>473.5</td>
</tr>
</tbody>
</table>

\(^a\) First admission data, 1975  
\(^b\) Discharge data, 1975

SOURCE: From Tables 1a, 1b, 1c, and 1d in M.J. Rosenstein and L.J. Milazzo-Sayre, 1975

Table 3.7.—Rates of Use (14 and Older) Per 100,000 Population by Marital Status and Sex for Inpatient Mental Health Facilities, 1975

<table>
<thead>
<tr>
<th>Marital(^a) Status</th>
<th>Rate per 100,000</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated/Divorced</td>
<td>2134</td>
<td>3618</td>
<td>1700</td>
</tr>
<tr>
<td>Never Married</td>
<td>847</td>
<td>1279</td>
<td>693</td>
</tr>
<tr>
<td>Widowed</td>
<td>533</td>
<td>1024</td>
<td>502</td>
</tr>
<tr>
<td>Married</td>
<td>396</td>
<td>444</td>
<td>462</td>
</tr>
</tbody>
</table>

\(^a\) Excludes Veteran's Administration data

SOURCE: From Chart 1 and Tables 1a, 1b, 1c, and 1d in M.J. Rosenstein and L.J. Milazzo-Sayre, 1975
facilities. Never married, widowed, divorced/separated men are roughly twice as likely than their female counterparts to be patients in overnight facilities.

The Belief in Higher Female Inpatient Treatment Rates

In light of the amount of data to the contrary, why does the belief persist that women are mentally hospitalized to a greater extent than men? The reasons seem to be both methodological and ideological. Two works that are frequently cited as evidence for the overrepresentation of women in mental institutions are WOMEN AND MADNESS, a 1972 book by Phyllis Chesler and ADULT SEX ROLES AND MENTAL ILLNESS, a 1973 article by Gove and Tudor. According to Chesler (1972) the official statistics on mental illness in the United States show:

......a consistently large female involvement with psychiatry in America, an involvement that has been increasing rather dramatically since 1964. In 1964, there were 1079 more women than men in psychiatric facilities. By 1968, 50,363 more women than men were psychiatrically hospitalized and publicly treated. In 1968, women of all ages comprised 50 per cent of the population in state and county mental hospitals. From 1964 through 1968, 125,351 more women than men were patients in all psychiatric institutions. Between 1950 and 1968, 228,268 more women than men....were confined in state and county mental hospitals (p.119-120).

There are three problems with this analysis that contribute to confusing the issue of gender and mental hospitalization. First, Chesler lumps together all forms of psychiatric intervention into contact with "psychiatric institutions". It is conceptually difficult to equate two visits to a therapist with being institutionalized for nine months with a diagnosis of schizophrenia in a state mental
Secondly, Chesler's data is calculated by percentages and not by age-adjusted rates per 100,000. Women over the age of 65 constitute a large portion of women who are institutionalized in state and county hospitals. Because women live longer than men, there are more women 65 and over, and more women in treatment facilities of all kinds in this age group. Table 2.8 shows that what Chesler may actually be measuring is that men who survive to old age tend to be healthier, both mentally and physically. For example, Chesler (1972) presents NIMH data showing 36 per cent of all female admissions to state and county mental hospitals in 1968 were 65 years of age or older. The comparable figure for men is 24 per cent.

A third problem with Chesler's presentation is that she uses residency rates and not first admission data. Residency rates are appropriate for determining the number of people "in treatment" at any time a hospital census is taken. These statistics can count people more than once and include people readmitted to the hospital a second, third, or fourth time, and become confounded with length of time in the hospital. For many purposes this is an important statistic. But if the intent is to demonstrate that a greater overall number of women are admitted to mental hospitals, it is important to use first admissions data.

The work of Gove and Tudor (1973) is the other oft-cited reference to demonstrate that women are more mentally ill than men. These authors present data that show women overrepresented in all psychiatric facilities and higher in rates of undiagnosed mental illness. As others have argued before (Smith, 1975; Dohrenwend and
Dohrenwend, 1976), it is important to recognize how Gove and Tudor (1973) define mental illness. To them it is:

......a disorder which involves personal discomfort (as indicated by distress, anxiety, etc.) and or mental disorganization (as indicated by confusion, thought blockage, motor retardation, and, in the more extreme cases, by hallucinations and delusions) that is not caused by an organic or toxic condition (p.50).

As reviewed in Chapter II, these are the types of symptoms women experience to a greater extent than men (psychophysiological, neurotic, depressive symptoms), or to the same extent as men (schizophrenia, functional psychoses). Gove and Tudor's (1973) definition of mental illness excludes all types of disorders in which men predominate. By excluding alcohol and drug disorders, personality disorders and other anti-social behaviors, it is easy to conclude that women are more mentally ill than men. Cooperstock and Parnell (1976) comment on the tactic of exclusion by definition utilized by Gove and Tudor:

A crude analogy might occur if one were to undertake a study of genito-urinary diseases as defined by the International Classification of Disease and omitted the diseases of the male genital organs (presumably because the symptoms are different) thus assuring the reader that these diseases are all women's diseases (p.1456).

The number of males suffering from alcohol and drug disorders is significant. Likewise, symptoms involving anti-social or personality disorders account for a sizable portion of male involvement with inpatient facilities. According to STATISTICS CANADA (1970:15):

Mental disorders such as alcoholism, alcohol psychoses, personality disorders, sexual deviantness, and drug dependence continued to be predominantly male disorders, while neuroses and
affective psychoses continued to be primarily female disorders.

Data from STATISTICS CANADA (1970) indicate that alcohol related disorders, drug dependence, personality disorders, and sexual deviation account for 46.5% of all male first admissions to all Canadian mental health institutions in 1970. These same disorders constituted 15.9% of all female disorders that resulted in hospitalization. The same pattern is evident in National Institute of Mental Health data. The most frequently diagnosed condition among male admissions to State and County mental hospitals are alcohol disorders accounting for 35.4% of all male admissions. Alcohol disorders account for 13.7% of all female admissions to these facilities (Russo and Sobel, 1980: 19). The percentage of alcohol related male mental disorders is more pronounced for specific age groups. The ALCOHOL, DRUG ABUSE AND MENTAL HEALTH NATIONAL DATA BOOK (1980) reports that 60% of male admissions to State and County mental hospitals between the ages 35-64 had alcohol disorder as a primary diagnosis.

This sex-linked pattern of diagnosis is also apparent in data from outpatient services. Belle and Goldman (1980) using 1971-1972 NIMH data report that age-specific rates for drug and alcohol disorders are considerably higher for males and females:

Sex differences (for alcohol and drug disorders) are particularly apparent at outpatient psychiatric services, where male utilization rates were approximately three times that of female utilization rates in the age group 18-24 for drug dependence and in the age group 25-44 for alcohol disorders (p.25-26).

National Institute of Mental Health data from 1975 shows that among
additions to Federally funded Community Mental Health Centers the leading diagnosis for men is alcohol disorders accounting for 15.9% of all diagnosis. Additions to outpatient facilities for 1975 show personality disorders to be the third leading clinical diagnosis among men at these services. These diagnoses are rare for women at both types of facilities (Russo and Sobel, 1981:10-11). Mazur (1974) kept a psychiatric register of the entire population of an American Island Community between January, 1964 and December, 1968 (N=5959). He reports that life predicaments that are anti-social in nature (alcohol abuse, violence. involvement with police) are overwhelmingly the province of males. The male rate of anti-social behavior being three times higher than that for females.

The omission of these types of disorders as part of the conception and measurement of mental illness automatically leads to the conclusion that women are sicker than men. Smith (1975) highlights this omission in her examination of Canadian statistics on mental illness in light of what Gove and Tudor (1973) count and do not count as a psychiatric case. According to Smith (1975), the definition used by Gove and Tudor when applied to Canadian statistics on mental illness suggests:

......that Gove and Tudor have selected a definition which eliminates all the diagnostic categories in which men predominate over women, with the exception of schizophrenia where the difference is not great.... If we accept the Gove and Tudor definition, women in Canada do have a markedly larger share of the total who are admitted to psychiatric facilities as mentally ill. There are 60% women in this category and only 40% men—a 20 percentage points difference. But when we include those that Gove and Tudor exclude, this difference disappears. In fact women with 48% have a slightly lower share of that total than men, with 52% (p.85).
Gender Differences and the Utilization of Outpatient Facilities

On the basis of inpatient statistics it seems that women are less likely than men to receive treatment in inpatient facilities. In fact, data from both inpatient and outpatient facilities indicates men have higher overall rates of treatment than women. Data from both inpatient and outpatient facilities from the National Institute of Mental Health (1975) indicate that 3.6 million persons in the United States were treated in state and county mental hospitals, general hospital, and Veteran's Administration inpatient psychiatric units, private mental hospitals, community mental health centers, and a variety of outpatient psychiatric services (Rosenstein and Milazzo-Sayre, 1981). Males accounted for 51% of all admissions, a sex ratio of 102 males per 100 females. The rate of admission for males was 1,768 per 100,000 compared to 1,618 per 100,000 females.

Men have not only a higher level of involvement with inpatient facilities, but a higher overall rate of treatment. Women have more contact with outpatient facilities. Russo and Sobel (1981) in their examination of 1975 NIMH statistics report that 55% of all patients served by outpatient facilities were female. However, if persons under 18 and over 65 are removed from analysis, 60% of white patients and 66% of non-white patients were female. When data is age-adjusted per 100,000, the same general pattern of sex differences in the use of these facilities remains. Belle (1981) using admission data from 1971 on community mental health centers reports a male rate of 1058.4 per 100,000 compared to a female rate of 1078.8 per 10,000. Male-female rates do vary by race. White females have a rate of 1049.9 and white males a rate of 1014.9. Non-white females have a rate of 1256.7 and
non-white males a rate of 1326.3. The same pattern is evident when examining admission data on outpatient psychiatric services. Again, Belle (1981) finds an overall female-male rate of 649.0 to 635.8. By race, white females have higher rates than white males, 434.8 to 417.6. Non-white males have a rate of 587.9 to a non-white female rate of 503.5.

**Sex-Marital Status Differences in the Use of Outpatient Psychiatric Services**

It was reported that men in all marital statuses except the married, have higher rates of mental hospitalization than women in comparable statuses. Married men and women have roughly equal rates of mental hospitalization. Data on the use of outpatient services presents a different picture of the sex-marital status composition of users. Table 3.8 presents the results of two studies of sex-marital status differentials in the use of outpatient psychiatric facilities. In both studies, never married males have higher rates than never married women. The situation is reversed for married, divorced, and separated women who report higher rates of utilization than men in these same marital statuses. The never married male rate of utilization is somewhat exaggerated for it includes persons aged 14-18. In 1975, males aged 14-18 had a rate of 673.5 at outpatient services compared to a female rate of 402.1 at these facilities. (Rosenstein and Milazzo-Sayre, 1981:23). These adolescents are usually taken to clinics by parents through the advise of school officials and other community agents. In discussions of sex-marital status differences in utilization behavior, they tend to distort overall rates.
Table 3.8.—Admission Rates (14 and Older) to Outpatient Psychiatric Services by Marital Status and Sex, United States, 1970, (Part A), and 1975, (Part B)

<table>
<thead>
<tr>
<th></th>
<th>Never Married</th>
<th>Married</th>
<th>Separated/ Divorced</th>
<th>Widowed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A a</strong></td>
<td>United States Outpatient Facilities (1970-71)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>995.4</td>
<td>285.8</td>
<td>1664.7</td>
<td>314.0</td>
<td>494.4</td>
</tr>
<tr>
<td>Females</td>
<td>953.3</td>
<td>354.8</td>
<td>1759.8</td>
<td>242.8</td>
<td>517.1</td>
</tr>
<tr>
<td><strong>Part B a</strong></td>
<td>United States Outpatient Facilities (1975)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>957.0</td>
<td>337.1</td>
<td>2451.0</td>
<td>320.2</td>
<td>624.7</td>
</tr>
<tr>
<td>Females</td>
<td>810.7</td>
<td>664.2</td>
<td>2998.2</td>
<td>435.9</td>
<td>834.7</td>
</tr>
</tbody>
</table>

* Excludes admissions to federally funded community mental health centers, Veteran's Administration psychiatric services, and private mental health practitioners.

The same distribution occurs in the use of community mental health centers (Zolik and Marches, 1968; Foss, 1973). Foss (1973) using data from four community mental health centers in the State of New Hampshire, finds a higher proportion of married women to married men, more separated women than separated men, and over two times the number of divorced women to divorced men utilizing these clinics during her study year. The situation is reversed for the never married, with over twice as many men than women utilizing these mental health facilities.

Married women and divorced/separated women report higher rates of utilization at outpatient facilities and community mental health centers than men in comparable statuses. But, again, there is little evidence that married women are more at risk to mental disorder than other women. Married women have a rate of use of outpatient services that is half the rate of never married women and one-quarter the rate of women whose marriages have been disrupted by divorce or separation.

Gender Differences in the Use of Other Professional Help-Sources

As is the case with outpatient psychiatric services, there are distinct gender differences in the use of help-sources such as private psychiatry, social service agencies, physicians, clergymen, and university related mental health services.

Private psychiatry throughout the last quarter century seems the special domain of younger women. Both Gurin et al., in 1960 and Veroff et al., (1980) in their follow up study of the original Gurin study find little overall difference between men and women in their use of private psychiatry except among the young where women outnumber men, especially among the never married. Ryan (1969) in a study of urban
psychiatry in Boston finds that between the years 1960-1962, women outnumbered men in treatment with private psychiatrists by a 2 to 1 margin. Schofield (1963) sent questionnaires to 140 psychiatrists belonging to the American Psychiatric Association. He reports that the average psychiatrist sees more female than male patients and expresses a preference for patients who are female, young, attractive, and possess no more than a B.A. degree. Bahn et al., (1965) in a survey of private psychiatrists in five regions of the country from 1963-1964 finds that women outnumbered men by three to two in private treatment. Gordon and Gordon (1958) find women outnumbering men in private treatment with psychiatry in their study of three U.S. counties. In Sweden, Hagnell (1966) in a ten-year study of the use of psychiatric services, finds the same pattern as reported in U.S. studies. Women consulted psychiatrists over twice as often as men and in all age groups. Women also see more psychiatrists outside of private practice. Kadushin (1969) in a study of psychiatric services in New York city reports that 54% of the patients in psychoanalytic oriented clinics are women; 57% of the patients in advanced psychotherapy clinics and personal psychology clinics are female; 59% of the patients in religious and psychiatry institutions are women, and 64% of the women at St. Francis clinic are women.

In addition to the overrepresentation of women in private psychiatry, women also outnumber men in social welfare agencies, family service agencies, and student mental health services. Horwitz (1977) in a study of 120 outpatients at a public community mental health center reports that women are almost twice as likely as men to consult marriage counselors, social service and family services before arriving
at the clinic. Kammeyer and Bolton (1968) report women more likely to be the users of a family service agency, while Linn (1967) finds women overrepresented in social service agency utilization. Scheff (1966) reports women students significantly more likely to use university psychiatric services, and Greenley and Mechanic (1976) in a study of over 1600 undergraduates at a large Midwestern University find women students the more likely users of a number of services including the university psychiatric clinic, the student counselling service, and other formal helping agencies. Veroff et al., (1981) in a nationally representative sample of over 2,200 adults finds that, overall, women are more frequent professional help-seekers than men. More women than men consult "mental health agencies, and other resources coded as other mental health sources...(p.159)". Lastly, Gourash (1978) in a review of a large number of studies on help-seeking at a variety of counselling centers reports that being female is one of the more consistent traits found among users of these services.

Formal psychiatric help sources are not the only services people approach for the resolution of emotional difficulties. In fact, according to the ALCOHOL, DRUG ABUSE AND MENTAL HEALTH NATIONAL DATA BOOK (1980), most help-seeking for emotional problems initiates with office based physicians. About half of all people seen by professionals on account of mental disorders are seen by physicians. Often, these people are referred to mental health services, but many times the physician is the sole professional help-source. Horwitz (1977) finds in a sample of community mental health center users, that the physician is often the first person seen for emotional difficulties. Several studies report quite large sex differences in contact with medical doctors for
problems of emotional distress. Atwell, Hotaling and Foss (1978) find women twice as likely as men to initiate help with medical personnel for emotional problems. Greenley and Mechanic (1976) find women undergraduates at a Midwestern university much more likely than men to have presented problems of psychological distress to general medical personnel. In a review article of U.S. and foreign studies of the use of general practitioners for problems of mental illness, Gove and Tudor (1973) report women more likely to seek such help in all twelve studies they reviewed. Their review finds that most people treated by general practitioners are suffering from a psychoneurotic disorder and that physicians play a major role channeling people into more specialized psychiatric care. The overrepresentation of women in these studies cannot be explained by assuming that women simply go to physicians more often than men. Shepherd et al., (1964) report that psychiatric distress ranked third among presenting problems to physicians by women and seventh among men. Gurin et al., (1960) and Veroff et al., (1981) both report that women are more likely than men to show up in physician offices with psychiatric complaints.

Many of these same studies concur in the finding that women are more likely than men to seek out the assistance of the clergy for emotional difficulties (Horwitz, 1977; Greenley and Mechanic, 1976; Atwell et al., 1978). Veroff et al., (1981) in the most recent study of formal help seeking processes finds women more likely than men to seek out the help of the clergy. These authors also report that the clergy was the most sought out help source among both men and women. Females are not only more likely to seek out the assistance of formal helpers but to also use family and friends to a great extent.
Throughout the 1970's there has been increasing interest in the role of informal help sources, or social networks in mental health problems. The importance of informal networks has been investigated for its role both in mitigating emotional distress and serving as a referral pool for those in need of help. In terms of the first issue, for example, Liem and Liem (1976), in a study of college students, report an inverse relationship between psychological distress and frequency of contact with informal network members. The same inverse relationship between distress and contact was reported in a study of residents of low income housing (Hessler et al., 1971).

The role of the informal network in the overall provision of help is not well understood. Research reviewed by Gourash (1978) on the characteristics that make informal networks effective in getting people into contact with more formal sources of help has yielded inconsistent results. Size and proximity (Kammeyer and Bolton, 1968; Baker, 1977; Horwitz, 1977), relative amounts of contact with friends as opposed to family (McKinlay, 1973; Horwitz, 1977), and number of reciprocal relationships (Zwerling et al., 1977; Tolstork, 1976) were found to predict both use and nonuse of formal sources of help. A few aspects of informal networks seem more certain. Once symptoms of emotional distress arise, the first step people take to resolve them is to discuss them with various members of their social network; spouses, kin, friends, and co-workers. They do so to seek explanations and remedies for the way they are feeling. The extent to which people involve members of their social network varies by sex. Studies to date have found women to be more likely to seek out the help of family and friends for emotional problems. Gurin et al., (1960) reports that women
are more likely than men to turn to family and friends in handling worry and anxiety. In the 1976 update of the Gurin study, Veroff et al., (1981) also find women more often turning to informal sources of help. 52 per cent of the women and 41 per cent of the men report turning to some informal help for handling worries. According to Veroff and his associates:

> Without seeking help from either loved ones or professionals, men either cope directly on their own, try to banish thoughts about their problems from their minds, or end up doing nothing (p.495).

Of those married men who turn to someone for help, over three-quarters turn to their spouses alone as a way of dealing with their worries. According to Veroff et al., (1981):

> In 1976.....72 per cent of married men who sought help said they spoke to their wives alone in handling their worries, while this was true for only 58 per cent of the married women who sought some support (p.415).

Women are more likely to turn to friends, extended family members and children for help with emotional difficulties, while men depend heavily on their wives in handling difficulties.

This same pattern of results emerges in other studies of the use of informal networks. Atwell et al., (1978) report women more likely to utilize the help of a number persons from kin and friendship groups for personal problems. Brown (1978) in an urban sample of 1106 adults found women more likely to utilize informal help and more likely to be users of both informal and formal assistance. Horwitz (1977) in a study of users of a community mental health clinic finds that, on the average,
men speak to only one member of their informal network about problems, women speak to about 4.5 people outside the family. According to Horwitz, the most striking sex difference is in the use of friends. Women speak to 82 per cent of their friends while men make contact with only about 2 per cent of their friends for information about coping with their difficulties.

The heavy reliance of married men on their wives for emotional support and help is also reported by Horwitz (1977):

While men do not reveal their problems to others, with the exception of spouses, women actually seek the aid of kin, friends, and workmates, as well as spouses, for help in resolving their problems. The only member of the informal network that men speak to in a majority of cases is their spouse. Women, on the other hand, speak to all types of network members, with the exception of extended kin, more than half the time, and place especially heavy reliance on parents, siblings, and friends (p. 172).

Conclusion

The vast majority of persons seeking help for emotional problems are doing so at outpatient services and/or with informal network members. Institutionalization for mental health problems has been declining for twenty years in favor of non-residential forms of treatment. In a discussion of sex differences and use of psychiatric facilities, it is very important to specify what type of treatment facility is under study. Facilities vary by the type and severity of mental health problems they encounter. Diagnoses also differ by facility according to the sex of the patient. For example, the two leading diagnoses for men at State and County mental hospitals are alcohol disorders and schizophrenia; for women at these facilities they are schizophrenia and depressive disorders (Rosenstin and
Milazzo-Sayre, 1981). In private mental hospitals, the primary diagnosis for both men and women is depressive disorders. At community mental health centers, males are most often diagnosed with the condition of alcohol disorders and childhood disorders. For women, depression is again the most common disorder followed closely by the classification, "no mental disorder", indicating that symptoms cannot be classified by existing nomenclature (Rosenstein and Milazzo-Sayre, 1981).

The most important reason for examining utilization rates for mental health facilities separately is that usage varies dramatically by gender and marital status. Men are much more likely than women to receive inpatient treatment for mental disorders. On the other hand, women predominate in the use of outpatient facilities and in the use of informal networks for problems of emotional distress. Marital status differences are also apparent at different types of facilities. The married of both sexes are least likely to find themselves institutionalized for mental illness. However, when outpatient facilities are the focus of attention, a marked reversal occurs among the married. Compared to married men, women are much more likely to utilize both formal and informal community services. As a general principle, women, especially married, separated and divorced women are more likely than men to maintain contact with the community in the face of problems of mental illness.

Overall, the review of epidemiological data in Chapter II and of mental health treatment data in this chapter lead to the same conclusion: it is the wrong question to ask "who is more mentally ill, men or women?" All data point to the conclusion that men and women
suffer from quite different kinds of "mental illness." Men are more likely to suffer from mental disorganization and disruptive acts that lead to treatment involving removal from the community: namely, in inpatient facilities. Women are more likely to suffer from symptoms of distress that reflect milder forms of psychiatric disorder. These symptoms of distress allow them to be treated in the community through a variety of outpatient facilities.

The findings reported in the last two chapters raise an important sociological question: why do we, as a society, cling to the belief that women pose a greater mental health problem than men? An attempt to examine this question is the central concern of Chapter IV.
CHAPTER IV

EXPANSION OF THE PSYCHIATRIC CASE: GENDER IMPLICATIONS

The first two chapters of this review find little evidence that women are more mentally ill than men. The most accurate observation that can be made about gender and mental illness is that since 1950, epidemiological research has been unable to produce an estimate of the overall vulnerability to mental illness of males and females. In terms of treatment statistics, men receive the most severe reaction to their mental illness by running a higher risk of mental hospitalization. On the other hand, women are overrepresented at all outpatient facilities for the treatment of emotional distress.

One fact concerning the nature of mental illness since World War II seems certain: the expansion in what is conceived of, and measured as, mental illness. Over the past forty years, three major factors have accounted for this expansion. First, the 1952 and 1968 Diagnostic and Statistical Manuels of the American Psychiatric Association represented a radical broadening of what counts as a psychiatric case. DSM III, the 1980 update of the manual includes considerably more categories of disorder than the previous two editions. Secondly, since around 1950, the items and indicators used in the community study of mental illness have actually measured a dimension of mental illness different from clinical psychiatric disorder (Dohrenwend et al., 1980; 1981). Lastly, the mental health movement itself, with its public education and public
relations focus, the corresponding broadening in the public's conception of mental illness, and the rapid expansion of agencies and facilities for treating the mentally ill, has been a post World War II phenomenon (Foss, 1979).

The Expansion of Female Mental Illness

The expansion in what is now considered mental illness has occurred precisely in those kinds of distress and disorders for which there has been a substantial increase in rates among women more than men. Likewise, the actual measurement of mental illness in community surveys and decisions made about the number and types of symptoms that are used to indicate impairment favors finding higher rates of disorder among women. In fact, the evidence for "greater female mental illness" comes largely from studies using symptom checklist scales. These scales are composed of items (ranging in number between sixteen and twenty-four) measuring physical and psychological symptoms of distress. The recommended cut-off point (established through a number of validation studies) between normalcy and impairment is usually 4+ symptoms. The section below will report evidence that taking a more restrictive position concerning the cut-off point results in much smaller differences between men and women in impairment.

The Cut-Off Point and Sex Differences in Psychological Distress

Epidemiological studies using symptom checklist scales typically find a greater number of women reporting four or more symptoms of distress. Since epidemiological researchers have varied the number of symptoms a person need report in order to be considered "impaired", it
is possible to examine how decisions concerning the cut-off point
effect male-female ratios of impairment.

Table 4.1 lists a number of epidemiological studies conducted in
the United States between 1960 and 1983. All these studies used symptom
checklist scales to examine gender differences in psychological
distress. They are different, however, in one important respect: they
set different criteria for a person to qualify as "impaired". While a
majority of studies use 4+ symptoms as a cut-off point for impairment,
others use 1+, 3+, 5+, 7+, and 10+ symptoms.

Table 4.1 presents female to male ratios of "impairment" listed in
order of increasing strictness of cut-off point. At the extreme of
liberalness, sex differences in impairment are largest. As the criteria
for "impairment" becomes stricter, the ratio of female to male cases
approaches unity. So, depending on the criteria for what constitutes a
psychiatric case, females are either two and one-half times more likely
or only just as likely to be counted among the ranks of the mentally
impaired.

Sex Differences in the Reporting of Serious Symptoms of Distress

It is possible females report more serious symptoms on checklist
scales. Persons reporting one or two symptoms of a serious nature could
be more impaired than a person reporting ten symptoms of mild distress.
One piece of research addresses this issue. Newmann (1982) in an area
sample of 1,026 adult community respondents does not find support for
the idea that women report more serious symptoms of mental distress
than men. Using the PERI (Psychiatric Evaluation Research Interview) to
measure depression, Newmann had a group of mental health professionals
Table 4.1 — Female-Male Ratio of Psychiatric Cases Using Symptom Checklist Scales With Different Cut-Off Points.

<table>
<thead>
<tr>
<th>Source of Study</th>
<th>Number of Symptoms Used as Cut-Off Point</th>
<th>Female-Male Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meile and Haese (1969)</td>
<td>1+</td>
<td>2.5</td>
</tr>
<tr>
<td>Public Health Service (1970)</td>
<td>3+</td>
<td>2.3</td>
</tr>
<tr>
<td>Haberman (1970) 2 samples:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 boroughs in NYC</td>
<td>4+</td>
<td>2.2</td>
</tr>
<tr>
<td>Washington Heights, NYC</td>
<td>4+</td>
<td>1.4</td>
</tr>
<tr>
<td>Markush and Favero (1974)</td>
<td>4+</td>
<td>2.3</td>
</tr>
<tr>
<td>2 samples:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington County, MD</td>
<td>4+</td>
<td>1.7</td>
</tr>
<tr>
<td>Kansas City, MO</td>
<td>4+</td>
<td></td>
</tr>
<tr>
<td>Phillips (1966)</td>
<td>4+</td>
<td>1.5</td>
</tr>
<tr>
<td>Phillips and Segal (1969)</td>
<td>4+</td>
<td>1.7</td>
</tr>
<tr>
<td>Gurin et al., (1960)</td>
<td>5+</td>
<td>1.7</td>
</tr>
<tr>
<td>Phillips (1966) b</td>
<td>7+</td>
<td>1.3</td>
</tr>
<tr>
<td>Srole et al., (1962)</td>
<td>10+</td>
<td>1.03</td>
</tr>
</tbody>
</table>

- Actual percentages for males and females scoring over designated cut-off point are: 1+: Meile and Haese, only F/M ratio given (1969: 239); 3+: Public Health Service (1970), 34.2% of females, 14.9% of males; 4+: Haberman (1970), NYC sample, 33.3% of females, 14.9% of males; Washington Heights sample, 25.3% of females, 18.2% of males; Markush and Favero (1974), Kansas City, MO sample, 15.0% of females, 9.0% of males; Washington Heights sample, 14.0% of females, 6.0% of males; Phillips (1966), 32.2% of females, 22.6% of males; Phillips and Segal (1969), 35.5% of females, 21.2% of males; 5+: Gurin et al., (1960), 40.1% of females, 22.6% of males; 7+: Phillips (1966), 9.9% of females, 7.4% of males; 10+: Srole et al., (1962), data by marital status. Among married, 19,800/100,000 among females, 19,300/100,000 among males. No sex differences in other marital statuses.

- Phillips (1966) study used both 4+ and 7+ symptoms as cut-off points in their sample.

- The mean Female/Male ratio in studies using 4+ symptoms as cut-off was 1.80.
evaluate each of the nineteen items in the depression scale in terms of its "indicativeness of poor mental health". The rating scale used by these clinicians ranged in score from 0 (not at all indicative of poor mental health) to 6 (highly indicative of poor mental health). Items such as "Have you ever thought about suicide?" received the highest scores and those dealing with sadness and mood variation such as "Have you felt like crying in the last week?" received the lowest scores.

On those symptoms which clinicians rated as "highly indicative of poor mental health", there were no significant sex differences in symptom reporting. The largest sex differences occurred among the relatively milder symptoms of distress, especially those items dealing with sadness. This research suggests that a substantial portion of the excess level of depression among women found in community samples is due to:

...relatively common, if not trivial, symptoms of distress tapping primarily mood variation rather than a more severe array of symptoms suggestive of a depressive syndrome (p. 16).

Why Do We Want to Believe That Women Are More Mentally Ill Than Men?

Given the lack of evidence for "greater female mental illness" why does this belief persist? Perhaps the most direct answer is that we cannot afford to promote the belief that men are more mentally ill than women. Societies that place a high value on the instrumental competence of males cannot afford to support a set of beliefs that could undermine confidence in male performance and jeopardize motivating males for the performance of important social tasks. A widespread belief in the vulnerability of men to mental illness would call into question their
capacity for labor, institutional dominance, and reliability as a fighting force for the nation's defense.

The belief that women are more mentally ill than men is similar to the belief that women rarely commit crime. Theories of criminal behavior typically ignore female involvement in crime (Balkan et al., 1980). Harris (1977) contends that this omission is due to the existence in the culture of "deviant type-scripts". These type-scripts are deeply held cultural assumptions which link types of actors to types of roles and serve dominant social interests. Type-scripts can be thought of as background norms that create strong expectations about who does what, including deviance, in a society (Harris, 1977:3). One function of type-scripts is the specification of what types of actors are to commit what types of deviance in a society, and what types of deviance are seen as unlikely or impossible for other types of actors to commit.

For example, according to Harris (1977), it is strongly type-scripted that street crimes represent the preserve of blacks and the poor. Similarly, because of the absence of type-scripts for high government crime, it was "impossible", until recently, for the highest officials in the land to act criminally. It is also "impossible" for women to attempt assassination, robbery, or rape. Such type-scripts or their absence are functional in that they represent part of a system of "stratification of behaviors and identities" which define appropriate and inappropriate deviance and serve to support the dominance of certain persons in society.

Male dominance in occupational, educational, political, and legal institutions is not served by allowing the development of type-scripts which lead to putting women in jail. Rather, the prime
structural mainstay of male institutional hegemony has been the continued assignment of females to the home and to the role of homemaker (Harris, 1977:13).

Female crime is inappropriate and its inappropriateness is socially useful. As Schur (1979) notes:

when students are asked to 'picture in your mind's eye a typical criminal', they almost always conjure up the image of a man,...part of what is operating here is the dominant tendency not to associate crime with women (p.103).

According to Harris (1977), the absence of type-scripts for female crime contribute to keeping women in the home, and out of prison. Women, in fact, make up only 4 percent of the nation's imprisoned adult population and many of these women lack family ties (Glick and Netto, 1977). According to Harris (1977), such a finding is consistent with the premise that the regular and routine assignment of women to prison would disrupt male advantage through the removal of women from the family. If women were assigned to prison in larger numbers Harris envisions: 1) the break-up of the nuclear family; or 2) the maintainence of the nuclear family only with grave financial burdens entailed in hiring a full time role replacement for the female; and/or 3) the partial or full-time withdrawal from the occupational sector of males so affected (p.13).

Leaving aside the exact nature of the functions of deviant type-scripts, there seems little doubt of the "existence and influence of typescripting as regards both crime and mental illness" (Schur, 1979:104). It seems we want to believe that women rarely commit crime, but we want to strongly believe that women are more mentally ill than men. Without specifying the exact functions of a "sicker woman"
ideology, the case can be made that there are a number of reasons for wanting to believe that women are more mentally ill than men. What is interesting about this belief is that it is shared by a number of interested parties who are typically antagonistic to one another. The fact that it is shared by a number of divergent parties accounts for both the widespread nature of the belief and its ability to withstand contradictory evidence.

There seem to be at least three uses for the continuing existence of type-scripts that promote the belief in the greater vulnerability of women to mental illness; especially of married women: 1) the belief in greater female mental illness is useful in discussions of female victimization and critiques of the oppressive nature of marriage and family; 2) the belief helps to avoid characterizing men as more mentally ill than women; and 3) the belief serves to justify women’s use of mental health outpatient services for "family problems".

Mental Illness as an Outcome Variable

The concern with the victimization of women in a variety of social contexts has led to the widespread use of the label of mental illness. Problems in living, whatever their degree of seriousness, have become increasingly subsumed as forms of mental disorder. There are a number of instances involving female victimization in which the likelihood of subsequent psychological difficulties is high. Wife abuse, sexual abuse and rape are types of severe stressors that could precipitate mild or severe forms of clinical psychiatric disorders. There is a lack of evidence, however, that these victims become psychiatrically disordered, and a paucity of evidence as to what type
of disorder is more likely to occur (exceptions include Walker's work on depression and battered wives (1983) and Shields and Hanneke's (1983) work on victims of marital rape).

The desire to bring to public awareness the victimization of women has led to the widespread use of the label of mental illness. This label has the advantage of making concrete the effects of victimization of women. It is a term whose value lies in moving victimization away from a purely moral concern to one with measurably damaging effects. For example, violence toward women can be opposed on moral grounds, or an argument against violence can be made by pinpointing the short and long-term physical and psychological injuries sustained because of such violence.

However, assumptions about the types of female victimization that result in mental illness have stretched even beyond the net of DSM III. In the Introduction to a recent volume entitled WOMEN AND MENTAL HEALTH (Howell and Bayes, 1981) the list of women who are "consumers of mental health services" is increased by definition:

The majority of clients for mental health services are women. Women comprise more than 50 percent of clients in general counseling and psychotherapy services and 100 percent of clients for abortion counseling, rape counseling, and programs for unwed mothers. Despite the preponderance of women as consumers of mental health services......"p.xi.

In this volume on mental health, the number of conditions in need of psychiatric treatment is sizable. These conditions include: being the victim of rape, sexual abuse, or violence, getting an abortion, divorce, separation, anorexia nervosa, bulimia, alcoholism, drug dependence, menarche, teenage pregnancy, postpartum experience,
parenting in dual career families, menopause, heading families, being a member of a lesbian family, widowhood, mastectomy, and orgasmic difficulties. These are all serious life problems, many of them traumatic in nature, and many that could precipitate psychological disturbances. But, in themselves, they do not constitute the basis for clinical psychiatric disorder. At least no evidence exists that would indicate how many victims of these problems suffer from clinical psychiatric disorder.

Women's roles may be more stressful than men's roles in modern societies. This point has been made previously by several authors (Bernard, 1972; Gove and Tudor, 1973). The necessary case that women's roles are indeed more stressful than men's roles and lead to mental illness is generally not made (Foss, 1975:1979). There are generally no direct comparisons of male-female exposure to stress and vulnerability to disorder. A strong case can be made that male roles are also highly stressful. Several studies have documented the economic burdens placed on men in American society (Scanzoni, 1970; Keniston, 1972; 1977); the personal alienation that results from the nature of work in American society (Bradburn, 1969; Anders, 1971); and the mental health problems that develop among males from unemployment (Brenner, 1975), and from alcohol and drug use (National Data Book, 1980).

It is unfortunate that at a time when female victimization in society is being recognized and organized against, that the label of mental illness must be used to justify the expenditure of funds and creation of programs for female victims. The mental illness label serves to reinforce the stereotype that women cannot deal with stress, are sicker, and more dependent than men.
The image of women as more vulnerable to stress and sickness is especially marked concerning married women. This group is consistently depicted as vulnerable to a great deal of stress and responsible for the overall female excess in mental disorders (Gove, 1972; Bernard, 1972). What is usually left out of these descriptions is the fact that married women as a group are highly protected against mental disorder. They are the group least likely of any group of men and women to experience hospitalization in a state or county mental hospital. They are the least likely of any group of females to be hospitalized in a private mental hospital or a general hospital inpatient unit. With the exception of the widowed, they are the least likely group of women to seek help at outpatient psychiatric facilities (see Chapter II for treatment statistics). Rates of various disorders are consistently lower for married women than divorced, separated, or widowed women (Gove, 1972). Average depression scores for married women are lower for married women than divorced, separated, widowed, or never married women (Radloff, 1975).

In many studies and discussions of sex differences in rates of mental illness there is a tendency to confuse who is being compared to whom. When rates of disorder of married women are compared to those of married men, it is clear that married women are not as protected by marriage as are males. However, compared to any other sex-marital status group, married women appear highly invulnerable to mental illness. This confusion of comparison groups is especially prominent in studies whose intent is a critique of marriage. For example, Bernard (1972) in her book THE FUTURE OF MARRIAGE argues that there are really two marriages in American society: one for men and one for women. She cites a number
of studies that show the sex differential between the married and concludes that marriage is bad for women. As Bernard puts it "Being a housewife makes women sick". The oppression and frustration of women in the home is real, but the evidence that marriage is bad for the mental health of women is non-existent.

The Avoidance of Characterizing Men as Mentally Ill

Male dominated societies cannot afford type-scripts that allow for the belief that men are more mentally ill than women. The preoccupation with denying that large numbers of men may be mentally ill occurred in this country's history at about the same time the belief was developing that women are more mentally ill than men. During the last years of World War II and into the late 1940's, the psychiatric community and others were seeking an explanation of the high rate of psychoneurosis found among men inducted into the Army. As discussed in Chapter I, during World War II, short psychological screening scales were used for the first time by American draft boards with frightening results. Almost two million men were rejected for military service because of psychoneurosis. Another 530,000 men were discharged because of mental disorders, and another one-half million men tried to evade the draft "...not hesitating to resort to any devise, however shameful, even to the wearing of female clothing" (Strecker, 1945:592).

The experience of a large scale crisis in American masculinity required an adequate explanation. Who or what was to blame? According to Ehrenreich and English (1979) "The spirit of the American male was being broken in babyhood" (p.235). The psychiatric community of the 1940's saw the primary reason for the debilitation of male mental
health as a problem in the socialization of male children. According to Edward Strecker (1945), the Consultant to the Surgeon's General of the Army and Navy and Chair of the Psychiatry department at the University of Pennsylvania, the high rejection rate of young men at induction centers during the war could be understood in this way:

In many it is merely necessary to retrace their lives for a few years beyond a decade of their current ages. Then, often one may uncover grave deficits in early childhood training to which the current neuropsychiatric disabilities are deducible (p. 595).

When it examined the socialization of boys in families, psychiatry saw mother as the central antagonist in the deterioration of the male spirit. Philip Wylie, a social commentator of the 1940's, was the first to popularize the idea that America was on the verge of a matriarchal nightmare. In his book, GENERATION OF VIPERS (1942), Wylie defines his task as unveiling mother's real nature: power hungry, dictatorial, and emasculating. American males, blinded by the romanticism surrounding motherhood, were being victimized by "mom".

"......megaloid momworship has got completely out of hand. Our land, subjectively mapped would have more silver cords and apron strings criss-crossing it than railroads and telephone wires. Mom is everywhere and everything and damned near everybody, and from her depends all the rest of the U.S. Disguised as good old mom, dear old mom, sweet old mom, your loving mom, and so on, she is the bride at every funeral and the corpse at every wedding (p.198)

In more clinical language, psychiatry also described "mom". Case histories of male neurotics by the thousands in the 1940's told the story of young men with cold mothers, dominating mothers, rejecting
mothers, or hyper-possessive, over-protective mothers. It seems these disparate types of mothers were reducible to a single prototype: the hostile women. Her hostility was directed at male family members and could take such opposing forms as rejection or overprotection. David Levy (1943), the first to clinically evaluate "mom" in his book MATERNAL OVERPROTECTION sees her as a product of a number of factors.

true maternal rejection occurs in naturally maternal women whose behavior as mothers has been intensified by the operation of certain psychic and cultural forces. By 'true' overprotection is meant exaggerated maternal love, that is, overprotection which is not determined primarily by neurosis (1943:148).

What were these cultural and psychic forces that led to problems of young draftees in the early 1940's? Among operative psychic forces were affect hunger and the experience of relative sterility, i.e., marital sexual incompatibility and penis envy. According to Levy, penis envy was a primary determining factor in explaining why male children were the ones primarily overprotected. In terms of cultural forces, the high degree of freedom accorded women in the child rearing enterprise was considered very harmful.

It was often difficult to know if you were overprotecting your child without the aid of clinical judgement. In the absence of clear-cut evidence of overprotection, it was best to assume you had the potential to be a "mom". Ehrenreich and English (1978) contend in their book FOR HER OWN GOOD: 150 YEARS OF EXPERT ADVICE TO WOMEN, overprotectiveness became an accusation that haunted mothers, especially those with an orientation to keeping up with the latest and best available child rearing advice.
Progressive-minded women, who tried to keep up with the latest scientific information, examined themselves anxiously for signs of this new danger. In her memoirs Margaret Mead describes her own docile reaction to Levy and his theories: '.....I had been a baby carriage peeker as Dr. Levy described the child with an absorbing interest in babies, and he identified this as one of the traits that predisposed one to become an over-protective mother. When I told, in a telephone conversation, that I was expecting a baby, he asked, in that marvelous therapeutic voice which he could project over the telephone 'Are you going to be an overprotective mother?' I answered. 'I'm going to try not to be...' Mead recalled, 'I knew that I would have to work hard not to overprotect my child' (1978:210-211).

Even for women who tried hard not to be overprotective, she was fighting a loosing battle against "momism". As Edward Strecker, the noted psychiatrist, reminds the woman who feels too overconfidant:

Actually, in every mother, no matter how mature she may be, there are traces of "mom" (1946:37).

This theme was reiterated in the 1947 best seller, MODERN WOMEN: THE LOST SEX by Maryina Farnham, a psychiatrist and Ferdinand Lundberg, a sociologist. Although American women were trying to avoid overprotection, she was still "afflicted very often with penis envy". As Ehrenreich and English (1978) put it "that unwomanly drive to power which, in the confines of the home, could only fester until it destroyed the people around her" (p.236).

The effects of "mom" were widespread as Friedan (1963) recalls about child-rearing literature of the 1940's and 1950's:

It was suddenly discovered that the mother could be blamed for about everything. In every case history of the troubled child; alcoholic, suicidal, schizophrenic, psychopathic, neurotic adult. impotent, homosexual, frigid, promiscuous, ulcerous. asthmatic. and otherwise disturbed American, could
be found a mother. A frustrated, repressed, disturbed, martyrred, never satisfied, unhappy woman. A demanding, nagging shrewish wife. A rejecting, overprotecting, dominating mother" (p.189).

It was especially in her role creating havoc with the American Armed Forces that "mom" received the most direct criticism. Edward Strecker, author of the bible of momism called THEIR MOTHER'S SONS (1946), first defines who "mom" is and then defines her role in the production of psychoneurotics:

'Mom', as I have used it, and will use it throughout this book, is merely a convenient verbal hook upon which to hang an indictment of the woman who has failed in the elementary mother function of weaning her offspring emotionally as well as physically (1946:13).

Given the opportunity of having known when he was eight to twelve years old, any one of the men who failed in his opportunity to serve in the armed forces because of psychoneurotic tendencies, and particularly of having known his mother, a competent psychiatrist could have forecast with reasonable accuracy the boy's future immaturity. In the vast majority of case histories, a 'mom' is at fault (p.23).

"Mom's" danger went beyond the destruction of her male offspring. Her actions threatened the integrity of our democratic way of life. Eugene Mayer, Chairman of the National Committee on Mental Hygiene in the 1940's praises the work of Strecker and other psychiatrists for:

...indicting the doting 'mom' for her sins of commission and omission against her children and therefore against our nation (1946:5)

Mayer chides Strecker for mincing his words in a 1945 lecture on "momism" at Bellvue Hospital in New York City.

Dr. Strecker called his lecture 'Psychiatry Speaks to Democracy'. His title understated his subject. He
could have called it 'Psychiatry Speaks to the Neurotic Moms of Psychoneurotics', for the darts of his comments were directed first at the apron-stringing 'moms' of our nation and indirectly at their effect upon our democracy (1946:5).

The psychoneurotic soldier was not the only casualty of "mom". She also played a large role in the life of the schizophrenic recruit.

In many schizophrenic patients a true bill of indictment can be drawn against mom--indictment for failure to prepare the child to meet even the minimal demands of adult life. Sometimes the immaturity is so great and complete that the only path open for the child is the retreat into the fantasy-of schizophrenia-to remain there forever enwombed (1946:111-112).

Schizophrenia is an unfailingly kind and loving mom (p.111)

There is little doubt that schizophrenia qualifies as a mom surrogate (p.112)

Additional alcoholism, homosexuality, draft evasion, and even industrial and social unrest were due to the conscious and unconscious needs of women.

.....mob candidates are likely to be men whose immaturity has relegated them to mediocre and obscure roles in life. The mob gives them center of the stage, where they play a brief and bloody part. Unwittingly. moms contribute a considerable quota to mobs (p.115)

From the viewpoint of psychiatry in the 1940's it was lucky for us that "momism" was a cross-cultural phenomenon. Our military victory in World War II was possible because the depth of the "momistic" influence on the Japanese was even stronger than the influence on the American soldier.

I doubt if even the atomic bomb had sufficient explosive force to diswomb the Japanese people.
After Japan yielded, thousands of Japanese bowed before the walls of the palace, abjectly begging the Emperor Mom to forgive them for not trying harder to win the war! (Strecker, 1946:139).

Other major psychiatric voices of the day accepted the veracity of maternal overprotection. Erikson (1950) decrying the rejection of so many young males for service in World War II because of psychoneurosis defined "mom" in this way:

- 'Mom' is a woman in whose life cycle remnants of infanthility join advanced senility to crowd out the middle-range of mature womanhood, which thus becomes self-absorbed and stagnant (p.291).

Perhaps the most dramatic passage directed to blaming mothers for the mental illness of their sons is the following by Karl Memminger, founder of the prestigious Memminger Clinic, who blames "mom" for her direct role in the holocaust. In the 1942 edition of his book Love Against Hate, Memminger states:

-......while the adult can react in various ways to the woman's aggressions, the little child has no such choice. He can only submit, and suppress his fear and bitterness, burying it beneath his intimidation, where it incubates for twenty years and comes out ten times stronger. What he didn't care to do once he later dares to do a hundredfold. Who can look fairly at the bitterness, the hatefulness, the sadistic cruelty of Adolf Hitler without wondering what Hitler's mother did to him that he now repays to millions of other helpless ones? (p.118).

The actions of adult men regardless of how heinous they are should be forgiven. These men are simply receptacles for their mother's neurotic impulses.

We must remind ourselves again and again that the men by whom women are frustrated are the grown-up sons of mothers who were chiefly responsible for the
personality of those sons (Memminger, 1942:118).

What is most apparent in this psychiatric literature is the awesome responsibility of the mother for the emotional well-being of husband and child. As King (1975) has noted in her review of psychiatry's view of women during the twentieth century:

Perhaps one of the most distressing implications for a woman is the probability that she will be held responsible for any mental disturbance in her child. If one of her children turns out to be a delinquent, neurotic or psychotic, she may attribute this to her failure as a mother (p.24).

Relative to men, women are depicted in psychiatric literatures as extremely powerful in influencing and shaping the psychological lives of the men around them. Again, in her review of psychiatry King (1975) concludes:

....the literature is devoted to exploring and discussing the nature of motherhood, female sexuality, the frustrations of being a woman, and so on. The male does not receive such attention, either negatively or positively. It is as though he is a given in the situation, whereas woman is the object of his study (p.35).

The husband-father was a rather shadowy figure in the psychiatric literature on "momism". He had little influence in the family compared to the psychic power of the woman. As Farnham and Lundberg (1947) remark in their book, MODERN WOMEN:THE LOST SEX:

The 'Battle of the Sexes' is a reality and one of its results has been the rather extensive psychological castration of the male (p.244).

But men do appear in the psychiatric literature of the 1940's-1960's
—typically as passive and powerless as compared to women. According to Reichard and Tillman (1950), the schizophrenic family was comprised of mothers who were:

......domineering, aggressive. married to quiet, ineffectual, withdrawn husbands whom they nag and despise, and with whom they are sexually frigid (p.251).

To Tietze (1949), the mother of the psychotic child was:

......overanxious. obsessive. domineering, restrictive. perfectionist, oversolicitous, dependent on approval from others (p.64-65).

Her domination causes problems particular to the husband.

......the husband withdraws from the relationship in an effort to preserve some integrity when defeated in the struggle, and may find solace in alcohol (Lidz, 1957:245).

The pathogenic family became the focus of studies of mental illness in the 1950's. The changing conceptualization of the etiology of mental disorder from individual pathology to interaction difficulties pushed the focus of concern toward the family system. The theme of the powerful women and the passive male is at the root of several interpretations of the role of the family in childhood pathology. The work of Theodore Lidz and his colleagues is the most explicit in terms of family structural effects on mental health. Sick families to Lidz are those wherein the proper differentiation of sex and age roles has been violated. In most of Lidz's work the influence of the work of Parsons (1954) on family role structure is explicitly acknowledged. To Lidz, the healthy family contains men who are instrumental leaders and
women play expressive-emotional roles:

I propose that the essential dynamic structure of the family rests upon the parent's ability to form a coalition, maintain boundaries between the generations, and adhere to their appropriate sex-linked roles. Then I examine how failure to meet these few requisites leads to distortions in the ego structuring of their children (Lidz, 1963:9).

According to Poster (1980), Lidz's theory of family structure and psychoses "defends patriarchal sex roles as crucial to mental health and general well-being" (p. 123). "Skewed" families are problem families. To Lidz, boys with schizophrenia are likely to come from families exhibiting skewed sex roles in which there are dominant mothers and passive fathers.

The contagious mother and wife whose own problems are spread to surrounding males is not an idea that has faded with time. In 1976, Hans Sebald published a volume entitled MOMISM: THE SILENT DISEASE. Sebald wonders why "the terrible harm .... of mothers.... has not received more attention until now" (p. 2). Sebald is particularly concerned with the problem he calls "neurosis in sequence". This refers to:

.....the situation where a deeply troubled mother--showing enough personality turmoil to justify the label neurotic--imposes her problems on the child and attempts to obtain compensation and alienation through him. Thus, in the course of raising him, she instills enough anxiety and complexes to create. ironically--another neurosis" p. 7.

Underlying much psychiatric literature on family and mental health since World War II are, at least, two important themes. First, the wife-mother is a major cause of a number of family problems including:
the mental impairment of children; alcoholism and other problems of the husband; and marital and family disharmony. The husband's withdrawn, passive stance as depicted in problem families absolves him of any direct responsibility for pathogenic outcomes. A second clear theme in this literature is the image of the powerful woman. The wife-mother is seen as much too powerful and influential in shaping the psychological lives of the men in her immediate environment.

The Appropriate
ess of Women Seeking Help For Self and Others

The "Momism" literature discovered the invidious power of the American woman in families. One thing seemed certain: the psychological dominance of women in families had to be controlled. Many "momism" writers not only held the woman responsible for the mental health problems of their husbands and sons, but also held them responsible for correcting the situation. This control could take one of two forms: either by the woman adhering to the norms of good motherhood and wifehood, i.e., acting according to sex role demands; or by freely seeking the guidance of trained psychiatric and psychological experts. Both strategies required that women open themselves to information from experts about family life.

The good wife and mother had to become the emotional manager of family problems. The survival of the family was dependent on her efforts to manage all problems and conflicts. As King (1975) has reported in terms of the literature on the wives of alcoholics, the wife should devote herself to the maintenance of the family system regardless of personal cost. In a 1972 article on the wives' responsibilities in alcoholic marriages, Rae and Drewery contend:
....the stability (of the marriage) is...achieved through the efforts of a woman who is able to perceive her husband as masculine and independent despite his obvious inadequacies, and see herself as highly feminine and dependent, notwithstanding the burdens and responsibilities of living with an alcoholic for many years (p.620).

....it is the wife's function to accept her husband partly on his own terms and partly in terms of the concept of masculinity endorsed by her social group, and to make any of the social and emotional adjustments which follow from this acceptance (p.621).

In the area of child-rearing, several writers have chronicled the extent to which child-rearing information and child education efforts have been directed exclusively at women (Brim, 1968; Ehrenreich and English, 1979). Following World War II, the emphasis on the mental health of the child (as exemplified by the fact that PARENTS MAGAZINE, which began publishing in the 1920's began to include in 1946, a new section in their magazine--"the psychological life of the child"), put more responsibility in the hands of mothers. Sebald (1976) has noted in reviewing mental health education literature that the message is directed almost exclusively to women:

for example the National Association of Mental Health publishes pamphlets under the motto 'What Every Child Needs for Good Mental Health'. trying to reach parents and educate them to raise emotionally healthy children. However. the vast majority of the literature adresses itself exclusively to the mother, not to the father. This is particularly obvious in pamphlet 525, presumably directed toward 'parents'. In actuality, the pictures and drawings accompanying the text reveal it to be exclusively oriented toward the mother-child relationship. The role of the father goes unnoticed (p.245).

In the 1940's, suggested methods for the control of mothering were more
direct. Strecker (1946) argued that:

There is no reason the institution of motherhood should not be investigated and evaluated just as any other institution (p.175).

Short of that Strecker (1946) recommended mothers seek out professional help or join lay mental hygiene groups that are designed to help clarify the psychological needs of the child. As regards these groups:

These efforts must not only be expanded, but those conducted by lay groups must have continuous and sensible psychological monitoring (Strecker, 1946:176).

The idea of "continuous and sensible psychological monitoring" was evident at the level of state mental health education efforts. For example, the Louisiana State Mental Health Society, in the early 1950's, initiated a public education effort through the creation of a series of pamphlets concerning the psychological needs of children. The "Pierre the Pelican" series was to be distributed to every mother of a newborn infant in the state. Any mother who refused to accept the pamphlets were visited by the staff of the office of mental hygiene and asked to explain their refusal. According to Chamberlain and De Schweinitz (1955), chroniclers of mental health education efforts during the 1950's:

Any home objecting to receiving the pamphlets was visited. In one instance it was found that an insane woman was taking care of a baby (p.60).

To refuse such information is an act of irresponsible mothering.
The responsible mother is eager to learn to be a good parent and, in the process, is open to professional advise and counselling (Sebald, 1976:245-246).

The help-seeking behavior of women. Official statistics on the seeking of help and the use of various services for psychological problems since 1950 indicate that women not only outnumber men, but are more likely to seek help for the problems of other members of the family group. Women seem to have accepted the role of the family "worrier" to a greater extent than men. This role is explicitly identified in the following passage from a publication of the National Association of Mental Health:

Women all over the country are airing their problems at 'Worry Clinics', sponsored by their local Mental Health Associations. The clinics provide an opportunity for them to relieve pent-up emotions and realize that others are in the same boat. The clinics take various forms and often revolve around a basic theme—marital problems, middle-age, finance, problems of the working wife and, most frequently, child rearing...Other problems which crop up frequently in the clinics include permissiveness, children's rivalry and fights, and underachievement in school. Worry clinics have been held in 29 states. One clinic in Oklahoma City reported an attendance of 1,500 women; and about 50 cities and towns in Indiana hold sessions regularly. Usually, however, the worry clinic is a one-time affair....(DHEW, Publication # 75-48. 1975 :p.11).

Women using outpatient mental health facilities and other psychological services exhibit a wide range of psychological distress (Ryan, 1969; Atwell et al., 1978). It is easy to assume that because women show up at clinics to a greater degree than men, they are more mentally ill. But like other agencies and organizations, mental health facilities order the complexities of their work into manageable and understandable frameworks. For example, Cicourel (1968) has argued that agency record
keeping translates statistics about its functioning into rates and figures that are usable and manageable. Clients are conceived of as discrete problem-bearers. Often, however, the reason clients seek out help is because of problems with their social group centering around interpersonal stress and conflict. Statistics about users of mental health services do not capture this reality. Ryan (1969) in a study of urban mental health services highlights the tunneling effect of agency work involved in defining a "case".

......consider the case of a depressed and defeated working-class housewife turning to someone for help with a multitude of problems that are overwhelming her: an alcoholic husband who disappears for days at a time; the piling up of pressing debts; an eviction notice from the landlord; two children in diapers and a third who is enuretic; a sickly daughter and a neglected older son whose school work is worsening daily; headaches and stomach aches; increasing trouble with her neighbors as she becomes more and more short-tempered; and a growing sense of guilt as she finds that she herself is turning to liquor for consolation. If this woman were viewed in a narrow mental health context, it is possible she would be diagnosed as suffering from depression. And if she were so diagnosed or identified, it is likely she would be referred for psychiatric treatment. Possibly she would be identified as a person with marital problems and then be referred for marital counselling. The question that comes to mind is: how logical would such a narrow definition be?....one might consider the question of whether it is even appropriate to make such a referral--to abstract, as it were, a 'disease' from this complex of problems. Her depression is a condition that might seem quite natural in view of what is happening to her. To call her situation a marital problem seems not only to her but to most people, a rather glaring understatement (p.48-49).

The point of this rather lengthy quote is that in terms of "rates of mental illness" this women would simply be one female client among many female clients who outnumber men in clinics. From such "rates of mental
illness" would it be accurate to conclude that women are more mentally ill than men?

The interpersonal aspects of help-seeking behavior. Studies that have focused on reasons for initiating professional assistance leave one with a very different impression of the help-seeking process than can be gleamed from official rates and diagnoses. Ryan (1969), for example, contends that the typical help-seeker of psychological services is not seriously disturbed but looking to get a handle on interpersonal difficulties. Ryan's assertion is supported by data on the presenting problems of individuals at a variety of clinics. Foss (1974) in a study of four mental health clinics in New England reports that 19.8% of the women compared to 8.0% of the men initiated help for parent-child problems; 40.6% of the women and 34.4% of the men were there for a marital problem; and 23.5% of the women initiated help for a problem in "family functioning" compared to 18.2% of the men. Atwell et al., (1978) in a survey of users of social service and mental health clinics found that 68% of the women who went for help initiated contact literally on behalf of husbands. for relational problems in marriage, or because of parent-child problems. Blessing (1976) in a report of a single mental health clinic finds 60% of the women and a small percentage of men presenting relational problems as the major type of complaint.

In a related vein, Mayer and Timms (1970) in a study of a family service agency in London, England find that the major conflict between clients, who were mostly women, and therapists was the latter's insistence on viewing the client's problems in terms of diagnostic categories and the client's insistence that the real problem centered
around conflict between family members. Menaghan (1978) finds in a study of middle-aged men and women that the women are much more likely to seek out formal and informal help for problems connected with their adult children. Lieberman (1978) in a study of children of the elderly finds women much more likely than men to experience worry and anxiety over aging parents. She also finds 80% of the children who sought help because of anxiety over aged parents were women.

It is not only the case that persons seek help because of interpersonal difficulties. A larger than expected percentage of persons are seeking help for others. Many act to initiate treatment for those who may not want it. Horwitz (1977) has shown in the case of men who resist seeking aid that wives and kin often act to coerce men with obvious emotional difficulties into treatment. The problems of children are usually recognized and identified as in need of help by parents and teachers. Children rarely seek help on their own. One of the earliest studies of this kind of help-seeking was by Yarrow et al. (1955). They detail how wives of disturbed husbands were the first to recognize symptoms, define the problem as in need of help, and initiate contact for help. Atwell et al. (1978) report in cases involving a husband in treatment, it was more often the wife who made the initial recognition of the problem and lobbied for the initiation of help.

The identification, recognition, and decisions about seeking help are most often negotiated by the problem bearer as well as the spouse, friends, kin and neighbors (Horwitz, 1977; Atwell et al., 1978). This is help-seeking, but of a quite different nature than depicted in individual decision-making models. The involvement of others in the help-seeking process is extensive and the decision is not always
arrived at consensually. Help seeking is often the result of conflict processes wherein the therapist acts as a mediator of interpersonal disputes.

Interpersonal and family conflicts underlie many of the stages in the help-seeking process (Horwitz, 1977; Finkelhor, 1977; Atwell et al., 1978). Conflict is the explicit theme of the above-mentioned study by Mayer and Timms (1970). Their study was concerned with the factors that determine the satisfaction and dissatisfaction with treatment of clients at a London Family Service Agency. Dissatisfied clients could best be described as those who held very different expectations for treatment than their therapists. The typical dissatisfied client was female and was seeking help because of conflict with someone in the family. She was there because she had exhausted attempts to deal with the conflict situation on her own. Her presenting complaint usually had to do with the husband's alcoholism, the husband's lack of communication, or problems in handling the children. The client expected two things of the therapist: 1) to listen to her complaints and make a moral assessment; and 2) to assist in rectifying the situation by actively helping to change the behavior of the husband or child. The therapist, on the other hand, insisted on giving the client a better understanding of her problems, by revealing how the client was contributing to them.

Whoever is correct is not at issue. The act of seeking help because of irresolvable conflicts is and has been mentioned by some marriage counselors. Sanctuary (1968) parallel the account of Mayer and Timms (1970):

When clients first come to see a counselor.....they almost always have a complaint to make about the way their partner is behaving. At first they usually blame their partner; in fact, when clients first start the interview by blaming themselves it is often because they are cloaking their own resentment against their partner, or because they want to enlist the sympathy of the counselor. During counselling, clients very frequently try to manipulate the counsellor into taking action for
them. Others expect the counsellor to persuade the partner to change his behavior (p.59-60).

Some have contended that conflict is the most important single factor in understanding the nature of psychiatric help-seeking. Borgman (1978), in fact, defines mental illness as:

"...those social conflicts involving disputes about behavior and the nature of reality...which are submitted to mental health practitioners for arbitration (p.58)."

Consequently, mental illness cannot be understood outside of relational considerations. People seek mental health services because their interests are being jeopardized.

Many problems presented by people to mental health practitioners might be regarded as involving social conflict between individuals and some social group. Persons voluntarily seeking mental health treatment often complain about the way they are treated by other people (Borgman, 1978: 60).

Issues of conflict and power are seen by Borgman (1978) as critical to understanding help-seeking behavior.

One of the most common conflicts involves a struggle over control. Conflict ensues when one party experiences or anticipates control by another, and wishes to preserve autonomy (p.60).

In the area of medical sociology, conflict has also been cited as an important factor motivating the seeking of medical care. Zola (1973) in a survey of out-patients at the Massachusetts General Hospital attempted to understand why people come when they do for the treatment of symptoms that had been going on, in many cases, for quite some time. Zola (1973) finds two prominent reasons to explain the decision. The
first is the occurrence of interpersonal conflict, the second he calls sanctioning, which refers to one person taking the primary responsibility for the decision to seek help for someone else. An example Zola presents as an illustration of seeking medical attention because of interpersonal conflict is the case of a forty year old women who is seeking help for a hearing difficulty she has had for many years. When questioned by Zola about her reasons for coming to the hospital she cannot pinpoint any particular reason except for a general feeling that something should be done. When she is asked about her family's concern she states:

My mother is very strict and very religious. She doesn't like the idea of my going out with a lot of men...She says I'm not a nice girl, that I shouldn't go out with a man unless I plan to marry....she doesn't like my keeping late hours or coming home late. She also expects the worst of me. This year has been miserable...I can't talk to her....she makes me very upset and its been getting worse...the other day...last week we (in lowered tones) had the argument. Miss Bella called for an appointment the next morning (p.63)

Another reason motivating the seeking of medical care uncovered by Zola's research is called sanctioning. This involves one person taking primary responsibility for another to seek help. Zola (1973) presents a few cases of people who expects others to push them toward treatment, but have to make the decision themselves. Their dismay over the lack of response of others sparks conflict.

One was a woman with a thyroid condition, swelling on the side of the neck who when asked why she came at this time blurted out almost in a shout 'Why did I come now? I've been walking around the house like this for several weeks now and nobody said anything so I had to come myself' (p. 683).
Research reviewed in this section indicates that the seeking of help for problems is not always a "personal" matter. More often than not there is an interpersonal basis to much help-seeking behavior. Women are more likely than men to report seeking help for the problems of others, family functioning, and situations of interpersonal conflict. Most theories of help-seeking do not emphasize this interpersonal dimension. The overrepresentation of women in clinics is interpreted as evidence of the greater illness of women rather than seeing the female excess as evidence of her role as family "worrier" and emotional monitor. The belief that women are more mentally ill than men because of her help-seeking behavior serves the purpose of avoiding a view of the family as an arena of conflict and turmoil and reinforces the belief in greater female sickness.

**Symptom Checklist Scales in Epidemiological Research**

Epidemiological data that support the belief that women are more mentally ill than men is largely based on responses to symptom checklist scales. Since these scales are so important to this entire discussion, it is important to understand the evidence on the exact relationship of these scales to clinical psychiatric disorders.

**The Meaning of Symptom Checklist Scales**

Over the years, mental health surveys have become decreasingly clinical and increasingly sociological in aim. With this change in form has come a change in function. According to Murphy (1978) mental health surveys seek:

......less to identify the sick than to assess the prevalence of psycho-social stress. With this shift,
symptom checklists administered by lay interviewers or completed by the subjects themselves have steadily replaced the physician's search for definite illness (p.67).

Researchers and clinicians have long suspected that symptoms tapped in checklist questionnaires do not correspond to recognized clinical psychopathology. Seiler (1973), for example, has pointed out that symptom scales differentiate only weakly between known mental patients and presumed normals. She also challenges what this type of validity check really means. In her review of empirical validations of checklist scales she notes:

Most troubling of all, however, is the heavy reliance upon 'known group' techniques for the validation of the 22-item scale. It appears that use of this technique has resulted from not fully differentiating two theoretical questions. The first question, the one upon which the 22-item scale's utility rests, is: Are respondents with some high number of symptoms, as represented in the 22-item scale, mentally ill? The second, which is tangential to the first is: Do the mentally ill evidence some unusually high number of the 22-item scale symptoms? If the answer to the second question is affirmative, that is, that mental patients evidence a statistically abnormal number of such symptoms, this does not imply that the answer to the first question is also affirmative, that those residing in the community who evidence a statistically abnormal number of symptoms are also mentally ill. This obviously is the fallacy of affirming the consequent (p.1461).

Dohrenwend and Dohrenwend (1976) also present evidence that symptom scales fail to identify most clinical disorders. Most notably, schizophrenia, personality disorders, and forms of psychoses. It should be noted, however, that originators of symptom checklist scales never intended their scales to be used to diagnose "true" mental illness. Psychiatrists, psychologists, and sociologists, headed by Stouffer
(1950) in the US Army Research Branch during World War II undertook to develop a brief, practical measure to screen out potential inductees who might prove ineffective as soldiers because of their psychiatric condition. The result of their careful work was a 15 item Psychosomatic Scale which showed itself to discriminate between soldiers on active duty and soldiers hospitalized as neurotic. The 15 item Psychoneurotic Scale became the core of the Neuropsychiatric Screening Adjunct questionnaire and was administered at all induction stations during the last year of the war (Dohrenwend et al., 1981). The 15 item scale was never intended as the sole criterion for rejection at induction. The scale was designed solely as a screening instrument for identifying those armed forces recruits most meriting a psychiatric evaluation.

Based on the seeming success of the US Army Research Branch, a number of scales have been developed since World War II which rely heavily on the logic of measurement expressed in the Neuropsychiatric Screening Adjunct. The Cornell Medical Index (Brodman et al., 1952), the Health Opinion Survey, a 24-item screening scale (Macmillan, 1957), the Gurin Mental Health Status Index, comprised of 20 items (Gurin et al., 1960), a 22-item psychiatric screening scale used in the Midtown Manhattan Study (Langner, 1962), the Indik Scale of Psychological Strain, a 16-item scale (Indik, 1968), are some of the best known and most frequently known screening devices.

These scales have been used in a number of epidemiologic studies and utilize almost identical items. As Dohrenwend et al., (1981) remind us specifically about the Health Opinion Survey and Langner's 22-item scale, these scales were:

...constructed on the assumption that psychopathology is unidimensional. The assumption of
multidimensionality is, however, far more widely accepted among experienced clinicians, as indicated, for example, in the World Health Organization's International Classification of Diseases and the American Psychiatric Association's Diagnostic and Statistical Manual (p.4-5).

Checklist scales do not differentiate between types of pathology such as depression, schizophrenia, or other recognized types of pathology but are designed to indicate the presence or absence of disorder. But even in this task there is confusion over what the screening scales are actually measuring. Seiler (1973) points out that investigators using screening scales have described these measures in terms of such constructs as "mental illness", "psychiatric disorder", "emotional disorder", "emotional disturbance", "absence of mental health", "symptoms of stress", and "psychophysiological symptoms". Due to this conceptual ambiguity, it is important to ask just what these scales are measuring.

What Checklist Scales Do Not Measure

There is increasing evidence that high scorers on screening scales as well as people seeking outpatient mental health assistance are typically suffering from symptoms that represent no specific psychopathologic distress (Dohrenwend et al., 1980; Murphy, 1978; Frank, 1973). Statistically, checklist scales meet requirements for being defined as a dimension. However, these scales do not correspond to current clinical psychiatric classifications. As Dohrenwend et al., (1980) have commented:

The items in the scale are generally associated with affective distress but are not specific to any particular psychiatric disorder....Clearly, elevated scores on these scales, like elevated temperature,
tell you that something is wrong. However, just as in physical medicine, where many diseases are not associated with elevated temperatures, a respondent may have serious psychopathology without having an elevated score (p. 1229-1230).

What then do these scales measure? Current evidence seems much clearer on what symptom scales do not measure.

The Relation of the Checklist Scale to Clinical Psychiatric Disorder

Murphy (1974) contends that most of the evidence on the relation of screening scales to psychiatric disorder centers around the ability of the measure to discriminate patients from non-patients and to correlate in general population samples with clinical evaluations by psychiatrists. Somewhat better in terms of establishing validity are studies that have tried to establish the relation of screening scales to independent measures of clinical psychiatric disorders. These types of studies yield consistently negative results. Weissman, Myers, and Harding (1978) found that a subset of five of the Gurin scale items plus three similar items, all of which meant to measure depression, were only weakly related to depression in a community sample of 515 persons. Of the highest scoring participants on this eight item scale, only 28 percent were diagnosed as having a major or minor depression by Research Diagnostic Criteria on the basis of interviews using the Schedule for Schizophrenia and Affective Disorders (Spitzer, Endicott, and Robbins, 1978). Schwartz, Astrachan, and Myers (1973) found 20 items from the Stirling County and Midtown study screening scales to be only weakly related to two other measures of psychopathology in a sample of patients diagnosed as schizophrenic. Two scales were used to measure schizophrenia and they were more strongly correlated with each
other (.67) than with the 20-item screening device (.55 and .39).

Examination of many of the screening scales used to measure disorder has led Dohrenwend et al., (1980) to wonder if these scales are actually measuring neurosis. This seems a very plausible hypothesis in light of the actual content of these scales with their emphasis on anxiety, immobilization, and physiological symptomology, as well as the fact that these scales were originally validated comparing normals to hospitalized neurotics. However, in both a community and prison sample, Dohrenwend et al., (1980) find no support for a relationship between high scorers on screening scales and neuroses.

Another possibility could be that screening scales are actually measuring a sub-clinical dimension of psychopathology. Symptoms tapped on screening scales could be an early warning of clinical disorder in the future. Two longitudinal studies have attempted to address this issue. Dohrenwend (1973) interviewed 55 adults using a structured clinical interview called the Psychiatric Status Schedule (PSS) (Spitzer, Endicott, Fleiss, and Cohen, 1970). The sample had previously been interviewed an average of four years earlier using the Langner 22-item screening scale. It was reported that about two-thirds of the respondents who were identified as "cases" on the basis of the cutting-point most commonly used on the Langner scale turned out not to be cases in the judgements of psychiatrists who interviewed them "blind" four years later. Also, about one-half of the respondents who turned out to be "cases" four years later would have been missed on the basis of their earlier screening scores. Murphy (1974) administered a screening scale to 1170 freshmen at the University of Singapore and then followed them for 2-3 years to learn who exhibited abnormal
behavior, sought psychiatric aid, or made much greater than average use of health services. He concluded on the basis of the follow-up that "the symptom checklist.....failed to identify vulnerable individuals" (p.260). Dohrenwend et al., (1980) reviewing these two studies concluded:

In the face of the results of these studies that provide prospective cross-checks with independent indicators of distress....these screening scales are not direct measures of either clinical psychiatric disorder or vulnerability to such disorder. Unfortunately, the studies offer little evidence on what the screening scales do measure (p.23).

Alternative Conceptions of What Screening Scales Measure

Dohrenwend et al., (1981) have summarized attempts to describe the psychological state tapped by screening scales. Foulds (1976) proposes the notion of "dysthymic states" consisting of anxiety, depressed mood, or elevation to express what checklist scales measure. Schofield (1964) has used the term "pseudo" or "quasi" neurosis to describe the state of persons who are in some way psychologically uncomfortable and maladjusted who are neither psychotic or neurotic. High scorers on screening scales, according to Schofield, are people experiencing normal anxiety and unhappiness in situations of marked situational stress.

According to Dohrenwend et al., (1980; 1981), the construct that best fits the data on screening scales is Jerome Frank's (1973) discussion of demoralization. To Frank, demoralization is a state common to all persons seeking psychotherapy or other personal help regardless of diagnostic label (1973:314). He suggests that:

.....a person becomes demoralized when he finds he cannot meet the demands placed on him by the
environment and cannot extricate himself from his predicament (p.316).

Demoralization is a psychological state brought on by predicaments in people's environments.

To demoralize is to deprive a person of spirit, courage, to dishearten, bewilder, to throw him into disorder or confusion (p.314).

Dohrenwend and his colleagues (1978) note that the construct of demoralization best fits the facts about what symptom checklist scales measure. They report that several of the most used checklist scales correlate highly with measures of self-esteem, helplessness-hopelessness, sadness, and anxiety, all of which are major facets of what Frank (1973) means by demoralization. High scorers on symptom checklists are likely to be those who are powerless to control their immediate environment. High scorers are likely to be persons with severe physical illnesses, particularly chronic illness, stressful life events, psychiatric disorders, and conditions of social marginality as experienced by minority groups and persons such as housewives and the poor whose social positions block them from mainstream strivings (Dohrenwend et al., 1980).

Demoralization can occur in conjunction with psychiatric disorder, but it is a condition in its own right. According to Dohrenwend et al., (1980), demoralization:

.....should be viewed as an important indicator of distress within the population. and within particular sub groups (p.117).

Based on the results of a number of community studies and two
nationwide surveys, Dohrenwend et al., (1980) conclude that:

The rate of demoralization in the United States approaches one-quarter of the population (p.126).

Chapter Summary

The expansion in concepts, measurement, and services relating to mental illness since World War II has led to the belief that women are more mentally ill than men. The belief has persisted in spite of epidemiological and treatment data that do not support the idea of "greater female illness". It was suggested in this chapter that the strength and persistence of the belief is due to its compatibility with the values of a number of interested parties. This belief serves to: avoid seeing men as more mentally ill than women; equate female victimization with mental illness; and legitimize the seeking of mental health assistance by women for "family problems".

It was also held that those symptoms that women are more likely to report are symptoms of demoralization, a condition without a clear relationship to clinical psychiatric disorder.
CHAPTER V

SEX DIFFERENCES IN DEMORALIZATION: A REVIEW OF LITERATURE

Social role theories of sex differences in demoralization are extremely popular in the sociological literature. These theories detail the manner in which the performance of social tasks differentially effect the mental health of men and women. In reality, the attempt to explain the greater rate of impairment among women has centered on the performance of a limited number of social roles concerned with marriage and parenthood.

It has long been known that one's marital status is a good predictor of mental health. Marital status is associated with the likelihood of becoming mentally ill, the likelihood of mental hospitalization, and the use of outpatient psychiatric facilities, as well as the chances of recovering from mental illness. The state of marriage is clearly protective compared to other marital status groups. Single persons have a greater prevalence of mental illness than married persons, and they also have a poorer prognosis in comparison to married persons (Gallagher, 1980:204). Persons who are divorced or separated have been repeatedly found to be overrepresented among psychiatric patients. Compared to the married and never married, those whose marriage has been disrupted consistently report higher rates of mental illness (Bloom et al., 1978). In a review of eleven studies of marital status and the incidence of mental disorder conducted over the past
thirty years, Crago (1972) did not find an exception to this conclusion: for adults, admission rates into psychiatric facilities are lowest among the married, intermediate among the widowed and never married and highest among the divorced and separated. The difference appears to be stable across age groups (Robertson, 1974), stable for each sex considered separately (Thomas and Locke, 1963; Malzberg, 1964), and as true for blacks as for whites (Malzberg, 1956; Rosenstein and Milazzo-Sayre, 1981).

What is it about marriage that protects so well against psychological disorder? Eaton (1980), for example, lists several reasons:

On the most general level marriage provides a source of emotional security and self-esteem based on a significant other, which does not depend so much on performance as on membership. The norm is to give the spouse emotional support regardless of his or her achievement, which is distinct from the economic world and from the rest of society generally. Having someone to talk to and share troubles with may be a great help in times of emotional stress and probably helps to stabilize swings of mood considerably (p.72).

Marriage is seen as protective because it prevents social isolation. Additionally, being married is a normatively approved status. As Veroff and his colleagues (1981) conclude about the benefits of marriage on mental health:

Marriage permits easy management of present life circumstances and anticipation of future possibilities ...the married state is the most comfortable integration into society. Institutions are arranged for the married.(p.405).

Marital Status and Sex Differences in Mental Illness

Proponents of a social role interpretation of gender differences in
mental health see marital status as a critical variable. Marriage, they contend, is more beneficial, however, to men than women. In fact, both Bernard (1972) and Gove and Tudor (1973) account for the overall sex difference in mental health as due to a large excess of impaired married women to married men. These authors argue that married women have higher rates of disorder than married men, but single women have lower rates than their male counterparts. Among the maritally disrupted there are no consistent sex differences. The explanation of higher female rates of mental impairment lies in a sex-marital status interaction effect, with married women being the vulnerable group.

The work of Gove (1972), Bernard (1972), and Gove and Tudor (1973) has become known as the specific sex role theory of mental illness. It suggests that sex differences in mental health are not due to some generalized aspect of sex-typed behavior but to the interaction between gender and marital status. Higher rates of female disorder are a response to the frustration and conflict inherent in women's modern roles. These strains are most prevalent among married women.

Problems in the Specific Sex Role Theory of Mental Illness

There are at least three problems with the specific sex role theory of mental illness that challenge its validity. They are: 1) the nature of the evidence supporting the existence of a sex-marital status interaction effect; 2) a confusion between the concepts of marital status and family role; and 3) internal ambiguities in the theory itself. Each of these problems will be examined separately.

Evidence for a Sex-Marital Status Interaction Effect
One of the most important findings of the review of epidemiological studies in Chapter two was the inability to uncover evidence for a sex-marital status interaction effect in regard to mild psychiatric disorders. The female excess in demoralization does not seem due to any large differential between married men and women, but due to a general difference between men and women, regardless of marital status. Fox (1980), for example, in a reexamination of three large data sets, reports that the sex difference in mental illness is not largest among the married in any of the three studies. In one data set the greatest sex difference occurs among the widowed and separated. In the other two data sets, the largest sex difference in symptoms of disorder occurs among the divorced. Epidemiological studies based on general population samples fail to find any evidence for a sex-marital status interaction effect to account for sex differences in mental health functioning (Warheit, 1976; U.S.P.H.S., 1970; Aneshensel et al., 1981; and Veroff et al., 1981).

Support for the existence of a sex-marital status interaction effect is largely based on studies using samples of persons treated for mental health problems. The problem here, of course, is that the excess of married women may simply reflect the fact that married women are more willing to use mental health services. Evidence for a sex-marital status interaction effect is confounded by a problem of social selection. As was discussed in Chapter IV, married women may not only be more likely to use clinics for their own problems, but also more likely to approach clinics for the problems of other family members.

The Confounding of Marital Status with Family Role
The specific sex role theory of mental illness tends to confuse the notions of status and role. Aneshensel et al., (1981) have argued that the distinction is an important one in sociological theory, but the family and mental health literature seems confused about the two terms. Status refers to a socially defined position, a place in the social structure (Robertson, 1980), while role refers to the rights, obligations, and normatively approved ways of behaving in a particular status. Knowing a person's status vis-a-vis marriage implies the presence or absence of only one particular role: husband or wife. It tells us nothing about the presence of children, the presence of preschool children, the number of children, or the presence or absence of other family roles. This distinction is important because the specific sex role theory of mental illness holds aspects of family roles to be important in sex differences in mental health, but uses marital status as an indicator of family roles.

The concept of marital status as an indicator of family roles is becoming increasingly unreliable. There has been, throughout the 1970's, an increasing lack of correspondence between marital status and family role. A brief look at U.S. Census Bureau data is quite convincing. For example, there are a number of persons performing the role of spouse without the status married. According to the Bureau of the Census, Current Population Reports (1980), in 1979 there were 1.35 million households shared by "two unrelated adults of the opposite sex" (p.3). These 2.7 million partners represent about 3 percent of all persons living as couples in 1979. Further complicating the relationship between marital status and family role is the fact that among persons living together, many have former spouses, another family
role not reflected in current marital status. Again, according to Census data, of the 2.7 million people living together, 28 percent of the women and 32 percent of the men also have the marital status divorced. 11 percent of the women and 5 percent of the men also have the marital status widowed. 7 percent of the women and 10 percent of the men also have the marital status separated. 2 percent of both sexes who were living together with a member of the opposite sex were also married to another person at the same time.

There are sizable numbers of persons with the status unmarried who are performing the role of spouse. The reverse situation also occurs. There are a number of persons with the marital status married who do not perform the role of spouse on a day to day basis. According to Current Population Reports (1980), in 1979, there were approximately 3.5 million married persons with spouse absent on a routine basis (p.4).

Marital status is even less informative about the presence or absence of other family roles, especially the parent role. The number of married women between the ages 18-39 who indicate they expect to remain childless has never been over 6 percent, but the number has been increasing since the question was first asked in 1967 (U.S. Bureau of the Census, 1967). The actual number of childless married couples is much higher during any particular year. Aneshensel et al., (1981) in a survey of family roles and depression report that in their sample 41.8% of married couples in their sample did not have children at the time of their study.

There are also a number of married couples with grown children no longer living in the parental home. This represents the performance of
the parental role quite different from the performance associated with the presence of pre-school children.

It is clear that the marital state does not automatically imply the presence or absence of parental roles. Similarly, the marital statuses never married, separated, divorced or widowed does not specify the presence or absence of parenting roles. According to Current Population Reports (1980), of the 62.4 million children under the age of 18 in the United States, close to 19% lived with only one parent. The vast majority of these single parent families were headed by women. Over one million of these children live with a parent who has never married. The remainder with divorced, separated or a widowed single parent. In effect, there are several million persons who do not function in the role of spouse, who perform the role of mother and/or father on a daily basis, many of whom have never married.

The use of marital status alone as an indicator of the presence or absence of stressful family roles should cease. The actual family roles people perform are becoming less and less reflective of marital status. The failure to distinguish between marital status and family role may be a primary reason for the inability of recent epidemiological research to find evidence of a sex-marital status interaction effect on mental health.

In mental health research, the distinction between marital status and family role is important for another reason. The specific sex role theory of mental illness is conceptually ambiguous concerning what exact aspects of family life account for the sex difference in mental health problems. Marital status has to be disaggregated into its component role parts to allow for an examination of particular family
roles and their impact on mental health. Is it simply the presence of a spouse? The absence of a spouse? The presence of children? Or a particular combination of family roles?

**Stressful Components of Women's Social Roles**

The specific sex role theory of mental illness cites a number of aspects of family and non-family roles in the lives of married women that are potentially stressful and implicated in mental health problems. Many of the aspects seem to apply to women regardless of marital status. This section outlines major facets of the theory and lists some of the theoretical ambiguities of the structure of the theory.

The specific sex role model of mental illness operates from a medical psychiatric perspective which holds that people develop symptoms of both physical and mental illness and seek help for these difficulties because of stressful situations in their lives. As Foss (1979) has summarized the position of true prevalence theorists, higher rates of female illness are a response to the frustrations and conflicts in modern women's roles, especially those of married women. Female stress is seen as having intensified since World War II, especially in modern industrial societies. Gove (1972) and Gove and Tudor (1973) list a number of factors about the female role in marriage that are responsible for the excess in mental health problems among married women. First, most women are restricted to a single major societal role, housewife, whereas most men occupy two such roles, household head and worker. Women, in effect, have only one source of gratification, while men have two. Second, a large number of women find
their major instrumental activities, raising children and keeping house, frustrating. Third, the role of housewife is relatively unstructured and invisible. This allows her to put things off and brood over her troubles. Also, because the housewife role is only vaguely defined, the women becomes responsible for everything that must be done in the house. Thus, the wife may experience considerable anxiety concerning whether she has done everything (Gallagher, 1980:206). Fourth, the married woman with a job is less satisfied than the married male because she faces occupational discrimination and underemployment. In addition, she puts in more hours than her husband because she still must perform household chores as well as outside job duties. Lastly, women are in less control over their lives than are men. For example, when their children grow up and move out of the house, she may feel meaningless because she no longer has one of the few sources of gratification once available to her.

Theoretical Ambiguities of the Specific Sex Role Theory

One internal problem of the specific sex role theory of mental health is that the conditions associated with the married female's role are sometimes contradictory, yet little attention is given to how such disparate elements are uniquely tied to mental health (Foss, 1974; 1979; Atwell et al., 1978). For example, some features of the female role are marked by role simplicity (confinement to the role of housewife) and others by role complexity (the performance of two full time jobs at home and at work). Is it confinement to a single, major role or the performance of several major roles that impact more severely on mental health?
A second problem has to do with the nature of family role stress. Performing several family roles (spouse, parent, kin member) provides one with several sources of potential stress but also with several sources of potential gratification. A fewer number of family roles offers less potential stress but also less potential gratification as well.

A third problem of the specific sex role theory is that its proponents never make the necessary case that women's roles are indeed more stressful than those of men. No direct comparison of gender differences in exposure to stress is typically made. A strong case can be constructed that modern men's family and non-family roles are also highly stressful. Several studies have documented the economic burdens placed on men in American society, especially in the fulfillment of the breadwinner role (Scanzoni, 1970; Keniston, 1972; 1977); the personal alienation that results from the nature of work in American society (Bradburn, 1969; Andreas, 1971); and the mental health problems that develop among males from the nature of work (Vanfossen, 1981) and from unemployment (Brenner, 1975). Male stress is typically downplayed by proponents of the specific sex role theory of mental illness. Gove and Tudor (1973), for example, in support of their theory of greater female stress, present data to show that the rate of female mental illness has risen dramatically since 1950. This is quite true based on results of community studies since World War II. What is ignored is the fact that rates of mental illness have risen dramatically for both men and women since 1950, and in all major psychiatric subclassifications (Dohrenwend and Dohrenwend, 1976:1450).

A fourth problem of the model, and one alluded to earlier, is the
most important problem in the specific sex role theory of mental illness. It refers to the specification of what aspects of family and non-family roles roles contribute to mental health problems. Within the specific sex role theory there are at least four models of the interaction of family and non-family roles that require elaboration. These models are: 1) Role Complexity: the performance of multiple family roles and non-family roles; 2) Role Simplicity: the performance of few family roles and few non-family roles; 3) Role Restriction: many family roles and few non-family roles; and 4) Role Imbalance: the performance of few family but involved as full-time worker. We now turn to an examination of these models.

Role Complexity: Many Family and Non-Family Roles

According to the specific sex role theory of mental illness, the advantage of never married women over married women lies in the absence of multiple family roles and family role demands. The diffuse and extensive responsibilities of the wife-mother role are seen as particularly hazardous. Not only are women responsible for the instrumental tasks involved in running the household and having major responsibility for child care, but are also responsible for the emotional well-being and psychological support of other family members. It is the wife-mother who specializes in providing emotional support and raises the morale and sense of well-being of other members of the family unconditionally. Bernard (1972) has added that the expressive function, which she calls the "stroking function", can be traced to all of women's roles in the social structure: in family, in work, play, and social life generally. The support women offer is seldom reciprocated.
Again, as Bernard (1976) has commented, women are dependent for the satisfaction of affiliative needs on their husbands, who typically lack training in being expressive.

Additionally, some women may experience the extra demands of holding a full-time job. The full-time working woman is typically not relieved of household tasks and child rearing responsibilities. Vanek (1980) presents data that employed wives work an average of 71 hours a week in family and non-family tasks. For employed women with children, work expands to an 80 hour week. In families with dual working spouses, men's responsibility for housework does not significantly increase (Robinson, 1977). Nor does it increase in the area of child rearing. Berk and Berk (1979) report in a study of 750 wives and 350 husbands that child-care activities of men with working wives constitutes "back-up" labor for a series of tasks which remain primarily women's responsibility. Gove and Tudor (1973) have cited this role overload situation of women as accounting for their greater rate of psychological disorder. These authors argue that these dual role demands and the fact that women are more likely to experience occupational discrimination and underemployment makes them vulnerable to demoralization.

This sub-model of the specific sex role theory of mental illness suggests that women's mental health problems are rooted in role complexity. Women who perform multiple family roles and who work should be the group reporting the highest demoralization.

Role Simplicity: Few Family Roles and Limited Non-Family Roles

In contradistinction to the above model is one that suggests that
those with few family roles and isolation from non-family situations will be more vulnerable to demoralization. No direct prediction is made about this group by the specific sex role theory of mental illness. Logically, we would expect this group to experience low demoralization because they are removed from those statuses which are stress producing. There is some evidence, however, that suggests that people out of roles that would permit access to mainstream cultural strivings may be most vulnerable to demoralization.

Multiple family roles are seen by the specific sex role theory of mental illness as being sufficient in and of themselves to cause stress and strain. The idea of family role "overload" is an appealing one but conflicts with some scattered evidence in physical and mental health studies done over the last ten years. For example, Rivkin (1972) in a study examining World Health Organization/National Collaboration Study of Medical Care data, collected in Baltimore, MD in 1968-1969 finds that women with a large number of role obligations report a lower incidence of physical illness and disability days. Lower morbidity rates were found among married women compared to single women. Lower rates were also found among women with children and no spouse compared to women with no children and no spouse. Lastly, women with children who worked reported less illness than women with children who did not work.

Marcus and Seeman (1981a) have reported in a study of 2,000 cases that health status differences among women are related to having children in the household. Women with children report lower rates of illness and disability than women without children. In a related paper, Marcus and Seeman (1981b) argue that sex differences in number of
chronic conditions and restricted activity because of illness are due to the absence of fixed role obligations in the lives of women relative to men. These authors present data from the Los Angeles Health Survey (from 1976-1977) that shows among persons who are heads of household, employed, and contributors of a large share of household income the sex differential in illness reporting is severely reduced. Verbrugge (1983) also presents evidence that multiple family roles are associated with less physical illness and disability. Persons who have spouses and children report less health problems than persons with few family obligations. In the area of mental health, Baruch and Barnett (1983) present evidence that multiple family and non-family roles are good for women's mental health. The women with the highest well-being in their study were married, had children and worked.

These findings support a supposition made by Mechanic (1976) when he suggested:

.....the area where the hypothesis of consistency of illness with women's role obligations may have the greatest interpretive power is in relation to limitation of activity (p.37).

This model suggests that those people most isolated from or limited in the performance of family and non-family roles may be the most vulnerable to demoralization. It is suggested here that it is role simplicity rather than role complexity that is most closely tied to demoralization.

Role Restriction: Multiple Family Roles and Limited Non-Family Roles

This model could be considered the central idea of the specific sex role theory of mental illness. Its vision is not limited to married
women but rather to those women who occupy the housewife role. As Bernard (1972) has pointed out:

That it is being relegates to the role of housewife rather than marriage itself which contributes heavily to the poor mental and emotional health of married women can be demonstrated by comparing housewives, all of whom may be presumed to be married, with working women, three-fifths of whom are also married. Marriage per se is thus at least partially rules out as an explanation of differences between them. The comparison shows that wives who are rescued from the isolation of the household by outside employment show up very well p.(46-47).

It is the woman confined to the household who performs multiple family roles who is seen as the prototype of the demoralized person. Rather than being overloaded by the demands of both family and non-family roles, the housewife is seen as a victim of both participation and non-participation in important social roles. Both Gove and Tudor (1973) and Bernard (1972) give several reasons why the housewife role is highly stressful to many women. First, it restricts women to the performance of family roles; hence, there is the possibility of only one source of gratification available to them. Second, the housewife's work is repetitive, boring, monotonous, and undervalued. Third, the housewife role is unstructured. The isolation and lack of structured role demands make it possible for her to brood over problems. Bernard (1972) especially emphasizes the isolation of the housewife role:

Isolation has negative psychological effects on people. It encourages brooding; it leads to erratic judgements, untempered by the leavening effect of contact with others. It renders one more susceptible to psychoses p.(46).
This model would project that women with multiple family roles whose routine is not interrupted by the demands of participation in the labor force and/or by participation in friendship networks may be the most vulnerable group to demoralization.

Role Imbalance: Few Family Roles and Developed Non-Family Roles

The woman with few family roles, whether married or not, who works full-time is seen by the specific sex role theory of mental health as least at-risk to demoralization. This women is typically seen as never married, but the number of women who are married without other family obligations is sizable, as is the number of women previously married with low obligations. The mental health of these women is seen as being comparable to male levels because their social roles are most similar to males. They are freed of extensive family role demands and obligations and enjoy the satisfactions associated with holding down a full-time job. Developed friendship networks may also be more common among this group given their involvement in work and additional time because of minimal family role obligations.

Beyond the Specific Sex Role Theory of Mental Illness

Each of the preceding models predicts a certain type of relationship between demoralization and the performance of family and non-family roles. Two further points have to be made about this relationship. The first concerns the issue of whether one model best predicts demoralization for all sub-groups of people. The second issue focuses on the question of how good a predictor the performance of family and non-family roles is in explaining demoralization. It is
quite possible that it is much more the quality of interaction in role relationships that best predicts morale for men and women. It is to the first issue we now turn.

**Sub-Group Variations in Models of Family and Non-Family Role Performance**

The basic premise here is that notions of role complexity or role simplicity, or any other model concerning family or non-family roles may be applicable only to certain groups. It can be plausibly argued that different models might apply only to particular groups according to sample type, gender, and social class.

**Sample Type.** Because the specific sex role theory comes mainly from treatment statistics, models of family and non-family roles to explain higher demoralization may only be applicable to persons in treatment for emotional and psychological distress. Women who seek help may be doing so because of the performance of multiple family roles and the additional stress of employment pressures, but this may not serve as a general model to explain demoralization. High demoralization in the community sample may not be explained by role complexity. There is evidence, cited earlier, that the absence of family and non-family roles may pose the greatest mental health risk.

**Gender.** What about men? The models of family and non-family roles presented earlier are primarily oriented to explaining higher or lower female demoralization. The specific sex role theory implies that the male advantage on mental health measures stems from their occupation of multiple family roles as well as meaningful non-family roles, i.e., employment. Their multiple roles, however, are not seen as leading to
stress and role overload. Men are seen as benefiting from having a spouse and children rather than these roles being detrimental to well being. Those men most at risk to demoralization are those who lack family roles and are not in the labor force. This contention can be examined among men in both treatment and community samples.

**Social Class.** Sub-groups of men and women may become demoralized in entirely different ways. An important variable differentiating both women and men is social class. There is much evidence to suggest that the lives of working-class women may be as different from the lives of middle-class women as the differences that exist between men and women, at least as far as mental health is concerned. Many features of family and non-family roles seen as important in discussions of sex differences in mental health are more characteristic of lower and working-class women than middle-class women. This idea has been presented by Meile et al., (1976) to account for mental health differences between women.

Life in working-class families may be more stressful for both men and women, but especially so for women. The lower and working-class women may be disadvantaged by the stresses of family and non-family roles over and above those stresses outlined in the specific sex role theory of mental illness.

The lower and working-class woman is likely to receive less emotional and instrumental support from her spouse. Single mothers are more likely to be in lower SES groups and not have the instrumental and emotional advantages of those with spouse present. As Komorovsky (1964) has noted, the role of wife and companion is of considerably less importance to lower than middle-class wives. It has also been argued
that parenthood is likely to be viewed by the working class mother as a source of dissatisfaction and problems. Langner and Michael (1963), for example, argue that working-class housewives are more likely than middle-class housewives to view their children as causing trouble.

Meile et al., (1976) have chronicled several social class differences of women in families. Lower-class married women have more children than middle-class women, thus increasing their confinement to the household (Westoff and Westoff, 1971). Additionally, the lower-class husband relative to his middle-class counterpart helps less with the socialization and care of children, and does fewer household tasks. These authors also contend that opportunities for gratification outside family roles increase with socioeconomic status. Booth (1972) finds that middle-class women are more likely to find employment that provides interesting and challenging career opportunities. The same could be true of middle-class men compared to working-class men, but working-class women may face additional problems in relation to outside work. Rubin (1976) has elaborated the complexities involved in the decision to seek work faced by working-class women. Rubin argues that the decision about the wife working is symbolically different in working-class families.

It is harder because, historically, it has been a source of status in working-class communities for a woman to be able to say 'I don't have to work.' Many men and women still feel keenly that it's his job to support the family, hers to stay home and take care of it. For her to take a job outside the house would be, for such a family, tantamount to a public acknowledgment of his failure (p. 171).

In addition, and because of, status uncertainty on the part of men, working-class women are more likely to meet active opposition from
their husbands to stay out of the labor market. One husband interviewed by Rubin (1976) had this to say about his wife working:

I think our biggest problem is her working. She started working and she started getting too independent. I never did want her to go to work, but she did anyway. I don't think I have to say-so that I should have ....... I feel the man should do the work, and he should bring home the money. And when he's over working, he should sit down and rest for the rest of the day (p.177).

Social class is also related to differences in friendship patterns for women. A consistent finding is that higher status women have more close friends than working-class women (Booth, 1972; Graham, 1980; Bell, 1981). Also, lower status women meet greater proportions of their friends in the neighborhood, while middle-class women recruit friends from wider social circles (Rubin, 1976; Bell, 1981).

The Power of Models of Family and Non-Family Roles

Demoralization may have more to do with the quality of family and non-family role performance than with the quantity of roles performed. At least three themes in the mental health literature suggest ways in which differences in the quality of adult interaction affect the mental health of people.

The first theme concerns the issue of emotional and instrumental support. Evidence relating to this theme seems relatively clear-cut. An absence of adult supportiveness is related to poor mental health in a number of studies. The presence of a confidant has been found to serve as a buffer against traumatic loss (Lowenthal and Haven, 1968). Brown and Harris (1978) report that emotional support from their husbands protects women from psychological depression. Relatedly, Weissman and Paykel (1974) found that depressed women are considerably more likely
than non-depressed women to report problems in marital intimacy and spouse communication. If these reports are accurate, women may be at a disadvantage in terms of support. Blood and Wolfe, in 1960, reported that men on the average do not perform supportive and nurturing tasks very well. About 30% of the husbands of 731 respondents were reported to respond to their wife's problems with criticism, rejection, passive listening, or dismissal of them as unimportant. The lack of supportive responses to wives' problems has mental health implications. Giles (1976) finds females who lack adult nurturance are more vulnerable to problems of emotional well-being. More recently, Vanfossen (1981) in a comparison of three groups: employed husbands, employed wives, and unemployed wives, finds two dimensions of spouse support strongly related to depression. She reports that affirmation and intimacy are negatively related to depression in each of the three groups. She concludes that for all three groups studied in her research "emotional depression is associated with a dearth of validating sentiment and action from marital partners" (p. 141).

While most evidence on the relationship between support and mental health problems have focused on the effects on women (with the exception of the Vanfossen 1981 study), there is some evidence that men rely to a great extent on women for emotional support. Past research has suggested that for men, their wives and/or female companions may be the only source of emotional support and nurturance available to them. Significantly more men than women report "not having a best friend" (Bell, 1980). On average, men report having fewer friends (Bell, 1980, Booth, 1978) and are less likely to discuss their problems with friends (Horwitz, 1977). Most important, men are twice as
likely to talk to no one about emotional problems and when they do talk they are likely to rely solely on their wives for support (Veroff et al., 1981). These authors conclude: "Men seem to be more isolated in crises because they spend less time and energy building relationships in everyday life" (p. 48).

A second theme relating to adult interaction and demoralization has to do with family problems and interpersonal conflicts. Problems in the family can take many forms including family deviance, parent-child problems, husband-wife conflicts, problems of work and finance, and problems relating to physical health problems. Each of these types of problems may be more critical for mental health to different sub-groups of men and women. For example, among men, problems of physical health of self and others may be more crucial to men's mental health (Dohrenwend and Dohrenwend, 1976; Veroff et al., 1981). On the other hand, women's mental health may be more affected by the total number of family based problems, including those of herself, her children and/or spouse. There is a great deal of evidence from family sociology to suggest that the impact of family problems and conflicts may be greater on women than men. The theoretical rationale for this idea is as old as Parson's (1954) and Zelditch's (1955) discussions of role differentiation within the family. To them, the spouse who specializes in providing emotional support raises the morale and well-being of all family members. According to the role differentiation notion, women are more likely than men to be socialized to "expressive roles" emphasizing nurturance and emotional subsistence, while men are more likely to be socialized to instrumental roles emphasizing achievement and accomplishment.
What exactly are the implications of these culturally defined roles for mental health? Bernard (1972) has argued that the expressive function, which she calls the "stroking function" is the all-pervading task of women in families. The expressive person is vitally concerned with the morale, spirit, and emotional health of the family unit. Such a person may be more vulnerable to demoralization because of problems in the wider family group. One piece of research has argued that the excess number of women in mental health outpatient clinics is the direct result of the wife-mother more often being the emotional monitor of the family group (Atwell et al., 1978). Women were found to seek help not only for their "personal" problems but, as often, for the behavioral problems of children, and for interpersonal conflicts between members of the family. These authors, as well as others, have noted the "other-directed" help-seeking behavior of women compared to men. Foss (1974) examined the presenting problems of users of four mental health clinics in New England. She finds that large numbers of women contacted clinics for parent-child conflicts, problems in family functioning, and for husband-wife conflict. For example, 19.8% of the women compared to 8.0% of the men contacted a clinic for parent-child problems; 40.6% of the women and 34.4% of the men sought help for marital conflicts. Veroff et al., (1981) in their national study of help-seeking processes, find that women are more likely than men to seek formal counsel for problems involving a child and problems of marital conflict. The Veroff et al. study is a follow-up to the Gurin et al., (1960) study AMERICANS VIEW THEIR MENTAL HEALTH. The other oriented nature of women's help seeking is one aspect of the help-seeking process that has changed little since 1960. As Veroff et
Women's roles orient them more toward the interpersonal aspects of living, while men's are more associated with striving for achievement and success. Thus, it is not surprising that women (and especially young women) tended to seek help for interpersonal problems, and men, for problems involving their work or education. In light of the changes in work-family patterns documented in Book I, one might reasonably have expected somewhat greater similarity between men and women in 1976 in the kinds of problems they tended to perceive as relevant for help—a change that is not, however, evident in these data (p. 59).

While women may be more likely to perform this "mental health" function for the family group, it is not clear whether their own mental health is impaired to a greater extent by the nature of problems and conflicts within the family group. This "contagion effect" among women has often been mentioned, but never explicitly tested.

A third theme concerning the relationship between role relationships and mental health concerns dependency. This theme has been overwhelmingly concerned with wife dependency and posits that, for women, dependency leads to various forms of emotional distress and depression. The higher rates of female disorder reflect the fact that women are more likely than men to be in dependent positions regardless of marital status.

There are several studies indicting dependency as a primary cause of emotional distress. Weissman and Klerman (1977) in their review of research on the causes of depression argue that societal wide discrimination against women contributes depression vulnerability. To these reviewers, real social discrimination leads to legal and economic helplessness, dependency on others, low self-esteem, low aspirations, and, ultimately, clinical depression. Beck and Greenberg (1974) also
hypothesize that the problems which typically trigger depression may be "sex-typed". These authors point out that the absence of objective power to control one's life is more commonly experienced by women than by men. The work of Greywolf et al., (1980) with low income women underscores the role of dependency in the development of psychological distress and clinical illness. In this study, those women with the highest rate of depression were continually faced with multiple and chronic stresses affecting both their children and themselves. Efforts to deal with these problems led to repeated frustration related to their dependency, i.e., few employment possibilities, poor housing conditions, no protection against violence and crime, and the insensitive attitudes and responses of social service and mental health agencies.

In light of clinical and experimental work, Seligman (1975) believes that people are more likely to become depressed when they have learned that their actions will have no effect. The "learned helplessness" hypothesis incorporates learning and cognitive theories to account for sex differences in emotional distress and suggests that the expectation of powerlessness and dependency and the inability to control one's destiny, whether real or perceived, prevents effective action on one's behalf (Radloff and Munroe, 1978; Radloff, 1980).

Problems in Social Role Theory

Even though social role theory has been applied extensively to understanding sex differences in forms of distress, there are several problems in this conceptualization. First, many of the predictions about the impact of social role performance seem contradictory. It is
not clear whether too many or too few roles contribute most to
distress. Second, there has been an almost exclusive focus on role
performance in family life and little focus on the impact of non-family
roles on distress.

Third, rarely have studies directly tested the impact of social
role performance on mental health while controlling for the effects of
socioeconomic variables. Socioeconomic variables have been largely
ignored in research on sex differences in distress.

Lastly, much of the evidence about social role performance and its
impact on distress fails to make a distinction between samples based on
treatment and non-treatment populations. The preponderance of married
women in outpatient treatment is taken as evidence of the greater
impairment of this group.

**Hypotheses**

The next chapter will describe the characteristics of a sample of
373 respondents composed of users and non-users of outpatient services.
This type of sample will allow for testing hypotheses about sample type
and how it effects the relationship between social role performance and
distress, here measured as demoralization.

**Hypothesis I.**

The effect of a sex-marital status interaction in the explanation
of sex differences in demoralization will vary by sample type.

It is contended that a higher rate of demoralization among married
females will only be found in treatment populations. Studies using
treatment samples fail to take into account the confounding of true
effects on mental health from the effects of help-seeking behavior.
Because more married females seek help, assumed they are more impaired.

Hypothesis II.

The effect of social role performance and quality of adult interaction on sex differences on demoralization will largely disappear when controlling for the effects of socioeconomic variables.

It is hypothesized that in the general non-treatment sample, the best predictor of sex differences in demoralization will be a sex x social class interaction effect. Lower SES women will be significantly more demoralized than lower SES men regardless of social role performance or the quality of family statuses. It is also predicted that no significant differences in demoralization will be present between higher SES men and women.

While there is a great deal of indirect evidence for this hypothesis (Meile et al., 1976; Graham, 1980; Rubin, 1976; Komorovksy, 1946; Langner and Michael, 1963), the issue of social class has largely been ignored in studies of sex differences in emotional distress.
CHAPTER VI

RESEARCH DESIGN AND MEASUREMENT OF VARIABLES

This chapter discusses the methods used in obtaining the data for this study and the statistical procedures utilized. Characteristics of the sample are examined and the measurement of dependent and predictor variables is discussed.

Sample Characteristics

The interviews used in this study were drawn from the first phase of a longitudinal study carried out in 1973 and 1976. The 1973 sample of 373 cases contained two sub-samples. One sub-sample consisted of persons who were clients at community guidance and counselling clinics. Four clinics in southeastern and central New Hampshire provided clients (two community mental health clinics, a family service agency, and a Catholic social service agency). The other sub-sample was comprised of a random sample of people living in areas served by these agencies, but not known to be involved with any helping agency. The generalizability of the sub-samples is limited since the samples were drawn from one state and only three cities within this state.

The agency sub-sample was obtained with the cooperation of personnel at each agency. Two stages of contact were used to enlist agency clients. First, clients were asked by staff at these clinics if they would be willing to participate in the study by being interviewed.

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by a member of our research staff. Unfortunately, no records were kept of the refusal rate at this stage. The representativeness of the agency sub-sample is unclear, but very similar in terms of age, education, sex, and family type to randomly selected samples of agency users reported in the literature (Horwitz, 1977; Foss, 1973), and to statistical profiles of clients of outpatient psychiatric clinics on a national level (Chesler, 1972; Rosenstein and Milazzo-Sayre, 1980). Those clients who expressed interest in participating in the study at stage one were contacted to arrange a time for an interview. Seventy-two percent of the clients who originally agreed to be interviewed were actually interviewed. This sub-sample contains 158 cases and comprises 42 percent of the 373 cases.

The nonclinical control group was gathered from a random sample of persons living in the same communities served by these service agencies. City and Town directories were used to select names of potential respondents. Procedurally, a number was drawn from a table of random numbers to determine the page of the city directory from which a name would be picked. A second random number was drawn to determine the location on the page. Finally, either husband or wife, if married, was selected as the respondent by the toss of a coin. Each person was then sent a letter describing the study. A telephone call or home visit from a member of the research staff was then made to elicit participation. The response rate for the random sub-sample was 49 percent. The total number of cases completed was 215 comprising 58% of the total sample.

Interviews covered a range of topics on family and marital interaction, demographic characteristics, family problems, sources of help sought for problems and scales of mental health status. The length
of time required to complete an interview varied widely depending on
the number of family problems and the number of informal and formal
sources of help sought for problems. For this reason, interviews with
agency clients were generally longer, from one and one-half to four
hours. Interviews with persons drawn from the random sample were
shorter, usually lasting between forty-five minutes to two hours.
Interviews took place either in the home of the respondent (46%) or at
a central interviewing site (54%). There were no significant
differences on important variables between persons interviewed in the
home rather than at the interviewing site.

In 1976, the attempt was made to recontact the original 373
respondents. Two hundred were reinterviewed. Thus, of the respondents
from the 1973 sample who were contacted in 1976, 54 percent agreed to
be reinterviewed. Nine cases from the 1976 sample of 200 were dropped
because of incomplete data or because different persons from the same
household were interviewed in 1976. Thus, 191 cases comprise the 1976
sample. This research reports data only from the 1973 sample.

Agency Versus Non-Agency Sub-Samples

Since the total sample is comprised of clients of human service
agencies as well as a random sample of community residents, it is
necessary to discover how similar these groups are to one another for
the purpose of combining them for analyses. Differences on important
variables would suggest the value of separate analyses.

Table 6.1 shows that there are a number of statistically
significant differences between sub-samples. Chi-squares were used for
contingency tables and T-tests were used to examine differences between
Table 6.1.—Demographic Characteristics of Agency and Nonagency Subsamples (1973)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Agency</th>
<th>Nonagency</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=158</td>
<td>N=215</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>22</td>
<td>36</td>
<td>.01</td>
</tr>
<tr>
<td>Female</td>
<td>78</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Education (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-8</td>
<td>11</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>9-12</td>
<td>59</td>
<td>43</td>
<td>.01</td>
</tr>
<tr>
<td>13+</td>
<td>30</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>In Labor Force</td>
<td>62</td>
<td>66</td>
<td>NS</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married, living together</td>
<td>52</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>12</td>
<td>8</td>
<td>.001</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>36</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Family Living Arrangement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Husband-Wife Family</td>
<td>52</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>In Female Headed Family</td>
<td>28</td>
<td>7</td>
<td>.001</td>
</tr>
<tr>
<td>Primary Individual</td>
<td>10</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>In Household (w/others)</td>
<td>10</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Children in Household</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>68</td>
<td>.05</td>
</tr>
<tr>
<td>Family Income (dollars)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3,999</td>
<td>29</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>4,000-9,999</td>
<td>39</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>10,000-14,000</td>
<td>19</td>
<td>27</td>
<td>.001</td>
</tr>
<tr>
<td>15,000-24,999</td>
<td>10</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>25,000+</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (Female)</td>
<td>31.5</td>
<td>42.6</td>
<td>.001</td>
</tr>
<tr>
<td>Age (Male)</td>
<td>33.7</td>
<td>43.8</td>
<td>.05</td>
</tr>
<tr>
<td>Occupational Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females (Duncan score)</td>
<td>36.4</td>
<td>42.5</td>
<td>.05</td>
</tr>
<tr>
<td>Males (Duncan score)</td>
<td>40.0</td>
<td>44.4</td>
<td>NS</td>
</tr>
<tr>
<td>Times Moved</td>
<td>1.8</td>
<td>0.8</td>
<td>.001</td>
</tr>
<tr>
<td>Family Size</td>
<td>4.5</td>
<td>4.0</td>
<td>.05</td>
</tr>
</tbody>
</table>
mean scores. The agency subsample has a higher proportion of females than the nonagency subsample. This difference reflects the greater use of mental health clinics by women cited in several studies (Gurin et al., 1960; Veroff et al., 1981; Greenley and Mechanic, 1975). The agency subsample is less well educated than the random subsample, although a greater proportion of agency respondents went to high school. Agency respondents are from families with lower incomes, and both men and women are younger than community respondents.

A look at family characteristics finds many more persons with disrupted marriages in the agency subsample as well as a greater number of female headed households. There are also disproportionately more families in the agency sample with children at home. This is also reflected in the larger family size of agency families compared to the random sample households. Agency families are also more likely to be geographically mobile.

Respondents from the two subsamples are most alike with respect to work. There are no significant differences between samples in work status. Persons from both groups are equally likely to be in the labor force. Among men in the labor force there are no significant differences between samples in terms of occupational prestige, but there is between women as measured by the Duncan Occupation Scale. To summarize, persons from the agency subsample are more likely to be female, younger, less educated, and more likely to be divorced or separated. Agency respondents are also more likely to have children at home, larger families, and to have changed residences in the recent past. These subsamples are very different from one another and should be treated as distinct samples. Accordingly, analyses will be performed
separately on each subsample.

**Measurement of Variables**

**Dependent Variable**

**Demoralization.** Items from the Indik Scale of Psychological Strain (1968) were used to form the measure of demoralization in this study. The Indik scale itself is comprised of 16 items from the original Gurin scale (1960). The Indik scale uses more response categories than the Gurin scale. The Gurin scale is one of the more widely used symptom checklist scales in epidemiological research. It is almost identical in item type to the Langner 22-item scale (Langner, 1962), the Cornell Medical Index (Brodman et al., 1952), and the 24-item Health Opinion Survey screening scale (Macmillan, 1957). In some recent research, Dohrenwend et al. 1979; 1980, has provided evidence that all these scales are highly intercorrelated. They also argue that the scales measure the construct demoralization because of their high correlation with measures of low self-esteem, helplessness-hopelessness, sadness and anxiety, all of which are major facets of what Frank (1973) meant by demoralization.

As can be seen in Appendix A.1, most of the items in the Indik scale tap physiological or psycho-physiological symptoms that are held to reflect emotional and mental distress. The interview schedule used in this study included not only the Indik scale but also the Bradburn scale of Psychological Well being (1969). Because both scales use very similar items it was felt they could be combined to form a stronger measure of demoralization. Accordingly, the 16 items from the Indik scale and the 10 items from the Bradburn scale were factor analyzed
together. The scales differed in their scoring. Responses to the Indik scale ranged from 0 (never) to 3 (nearly all the time) while responses to the Bradburn scale were 0 (no) to 1 (yes).

Responses to both scales were factor analyzed using a principal components solution with oblique rotation. Oblique rotation was used instead of varimax rotation because these are scale items and we expected some correlation between them. Based on a plot of eigenvalues, three factors (all with eigenvalues greater than 1.0) were extracted from a 26 x 26 item intercorrelation table. All three factors were found to be interpretable as well as to possess factor loadings of sufficient magnitude (> .30) (Comrey, 1973) to warrant interpretation and subsequent scoring.

Table 3 in Appendix A presents the factor loadings on each of the three factors. Factor 1 is composed of 14 of the original 16 Indik items. Factor 1 accounts for 76% of the common variance in the matrix and has an eigenvalue of 6.24. Factor 1 is used here as the measure of demoralization. Factor 2 is comprised of five items of the Bradburn scale of Psychological Well Being that Bradburn (1969) held to be a measure of "negative affect" and two items from the Indik scale having to do with immobilization. The seven items comprising Factor 2 tap symptoms of anxiety and immobilization, two aspects of mild depression (Radloff, 1975; Weissman and Klerman, 1980). Factor 3 is comprised of five items from Bradburn's scale of Psychological Well Being. They are the same five items he identified as measuring "positive affect". Here, they also form a clear factor and measure not just the absence of symptoms of distress but a positive state of mental health.

The three factors of demoralization, negative affect and positive
affect are correlated with each other in the following way: demoralization with negative well-being \( r = 0.43 \); demoralization with positive well-being \( r = -0.15 \); positive with negative well being \( r = -0.08 \).

Factor scores were computed for the demoralization measure using factor score coefficients. The resulting factor score of demoralization was highly correlated with the summed score of unweighted indicators \( r = 0.99 \). Unless otherwise noted, the factor score version of the demoralization measure is used throughout this research.

**Predictor Variables**

**Sex.** The major focus of this study concerns sex differences in demoralization. The importance of this variable has been documented throughout earlier chapters. The variable is coded here (1) Male, (2) Female. In the agency sample there were 35 males, 123 females. In the community sample there were 77 males, 137 females. When this variable is used in regression equations in interaction terms it was recoded (1) Female, (0) Male.

**Age.** Age data was collected on all household members in both samples. Age was coded as an interval level variable. The actual age range of respondents in study was 18 to 84. The theoretical focus of this study is not on age, but the variable has been found to be quite important in studies of mental health (Veroff et al., 1980; Aneshensel et al., 1981).

**Marital Status.** Categories here include (1) Never Married, (2) Married, (3) Separated, (4) Divorced, (5) Widowed, (6) Living Together. For purposes here, categories 1 and 6 were combined in analyses. In
mental health research, marital status is an important variable. Most major theories of sex differences in mental health functioning have found marital status to be among the strongest predictors of impairment (Gove, 1972; Crago, 1968; Veroff et al., 1980). Because of the small sample size, for most of the analyses, this variable is dichotomized: (1) Married, (0) Nonmarried.

Sample Type. As mentioned in the preceding section, persons from the treatment subsample were appreciably different on important indicators from persons in the community sample. For this reason, separate analyses were conducted on each sample. Variable coded here as (1) Agency, (2) Control.

Employment Status. This variable treated as both a categorical and ordinal variable. As a categorical variable of employment status, eight statuses were used to determine the respondents relationship to the labor force: (1) employed full-time, (2) employed part-time, (3) student, (4) unemployed, looking for a job, (5) housewife, (6) unemployed, not looking for a job, (7) disabled, (8) retired. This variable was also used as an ordinal variable denoting degree of labor force participation. For this purpose, the variable was trichotomized: (1) works full-time, (2) works part-time, (3) not in labor force. Information was collected about employment status of respondent and spouse if married or separated.

Family Size. This variable is used in this study not as a measure of household size, but as a measure of the number of people related by blood or marriage in household and number of children not currently in household. Size of nuclear families in this sample ranged between 1 and 10. The mean family size is 4.2 members. In most analyses, family size
is used as a control variable.

**Family Network Size.** This variable is used as an indicator of the amount of family support available to a person. The size of this network can be specified in only a rough manner since it is often difficult to determine whether a network member should be considered available for interaction (Horwitz, 1977). Those considered part of the family network are spouses, other live-in kin, children over 16 years old in home, children over 16 not in home but living within 50 miles of home, and siblings, if living within 50 miles of respondent's household. A score of "1" was given to each person who met one of these criteria and the size of the network is a simple additive score. Actual scores ranged from 0-11 with a mean family network size of 5.19. It is important to remember this is not a measure of family and kin interaction. but only a measure of the potential pool of kin members available for support.

**Amount of Contact with Kin.** Amount of contact was estimated by a global measure of the amount of interaction that occurred with non-household kin in the past month. The actual question read: "In the past month, how often have you had contact with relatives, excluding those you live with, by getting together with them, writing to them, or telephoning them?" Responses were scored as follows: (4) everyday, (3) several times a week, (2) at least once a week, (1) at least once in the past month, (0) not at all. The mean for this variable was 2.39.

**Non-Kin Network Size.** As with the variable measuring family network size, this variable is used as an attempt to estimate the size of the non-kin network available for interaction. A person who worked full-time, part-time, or was in school received a score of "1". An
additional "1" was added for each person (non-kin) who was mentioned as someone with whom the respondent got together socially over the past month. Non-kin network size in this sample ranged from 0-8 with a mean size of 3.47.

**Amount of Contact With Non-Kin.** This is a global measure of the amount of interaction that occurs with non-kin. It is a very rough measure of social interaction procured by the following question: "In the past month, how often have you had contact with friends by getting together with them, writing to them, or telephoning them"? Responses were scored as follows: (4) everyday, (3) several times a week, (2) at least once a week, (1) at least once in the past month, (0) not at all. Mean score for this variable was 2.66.

**Social Class.** The measurement of social class used Hollingshead's Two Factor Index of Social Position (1957). This measure has been used extensively, especially in mental health research, and is comprised of the weighted sum of the occupational and educational level of the head of household in each family. Both occupation and education are ranked on seven point scales with "1" being the highest level in each case. A respondent's score on the occupation factor was multiplied by 7 (see Appendix A.4 for the ranking of occupational groupings used in this measure), and his or her score on the educational factor was multiplied by 4 (see Appendix A.4 for the ranking of educational levels). For example, if a respondent reports she is a physician, she would be ranked in the top occupational group "1" and this score would be multiplied by "7" yielding an occupational score of "7". If she lists her educational level as "graduate training" she would receive a score of "1" on the education factor. This score would then be
multiplied by "4". Her total score takes the weighted occupational score added to the weighted educational score for a total score of "11". This index, then, takes occupation to be the more important of the two factors in determining an individual's class rank.

The minimum possible score on this index is 11; the maximum possible score is 77. A respondent's social class was determined by grouping the index scores in the following way: Class I (scores 11-17); Class II (scores 18-27); Class III (scores 28-43); Class IV (scores 44-60); Class V (scores 61-77). In this sample, the actual range of scores was from 11 to 77. Because of the small sample size, the five class system was dichotomized into Classes I, II, and III and Classes IV and V for several of the analyses.

FAMILY ROLES.

Each of several family roles were measured separately and together in this research. Under the assumption that role demands would be different in various family role relationships, the spouse role and parent role were disaggregated. For example, a parent's role relationship and role demands are different if he/she is parent to a preschool child(ren), to children living at home and in school, or to children who no longer live in the household. Also, the demands are very different if all three role relationships are performed by parents. Among the family role relationships measured for this research are the following.

The Presence of a Spouse. The measurement of this variable is based on the presence or absence of the spouse role relationship. Persons in household occupying spouse or spouse equivalent roles were
counted as a spouse. In this sample, 253 persons reported the presence
of a spouse role relationship, 120 reported its absence. Among those
with spouse role relationship present, the vast majority were currently
married. However, one person was never married and three identified
themselves with the marital status divorced, but with spouse equivalent
present.

**Presence of Former Spouse.** This variable was created through
information asked directly about former marriages and divorces and
their time occurrence. The measure was not constructed on the basis of
current marital status. 30 persons or 8% of the sample whose marital
status is currently married have former spouses. Among persons
currently divorced, 13 or 3.5% report an additional former spouse. In
this sample, 259 or 69.5% of the persons report no former spouses; 101
or 27.1% report having one former spouse; and 13 or 3.5% report having
two former spouses. For purposes here, if a person reported being
separated for more than one year with spouse not in household, that
person was considered to have a former spouse. All widowed persons were
considered to have a former spouse.

**Preschool Children.** This variable was measured by summing the
number of children in the household under the age of 6. In this sample,
61.7 per cent. 230 persons reported no children in household. 24.1 per
cent or 90 persons reported one preschool child in the household; 11.8
per cent or 44 reported two; and 2.4 per cent reported more than two
preschool children in the family. The mean number of preschool children
in families in this sample is 0.56.

**School Age Children in Home.** This variable was measured by
summing the number of children currently living in the household who
are six years of age or older. 26.5 per cent or 99 persons reported no children in the household. 19.8% or 74 reported one child in the family; 22.0 per cent or 82 persons had 2 children six years of age or older living in the household; 13.1 per cent or 49 reported 3; 10.7 per cent or 40 reported 4; and 7.9 per cent or 29 reported more than four school age children in the household. The mean number of school age children living in the home in this sample is 2.62.

**Children Not in Home.** This variable reflects the number of children in the family not currently living in the household. 67.8 per cent or 253 persons report no children living outside the household; 12.9% or 48 report one; 8.8 per cent or 33 report two. 5.9 per cent or 22 report three; and 4.6 per cent or 17 report more than three children living outside the household. The mean number of children in this situation is 0.72.

**Multiple Family Roles.** This is a measure of the number of family roles performed by an individual. The particular family role concerned with the existence of former spouses was not used in the calculation of this variable since we have no information on the amount of contact one has with former spouses. Also, this is intended as a measure of the amount of day to day family role interaction people are engaged in. The variable was measured by adding four dichotomous variables: being a spouse; the parent of a preschool child(ren); the parent of a child(ren) in the home six years of age or older; and the parent of a child(ren) not currently in the household. Persons scores could range from 0 (none of these family roles) to 4 (all of these family roles). In this sample, 43 persons or 11.5 per cent of the sample reported no family roles of this type; 28 or 7.5 per cent of the sample reported
one family role; 52 or 13.9 per cent reported two family roles; 146 or 39.1 per cent of the sample reported three family roles; and 104 or 27.9 per cent of the sample reported currently performing all four of these family based roles. The mean number of family role relationships being performed was 2.64. For some purposes, i.e., when using analysis of variance, this variable was dichotomized into those persons with two or fewer family role relationships and those with 3 or more.

Quality of Role Interaction

In addition to variables which tap the number of family and non-family roles, there are some additional measures of the quality of these roles in terms of satisfactions, problems, conflicts, and supports associated with performance. The first set of these variables are concerned with problems and conflicts that occur between family members.

Family Conflicts and Problems

One of the goals of the interview was to collect data on the number and types of problems which families experience. For this purpose, a checklist of family problems was included in the interview. These items dealt with a number of problems areas in family life including several issues relating to husband-wife conflict, problems between parents and children, problems relating to work and finances, problems relating to the health of family members, and problems of family deviance including the use of alcohol or drugs by family members and involvement with police.

Items comprising the list were drawn from intake forms used by the New Hampshire Department of Mental Health and from research reports.
both clinical and academic, concerned with family problems. Since no checklist of this type can completely cover the wide variety of problems families experience. care was taken to allow respondents to list other problems which members of their family experienced. The reliability of the checklist has never been tested but it was considered comprehensive by those involved in the research. Indirect evidence of the comprehensiveness of the checklist is that respondents, when asked if there were any other problems that they had which were not on the checklist rarely responded in the affirmative. When they did it was to say the only other problem was a combination of those already on the list.

It is important to remember that the respondent to this interview served as the family "problem representative". The problems he/she listed were not only personal problems, but problems of other persons, or relational problems. For the purposes of this research, six types of family problems were examined. They are listed and described below.

Husband-Wife Problems. Ten problems centering on the spouse role relationship were summed to create this measure. Total scores reflect the number of husband-wife problems reported by each respondent. The problems are listed in Appendix A.5. Scores on this variable could range from 1 to 10. The mean number of spouse role problems reported was 2.7. Items of husband-wife problems were answered by only part of the sample. People who were unmarried, living alone, and people who were divorced, separated, or widowed for longer than two years did not respond to this section. The responses of persons who were currently married, or persons who were separated, divorced or widowed within the last two years were included here. 304 of the 373 persons in the sample
completed this section.

This measure could be considered an index of husband-wife conflict since most of the items reflect conflicts of interest in amount of communication that takes place between spouses, trouble with in-laws, arguments, the use of force in sex, and the use of physical violence. Further, this index correlates highly with an item concerning the amount of disagreement that occurs between couples in the household. There is a correlation of .48 between amount of disagreement over household issues and the number of husband-wife problems.

Validity considerations aside, this a reliable measure. The internal consistency of the index, measured by Cronbach's alpha coefficient of reliability is .81 (Cronbach, 1949).

**Parent-Child Problems.** Five problems concerned with the parent-child role relationship were included under this variable. These problems are listed in Appendix A.5. Totalscores reflect the number of parent-child problems reported by each respondent. Scores on this variable range from 0-5. The mean number of problems reported was 1.6. This information was only collected from persons with children, regardless of marital status. 284 of the 373 persons in the sample completed this section. The internal consistency of this 5 item index, measured by Cronbach's alpha coefficient of reliability is .68.

**Problems of Family Health.** Four problems about illness, disability, and death were initially used to comprise this measure. The actual questions are listed in Appendix A.5. These questions refer to the health problems of any family member. The internal consistency of these items was low: .40. However, the coefficient of reliability rose to .58 with the deletion of the item concerning the death of a family
member. This item correlated only weakly with the other three items ($r=-.004$) and was eliminated from this index.

Work-Income Problems. Five items concerning money and employment make up this index. These problems are listed in Appendix A.5. All respondents were asked about these problems regardless of marital status or family roles. Scores on this index range from 0-5. The mean number of work-money problems reported was 1.2. Cronbach's (1948) measure of reliability on this measure was .48. The relatively low inter-item reliability is not uncommon with social psychological measures (See Kalmuss and Straus, 1982). Moreover, factor analysis of all problems used here produced five dimensions corresponding to the five problems types. The five work items formed one clear dimension.

Family Deviance Problems. This category contains behavioral problems of individual family members. The items are concerned primarily with anti-social actions. Problems with excessive drinking, the use of drugs, the use of violence outside the family, involvement with the law, suicide attempts, and problems getting along with people are included here. The complete list of these problems appears in Appendix A.5. Again, all respondents were asked about these problems regardless of marital or family roles. Scores on this index could range from 0-6. The mean score on this item was 0.76. The internal consistency of this 6-item index, measured by Cronbach’s alpha was .61.

Total Family Problems. This is an aggregate measure of all family problems discussed above. Since many of the relational problems were not asked of some people depending on the extensiveness of their family roles, a method of standardization was developed. On this measure, the total number of family problems was divided by the number
of family roles one performed. Scores on this measure ranged from 0-18. Mean number of family problems reported was 3.2.

Work Satisfaction. Two separate questions were asked about satisfaction with work. One question concerned the quality of work experience and read: "How satisfied are you with the kind of work that you do?" The other question is concerned with income satisfaction and read: "How satisfied are you with your earnings?" Responses for these questions were on a four point scale: 1) very satisfied, 2) unsatisfied, 3) satisfied, 4) very satisfied. These questions were asked of everyone, including housewives and those not in the labor force. These items were not combined for purposes of analysis, but treated as separate items. Mean score on the quality of work item was 3.30 with a standard deviation of 0.71. The mean score on the income satisfaction item was 2.92 with a standard deviation of 0.86.

Adult Support. The interview schedule contained a ten point scale of spouse supportiveness developed by Straus (1972). The scale is designed to measure how often the respondent's spouse or spouse equivalent extended instrumentally and/or emotionally supportive acts to the respondent during the past year. An initial glance at the content of the ten items (listed in Appendix A.10) indicates the presence of two dimensions of supportive acts: instrumental support dealing with helping the spouse or doing things for the spouse and, emotional support, providing comfort, reassurance, and respect. Straus (1972) provides no reliability information on this measure, so a factor analysis of the ten items was undertaken. Principal factoring with iteration and varimax rotation of the ten items yielded only one factor (all with loadings greater than +.58). The eigenvalue for this single
factor is 6.05 (see Appendix A.10 for factor loadings). Factor scores were computed for the support measure using factor score coefficients.

Objective Dependency. The variables associated with objective dependency are primarily economic in nature. People who are not economically self-sufficient must rely upon someone or some agency for basic needs. Their dependent relationship could be with a parent, a spouse, the state, or a combination of these. Labor force participation is a main indicator of dependency, but not sufficient to describe dependency. Working does not necessarily guarantee independence. A person's income may be too low to insure self-sufficiency. In the case of married women in particular, income derived from their own labor may be a small part of total household income. Additionally, the presence of pre-school children may limit participation in the labor force, especially for women.

This measure of objective dependency is very similar to an index used by Kalmuss and Straus (1982) called the index of wife's objective dependency. The scale used here is not limited only to wives. It can be applied to men as well as to women who are not wives.

This index is the sum of scores on three trichotomous variables: labor force participation, scored (0) full-time, (1) part-time, (2) no participation; percentage of income contributed to household income, scored (2) 0-24 per cent, (1) 25-49 per cent, and (0) 50 percent and over; and the presence of preschool children—scored (0) none, (1) one, and (2) more than one. The value of this index ranged from 0 (low objective dependency) to 6 (high objective dependency). The internal consistency of the index, measured by Cronbach's alpha coefficient of reliability was .59, the exact alpha of this index of objective
dependency used by Kalmuss and Straus (1982:6).

**Statistical Procedures**

Several statistical tests will be used in this study. Student's T statistic will be used to show group differences in mean demoralization scores. Pearson's product-moment correlation will also be computed to show the strength of relationship between demoralization and a number of social roles and other variables of interest. Another statistical test to be used will be two-way analysis of variance (ANOVA). This test allows the simultaneous comparison of the direct and interaction effects of two or more variables on the mean scores of dependent variables. ANOVA is particularly valuable to these analyses in that interaction effects between family and non-family roles as well as between the quantity and quality of family roles may be compared to their direct effects. The size of the F-value obtained for each ANOVA table is used to determine whether hypotheses will be accepted or rejected at the .05 level of significance.

All analyses will be conducted separately on the treatment and random sub-samples. Because a major part of this analysis is a search for possible sex-marital status interaction effects in the treatment and/or random sample, regression analyses will be used to control for the effects of other variables and interaction terms.

**The Construction of Interaction Terms**

A particular set of procedures will be followed to generate interaction terms. Taking each sub-sample separately, a number of variables, thought to be important in a discussion of sex differences
in demoralization, will be examined in a regression equation using backward elimination. Separate regression models will be used for men and women. In effect, four separate regression models will be estimated: one for males in the treatment sample, one for females in the treatment sample, a third for males in the community sample, and a fourth for females in the community sample. The variables used in each model include family and non-family roles as well as a number of control variables. For each regression equation, variables will be eliminated one by one until all remaining variables are statistically significant at the .10 level. This procedure is used to isolate a subset of predictor variables that will yield an optimal prediction equation with as few terms as possible.

The next step involves a comparison between regression equations of men and women within each sub-sample. For example, the regression equations of men and women within the treatment sub-sample will be examined. Confidence intervals will be drawn around the regression coefficients in each equation. On each variable, the male and female equations will be examined to locate those that show a significantly different relationship to demoralization for each sex. For example, the presence of preschool children might show a strong relationship to demoralization among women, but, among men, there might be no relationship or a strong negative relationship. For each of these variables, interaction terms will be constructed with sex. Following the construction of interaction terms, all significant variables and interaction terms will be entered into a regression equation containing male and female cases. Regression analysis will be used here to examine the relationship between demoralization and a particular variable,
i.e., a sex-marital status interaction variable, while controlling for the effects of other variables.

Interaction terms to be used in regression equations will be created in the following manner. For example, a sex-marital status interaction variable would be measured by first recoding sex as (1) female, (0) male. Marital status would be recoded as well, (1) married, (0) nonmarried. A new variable would be created by multiplying sex x marital status. A strong positive beta would indicate a sex-marital status effect with demoralization in the direction of higher rates for married females. A strong negative beta would indicate a sex-marital status effect with demoralization in the direction of low rates of demoralization for married females.
CHAPTER VII

FAMILY ROLE PERFORMANCE AND SEX DIFFERENCES IN DEMORALIZATION.

A major question to be examined in this chapter is whether a sex-marital status interaction effect can account for the frequently observed sex difference in demoralization. A second purpose of this chapter is to examine whether a sex-marital status interaction effect appears only in the treatment sample or is also present in the general community sample. Previous chapters have pointed out that epidemiological studies have failed to reveal a sex-marital status effect when examining samples not drawn exclusively from treatment populations. Most epidemiological research finds that women in all marital statuses report higher rates of a number of types of mild psychiatric disorder rather than higher rates only among married women compared to married men.

A good deal of support for a sex-marital status interaction effect is based on treatment samples. The work of Gove (1972) and Gove and Tudor (1973) contends that the female excess in mental health problems is due to an excess of married women in the high risk group. Because the work of these authors is based almost exclusively on treatment samples, it is not clear if the excess numbers of married women is due to real mental health problems or a greater willingness to seek mental health treatment. The higher rates of use of clinics and other services by married women may reflect their role as problem managers in family
crises (as reviewed in Chapter IV). The existence of a sex-marital status interaction effect may be present only in treatment populations because its existence is an artifact of sample type rather than a more general effect in accounting for sex differences in demoralization.

As reported in practically all studies of gender and mild psychiatric disorders, data find higher mean demoralization scores for women in both treatment and community samples. In the treatment sample here, females report a mean demoralization score of 16.5, and men, a score of 12.9. The same sex difference appears in the community sample with women reporting a mean demoralization score of 10.1 and men, a score of 7.9.

Data in Table 7.1 shows the zero order correlations between demoralization and different family roles in both the treatment and community sample. Data show a number of things. First, in the community sample, the simple correlations between demoralization and various family roles are uniformly small. For both women and men, there are no significant relationships between the measure of demoralization and any family role variable. Second, among women in the treatment sample, demoralization is positively related to being the parent of preschool children and having the status of former spouse. Among men in the treatment sample, demoralization is negatively related to having a spouse, being the parent of a preschool child(ren), and performing multiple family roles. It is in the treatment sample that one finds initial support for the contentions of the specific sex role theory of mental illness. Men in this sample benefit from having a spouse and children. Third, there is some indication in the treatment sample of the existence of sex and family role interaction effects. Being a
Table 7.1—Simple Correlations Between Various Family Roles and Demoralization for Men and Women in Treatment and Community Samples

<table>
<thead>
<tr>
<th>Family Role</th>
<th>Community Sample</th>
<th></th>
<th>Treatment Sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female (137)</td>
<td>Male (76)</td>
<td>Female (123)</td>
<td>Male (35)</td>
</tr>
<tr>
<td>Spouse</td>
<td>-.01</td>
<td>.07</td>
<td>-.06</td>
<td>-.31*</td>
</tr>
<tr>
<td>Parent (Children not in home)</td>
<td>-.03</td>
<td>.08</td>
<td>-.02</td>
<td>-.11</td>
</tr>
<tr>
<td>Parent (Children in home)</td>
<td>-.05</td>
<td>.00</td>
<td>-.03</td>
<td>-.34*</td>
</tr>
<tr>
<td>Parent (Pre-school children)</td>
<td>.06</td>
<td>.01</td>
<td>.20**</td>
<td>-.35*</td>
</tr>
<tr>
<td>Former Spouse</td>
<td>-.07</td>
<td>.05</td>
<td>.15*</td>
<td>-.02</td>
</tr>
<tr>
<td>Number of Family Roles (excl. former spouse)</td>
<td>.05</td>
<td>.07</td>
<td>.07</td>
<td>-.45**</td>
</tr>
</tbody>
</table>

* p < .05  
** p < .01
parent of preschool children, being a spouse, and occupying multiple family statuses have opposite effects on the demoralization scores of men and women.

Evidence for a Sex-Marital Status Interaction Effect

This chapter started with the intent of testing for the existence of a sex-marital status interaction effect. Data in Table 7.2 presents the analysis of variance for sex and marital status on demoralization in the treatment and community samples. There is some initial evidence here of a "type of sample" interpretation of the existence of a sex by marital status interaction effect on mental health. In the treatment sample, there is weak evidence of a sex-marital status interaction effect. The gap between married men and women in the treatment sample in demoralization is much larger than the difference in demoralization scores between nonmarried men and women. Even though women have higher demoralization scores regardless of marital status, the gap between married men and women is four times as large as the gap between nonmarried men and women.

The most important information in Table 7.2 is the complete lack of evidence for a sex-marital status interaction effect in the non-treatment sample. Again, women report higher demoralization scores regardless of marital status, but the gap between men and women is actually larger among the nonmarried than among the married.

Type of Sample and the Sex-Marital Status Interaction Effect.

There is some initial evidence for the idea that the power of a sex-marital status interaction effect may be sample-specific. These
### TREATMENT SAMPLE

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Unmarried</td>
<td>15.8</td>
<td>17.0</td>
</tr>
<tr>
<td></td>
<td>(16)</td>
<td>(60)</td>
</tr>
<tr>
<td></td>
<td>10.6</td>
<td>16.0</td>
</tr>
<tr>
<td></td>
<td>(19)</td>
<td>(63)</td>
</tr>
<tr>
<td></td>
<td>13.0</td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>(35)</td>
<td>(123)</td>
</tr>
</tbody>
</table>

Sex: F = 4.9, p = .02; Marital Status: F = 2.1, p = .14; Sex X Marital Status: F = 1.7, p = .18

### COMMUNITY SAMPLE

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Unmarried</td>
<td>6.8</td>
<td>10.2</td>
</tr>
<tr>
<td></td>
<td>(9)</td>
<td>(34)</td>
</tr>
<tr>
<td></td>
<td>8.1</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>(67)</td>
<td>(103)</td>
</tr>
<tr>
<td></td>
<td>7.9</td>
<td>10.1</td>
</tr>
<tr>
<td></td>
<td>(76)</td>
<td>(137)</td>
</tr>
</tbody>
</table>

Sex: F = 5.4, p = .02; Marital Status: F = 0.02, p = .87; Sex X Marital Status: F = 0.34, p = .56
findings begin to clarify the paradox reported in Chapter II. That is, recent epidemiological surveys with untreated populations have been unable to find any evidence for a sex-marital status interaction effect. On the other hand, studies using samples of treatment populations have consistently reported the finding of higher rates of distress among married women relative to married men, while among those without a spouse, women seem to hold a mental health advantage over nonmarried men.

**Family Role Performance and Demoralization**

It could very well be that the higher relative rates of psychological distress among married women might be due to other aspects of family role performance besides having a spouse. Table 7.3 reports ANOVAS on demoralization for sex and a number of family roles and their interaction effects for both treatment and non-treatment samples. This data show the existence of two highly significant interaction effects in the treatment sample. The first is a sex by presence of preschool children effect, and the second is a sex by total number of family roles performed interaction effect.

**A Sex and Presence of Preschool Children Interaction Effect.**

Table 7.4 looks closer at the ANOVA for the effects of sex and the existence of preschool children on demoralization in both types of samples. In the treatment sample, the interaction effect is clear. Among men and women performing the role of parent to a pre-school child or children, the variable effect on demoralization is pronounced. Women as parents of preschoolers report very high demoralization scores,
Table 7.3—Analysis of Variance for Demoralization by a Number of Family Role Variables in Treatment and Non-Treatment Samples.

<table>
<thead>
<tr>
<th>Main and Interaction Effects</th>
<th>N</th>
<th>Mean Squares</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TREATMENT SAMPLE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>158</td>
<td>143.5</td>
<td>1</td>
<td>2.15</td>
<td>.145</td>
</tr>
<tr>
<td>Sex</td>
<td>158</td>
<td>328.6</td>
<td>1</td>
<td>4.92</td>
<td>.028</td>
</tr>
<tr>
<td>Sex and Marital Status</td>
<td>158</td>
<td>114.8</td>
<td>1</td>
<td>1.72</td>
<td>.182</td>
</tr>
<tr>
<td>Children in Home (6+ years old)</td>
<td>158</td>
<td>31.9</td>
<td>1</td>
<td>0.48</td>
<td>.410</td>
</tr>
<tr>
<td>Sex</td>
<td>158</td>
<td>361.9</td>
<td>1</td>
<td>5.42</td>
<td>.021</td>
</tr>
<tr>
<td>Sex and Children in Home</td>
<td>158</td>
<td>235.9</td>
<td>1</td>
<td>3.53</td>
<td>.062</td>
</tr>
<tr>
<td>Children, but not in Home</td>
<td>158</td>
<td>83.8</td>
<td>1</td>
<td>1.24</td>
<td>.268</td>
</tr>
<tr>
<td>Sex</td>
<td>158</td>
<td>285.7</td>
<td>1</td>
<td>4.22</td>
<td>.042</td>
</tr>
<tr>
<td>Sex and Children, but not in Home</td>
<td>158</td>
<td>44.7</td>
<td>1</td>
<td>0.66</td>
<td>.418</td>
</tr>
<tr>
<td>Preschool Children</td>
<td>158</td>
<td>173.4</td>
<td>1</td>
<td>2.72</td>
<td>.101</td>
</tr>
<tr>
<td>Sex</td>
<td>158</td>
<td>182.1</td>
<td>1</td>
<td>2.85</td>
<td>.093</td>
</tr>
<tr>
<td>Sex and Preschool Children</td>
<td>158</td>
<td>547.9</td>
<td>1</td>
<td>8.58</td>
<td>.004</td>
</tr>
<tr>
<td>Former Spouse</td>
<td>158</td>
<td>97.9</td>
<td>1</td>
<td>1.45</td>
<td>.230</td>
</tr>
<tr>
<td>Sex</td>
<td>158</td>
<td>264.7</td>
<td>1</td>
<td>3.92</td>
<td>.050</td>
</tr>
<tr>
<td>Sex and Former Spouse</td>
<td>158</td>
<td>56.2</td>
<td>1</td>
<td>0.83</td>
<td>.363</td>
</tr>
<tr>
<td>Total Family Roles</td>
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<td>4.4</td>
<td>1</td>
<td>0.06</td>
<td>.796</td>
</tr>
<tr>
<td>Sex</td>
<td>158</td>
<td>337.2</td>
<td>1</td>
<td>5.09</td>
<td>.025</td>
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<td>Sex and Total Family Roles</td>
<td>158</td>
<td>361.7</td>
<td>1</td>
<td>5.47</td>
<td>.021</td>
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<tr>
<td><strong>NON-TREATMENT SAMPLE</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
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<td>0.9</td>
<td>1</td>
<td>0.02</td>
<td>.876</td>
</tr>
<tr>
<td>Sex</td>
<td>213</td>
<td>218.6</td>
<td>1</td>
<td>5.41</td>
<td>.021</td>
</tr>
<tr>
<td>Sex and Marital Status</td>
<td>213</td>
<td>13.9</td>
<td>1</td>
<td>0.34</td>
<td>.559</td>
</tr>
<tr>
<td>Children in Home (6+ years old)</td>
<td>213</td>
<td>30.8</td>
<td>1</td>
<td>0.76</td>
<td>.383</td>
</tr>
<tr>
<td>Sex</td>
<td>213</td>
<td>237.1</td>
<td>1</td>
<td>5.88</td>
<td>.016</td>
</tr>
<tr>
<td>Sex and Children in Home</td>
<td>213</td>
<td>0.0</td>
<td>1</td>
<td>0.00</td>
<td>.992</td>
</tr>
<tr>
<td>Children, but not in Home</td>
<td>213</td>
<td>9.8</td>
<td>1</td>
<td>0.24</td>
<td>.621</td>
</tr>
<tr>
<td>Sex</td>
<td>213</td>
<td>224.2</td>
<td>1</td>
<td>5.55</td>
<td>.019</td>
</tr>
<tr>
<td>Sex and Children, but not in Home</td>
<td>213</td>
<td>7.6</td>
<td>1</td>
<td>0.19</td>
<td>.664</td>
</tr>
<tr>
<td>Preschool Children</td>
<td>213</td>
<td>45.8</td>
<td>1</td>
<td>1.14</td>
<td>.287</td>
</tr>
<tr>
<td>Sex</td>
<td>213</td>
<td>222.3</td>
<td>1</td>
<td>5.53</td>
<td>.020</td>
</tr>
<tr>
<td>Sex and Preschool Children</td>
<td>213</td>
<td>14.5</td>
<td>1</td>
<td>0.36</td>
<td>.549</td>
</tr>
<tr>
<td>Former Spouse</td>
<td>213</td>
<td>32.9</td>
<td>1</td>
<td>0.82</td>
<td>.366</td>
</tr>
<tr>
<td>Sex</td>
<td>213</td>
<td>223.5</td>
<td>1</td>
<td>5.58</td>
<td>.019</td>
</tr>
<tr>
<td>Sex and Former Spouse</td>
<td>213</td>
<td>47.3</td>
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<td>1.18</td>
<td>.279</td>
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<tr>
<td>Total Family Roles</td>
<td>213</td>
<td>28.8</td>
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<td>0.71</td>
<td>.399</td>
</tr>
<tr>
<td>Sex</td>
<td>213</td>
<td>215.5</td>
<td>1</td>
<td>5.35</td>
<td>.022</td>
</tr>
<tr>
<td>Sex and Total Family Roles</td>
<td>213</td>
<td>17.7</td>
<td>1</td>
<td>0.43</td>
<td>.508</td>
</tr>
</tbody>
</table>
Table 7.4—ANOVA for Sex and Presence of Preschool Children on Demoralization Among Men and Women in Treatment and Community Samples

### TREATMENT SAMPLE

<table>
<thead>
<tr>
<th>Number of Preschool Children</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>None</td>
<td>14.5</td>
<td>13.9</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
<td>(46)</td>
</tr>
<tr>
<td>One or more</td>
<td>8.5</td>
<td>18.0</td>
</tr>
<tr>
<td></td>
<td>(9)</td>
<td>(77)</td>
</tr>
<tr>
<td></td>
<td>12.9</td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>(35)</td>
<td>(123)</td>
</tr>
</tbody>
</table>

Sex: F = 2.8, p = .09; Preschool Children: F = 2.7, p = .10; Sex X Preschool Children: F = 8.6, p = .004

### COMMUNITY SAMPLE

<table>
<thead>
<tr>
<th>Number of Preschool Children</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>None</td>
<td>7.9</td>
<td>9.7</td>
</tr>
<tr>
<td></td>
<td>(55)</td>
<td>(101)</td>
</tr>
<tr>
<td>One or more</td>
<td>8.1</td>
<td>11.2</td>
</tr>
<tr>
<td></td>
<td>(21)</td>
<td>(36)</td>
</tr>
<tr>
<td></td>
<td>7.9</td>
<td>10.1</td>
</tr>
<tr>
<td></td>
<td>(76)</td>
<td>(137)</td>
</tr>
</tbody>
</table>

Sex: F = 5.5, p = .02; Preschool Children: F = 1.1, p = .28; Sex X Preschool Children: F = 0.4, p = .55
while fathers of preschoolers seem very well off in a mental health sense. Table 7.4 also shows something very interesting among those without preschool children. Among this group, men report higher demoralization scores than do women. This is one of the few instances in which demoralization scores are higher among sub-groups of men than women. The group of persons in the sample without preschoolers include not only married persons without children, but also married persons with children over the age of six, the nonmarried without children, and the nonmarried with children who are six years of age or older.

In the community sample, Table 7.3 shows no significant interaction effects between gender and any of the family roles on demoralization. Looking specifically at the relationship between sex, the existence of preschool children and demoralization in Table 7.4, there is no evidence of an important interaction effect. There is no evidence here of a main effect of being the parent of preschooler(s), but, again, there is a main effect due to sex.

The Effects of Sex and Number of Family Roles on Demoralization

In Table 7.5 we find the same strong effect of sample type on the relationship between sex, family roles and demoralization. In the treatment sample, there is evidence of a sex by number of family roles interaction effect. Women who perform multiple family roles report significantly higher demoralization scores than men with the same amount of family role demands. Among those who perform few family roles, men and women report comparable demoralization scores. Aneshensel et al., (1981) report similar findings in a study of sex differences in depression. They find that men and women with low family
Table 7.5—Analysis of Variance for Sex and Number of Family Roles on Demoralization Among Men and Women in Treatment and Community Samples.

**TREATMENT SAMPLE**

<table>
<thead>
<tr>
<th>Number of Family Roles</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Low</td>
<td>15.9</td>
<td>15.0</td>
</tr>
<tr>
<td></td>
<td>(17)</td>
<td>(26)</td>
</tr>
<tr>
<td>High</td>
<td>10.2</td>
<td>16.9</td>
</tr>
<tr>
<td></td>
<td>(18)</td>
<td>(97)</td>
</tr>
<tr>
<td></td>
<td>13.0</td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>(35)</td>
<td>(123)</td>
</tr>
</tbody>
</table>

Sex: F= 5.1, p= .02; Family Role: F= 0.07, p= .79; Sex X Family Role: F= 5.47, p= .02

**COMMUNITY SAMPLE**

<table>
<thead>
<tr>
<th>Number of Family Roles</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Low</td>
<td>7.97</td>
<td>9.29</td>
</tr>
<tr>
<td></td>
<td>(29)</td>
<td>(49)</td>
</tr>
<tr>
<td>High</td>
<td>7.94</td>
<td>10.50</td>
</tr>
<tr>
<td></td>
<td>(47)</td>
<td>(88)</td>
</tr>
<tr>
<td></td>
<td>7.95</td>
<td>10.07</td>
</tr>
<tr>
<td></td>
<td>(76)</td>
<td>(137)</td>
</tr>
</tbody>
</table>

Sex: F= 5.36, p= .02; Family Role: F= 0.72, p= .40; Sex X Family Role: F= 0.44, p= .51
role demands report comparable numbers of depressive symptoms.

Possibly more important than the above findings is the total lack of evidence of a sex by number of family role interaction effect on demoralization in the non-treatment sample. The community population shows little variation in demoralization scores regardless of the performance of few or many family roles. Here, again, however we find a main effect due to sex.

The Effect of Sex and the Number of Children in the Home on Demoralization

Table 7.6 presents the ANOVA for sex, the number of children in the home and demoralization. In line with other family roles we have examined thus far, results in the treatment sample are very different from results in the non-treatment sample. In the treatment sample, women with two or more children living at home report a much higher mean demoralization score than men in a comparable position. Among those with one child in the home or no children in the home, the sex difference is much smaller.

Again, in the non-treatment sample, there is no evidence of a sex and number of children in home interaction effect. The number of children living in the home has little, if any effect on the demoralization scores of men and women. Similarly, the extent of difference between men and women is similar regardless of number of children in the home.

All in all, there does not seem to be a strong effect due to family and marital roles on demoralization, at least in the community sample. The relationship is different in the treatment sample.
Table 7.6—Analysis of Variance for Sex and Number of Children in Home on Demoralization Among Men and Women in Treatment and Community Samples.

### TREATMENT SAMPLE

<table>
<thead>
<tr>
<th>Number of Children in Home</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>0 or 1</td>
<td>14.83(24)</td>
<td>16.35(65)</td>
</tr>
<tr>
<td>2 or more</td>
<td>8.91(11)</td>
<td>16.67(58)</td>
</tr>
</tbody>
</table>

Sex: F= 5.42, p= .02; No. of Children: F= 0.48, p= .49; Sex X No. of Children: F= 3.53, p= .06

### COMMUNITY SAMPLE

<table>
<thead>
<tr>
<th>Number of Children in Home</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>0 or 1</td>
<td>8.09(64)</td>
<td>10.31(100)</td>
</tr>
<tr>
<td>2 or more</td>
<td>7.17(12)</td>
<td>9.41(37)</td>
</tr>
</tbody>
</table>

Sex: F= 5.88, p= .01; No. of Children: F= 0.76, p= .38; Sex X No. of Children: F= 0.00, p= .992
The most definitive finding from these initial analyses is the importance of sample type. In the treatment sample, sex differences in demoralization showed great variation depending on the number and types of family roles men and women perform. The finding of variations in demoralization by family role is in line with the specific sex role theory of mental illness. From this perspective, women with a spouse, with preschool children in the home, and women who perform multiple family roles should report the highest demoralization scores. However, it is important to realize that it did not work out that way in the non-treatment sample. In the community sample, the performance or non-performance of family roles had little to do with explaining sex differences in demoralization. Throughout these analyses, females reported higher demoralization scores than males regardless of family role performance.

These initial findings cast doubt on the general claim that higher rates of psychological distress among women are due to the nature of family roles they perform. This may be true in the treatment sample primarily because of the nature of the sample.

We now turn to a more careful examination of the effects of family roles on sex differences in demoralization. The next section examines the effects of family roles and some social characteristics on sex differences in demoralization. Family role variables will be examined while statistically controlling for the effects of other family and non-family role variables.

Based on prior research, social class and other economic indicators should prove to be important determinants of demoralization when examined in conjunction with family role variables.
This section examines whether the results obtained thus far will be altered when controlling for the effects of social-demographic variables and for the effects of family role variables on one another.

A particular strategy was followed in an attempt to find whether interaction effects existed between sex and other variables when controlling for a number of other variables. Each sample was examined separately and each sex was examined separately within each sample.

**The Treatment Sample**

Separate regression equations containing thirteen variables were computed for men and women. The thirteen variables were: marital status, number of children in the home, number of preschool children, number of former spouses, total number of family roles, social class, family income level, age, employment status, amount of contact with friends, amount of contact with relatives, work satisfaction, and satisfaction with income. These variables were chosen because they have been frequently cited in the mental health literature as important in a discussion of sex differences in psychological distress (see Chapter II and Chapter V). Backward elimination was used in order to isolate a subset of available predictor variables that would yield an optimal prediction equation with as few terms as possible. For men and women separately, predictors were eliminated one by one from the regression equation until all remaining variables were significant at the .10 level.

Of the original thirteen variables examined separately for men and women, a total of seven survived the elimination procedure. Two variables survived the procedure for males: low family income and not
having a spouse. Five variables survived the procedure for women: having a former spouse, young age, the presence of preschool children, no labor force participation, and low amount of contact with relatives.

The next step involved the construction of interaction terms for some of these variables. To determine which would have interaction terms, confidence intervals and mid points were constructed around each of the surviving seven variables separately for men and women. Table 7.7 presents the confidence intervals and mid points for these seven variables for men and women in the treatment and non-treatment samples. Confidence intervals were drawn using the formula $b \pm 1.96\sigma_b$.

In the treatment sample, interaction terms were created between sex and five variables: having a former spouse, the presence of preschool children, being in the labor force, family income, and the presence of a spouse. For each of these variables, the mid point of the interval for males and/or females fell outside of the confidence interval of the opposite sex group. This indicated a different relationship between a particular variable and demoralization for men and women.

Following the computation of interaction variables, they and four variables significantly related to demoralization for either men or women were entered into a single regression equation for the entire treatment sample (four of the five interaction variables were included in this equation. The sex x number of preschool children variable was omitted from the equation because its high correlation with the variable number of preschool children, $r=.95$, caused problems of multicollinearity).

Data in Table 7.8 shows the results of the regression equation on
Table 7.7 -- B, Se B, Confidence Interval, and Point Interval for Surviving Variables For Males and Females Separately in Treatment and Non-Treatment Samples.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Treatment Sample</th>
<th></th>
<th></th>
<th>Non-Treatment Sample</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females</td>
<td>Males</td>
<td></td>
<td>Females</td>
<td>Males</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B, Se B</td>
<td>B, Se B</td>
<td></td>
<td>B, Se B</td>
<td>B, Se B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Confidence Interval</td>
<td>Confidence Interval</td>
<td></td>
<td>Confidence Interval</td>
<td>Confidence Interval</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Point Interval</td>
<td>Point Interval</td>
<td></td>
<td>Point Interval</td>
<td>Point Interval</td>
<td></td>
</tr>
<tr>
<td>Contact with Relatives</td>
<td>-0.70, 0.60</td>
<td>(0.46, -1.86)</td>
<td>0.70</td>
<td>-1.25, 1.61</td>
<td>(1.90, -4.40)</td>
<td>-1.25</td>
</tr>
<tr>
<td>Former Spouse</td>
<td>4.61, 1.66</td>
<td>(7.85, 1.32)</td>
<td>4.60</td>
<td>-0.17, 2.99</td>
<td>(1.08, -9.88)</td>
<td>-4.40</td>
</tr>
<tr>
<td>Age</td>
<td>-2.42, 0.81</td>
<td>(-0.83, -4.00)</td>
<td>-2.40</td>
<td>-0.54, 1.26</td>
<td>(1.76, -4.61)</td>
<td>-1.42</td>
</tr>
<tr>
<td>Preschool Children</td>
<td>-0.03, 0.86</td>
<td>(1.65, -1.71)</td>
<td>0.03</td>
<td>-4.40, 2.80</td>
<td>(1.65, -1.71)</td>
<td>0.03</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>-2.14, 0.91</td>
<td>(-0.35, -3.90)</td>
<td>-2.13</td>
<td>-0.95, 1.87</td>
<td>(2.99, -1.91)</td>
<td>0.54</td>
</tr>
<tr>
<td>Family Income</td>
<td>-0.84, 0.50</td>
<td>(0.12, -1.80)</td>
<td>-0.84</td>
<td>-1.85, 0.89</td>
<td>(-0.09, -3.58)</td>
<td>-1.83</td>
</tr>
<tr>
<td>Presence of Spouse</td>
<td>5.54, 2.64</td>
<td>(10.7, 0.36)</td>
<td>5.53</td>
<td>0.73, 4.32</td>
<td>(8.61, -8.00)</td>
<td>0.30</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
<td>-0.80, 0.72</td>
<td>(0.64, -2.24)</td>
<td>-0.80</td>
<td>-1.45, 0.89</td>
<td>(0.33, -3.23)</td>
<td>-1.45</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>-1.74, 0.61</td>
<td>(-0.52, -2.96)</td>
<td>-1.61</td>
<td>-0.09, 0.96</td>
<td>(1.83, -2.01)</td>
<td>0.83</td>
</tr>
<tr>
<td>Age</td>
<td>-0.15, 0.04</td>
<td>(0.23, -0.23)</td>
<td>-0.11</td>
<td>0.01, 0.06</td>
<td>(0.10, -0.11)</td>
<td>0</td>
</tr>
<tr>
<td>Friendship Contact</td>
<td>-0.83, 0.47</td>
<td>(0.11, -1.77)</td>
<td>-0.83</td>
<td>0.58, 0.62</td>
<td>(1.80, -0.64)</td>
<td>0.58</td>
</tr>
<tr>
<td>Social Class</td>
<td>0.09, 0.03</td>
<td>(0.14, 0.02)</td>
<td>0.08</td>
<td>0.01, 0.04</td>
<td>(0.07, -0.08)</td>
<td>0</td>
</tr>
<tr>
<td>Spouse Present</td>
<td>0.97, 1.49</td>
<td>(3.94, -2.02)</td>
<td>0.96</td>
<td>-0.01, 3.29</td>
<td>(6.57, -6.57)</td>
<td>0.01</td>
</tr>
<tr>
<td># Family Roles</td>
<td>-1.37, 0.57</td>
<td>(-0.20, -2.48)</td>
<td>-1.34</td>
<td>0.46, 0.86</td>
<td>(2.18, -1.26)</td>
<td>0.46</td>
</tr>
</tbody>
</table>

Underlined Point Intervals Fall Outside of the Confidence Interval of Opposite Sex Group.
Table 7.8 — Regression Equation on Treatment Sample Examining Effects of Interaction Terms and Control Variables on Demoralization Variables Listed From Highest to Lowest Betas

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex x Presence of Spouse (^a)</td>
<td>.27</td>
<td>.15</td>
<td>.04</td>
<td>.15</td>
<td>1.80</td>
<td>.07</td>
</tr>
<tr>
<td>Family Income</td>
<td>-.25</td>
<td>.15</td>
<td>-.29</td>
<td>-.14</td>
<td>-1.69</td>
<td>.09</td>
</tr>
<tr>
<td>Sex x Having Former Spouse (^b)</td>
<td>.21</td>
<td>.10</td>
<td>.19</td>
<td>.17</td>
<td>2.01</td>
<td>.05</td>
</tr>
<tr>
<td>Age</td>
<td>-.18</td>
<td>.09</td>
<td>-.15</td>
<td>-.17</td>
<td>-2.12</td>
<td>.04</td>
</tr>
<tr>
<td>Extent of Labor Force Participation</td>
<td>-.17</td>
<td>.17</td>
<td>-.33</td>
<td>-.09</td>
<td>-1.02</td>
<td>.31</td>
</tr>
<tr>
<td>Sex x Labor Force Participation (^c)</td>
<td>-.09</td>
<td>.17</td>
<td>-.17</td>
<td>-.04</td>
<td>-0.54</td>
<td>.59</td>
</tr>
<tr>
<td>Amount of Contact with Relatives</td>
<td>-.09</td>
<td>.08</td>
<td>-.07</td>
<td>-.09</td>
<td>-1.08</td>
<td>.28</td>
</tr>
<tr>
<td>Number of Preschool Children</td>
<td>-.05</td>
<td>.09</td>
<td>.15</td>
<td>-.05</td>
<td>-0.62</td>
<td>.54</td>
</tr>
<tr>
<td>Sex x Family Income (^d)</td>
<td>-.04</td>
<td>.21</td>
<td>-.02</td>
<td>-.02</td>
<td>-0.19</td>
<td>.84</td>
</tr>
</tbody>
</table>

Multiple r = .47; R\(^2\) = .22; Adjusted R\(^2\) = .17

\(^a\) Sex coded as (1) Female (0) Male; Spouse Present (1) Yes (0) No
\(^b\) Sex coded as (1) Female (0) Male; Former Spouse (1) Yes (0) No
\(^c\) Sex coded as (1) Female (0) Male; In Labor Force (1) No (0) Yes
\(^d\) Sex coded as (1) Female (0) Male; Family Income (1) High (0) Low
demoralization for both men and women in the treatment sample. The
sex-marital status interaction variable is an important variable in
this equation. Compared to other variables in the equation it has the
largest beta (.27), and indicates that married women are a group at
high risk to demoralization. The variables family income, age,
employment status, and the sex x having a former spouse variable also
have sizable betas.

At this point in the analyses, it appears that the sex-marital
interaction variable is an important variable in explaining variations
in demoralization scores, at least in treatment populations. When
controlling for a number of relevant variables, its effect is
maintained. However, when backward elimination is used on this
regression equation, the sex-marital status interaction effect does not
survive the removal procedure. Three variables survive the procedure,
one of them interaction variables. They are: participation in the
labor force, level of family income, and age (see Table 7.10). Using
this more stringent criteria, the sex-marital status interaction effect
does not come in as a good predictor of demoralization scores. For that
matter, neither do any of the interaction variables.

The Community Sample

The same procedure used to generate interaction terms in the
treatment sample was used in the non-treatment sample. The same
thirteen variables were entered into separate regression equations for
men and women. The pattern of results are very different in this
sample. Seven variables survived the elimination procedure. Of these
seven, three variables were found that related differently to
demoralization for men and women (see Table 7.7). They were social
class, amount of contact with friends, and total number of family
roles. Interaction terms between sex and each of the three variables
were created.

The seven variables that survived the original elimination
procedure and the three interaction variables: sex x social class, sex
x amount of friend contact, and sex x number of family roles were
entered into a regression equation.

Data in Table 7.9 shows the results of the regression equation on
demoralization for both men and women in the non-treatment sample. In
the sample as a whole, three variables show a significant relationship
to demoralization: sex x social class, age, and participation in the
labor force. What this indicates, as earlier suggested, is that young,
non-working women in low SES groups seem most at risk of demoralization
in this sample.

This regression equation with ten variables was re-run using
backward elimination with removal criteria set at p = 05. Results
remain unchanged. Three variables survived the elimination procedure
(see Table 7.11) with the sex x social class interaction variables
showing the largest beta, followed by age and participation in the
labor force. As hypothesized, the sex x social class interaction effect
is a strong one in the non-treatment sample.

The ANOVA in Table 7.12 shows that the sex by social class
interaction effect operates only in the non-treatment sample. In the
treatment sample, women, regardless of social class level, report
higher demoralization scores. In the non-treatment sample, women and
men in higher SES groups report very similar levels of demoralization,
Table 7.9 — Regression Equation on Non-Treatment Sample Examining Effects of Interaction Terms and Control Variables on Demoralization. Variables Listed From Highest to Lowest Betas.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex x Social Class^a</td>
<td>.37</td>
<td>.17</td>
<td>.20</td>
<td>.16</td>
<td>2.18</td>
<td>.03</td>
</tr>
<tr>
<td>Sex x Amount of Friendship Contact^b</td>
<td>-.17</td>
<td>.17</td>
<td>-.07</td>
<td>-.07</td>
<td>-1.02</td>
<td>.31</td>
</tr>
<tr>
<td>Age</td>
<td>-.17</td>
<td>.08</td>
<td>-.12</td>
<td>-.17</td>
<td>-2.23</td>
<td>.02</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>-.17</td>
<td>.08</td>
<td>-.15</td>
<td>-.16</td>
<td>-2.18</td>
<td>.03</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
<td>-.14</td>
<td>.07</td>
<td>-.12</td>
<td>-.14</td>
<td>-1.89</td>
<td>.06</td>
</tr>
<tr>
<td>Sex x Number of Family Roles^c</td>
<td>-.09</td>
<td>.16</td>
<td>.14</td>
<td>-.04</td>
<td>-0.55</td>
<td>.58</td>
</tr>
<tr>
<td>Spouse Present</td>
<td>.04</td>
<td>.10</td>
<td>-.03</td>
<td>.03</td>
<td>0.39</td>
<td>.70</td>
</tr>
<tr>
<td>Number of Family Roles</td>
<td>.03</td>
<td>.12</td>
<td>.03</td>
<td>.02</td>
<td>0.26</td>
<td>.80</td>
</tr>
<tr>
<td>Amount of Friendship Contact</td>
<td>.02</td>
<td>.11</td>
<td>-.04</td>
<td>.01</td>
<td>0.15</td>
<td>.88</td>
</tr>
<tr>
<td>Social Class</td>
<td>-.01</td>
<td>.10</td>
<td>.11</td>
<td>-.01</td>
<td>-0.12</td>
<td>.90</td>
</tr>
</tbody>
</table>

Multiple r = .33; R^2 = .11; Adjusted R^2 = .06

^aSex coded as (1) Female (0) Male; Social Class (1) Low (0) High
^bSex coded as (1) Female (0) Male; Friendship Contact (1) Low (0) High
^cSex coded as (1) Female (0) Male; # of Family Roles (1) High (0) Low
Table 7.10 — Regression Equation Results of Interaction Variables and Control Variables on Demoralization in Treatment Sample Using Backward Elimination. Results After Removal — Pout set at .05.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor force Participation</td>
<td>-0.31</td>
<td>0.08</td>
<td>-0.33</td>
<td>-0.31</td>
<td>-3.95</td>
<td>.000</td>
</tr>
<tr>
<td>Family Income</td>
<td>-0.20</td>
<td>0.08</td>
<td>-0.29</td>
<td>-0.20</td>
<td>-2.52</td>
<td>.013</td>
</tr>
<tr>
<td>Age</td>
<td>-0.14</td>
<td>0.08</td>
<td>-0.15</td>
<td>-0.15</td>
<td>-1.89</td>
<td>.061</td>
</tr>
<tr>
<td>Sex x Presence of Spouse</td>
<td>0.12</td>
<td>0.09</td>
<td>0.04</td>
<td>0.11</td>
<td>1.33</td>
<td>.185</td>
</tr>
<tr>
<td>Sex x Having Former Spouse</td>
<td>0.11</td>
<td>0.08</td>
<td>0.19</td>
<td>0.11</td>
<td>1.39</td>
<td>.165</td>
</tr>
<tr>
<td>Sex x Family Income</td>
<td>0.10</td>
<td>0.10</td>
<td>-0.02</td>
<td>0.08</td>
<td>1.02</td>
<td>.308</td>
</tr>
<tr>
<td>Amount of Contact with Relatives</td>
<td>-0.05</td>
<td>0.08</td>
<td>-0.07</td>
<td>-0.06</td>
<td>-0.68</td>
<td>.500</td>
</tr>
<tr>
<td>Sex x Labor force Participation</td>
<td>0.05</td>
<td>0.17</td>
<td>-0.17</td>
<td>0.04</td>
<td>0.52</td>
<td>.606</td>
</tr>
<tr>
<td>Number of Preschool Children</td>
<td>0.02</td>
<td>0.09</td>
<td>0.15</td>
<td>0.02</td>
<td>0.24</td>
<td>.809</td>
</tr>
</tbody>
</table>
Table 7.11 -- Regression Equation Results of Interaction Variables and Control Variables on Demoralization in Non-Treatment Sample Using Backward Elimination. Results After Removal -- Pout set at .05.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex x Social Class</td>
<td>.30</td>
<td>.10</td>
<td>.20</td>
<td>.22</td>
<td>3.17</td>
<td>.002</td>
</tr>
<tr>
<td>Sex x Friendship Contact</td>
<td>-.18</td>
<td>.10</td>
<td>.07</td>
<td>-.13</td>
<td>-1.86</td>
<td>.065</td>
</tr>
<tr>
<td>Age</td>
<td>-.17</td>
<td>.07</td>
<td>-.12</td>
<td>-.17</td>
<td>-2.42</td>
<td>.017</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>-.15</td>
<td>.07</td>
<td>-.15</td>
<td>-.15</td>
<td>-2.11</td>
<td>.036</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
<td>-.13</td>
<td>.06</td>
<td>.07</td>
<td>-.13</td>
<td>-1.85</td>
<td>.065</td>
</tr>
<tr>
<td>Sex x Number of Family Roles</td>
<td>-.03</td>
<td>.16</td>
<td>.14</td>
<td>.02</td>
<td>0.27</td>
<td>.791</td>
</tr>
<tr>
<td>Spouse Present</td>
<td>.03</td>
<td>.10</td>
<td>-.03</td>
<td>.03</td>
<td>0.38</td>
<td>.708</td>
</tr>
<tr>
<td>Amount of Friendship Contact</td>
<td>.03</td>
<td>.11</td>
<td>-.04</td>
<td>.02</td>
<td>0.27</td>
<td>.789</td>
</tr>
<tr>
<td>Number of Family Roles</td>
<td>.02</td>
<td>.12</td>
<td>.03</td>
<td>.02</td>
<td>0.27</td>
<td>.791</td>
</tr>
<tr>
<td>Social Class</td>
<td>.01</td>
<td>.10</td>
<td>.11</td>
<td>.01</td>
<td>0.09</td>
<td>.927</td>
</tr>
</tbody>
</table>
Table 7.12—ANOVA for Sex and Social Class on Demoralization Among Men and Women in Treatment and Community Samples.

**TREATMENT SAMPLE**

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>High SES Status</td>
<td>12.0</td>
<td>15.3</td>
</tr>
<tr>
<td></td>
<td>(18)</td>
<td>(46)</td>
</tr>
<tr>
<td>Low SES Status</td>
<td>14.0</td>
<td>17.2</td>
</tr>
<tr>
<td></td>
<td>(17)</td>
<td>(77)</td>
</tr>
<tr>
<td></td>
<td>13.0</td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>(35)</td>
<td>(123)</td>
</tr>
</tbody>
</table>

Sex: F = 4.2, p = .04; Social Class: F = 2.1, p = .15; Sex X Social Class: F = 0.0, p = .98

**COMMUNITY SAMPLE**

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Sex</th>
<th>Female Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>High SES Status</td>
<td>8.2</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>(44)</td>
<td>(82)</td>
</tr>
<tr>
<td>Low SES Status</td>
<td>7.6</td>
<td>11.7</td>
</tr>
<tr>
<td></td>
<td>(32)</td>
<td>(55)</td>
</tr>
<tr>
<td></td>
<td>8.0</td>
<td>10.1</td>
</tr>
<tr>
<td></td>
<td>(76)</td>
<td>(137)</td>
</tr>
</tbody>
</table>

Sex: F = 5.7, p = .01; Social Class: F = 3.1, p = .08; Sex X Social Class: F = 3.3, p = .07
Table 7.13 - Analysis of Variance for Demoralization by Sex and Social Class Controlling for Marital Status, Presence of Preschool Children, Total Number of Family Roles, Age, and Amount of Contact with Friends.

<table>
<thead>
<tr>
<th>Control Variables: Two and Three Way Interaction Effects</th>
<th>N</th>
<th>Mean Squares</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex and Marital Status</td>
<td>213</td>
<td>0.7</td>
<td>1</td>
<td>0.02</td>
<td>.89</td>
</tr>
<tr>
<td>Social Class and Marital Status</td>
<td>213</td>
<td>13.1</td>
<td>1</td>
<td>0.33</td>
<td>.56</td>
</tr>
<tr>
<td>Sex, Social Class, and Marital Status</td>
<td>213</td>
<td>1.6</td>
<td>1</td>
<td>0.04</td>
<td>.84</td>
</tr>
<tr>
<td>Sex and Number of Family Roles</td>
<td>213</td>
<td>41.6</td>
<td>1</td>
<td>1.07</td>
<td>.30</td>
</tr>
<tr>
<td>Social Class and Number of Family Roles</td>
<td>213</td>
<td>123.9</td>
<td>1</td>
<td>3.19</td>
<td>.07</td>
</tr>
<tr>
<td>Sex, Social Class, and Number of Family Roles</td>
<td>213</td>
<td>0.0</td>
<td>1</td>
<td>0.01</td>
<td>.99</td>
</tr>
<tr>
<td>Sex and Presence of Preschoolers</td>
<td>213</td>
<td>40.9</td>
<td>1</td>
<td>1.11</td>
<td>.29</td>
</tr>
<tr>
<td>Social Class and Presence of Preschoolers</td>
<td>213</td>
<td>510.0</td>
<td>1</td>
<td>13.87</td>
<td>.001</td>
</tr>
<tr>
<td>Sex, Social Class and the Presence of Preschoolers</td>
<td>213</td>
<td>64.9</td>
<td>1</td>
<td>1.76</td>
<td>.19</td>
</tr>
<tr>
<td>Sex and Level of Employment</td>
<td>213</td>
<td>50.1</td>
<td>1</td>
<td>1.31</td>
<td>.25</td>
</tr>
<tr>
<td>Social Class and Level of Employment</td>
<td>213</td>
<td>74.8</td>
<td>1</td>
<td>1.96</td>
<td>.16</td>
</tr>
<tr>
<td>Sex, Social Class and Level of Employment</td>
<td>213</td>
<td>93.6</td>
<td>1</td>
<td>2.45</td>
<td>.12</td>
</tr>
<tr>
<td>Sex and Age</td>
<td>213</td>
<td>9.6</td>
<td>1</td>
<td>0.25</td>
<td>.61</td>
</tr>
<tr>
<td>Social Class and Age</td>
<td>213</td>
<td>301.2</td>
<td>1</td>
<td>8.05</td>
<td>.005</td>
</tr>
<tr>
<td>Sex, Social Class and Age</td>
<td>213</td>
<td>35.2</td>
<td>1</td>
<td>0.90</td>
<td>.33</td>
</tr>
<tr>
<td>Sex and Friend Contact</td>
<td>213</td>
<td>65.9</td>
<td>1</td>
<td>1.67</td>
<td>.19</td>
</tr>
<tr>
<td>Social Class and Friend Contact</td>
<td>213</td>
<td>10.3</td>
<td>1</td>
<td>0.26</td>
<td>.61</td>
</tr>
<tr>
<td>Sex, Social Class and Friend Contact</td>
<td>213</td>
<td>10.6</td>
<td>1</td>
<td>0.27</td>
<td>.60</td>
</tr>
</tbody>
</table>
Table 7.14—Mean Demoralization Scores for Low SES Men and Women and High SES Men and Women by Marital Status, Total Number of Family Roles, the Presence of Preschool Children, Labor Force Participation, Age, and Amount of Friend Contact.

<table>
<thead>
<tr>
<th>Sub-Group</th>
<th>Low SES Women</th>
<th>Low SES Men</th>
<th>High SES Women</th>
<th>High SES Men</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>12.2 (33)</td>
<td>8.0 (26)</td>
<td>9.0 (70)</td>
<td>8.2 (41)</td>
<td>9.3 (170)</td>
</tr>
<tr>
<td>Nonmarried</td>
<td>11.0 (22)</td>
<td>6.0 (6)</td>
<td>8.8 (12)</td>
<td>8.3 (3)</td>
<td>9.4 (43)</td>
</tr>
<tr>
<td><strong>Number of Family Roles</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many</td>
<td>14.2 (20)</td>
<td>8.7 (15)</td>
<td>9.4 (36)</td>
<td>7.6 (21)</td>
<td>9.9 (92)</td>
</tr>
<tr>
<td>Few</td>
<td>10.3 (35)</td>
<td>6.7 (17)</td>
<td>8.6 (46)</td>
<td>8.7 (23)</td>
<td>8.8 (121)</td>
</tr>
<tr>
<td><strong>Preschool Children?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18.2 (11)</td>
<td>9.6 (8)</td>
<td>8.1 (25)</td>
<td>7.2 (13)</td>
<td>10.0 (57)</td>
</tr>
<tr>
<td>No</td>
<td>10.1 (44)</td>
<td>6.9 (24)</td>
<td>9.4 (57)</td>
<td>8.6 (31)</td>
<td>9.0 (156)</td>
</tr>
<tr>
<td><strong>Labor Force Member?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9.3 (29)</td>
<td>7.9 (28)</td>
<td>8.6 (45)</td>
<td>8.0 (36)</td>
<td>8.5 (138)</td>
</tr>
<tr>
<td>No</td>
<td>14.4 (26)</td>
<td>5.8 (4)</td>
<td>9.4 (37)</td>
<td>8.9 (8)</td>
<td>10.9 (75)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 33</td>
<td>17.1 (12)</td>
<td>10.1 (10)</td>
<td>9.0 (29)</td>
<td>8.5 (13)</td>
<td>10.6 (64)</td>
</tr>
<tr>
<td>33 or Older</td>
<td>10.2 (43)</td>
<td>6.5 (22)</td>
<td>9.0 (53)</td>
<td>8.0 (31)</td>
<td>8.8 (149)</td>
</tr>
<tr>
<td><strong>Friend Contact</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>11.8 (23)</td>
<td>6.1 (17)</td>
<td>9.2 (35)</td>
<td>7.7 (23)</td>
<td>8.9 (98)</td>
</tr>
<tr>
<td>High</td>
<td>11.6 (32)</td>
<td>9.3 (15)</td>
<td>8.8 (47)</td>
<td>8.8 (21)</td>
<td>9.6 (115)</td>
</tr>
</tbody>
</table>
while a large gap in scores exists between men and women in low SES groups. As was hypothesized, a sex by social class interaction effect was expected in the non-treatment sample based on the reports of some authors (Meile, 1976; Rubin, 1976) that the social roles of lower SES women make them vulnerable to psychological distress.

This sex by social class interaction effect is not altered when controlling for a number of variables singly or in combination. In Table 7.13, three way analyses of variance were run on sex and social class controlling for marital status, total number of family roles, the presence of preschool children, level of employment, age, and amount of friend contact. In no instance did any of these control variables alter the joint influence of sex and social class on demoralization. Low-SES women experience the highest levels of demoralization regardless of marital status, the presence of preschool children, number of family roles, labor force participation, age, or the size of their friendship networks (see also Table 7.14).

Chapter Conclusion

A possible explanation for why a sex-marital status interaction effect is the most cited explanation of sex differences in psychological distress is offered in this chapter. Very simply, it is because the studies that find such an effect use treatment samples. It was noted in Chapter I that evidence for a sex-marital status interaction effect was ambiguous in epidemiological research. Most support for this effect comes from studies of treatment populations. In epidemiological studies of normal populations, there is no evidence for a sex-marital status interaction effect. Results reported in this
There is evidence of a sex-marital status interaction effect but only in the treatment sample. No evidence was found for this effect in the non-treatment sample using analysis of variance or regression techniques. In the non-treatment sample, evidence was found for a sex-social class interaction effect.

This finding is important to the sociology of mental illness literature. Women may be more vulnerable to demoralization not exclusively because of the roles they perform in marriage or family, but because of the social roles they do not play in the larger social arena. The lives of lower SES women may make them more vulnerable to psychological distress, regardless of marital status, or the performance of particular family roles. In this sense, their life style and subsequent mental health may be as different from the life styles of men as it is from women in higher SES groups.

This chapter has only isolated groups that appear more vulnerable to demoralization. It has not attempted to explain why married women in the treatment sample are more vulnerable to demoralization than other groups. This will be the focus of analyses in Chapter VIII. Also, the question of what it is about the lives of lower SES women that accounts for their high rates of demoralization is the task of Chapter IX.
Chapter VIII

DETERMINANTS OF DEMORALIZATION: THE TREATMENT SAMPLE.

The purpose of this chapter is to compare males and females within the treatment sample to examine the separate and common factors associated with variations in demoralization scores. Evidence in the last chapter suggested that sex differences in psychological distress vary by sample type. Evidence was found in the treatment sample for a sex-marital status interaction effect, whereas in the general community sample no such effect was found. In the non-treatment sample, a sex-social class interaction effect was the most significant predictor of demoralization.

Chapter VIII will focus attention on the treatment sample. Males and females will be examined as separate groups to attempt to understand what variables account best for variations in demoralization. The focus here will be on the performance of family and non-family roles as well as on the quality of family and non-family roles. In Chapter IX, these issues will be examined for men and women in the non-treatment sample.

The Issue of Involvement - Non-Involvement in Social Roles

A persistent theme in the literature on sex differences in psychological distress is the effect of social role participation on mental health. Are people under the demands of both work and family
roles "over-stressed" and more vulnerable to disorder? This is suggested in the work of Gove and Tudor (1973) who hold that the role set wife-mother-full-time worker creates a role overload situation for women and accounts for the higher overall rate of female distress. As Gove and Tudor (1973) note:

....working wives appear to be under a greater strain than their husbands. In addition to their job, they apparently typically perform most of the household chores, which means that they work considerably more hours per day than their husbands. (p. 815)

The additional burdens of raising children and dealing with the emotional burdens of family life add to the role overloading of women. As Gove and Hughes (1979) note in regard to physical illness:

Women, as compared to men, typically have more role obligations that require constant ongoing activities vis-a-vis their spouse, children, and others (such as parents) living in the home and....these obligations can interfere with self-care and have a negative effect on one's health (p.132).

In a summary of the possible reasons for the higher female rate of mild psychiatric disorder, Eaton (1980) suggests that the woman burdened by extensive family and non-family roles is vulnerable to psychological distress. For the women who decides to go to work:

.....the cultural norm is that she still must fulfill most of the demands of the housewife role, and there is evidence, in fact, that working women do all or most of the housework as well as their jobs outside the home. The extra burden of performing two demanding roles could well contribute to mental disorder (Eaton, 1980:78).
In a more recent study, Cleary and Mechanic (1983) contend that the strain of working outside of the home and doing the majority of the work associated with raising children increases distress among married women.

The logic of role overload and its effect of women's mental and physical health is summarized by Verbrugge (1983):

There is increasing concern that women's increasing involvement in multiple roles (job plus family responsibilities) may harm their physical health. The rationale is as follows: typically, women are responsible for household management. Employment adds obligations to their life, and there is seldom any compensatory decrease in their domestic tasks. By contrast, men concentrate on job responsibilities, and other women specialize in household tasks (homemakers) or in a job (employed women without family ties (employed women without family ties). Compared to these groups, women with multiple roles end up with more duties, time pressures, and stresses. These increase their risks of acute and chronic health problems and decrease their ability to spend time on health problems (p. 16).

There is a second perspective on the participation non-participation dimension of social roles and their effect on health. This model holds that it is not role overload that contributes to high female rates of disorder, but a particular combination of family demands and extra-social isolation. Specifically, it is suggested that women with multiple family roles and little participation in social life outside the family will be most vulnerable to demoralization. Known as the "housewife syndrome", it is held that the restriction of roles to the realm of the family as well as the multiplicity of family roles lies behind psychological distress. Gove (1972), Gove and Tudor (1973) and Bernard (1972) have been most responsible for popularizing this perspective. These theorists hold that the women with only family
roles are: 1) restricted to one major role in life; if things go wrong in this sphere she is without an alternative source of gratification and self-esteem; 2) frustrated by the monopoly of raising children and keeping house; 3) vulnerable because of the unstructured and invisible nature of the housewife role. Since she has no major non-family roles to perform she can afford to "brood over her troubles" and "become obsessed with worry" (Gove and Tudor 1973:814). Bernard (1972) emphasizes the role of isolation in the housewife role:

Isolation has negative psychological effects on people. It encourages brooding; it leads to erratic judgements, interspersed by the leavening effect of contact with others. It renders one susceptible to psychoses p.46.

In addition to these two major perspectives on mild psychiatric disorders, "role overload" and the "housewife syndrome", there are two other possible relationships between family and non-family role performance. One of these refer to persons who perform few family based roles and few non-family based roles. There is some indication in the health literature of the vulnerability of persons whose lives are marked by an absence of fixed role obligations. Rivkin (1972), for example, in a study examining World Health Organization National Collaboration Study of Medical Care data, collected in Baltimore, Md. in 1968-1969, finds that women with the fewest role obligations report the highest incidence of physical illness and disability days. Women without spouses report higher impairment than women without spouses, women without children more than women with children, and women not in the labor force more impairment than women in the labor force. Marcus and Seeman (1981a) also find that women with few social role
obligations report the higher number of chronic conditions and disability days. Verbrugge (1983) also reports data that strongly indicates that the fewer the number of family and non-family roles, the higher the reports of impaired health.

A fourth possible combination of family and non-family social roles is one of few family roles but a number of non-family roles. Not much has appeared in the literature concerning this group. These are "career oriented" people and not much is known about sex differences in demoralization in this category.

**Models of Role Involvement: The Treatment Sample.**

In Table 8.1, the ANOVA for demoralization by number of family roles and labor force participation (in the literature, the most important non-family social role) is presented separately for men and women in the treatment sample. The most obvious result in this table is that women in all sub-groups of social role participation report higher demoralization scores than men. However, there are substantial sub-group differences for each sex considered separately. For both men and women, the group reporting the highest mean demoralization scores are persons not in the labor force with multiple family role obligations. Both men and women in this group report very similar mean scores (18.8 for women, 17.3 for men). This initial data supports the notion of a "housewife syndrome" (Bernard, 1972; Gove and Tudor, 1973). While the number of men in this category is quite small, one can at least speculate over this sub-group. It is interesting to note that these men share some basic similarities to the typical housewife, at least in terms of traditional family roles. The men in this cell find...
Table 8.1—Analysis of Variance for Number of Family Roles and Labor Force Participation on Demoralization for Men and Women in the Treatment Sample.

**WOMEN**

<table>
<thead>
<tr>
<th>Number of Family Roles</th>
<th>Labor Force Participation?</th>
<th>Non-Worker Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Few</td>
<td>17.8</td>
<td>15.0</td>
</tr>
<tr>
<td></td>
<td>(32)</td>
<td>(36)</td>
</tr>
<tr>
<td>Many</td>
<td>18.8</td>
<td>13.2</td>
</tr>
<tr>
<td></td>
<td>(35)</td>
<td>(20)</td>
</tr>
<tr>
<td></td>
<td>18.3</td>
<td>14.4</td>
</tr>
<tr>
<td></td>
<td>(67)</td>
<td>(56)</td>
</tr>
</tbody>
</table>

Family Roles: F= 0.01, p= .91; Labor Force Participation: F= 6.80, p= .01; Family Roles X Labor Force Participation: F= 1.36; p=.24

**MEN**

<table>
<thead>
<tr>
<th>Number of Family Roles</th>
<th>Labor Force Participation?</th>
<th>Non-Worker Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Few</td>
<td>16.0</td>
<td>14.6</td>
</tr>
<tr>
<td></td>
<td>(6)</td>
<td>(16)</td>
</tr>
<tr>
<td>Many</td>
<td>17.3</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>(3)</td>
<td>(10)</td>
</tr>
<tr>
<td></td>
<td>16.4</td>
<td>11.8</td>
</tr>
<tr>
<td></td>
<td>(9)</td>
<td>(26)</td>
</tr>
</tbody>
</table>

Family Roles: F= 3.86; p= .06; Labor Force Participation: F= 2.2, p=.15; Family Roles X Labor Force Participation: F= 1.97, p=.17
themselves in a weak power position in the family. All three are out of the labor force due to physical health problems, had wives who worked, and were dependent on wives for a major share of household income. Additionally, and in contrast to other men in the sample, these men reported frequent disagreements over the distribution of decision-making in the family.

Perhaps the most interesting finding in Table 8.1 is the data concerning the group most vulnerable to "role overload". For women as well as men, those in the labor force and reporting multiple family roles have substantially lower demoralization scores than the other sub-groups. Those persons engaged in the most social role participation clearly have the lowest mean demoralization scores. The stresses and strains associated with multiple social roles do not translate into demoralization. This is not to say they do not make a person susceptible to other forms of mental distress, but in this data I do not find a relationship between overload and morale. Table 8.1 also indicates that labor force participation has a stronger effect on demoralization than number of family roles.

Social Roles, Control Variables and Demoralization

The data in Table 8.1 was reexamined controlling for other variables thought to be important predictors in the onset of demoralization. Three-way analyses of variance were run on the relationship between number of family roles and labor force participation controlling one at a time for marital status, age, amount of contact with friends, presence of preschool children, social class, family income, and total number of family problems (a measure of family
Table 8:2—Analysis of Variance for Demoralization Among Women in the Treatment Sample by Number of Family Roles and Labor Force Participation Controlling for Marital Status, Age, Friend Contact, Presence of Preschool Children, Number of Family Problems, Social Class, and Family Income

<table>
<thead>
<tr>
<th>Control Variables: Two and Three Way Interactions</th>
<th>N</th>
<th>Mean Squares</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Roles and Marital Status Labor Force Part. and Marital Status</td>
<td>123</td>
<td>6.6</td>
<td>1</td>
<td>0.10</td>
<td>0.75</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Marital Status</td>
<td>123</td>
<td>235.6</td>
<td>1</td>
<td>3.77</td>
<td>0.05</td>
</tr>
<tr>
<td>Family Roles and Age Labor Force Part. and Age</td>
<td>123</td>
<td>111.4</td>
<td>1</td>
<td>1.78</td>
<td>0.19</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Age</td>
<td>123</td>
<td>51.1</td>
<td>1</td>
<td>0.81</td>
<td>0.37</td>
</tr>
<tr>
<td>Family Roles and Friend Contact Labor Force Part. and Friend Contact</td>
<td>123</td>
<td>11.4</td>
<td>1</td>
<td>0.18</td>
<td>0.67</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Friend Contact</td>
<td>123</td>
<td>27.0</td>
<td>1</td>
<td>0.42</td>
<td>0.52</td>
</tr>
<tr>
<td>Family Roles and Social Class Labor Force Part. and Social Class</td>
<td>123</td>
<td>257.3</td>
<td>1</td>
<td>4.16</td>
<td>0.04</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Social Class</td>
<td>123</td>
<td>44.5</td>
<td>1</td>
<td>0.72</td>
<td>0.40</td>
</tr>
<tr>
<td>Family Roles and Preschoolers Labor Force Part. and Preschoolers</td>
<td>123</td>
<td>101.6</td>
<td>1</td>
<td>1.65</td>
<td>0.20</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Preschoolers</td>
<td>123</td>
<td>12.0</td>
<td>1</td>
<td>0.18</td>
<td>0.67</td>
</tr>
<tr>
<td>Family Roles and Family Income Labor Force Part. and Family Income</td>
<td>123</td>
<td>93.1</td>
<td>1</td>
<td>1.42</td>
<td>0.24</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Family Income</td>
<td>123</td>
<td>8.8</td>
<td>1</td>
<td>0.14</td>
<td>0.71</td>
</tr>
<tr>
<td>Family Roles and Family Problems Labor Force Part. and Family Problems</td>
<td>123</td>
<td>41.3</td>
<td>1</td>
<td>0.66</td>
<td>0.42</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Family Problems</td>
<td>123</td>
<td>81.3</td>
<td>1</td>
<td>1.30</td>
<td>0.26</td>
</tr>
<tr>
<td>Family Roles and Family Income Labor Force Part. and Family Income</td>
<td>123</td>
<td>17.2</td>
<td>1</td>
<td>0.30</td>
<td>0.87</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Family Income</td>
<td>123</td>
<td>0.5</td>
<td>1</td>
<td>0.01</td>
<td>0.93</td>
</tr>
<tr>
<td>Family Roles and Family Problems Labor Force Part. and Family Problems</td>
<td>123</td>
<td>173.4</td>
<td>1</td>
<td>2.88</td>
<td>0.09</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Family Problems</td>
<td>123</td>
<td>22.2</td>
<td>1</td>
<td>0.04</td>
<td>0.85</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Family Problems</td>
<td>123</td>
<td>67.3</td>
<td>1</td>
<td>1.11</td>
<td>0.30</td>
</tr>
</tbody>
</table>
In Table 8.2, three way analyses of variance are reported for women in the treatment sample between number of family roles and labor force participation controlling for a number of variables. In no instance do the controls alter the substantive findings. In fact, in every comparison, those women reporting multiple family roles and labor force participation report the lowest demoralization scores. That is, whether married or unmarried, young or old, with many friends or few, with or without pre-school children in the home, with few or many family problems, in high or low SES groups, or with high or low income, those women with the greatest social role participation report the best mental health.

The same relationships are examined among men in the treatment sample. Although the N is small here, an examination of higher order interactions was possible with age, social class, family income, amount of contact with friends, and total number of family problems. Again, in every instance, men with multiple family roles who are in the labor force reported the lowest demoralization scores of all male sub-groups.

The analyses up to now have not addressed the issue of the relative effects of family and non-family roles on mental health while simultaneously controlling for the effects of important predictors. The next section deals with this issue.

The Power of Family and Non-Family Roles

The question in this section centers on the strength of family and non-family role performance compared to other important variables in the explanation of demoralization. In addition to family and non-family
roles, a number of predictors were examined separately for men and women. Data in Table 8.3 presents the zero order correlations between a number of selected variables and demoralization first for men and then for women.

Looking first at the correlations in the left-hand column for males, there are several significant relationships. As suggested in the mental health literature (Keniston, 1976; Brenner, 1975), men's demoralization scores vary most dramatically with economic variables. Men not in the labor force, men who express dissatisfaction with the amount of money they make and men with a low SES have higher demoralization scores. A significant correlation exists between demoralization and the presence of physical health problems. It is also obvious from Table 8.3 that among males in the treatment sample those without family roles report low morale. Males without spouses, without children, and men without pre-school children seem more vulnerable to demoralization.

The strongest correlation among men in the treatment sample is found, however, between family income and demoralization ($r=.51$). This is consistent with data reported in a recent study by Kessler (1982). Kessler reanalysed eight epidemiologic surveys to estimate the relative importance of income, education, and occupational status in predicting psychological distress. He found each aspect of socioeconomic status associated with distress net of the others. More importantly, he found income level to be the most important predictor of distress, but only among the males.

The correlation between physical health problems and psychological health ($r=.41$) has long been recognized (Gurin et al., 1960; Mechanic,
Table 8.3—Zero Order Correlations Between Selected Variables and Demoralization for Men and Women in the Treatment Sample

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Family Roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>-.01</td>
<td>.32***</td>
</tr>
<tr>
<td>Number of Husband-Wife Problems</td>
<td>-.15</td>
<td>.23**</td>
</tr>
<tr>
<td>Number of Parent-Child Problems</td>
<td>.13</td>
<td>.02</td>
</tr>
<tr>
<td>Number of Anti-Social Problems</td>
<td>.08</td>
<td>.15</td>
</tr>
<tr>
<td>Family Statuses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having a Spouse</td>
<td>-.31*</td>
<td>-.06</td>
</tr>
<tr>
<td>Number of Children in Home</td>
<td>-.34*</td>
<td>-.03</td>
</tr>
<tr>
<td>Number of Preschool Children</td>
<td>-.35*</td>
<td>.20*</td>
</tr>
<tr>
<td>Total Number of Family Roles</td>
<td>-.40**</td>
<td>.08</td>
</tr>
<tr>
<td>Economic Factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Family Income</td>
<td>-.51***</td>
<td>-.21**</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>-.32*</td>
<td>-.30***</td>
</tr>
<tr>
<td>Social Class</td>
<td>.38**</td>
<td>.12</td>
</tr>
<tr>
<td>Objective Dependency</td>
<td>.16</td>
<td>.25**</td>
</tr>
<tr>
<td>Quality of Work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Work Problems</td>
<td>.01</td>
<td>.16*</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
<td>-.15</td>
<td>-.18*</td>
</tr>
<tr>
<td>Satisfaction with Income</td>
<td>-.39**</td>
<td>-.14</td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Physical Health Problems (Self)</td>
<td>.42**</td>
<td>.24**</td>
</tr>
<tr>
<td>Number of Physical Health Problems (Others)</td>
<td>.15</td>
<td>.05</td>
</tr>
<tr>
<td>Social Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Size of Friendship Network</td>
<td>-.03</td>
<td>-.16</td>
</tr>
<tr>
<td>Amount of Contact with Friends</td>
<td>-.20</td>
<td>.11</td>
</tr>
<tr>
<td>Size of Kin Network</td>
<td>.09</td>
<td>-.01</td>
</tr>
<tr>
<td>Amount of Contact with Kin</td>
<td>.01</td>
<td>-.12</td>
</tr>
<tr>
<td>Age</td>
<td>.03</td>
<td>-.20**</td>
</tr>
</tbody>
</table>

* p < .05
** p < .01
*** p < .001
Whether problems become defined as physically or mentally based may be a matter of attribution. Much of the delivery of mental health assistance is given in the United States by primary care physicians. Often, when people seek out mental health aid, their problems are often presented in physical or psychophysiological terms (Shephard et al., 1966; Gardner, 1970; Hotaling, 1975). In this sample of men, all of whom sought mental health assistance, 21% began their search by seeking the help of a physician and were eventually referred to more direct mental health services. The measure of physical health problems used in this research is not a measure of current health status but a measure of past illness, disability and/or hospitalization.

For women in the treatment sample, demoralization is also tied primarily to family and economic considerations; although somewhat more strongly for qualitative dimensions of family life. The strongest correlation for these women is between demoralization and the total number of self-reported problems occurring in the family (r=.32). In fact, many of the qualitative aspects of family life are related to demoralization among the women including the number of husband-wife problems (r= .23), the number of work-financial problems (r= .16), and the extent of dependency on the marriage experienced by the woman (r= .25). As was the case for males, economic factors loom large for female morale. Women not in the labor force, women with low family incomes, and women dissatisfied with the type of work they do report high demoralization scores.

Variables with a significant zero-order correlation with demoralization were entered into separate regression equations for men
and women using backward elimination. With backward elimination, variables are entered as a group and are then removed from the equation one at a time. At each step the independent variables already in the equation are examined for removal. The variable with the smallest F value is removed if the probability of that F is larger than the removal criteria. The removal criterion in this instance was set liberally at $p = .10$.

For males, seven of the nine variables with significant zero-order effects were entered into a regression equation. Social class and family income were highly intercorrelated and caused problems of multicollinearity when entered together. The social class variable was dropped from the equation. The same problem arose between the variables number of pre-school children and total number of family roles. Number of pre-school children was eliminated from the equation.

As can be seen in Table 8.4, after the seven variables were entered, none of the variables were significant at the .05 level before the elimination procedure began. The variables with the largest betas are number of family roles, physical health problems and family income. After elimination, only two variables passed the survival criteria: family income and number of physical health problems. These two variables account for 28% of the adjusted variance in demoralization scores among men and represent findings consistent with the existing mental health literature. The highest demoralization scores among men who have sought mental health aid occur among low income men and those with physical health problems.

The same procedure was followed with the female treatment sub-sample. Eleven variables with significant zero-order effects were
Table 8.4 -- Regression Equation Using Backward Elimination on Males in the Treatment Sample with Selected Variables Before and After Elimination

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Family Roles</td>
<td>-.48</td>
<td>.30</td>
<td>-.42</td>
<td>-.30</td>
<td>-1.56</td>
<td>.132</td>
</tr>
<tr>
<td>Number of Physical Health Problems</td>
<td>.36</td>
<td>.19</td>
<td>.20</td>
<td>.35</td>
<td>1.84</td>
<td>.078</td>
</tr>
<tr>
<td>Family Income</td>
<td>-.31</td>
<td>.18</td>
<td>-.47</td>
<td>-.32</td>
<td>-1.57</td>
<td>.107</td>
</tr>
<tr>
<td>Presence of Spouse</td>
<td>.18</td>
<td>.31</td>
<td>-.27</td>
<td>.12</td>
<td>0.59</td>
<td>.563</td>
</tr>
<tr>
<td>Satisfaction with Earnings</td>
<td>.12</td>
<td>.17</td>
<td>-.15</td>
<td>.14</td>
<td>0.69</td>
<td>.493</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>.06</td>
<td>.19</td>
<td>-.25</td>
<td>.06</td>
<td>0.30</td>
<td>.765</td>
</tr>
<tr>
<td>Number of Children in Home</td>
<td>-.01</td>
<td>.23</td>
<td>-.28</td>
<td>-.01</td>
<td>0.04</td>
<td>.971</td>
</tr>
</tbody>
</table>

AFTER REMOVAL

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Income</td>
<td>-.40</td>
<td>.15</td>
<td>-.47</td>
<td>-.43</td>
<td>-2.55</td>
<td>.016</td>
</tr>
<tr>
<td>Number of Physical Health Problems</td>
<td>.33</td>
<td>.15</td>
<td>.42</td>
<td>.36</td>
<td>2.08</td>
<td>.046</td>
</tr>
</tbody>
</table>

Multiple r = .570; $R^2 = .32$; Adjusted $R^2 = .28$
entered into a regression equation. No multicollinearity problems were encountered. The data in Table 8.5 indicates that before elimination only two variables showed a significant relationship with demoralization scores: the number of family problems; a measure of family stress and age. However, after the elimination procedure, four variables survived. Listed in order of the size of their betas, they are: labor force participation, number of family problems, age, and physical health problems.

What is most interesting about these findings is the extent to which they conform to prevalent notions of sex differences in psychological distress described in the literature. Men, whose self validation derives from achievement in the economic sphere, are more likely demoralized when family income is low. The regression equation for males before elimination showed that having few family roles was strongly related to demoralization. Again, this is consistent with ideas about the relationship of family to mental health for males. Bernard (1972) and Gove and Tudor (1973) see males as benefiting through the occupation of family roles, not being stressed by them. To these authors, having a wife is especially valuable. Some literature also suggests positive effects of fatherhood on men. For example, Skolnick (1978) argues that the father role has traditionally been seen as proof of manhood. Blau and Duncan (1967) see the father role as a source of pride and achievement.

The findings for females in the treatment sample are also consistent with the major contours of the specific sex role theory of mental illness. There is, however, one notable exception. It is the quality of family role interaction and not marital status that shows a
### Table 8.5 — Regression Equation Using Backward Elimination on Females in Treatment Sample with Selected Variables Before and After Elimination.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Elimination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>.58</td>
<td>.27</td>
<td>.31</td>
<td>.23</td>
<td>2.13</td>
<td>.035</td>
</tr>
<tr>
<td>Age</td>
<td>-.24</td>
<td>.12</td>
<td>-.19</td>
<td>-.22</td>
<td>-2.03</td>
<td>.046</td>
</tr>
<tr>
<td>Number of Family Deviance Problems</td>
<td>-.18</td>
<td>.15</td>
<td>.11</td>
<td>-.13</td>
<td>-1.18</td>
<td>.239</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>-.17</td>
<td>.20</td>
<td>-.26</td>
<td>-.09</td>
<td>-0.82</td>
<td>.413</td>
</tr>
<tr>
<td>Number of Work Problems</td>
<td>-.16</td>
<td>.14</td>
<td>.16</td>
<td>-.12</td>
<td>-1.11</td>
<td>.269</td>
</tr>
<tr>
<td>Number of Husband-Wife Problems</td>
<td>-.15</td>
<td>.18</td>
<td>.22</td>
<td>-.09</td>
<td>0.82</td>
<td>.412</td>
</tr>
<tr>
<td>Number of Physical Health Problems</td>
<td>.12</td>
<td>.12</td>
<td>.29</td>
<td>.11</td>
<td>1.00</td>
<td>.318</td>
</tr>
<tr>
<td>Objective Dependency</td>
<td>.09</td>
<td>.24</td>
<td>.25</td>
<td>.04</td>
<td>0.35</td>
<td>.724</td>
</tr>
<tr>
<td>Number of Preschool Children</td>
<td>.05</td>
<td>.16</td>
<td>.23</td>
<td>.03</td>
<td>0.28</td>
<td>.775</td>
</tr>
<tr>
<td>Family Income</td>
<td>.04</td>
<td>.13</td>
<td>-.19</td>
<td>-.04</td>
<td>-0.32</td>
<td>.747</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
<td>.01</td>
<td>.11</td>
<td>-.17</td>
<td>.01</td>
<td>0.07</td>
<td>.946</td>
</tr>
<tr>
<td>AFTER REMOVAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>-.25</td>
<td>.09</td>
<td>-.26</td>
<td>-.26</td>
<td>-2.52</td>
<td>.013</td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>.24</td>
<td>.10</td>
<td>.31</td>
<td>.26</td>
<td>2.47</td>
<td>.016</td>
</tr>
<tr>
<td>Age</td>
<td>-.22</td>
<td>.09</td>
<td>-.19</td>
<td>-.23</td>
<td>-2.24</td>
<td>.028</td>
</tr>
<tr>
<td>Number of Physical Health Problems</td>
<td>.21</td>
<td>.10</td>
<td>.29</td>
<td>.22</td>
<td>2.12</td>
<td>.037</td>
</tr>
</tbody>
</table>

Multiple $r = .49$; $R^2 = .24$; Adjusted $R^2 = .20$
more significant relationship to demoralization. Women, whatever their marital status, have their morale affected by the amount of family stress in their environment. The strongest predictor of demoralization among women in the treatment sample is not the quantity or quality of family roles, but their relationship to the labor force. Consistent with the specific sex role theory of Bernard (1972) and Gove and Tudor (1973) women not in the labor force in stressful family environments are more vulnerable to psychological distress.

Chapter Summary

The original analyses in this chapter examined the issue of social role involvement and demoralization. The two primary areas of role involvement in people's lives were examined: family roles and work roles. For both men and women, those involved in multiple family roles and also in the labor force were the persons with the best morale. This finding was not altered controlling singly for marital status, age, amount of contact with friends, social class, the presence of preschool children, family income, or the number of family problems reported by respondents.

These findings run counter to the argument made by several authors (Gove and Tudor, 1973; Gove and Hughes, 1979; Eaton, 1980) that the higher reported rates of psychological distress reported by women are due to role overload. Rather, it would seem the greater number of bases of social involvement actually improves morale. Persons with multiple family roles and out of the labor force are most demoralized, regardless of gender.

When social role participation was examined along with other
predictors of demoralization, it was clear that economic factors play a significant part in the understanding of demoralization. Among men, family income and number of physical health problems were the most important predictors of demoralization. Among women, not being in the labor force, number of family problems, age, and number of physical health problems were the strongest surviving predictors in regression analyses.

The general findings in this treatment sample conform, for the most part, to accepted notions of sex differences in psychological distress. The image of the demoralized women as developed by Bernard, 1972 and Gove and Tudor, 1973 rings true here. Women not in the labor force in a family environment of stress have time "to brood over troubles, and her distress may feed upon itself" (Gove and Tudor, 1973:815). These findings support the notion that there a sex role basis for experiencing distress. As one researcher puts it:

Men's anxieties revolve around actual or threatened failure in creative work, inability to find a meaningful type of vocation, or difficulty in mastering the increasingly complex world of modern technology. Women's worries center around lack of competence in interpersonal relations, inability to achieve intimacy with a man, personality flaws, lack of positive self-image, and insufficient approval, encouragement, and reassurance from others. With regard to family interaction, women's worries concern unsatisfactory fulfillment of the role of homemaker .......whereas men worry about inadequacies in the fulfillment of the provider role (Garai, 1970:136).

At the same time, SES effects should not be interpreted solely in psychological terms or by reference to social role analysis. The findings in this chapter reflect the fact that poor people are unhappy because the social conditions they find themselves in are worse. So,
even though the results in this treatment sample could be interpreted in line with a social role analysis, economic variables offer a more direct interpretation.

These analyses, it should be remembered, have been conducted on a sample of persons who have sought professional mental health assistance. Even among such a sample, there are large variations in scores of demoralization and it is important to understand these differences. As Dohrenwend et al., (1980) contend, demoralization is different from clinical psychiatric disorder, and it is not the only reason people seek help. It is entirely possible for persons to be clinically disordered but not demoralized and vice-versa. According to Dohrenwend et al., (1980)

.....it is possible for persons to become demoralized in the absence of clinical disorder; for example, it is likely that demoralization is a more frequent reaction than clinical psychiatric disorder on the part of previously normal persons facing severe physical illness, or other stressful life events (p. 127).

Persons suffering from psychiatric impairment may not be demoralized. In this sample, there were many persons with low demoralization scores, who, nevertheless, sought out mental health assistance. While the data here do not bear directly on this issue, this is an important group for further study. Such persons may be more responsive to treatment and/or more willing to actively participate in finding solutions to their problems.

We now turn to these issues in the community sub-sample. The results in this chapter may only be applicable to persons who have initiated help seeking for personal and interpersonal problems.
CHAPTER IX

DETERMINANTS OF DEMORALIZATION: THE COMMUNITY SAMPLE

This chapter will examine males and females separately in an attempt to understand what variables account best for variations in demoralization. As in the last chapter the focus will be on the performance and quality of family and non-family roles. In the examination of these factors for the treatment sample, reported in the last chapter, economic factors are crucial. For men, income level was the strongest predictor of demoralization, while for women, labor force status was foremost. Women not employed, regardless of family role obligations, reported high demoralization scores.

The Issue of Involvement - Non-Involvement in Social Roles.

As reviewed in Chapter VIII, role theory suggests that having several roles with conflicting obligations and demands may cause psychological distress, even if having any specific role by itself does not. The two social roles most often cited in the mental health literature as having the greatest potential for conflicting expectations are family and employment roles. The norms surrounding behavior in these roles involve different expectations, obligations and rules for interaction (Zelditch, 1955). Attempts to reconcile demands from both spheres leads to role conflict (Bernard, 1972; Gove and Tudor, 1973) and role overload (Gove and Hughes, 1979; Eaton, 1980).
Women are depicted as more vulnerable to role conflict than men. Family roles for women are held to more central and their demands and obligations easily become confounded with demands from non-family sectors. On the other hand, men are not as vulnerable to role conflict because their lower commitment to family shields them from the contradictory demands of family and work. They may experience stress from work, but they are less likely than women to experience conflicting role demands between work and home.

In the treatment sample it was found that persons involved in potential role overload situations, those persons with multiple family roles and full-time labor force participation reported the lowest demoralization scores. The same is true of the community sample. Table 9.1 shows the ANOVA for demoralization by family roles and labor force participation presented separately for men and women. For women, the pattern of findings here mirrors the earlier findings for women in the treatment sample with the exception that the overall scores for women are lower in the community sample. Those women with multiple family roles who are not in the labor force report the highest demoralization scores.

The sub-group with the lowest mean demoralization scores are women with multiple family roles and full-time participation in the labor force. In contrast to the theory of role overload or role conflict, women performing these supposedly contradictory roles report the best morale. It can also be seen in Table 9.1 that in terms of main effects, being employed outside the home is a more important variable than number of family roles. Those women with multiple family roles are among the groups with both the best and worse morale depending on their
Table 9.1—Analysis of Variance for Number of Family Roles and Labor Force Participation on Demoralization for Women and Men in the Community Sample

### WOMEN

<table>
<thead>
<tr>
<th>Number of Family Roles</th>
<th>Labor Force Participation?</th>
<th>Non-Worker Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Few</td>
<td>9.87</td>
<td>10.6</td>
</tr>
<tr>
<td></td>
<td>(15)</td>
<td>(16)</td>
</tr>
<tr>
<td>Many</td>
<td>11.9</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>(48)</td>
<td>(58)</td>
</tr>
<tr>
<td></td>
<td>11.4</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>(63)</td>
<td>(74)</td>
</tr>
</tbody>
</table>

Family Roles: $F = .001$, $p = .93$; Labor Force Participation: $F = 5.4$, $p = .02$; Family Roles X Labor Force Participation: $F = 3.2$, $p = .07$

### MEN

<table>
<thead>
<tr>
<th>Number of Family Roles</th>
<th>Labor Force Participation?</th>
<th>Non-Worker Excess in Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Few</td>
<td>11.0</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>(3)</td>
<td>(10)</td>
</tr>
<tr>
<td>Many</td>
<td>8.2</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>(6)</td>
<td>(54)</td>
</tr>
<tr>
<td></td>
<td>9.1</td>
<td>8.0</td>
</tr>
<tr>
<td></td>
<td>(9)</td>
<td>(54)</td>
</tr>
</tbody>
</table>

Family Roles: $F = 0.01$, $p = .92$; Labor Force Participation: $F = 0.29$, $p = .60$; Family Roles X Labor Force Participation: $F = 0.62$, $p = .44$
relationship to the world of work.

In the community sample of men there is little variation when examining family and employment roles. Three-fourths of the men have full-time jobs and multiple family roles. Furthermore, as seen in Table 9.1, there is little variation in demoralization scores among at least three sub-groups of men. Men with low participation in family and non-family roles are clearly the more demoralized. The sub-group reporting the lowest demoralization scores are those who are employed full-time with few family obligations.

Data in Table 9.1 was reexamined controlling for the effects of a number of important variables including marital status, age friend contact, presence of preschool children, social class, family income, and number of family problems. In Table 9.2 three way analyses of variance are reported for women in the community sample. In no instance do the control variables change the initial pattern of findings. A few of the findings, however, require special mention. Most important, marital status does not alter the relationship between number of family roles and employment on demoralization. That is, among the married, those with more family roles who also work full-time report the lowest demoralization scores while women with multiple family roles not in the labor force report the highest demoralization scores. The same is true for women without spouses. Those with multiple family roles, in this case, multiple parental roles and work full-time, report the lowest demoralization compared to those women with multiple family roles and not employed outside the home. Among women, the relationship between family roles, employment and demoralization also holds controlling for the presence of pre-school children. This is also true controlling for
Table 9.2—Analysis of Variance for Demoralization Among Women in the Community Sample by Number of Family Roles and Labor Force Participation Controlling for Marital Status, Age, Friend Contact, Social Class, Family Income, and Number of Family Problems

<table>
<thead>
<tr>
<th>Control Variables: Two and Three Way Interactions</th>
<th>N</th>
<th>Mean Squares</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Roles and Marital Status</td>
<td>137</td>
<td>2.44</td>
<td>1</td>
<td>0.06</td>
<td>.81</td>
</tr>
<tr>
<td>Labor Force Part. and Marital Status</td>
<td>137</td>
<td>8.76</td>
<td>1</td>
<td>0.21</td>
<td>.65</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Marital Status</td>
<td>137</td>
<td>3.50</td>
<td>1</td>
<td>0.08</td>
<td>.77</td>
</tr>
<tr>
<td>Family Roles and Age</td>
<td>137</td>
<td>28.43</td>
<td>1</td>
<td>0.70</td>
<td>.41</td>
</tr>
<tr>
<td>Labor Force Part. and Age</td>
<td>137</td>
<td>16.02</td>
<td>1</td>
<td>0.39</td>
<td>.53</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Age</td>
<td>137</td>
<td>129.20</td>
<td>1</td>
<td>3.17</td>
<td>.07</td>
</tr>
<tr>
<td>Family Roles and Amount Friend Contact</td>
<td>137</td>
<td>144.37</td>
<td>1</td>
<td>2.50</td>
<td>.12</td>
</tr>
<tr>
<td>Labor Force Part. and Amount Friend Contact</td>
<td>137</td>
<td>91.76</td>
<td>1</td>
<td>1.59</td>
<td>.21</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Amount Friend Contact</td>
<td>137</td>
<td>54.29</td>
<td>1</td>
<td>0.94</td>
<td>.33</td>
</tr>
<tr>
<td>Family Roles and Social Class</td>
<td>137</td>
<td>12.98</td>
<td>1</td>
<td>0.23</td>
<td>.63</td>
</tr>
<tr>
<td>Labor Force Part. and Social Class</td>
<td>137</td>
<td>401.20</td>
<td>1</td>
<td>7.16</td>
<td>.01</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Social Class</td>
<td>137</td>
<td>119.20</td>
<td>1</td>
<td>2.13</td>
<td>.15</td>
</tr>
<tr>
<td>Family Roles and Family Income</td>
<td>137</td>
<td>58.73</td>
<td>1</td>
<td>1.04</td>
<td>.31</td>
</tr>
<tr>
<td>Labor Force Part. and Family Income</td>
<td>137</td>
<td>11.98</td>
<td>1</td>
<td>0.21</td>
<td>.65</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Family Income</td>
<td>137</td>
<td>0.82</td>
<td>1</td>
<td>0.01</td>
<td>.91</td>
</tr>
<tr>
<td>Family Roles and Number of Family Problems</td>
<td>137</td>
<td>4.72</td>
<td>1</td>
<td>0.12</td>
<td>.74</td>
</tr>
<tr>
<td>Labor Force Part. and Number of Family Problems</td>
<td>137</td>
<td>86.70</td>
<td>1</td>
<td>2.11</td>
<td>.15</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Number of Family Problems</td>
<td>137</td>
<td>3.24</td>
<td>1</td>
<td>0.08</td>
<td>.80</td>
</tr>
</tbody>
</table>
the effects of age, social class, and number of family problems.

There is some suggestion here that the greater the number of sources of social role participation the lower the demoralization. In fact, among that sub-group of women with multiple family roles, who work full-time, and who report high contact with friends, demoralization scores are lower than any other sub-group of women in the sample.

For men the original relationship between family roles and employment with demoralization was reexamined controlling for the same variables as was done for women in the community sample. Initial findings did not change significantly when controlling for these other variables. Under all conditions, the males with the least degree of social participation, those with few family roles and no employment, were the more demoralized sub-group. Controlling for marital status did alter findings relating to the group with the best morale. Among men who are married, those with multiple family roles and full-time employment are the men with the lowest demoralization. High participators were also found to have the least demoralization among women in the community sample and among both men and women in the treatment sample.

In general, findings from the community sample mirror those found in the treatment sample. There seems to be a definite degree of protection against demoralization among those with multiple family roles and full-time employment. In all instances, this group reports the best morale. Perhaps the often found overrepresentation of women among the demoralized is due to the fact that fewer women than men occupy multiple social roles. This is true in both of the sub-samples
reported on here. In the treatment sample, 29% of the men compared to 16% of the women perform multiple family roles and employment roles. In the community sample, 73% of the men compared to 42% of the women occupy multiple social roles.

Not only are more men engaged in multiple social roles than are women, the extent of occupation is directly related to morale. If we examine that group of women and men who occupy several social roles, the effect seems stronger for women than men. Among women employed outside of the home, who have multiple family roles, and are also involved in an active friendship network, mean demoralization scores are very low. These highly engaged women have a mean score of 7.5 compared to a mean of 10.1 for all women in the community sample. For males with this same multiple role profile the mean demoralization score is 8.4 compared to a mean of 8.1 for all men in the community sample. This is one of the few instances in which a sub-group of women report a lower distress score than a comparable group of men.

The Power of Family and Non-Family Status Occupancy

In Chapter VIII the treatment sample was examined for the relative effects of family and employment roles on demoralization controlling for the effects of other important variables. In this chapter the same logic will be followed with the community sample. Males and females will be examined separately.

Table 9.3 presents the zero order correlations between a number of selected variables and demoralization for men and women. For men, the strongest zero order correlations occur between between demoralization and the number of physical health problems of the respondent followed
Table 9.3—Zero Order Correlations Between Selected Variables and Demoralization for Men and Women in the Community Sample

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality of Family Roles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>.35***</td>
<td>.20***</td>
</tr>
<tr>
<td>Number of Husband-Wife Problems</td>
<td>.16</td>
<td>.19**</td>
</tr>
<tr>
<td>Number of Parent-Child Problems</td>
<td>.09</td>
<td>.17**</td>
</tr>
<tr>
<td>Number of Anti-Social Problems</td>
<td>.29**</td>
<td>.06</td>
</tr>
<tr>
<td><strong>Family Statuses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having a Spouse</td>
<td>.07</td>
<td>-.01</td>
</tr>
<tr>
<td>Number of Children in Home</td>
<td>.00</td>
<td>-.05</td>
</tr>
<tr>
<td>Number of Preschool Children</td>
<td>.01</td>
<td>.04</td>
</tr>
<tr>
<td>Total Number of Family Roles</td>
<td>.08</td>
<td>.05</td>
</tr>
<tr>
<td><strong>Economic Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Family Income</td>
<td>-.07</td>
<td>-.03</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>.05</td>
<td>-.18**</td>
</tr>
<tr>
<td>Social Class</td>
<td>.12</td>
<td>.21***</td>
</tr>
<tr>
<td>Objective Dependency</td>
<td>-.06</td>
<td>.17*</td>
</tr>
<tr>
<td><strong>Quality of Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Work Problems</td>
<td>.24*</td>
<td>.19*</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
<td>-.18*</td>
<td>-.08</td>
</tr>
<tr>
<td>Satisfaction with Income</td>
<td>-.20*</td>
<td>.01</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Physical Health Problems (Self)</td>
<td>.36***</td>
<td>.39***</td>
</tr>
<tr>
<td>Number of Physical Health Problems (Other)</td>
<td>.29**</td>
<td>.03</td>
</tr>
<tr>
<td><strong>Social Support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Size of Friendship Network</td>
<td>-.10</td>
<td>-.10</td>
</tr>
<tr>
<td>Amount of Contact with Friends</td>
<td>.08</td>
<td>-.13*</td>
</tr>
<tr>
<td>Size of Kin Network</td>
<td>-.04</td>
<td>.07</td>
</tr>
<tr>
<td>Amount of Contact with Kin</td>
<td>-.12</td>
<td>.04</td>
</tr>
<tr>
<td>Age</td>
<td>.06</td>
<td>-.15*</td>
</tr>
</tbody>
</table>

* p < .05
** p < .01
*** p < .001
closely by the number of family problems. Significant correlations occur between demoralization and number of anti-social problems of the respondent and between demoralization and the quality of work experience. Men who report problems with work, including job dangerousness, sporadic unemployment, and/or working too many hours report high demoralization. Most surprizing was the strong correlation between demoralization and the physical health problems of other family members. This relationship was not found among men or women in the treatment sample.

Among women in the community sample the first thing that is obvious is the different types of variables that show a significant relationship to demoralization. This is especially true in regard to social participation variables. Women in low SES categories, women out of the labor force, women who are dependent on others for economic support, and women with low friend contact report high demoralization scores. Also noteworthy are the significant correlations between demoralization and the quality of family life. As was true for males, women with a high number of family problems report high demoralization, but demoralized women are also more likely to report a high number of husband-wife problems, and parent-child problems. Unlike males, females report a very weak correlation between family deviance problems and demoralization.

The strongest correlation in this set of variables is with physical health problems of self. As can be seen in Table 9.3, the correlation between physical health problems and demoralization is very strong for men and women. What is different is the correlation for physical health problems of other family members. It is significant for
men and weak for women.

As was done with the treatment sample, separate regression equations using backward elimination were run for men and women. As earlier, the removal criteria was set at .10. Only variables that contribute significantly are entered and retained.

**Demoralization Among Males in the Community Sample**

For men in the community sample, all seven variables with a significant zero order relationship to demoralization were entered into a regression equation using backward elimination. One additional variable was added to the equation, the amount of contact with kin. Of the eight variables, four were significant at $p < .1$. With criterion set at $p = .05$, three variables survived elimination. In Table 9.4, results of the regression equation before and after removal are presented. Before elimination, only one variable is significant at the .05 level: the number of physical health problems of others in the family. Variables are listed here in order of largest to smallest betas. After elimination, three variables are significant: the number of physical health problems of other family members, the physical health problems of the self, and the number of work related problems. All three variables involve significant sources of stress and account for 21% of the adjusted variance in demoralization scores ($F = 7.50, p = .001$).

The relationship between psychological distress and physical health problems has long been recognized if not completely understood. Even less understandable is the relationship found here between demoralization and the physical health problems of other family members. What both types of health problems may have in common in
Table 9.4---Regression Equation Using Backward Elimination on Males in the Community Sample
with Selected Variables Before and After Elimination.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>SEBeta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health Problems of others</td>
<td>.33</td>
<td>.11</td>
<td>.33</td>
<td>.34</td>
<td>2.94</td>
<td>.004</td>
</tr>
<tr>
<td>Physical Health Problems of Self</td>
<td>.18</td>
<td>.11</td>
<td>.25</td>
<td>.19</td>
<td>1.59</td>
<td>.116</td>
</tr>
<tr>
<td>Anti-Social Problems</td>
<td>.13</td>
<td>.15</td>
<td>.26</td>
<td>.11</td>
<td>0.88</td>
<td>.383</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
<td>-.12</td>
<td>.11</td>
<td>-.20</td>
<td>-.13</td>
<td>-1.09</td>
<td>.276</td>
</tr>
<tr>
<td>Number of Work Problems</td>
<td>.12</td>
<td>.13</td>
<td>.30</td>
<td>.11</td>
<td>0.92</td>
<td>.361</td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>.09</td>
<td>.17</td>
<td>.38</td>
<td>.06</td>
<td>0.53</td>
<td>.599</td>
</tr>
<tr>
<td>Satisfaction with Income</td>
<td>-.07</td>
<td>.10</td>
<td>-.17</td>
<td>-.09</td>
<td>-0.69</td>
<td>.493</td>
</tr>
<tr>
<td>Amount of Contact with Kin</td>
<td>-.03</td>
<td>.11</td>
<td>-.04</td>
<td>-.04</td>
<td>-0.29</td>
<td>.774</td>
</tr>
</tbody>
</table>

After Removal

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>SEBeta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health Problems of Others</td>
<td>.33</td>
<td>.10</td>
<td>.33</td>
<td>.36</td>
<td>3.22</td>
<td>.002</td>
</tr>
<tr>
<td>Physical Health Problems of Self</td>
<td>.21</td>
<td>.11</td>
<td>.25</td>
<td>.23</td>
<td>2.00</td>
<td>.049</td>
</tr>
<tr>
<td>Number of Work Problems</td>
<td>.27</td>
<td>.11</td>
<td>.30</td>
<td>.29</td>
<td>2.53</td>
<td>.014</td>
</tr>
</tbody>
</table>

Multiple r = .49; $R^2 = .24$; Adjusted $R^2 = .21$
addition to the obvious stress in the financial strain that could be placed on the family by illness and/or hospitalization. In this sense men may be more affected by the ill health of other family members because it directly impacts on their identity as provider.

If there is merit to this argument, there should be some variation in the relationship of demoralization and family illness by social class. Specifically, lower SES men should be more likely than higher SES men to experience assaults on their morale as providers due to family illness.

Using the same set of variables as used in the regression equation for all men in the community sample, separate regression equations were run on low SES men and high SES men. This procedure reveals that the relationship between demoralization and the physical illnesses of other family members is largely restricted to lower SES men. Among men in higher socioeconomic statuses, the backward elimination procedure reveals little relationship between demoralization and the illnesses of others or the illnesses of self. The only variable to survive the elimination procedure and show a significant relationship to demoralization among high SES men is the number of anti-social problems such as drinking and violence reported by these men. Among lower SES men, two variables show a significant relationship to demoralization: the number of physical health problems of self and the number of physical health problems of other family members. The full results of both regression equations appear in Appendix A, Tables A.8 and A.9. Lower SES men who report physical health problems of family members are also more likely to report lower income \((r=-.21)\), less satisfaction with their jobs \((r=-.22)\) and less satisfaction with income \((r=-.24)\).
This further suggests that the relationship between the health status of other family members and male demoralization may be an economic one placing inordinate demands upon the provider role. It is suggested here that as a family stressor, the ill health of other family members may be a "double stressor" in the sense that the ill health of spouses and children is inherently stressful and also places the family under increased economic burdens.

Research on this issue is sparse but at least one study bears on this relationship. Cafferata et al., (1982) in a national study of gender differences in psychotropic drug use found that of a number of family stressors, the illness of a spouse was one of a few stressful events to significantly raise the use of drugs among men. It is not known how generalizable this finding is to other locales or to other forms of psychological distress, but it is a question worthy of further attention.

Demoralization Among Females in the Community Sample

As was done for males in the community sample, all variables with a significant zero order correlation to demoralization were entered into a regression equation. As reported in Table 9.3, ten variables were statistically significant. These variables are: the number of family problems, the number of husband - wife problems, the number of parent - child problems, labor force participation, social class, objective dependency, the number of work related problems, number of physical health problems of self, amount of contact with friends, and age.

Table 9.5 presents the results of the regression before and after
Table 9.5---Regression Equation Using Backward Elimination on Women in the Community Sample With Selected Variables Before and After Elimination

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEFORE ELIMINATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health Problems of Self</td>
<td>.32</td>
<td>.09</td>
<td>.36</td>
<td>.33</td>
<td>3.80</td>
<td>.000</td>
</tr>
<tr>
<td>Social Class</td>
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<td>.10</td>
<td>.19</td>
<td>.21</td>
<td>2.31</td>
<td>.027</td>
</tr>
<tr>
<td>Amount of Contact with Friends</td>
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<td>.09</td>
<td>-.18</td>
<td>-.22</td>
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<td>.016</td>
</tr>
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<td>.10</td>
<td>-.11</td>
<td>-.18</td>
<td>-1.99</td>
<td>.049</td>
</tr>
<tr>
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<td>.18</td>
<td>-.16</td>
<td>-.09</td>
<td>-0.96</td>
<td>.339</td>
</tr>
<tr>
<td>Size of Friendship Network</td>
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<td>.09</td>
<td>-.08</td>
<td>.08</td>
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<td>.377</td>
</tr>
<tr>
<td>Number of Work Related Problems</td>
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<td>.11</td>
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<td>.506</td>
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<tr>
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<td>.659</td>
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<tr>
<td>Objective Dependency</td>
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<td>.01</td>
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<td>.925</td>
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<tr>
<td>Number of Family Roles</td>
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</table>

<table>
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<tr>
<th>Variable</th>
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<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFTER REMOVAL</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health Problems of Self</td>
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<td>.08</td>
<td>.36</td>
<td>.36</td>
<td>4.33</td>
<td>.000</td>
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<tr>
<td>Age</td>
<td>-.24</td>
<td>.08</td>
<td>-.11</td>
<td>-.26</td>
<td>-2.96</td>
<td>.004</td>
</tr>
<tr>
<td>Social Class</td>
<td>.22</td>
<td>.08</td>
<td>.19</td>
<td>.23</td>
<td>2.66</td>
<td>.009</td>
</tr>
<tr>
<td>Amount of Contact with Friends</td>
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<td>.08</td>
<td>-.18</td>
<td>-.23</td>
<td>-2.56</td>
<td>.012</td>
</tr>
<tr>
<td>Labor Force Participation</td>
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<td>.08</td>
<td>-.11</td>
<td>-.26</td>
<td>-2.28</td>
<td>.024</td>
</tr>
</tbody>
</table>

Multipl r = .51; R² = .26; Adjusted R² = .23
removal. Before removal, with all variables entered, four predictors are significantly related to demoralization. After removal, five variables are significantly related to demoralization. They are: physical health problems of self (beta = .34), age (beta = -.24), social class (beta = .22), amount of friend contact (beta = -.20), and labor force participation (beta = -.18)

What These Factors Have in Common

These five variables, which account for 23% of the adjusted variance in demoralization among women in the community sample support a number of previous research findings. In general, these variables point to a relationship between demoralization and the lack of sources for the validation of esteem. Physical health problems of a serious nature tend to restrict the normal social activities of people. Being without paid work does not promote self perceptions of adequacy and involvement. A lack of friends and acquaintances reinforces isolation and is one characteristic of the more restrictive life style of lower SES groups.

Notions of restrictive social activity and social isolation have long pervaded the sociological literature on psychological distress (Jacq, 1954; Lowenthal and Haven, 1968; Ryan, 1969; Brown and Harris, 1978). More recently, the restrictiveness of social roles and its effects on physical health problems has gained attention (Marcus and Seeman, 1981; Verbrugge, 1983). Brown and Harris (1978) in their sample of clinically depressed women report findings very similar to those reported in this research. These authors were not concerned with explaining sex differences in depression but in explaining sex
differences among women. They list a number of vulnerability factors which raise the risk of depressive response in the face of stressful life events. One significant life event frequently mentioned by depressed women in their sample is the serious physical health problems of self and other family members. These authors report that among the women with chronic psychiatric depression they studied, there was a very high rate of health difficulties. Among these women:

....marked difficulties concerning their own health were five times more common than among normal women and more minor ones nearly twice as common; marked health difficulties concerning others were three times as common and more minor ones nearly twice as common (Brown and Harris, 1978:144)

These authors also find that a number of factors operated to soften the effects of stressful events such as physical health problems. Most notable among these were the presence of an intimate or confidant or other source of social support, being employed, and not being a member of the working classes. The role of social class is central in their research. These writers contend that it is working class women who are more vulnerable to depression because the rate of family physical illness is higher, these women are less likely to report developed friendship networks, and are also more likely to be out of the labor force. All in all, this research describes the role of social isolation in promoting hopelessness, lowered self-esteem, and ultimately depression.

What seems obvious in the research reported here is the similarity of findings to those reported by Brown and Harris (1978) on depression. Demoralized women in this sample report a paucity of sources for the validation of their worth. Rather than being overloaded by the demands
of several statuses, these women report few bases for social participation. This lack of sources for validation applies to family as well as non-family statuses. Past research, with a somewhat limited focus only on married men and women tends to gloss over the fact that persons most vulnerable to psychological distress are often without family based sources of support. This is not to say that married persons, simply because they are married, exist in totally supportive, validating environments. In fact, recent research, (Vanfossen, 1981), finds evidence for a strong negative relationship between depression and spouse support. In the data examined here, if we look at women in the community sample currently living with a mate, there is a strong correlation between demoralization and the amount of support they receive from spouses. The correlation between ten items measuring instrumental and expressive support and demoralization is \( r = -.27; p = .003 \). Three items in particular show a significantly negative relationship to demoralization: "My spouse praises me" \( r = -.31; p = .001 \) -- "My spouse is thoughtful when I am tired out" \( r = -.28; p = .002 \) and "My spouse makes me feel I am loved" \( r = -.25; p = .005 \).

**Social Class and Demoralization Among Females in the Community Sample**

There are two reasons why it may be wise to separately examine groups of women by socioeconomic level: 1) in Chapter VII it was found that a sex-social class interaction effect was a strong predictor of demoralization; and 2) if factors related to social restrictiveness are related to demoralization among all women, this relationship should be more pronounced among lower SES women and possibly show a very different relationship to demoralization among high SES women (Rubin,
Data in Table 9.6 presents the regression equation for a number of variables and demoralization among low SES women. Social restrictiveness variables show a significant relationship to demoralization. Compared to all women in the sample, the indicators of social participation are good predictors of demoralization among low SES women. Data here indicate that a restrictiveness of non-family social roles has more to do with demoralization than do indicators of role overload. Furthermore, no evidence is found that family roles account for much variation in demoralization scores.

A different picture emerges when data on higher SES women is examined. None of the variables indicative of social restrictiveness are significantly related to demoralization. Results in Table 9.7 indicate that the two best predictors of demoralization among high SES women are amount of family stress and size of friendship network. Women with a high number of family problems and many friends report high demoralization.

There is also a different relationship between demoralization and spouse support among married females by social class. The simple correlation between these two variables for lower SES women is highly significant \((p = .011)\), while the correlation for high SES women is not significant \((p = .18)\). Items from the support scale most strongly correlated with demoralization among lower SES women are not those dealing with instrumental assistance but those dealing with the validation of self-esteem. For example, the three items with the strongest relationship to demoralization are "My spouse praises me" \((r = -.48; p = .002)\), "My spouse likes to have me around" \((r = -.44; p = .002)\), and "My spouse shows love and affection for me" \((r = -.45; p = .002)\).
Table 9.6---Regression Equation Using Backward Elimination on Low SES Women in the Community Sample With Selected Variables Before and After Elimination

### BEFORE ELIMINATION

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.57</td>
<td>.16</td>
<td>-.40</td>
<td>-.51</td>
<td>-3.68</td>
<td>.001</td>
</tr>
<tr>
<td>Physical Health Problems of Self</td>
<td>.51</td>
<td>.12</td>
<td>.48</td>
<td>.56</td>
<td>4.18</td>
<td>.000</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>-.41</td>
<td>.28</td>
<td>-.34</td>
<td>-.23</td>
<td>-1.47</td>
<td>.150</td>
</tr>
<tr>
<td>Objective Dependency</td>
<td>-.20</td>
<td>.28</td>
<td>.43</td>
<td>-.12</td>
<td>-0.72</td>
<td>.476</td>
</tr>
<tr>
<td>Size of Friendship Network</td>
<td>-.20</td>
<td>.13</td>
<td>-.29</td>
<td>-.24</td>
<td>-1.51</td>
<td>.139</td>
</tr>
<tr>
<td>Total Number of Family Problems</td>
<td>.15</td>
<td>.15</td>
<td>.24</td>
<td>-.15</td>
<td>-0.95</td>
<td>.351</td>
</tr>
<tr>
<td>Family Income</td>
<td>.13</td>
<td>.13</td>
<td>.22</td>
<td>.15</td>
<td>0.95</td>
<td>.351</td>
</tr>
<tr>
<td>Amount of Friendship Contact</td>
<td>.10</td>
<td>.12</td>
<td>-.22</td>
<td>-.13</td>
<td>-0.78</td>
<td>.440</td>
</tr>
<tr>
<td>Number of Work Related Problems</td>
<td>.04</td>
<td>.15</td>
<td>.25</td>
<td>.05</td>
<td>0.28</td>
<td>.782</td>
</tr>
<tr>
<td>Number of Family Roles</td>
<td>.02</td>
<td>.13</td>
<td>.20</td>
<td>-.02</td>
<td>-0.12</td>
<td>.902</td>
</tr>
</tbody>
</table>

### AFTER REMOVAL

| Physical Health Problems of Self | .49  | .11     | .48         | .57                 | 4.61 | .000       |
| Age                               | -.48 | .10     | .40         | -.58                | -4.77| .000       |
| Size of Friendship Network        | -.25 | .10     | -.29        | -.34                | -2.38| .022       |
| Labor Force Participation         | -.19 | .11     | -.34        | -.26                | -1.75| .082       |

Multiple r = .75; R² = .56; Adjusted R² = .52
Table 9.7---Regression Equation Using Backward Elimination on High SES Women in the Community Sample With Selected Variables Before and After Elimination

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of Friendship Network</td>
<td>.28</td>
<td>.12</td>
<td>.18</td>
<td>.29</td>
<td>2.47</td>
<td>.015</td>
</tr>
<tr>
<td>Amount of Friend Contact</td>
<td>-.22</td>
<td>.12</td>
<td>-.15</td>
<td>-.21</td>
<td>-1.82</td>
<td>.073</td>
</tr>
<tr>
<td>Physical Health Problems of Self</td>
<td>.21</td>
<td>.12</td>
<td>.20</td>
<td>.21</td>
<td>1.81</td>
<td>.074</td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>.21</td>
<td>.16</td>
<td>.25</td>
<td>.16</td>
<td>1.32</td>
<td>.192</td>
</tr>
<tr>
<td>Objective Dependency</td>
<td>.20</td>
<td>.29</td>
<td>.04</td>
<td>.08</td>
<td>0.69</td>
<td>.493</td>
</tr>
<tr>
<td>Family Income</td>
<td>-.12</td>
<td>.13</td>
<td>-.05</td>
<td>-.11</td>
<td>-0.90</td>
<td>.369</td>
</tr>
<tr>
<td>Age</td>
<td>.08</td>
<td>.13</td>
<td>.05</td>
<td>.08</td>
<td>0.63</td>
<td>.531</td>
</tr>
<tr>
<td>Number of Family Roles</td>
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<td>.15</td>
<td>-.01</td>
<td>-.07</td>
<td>-0.58</td>
<td>.563</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>.07</td>
<td>.26</td>
<td>-.04</td>
<td>.03</td>
<td>0.26</td>
<td>.795</td>
</tr>
<tr>
<td>Number of Work Problems</td>
<td>.01</td>
<td>.15</td>
<td>.18</td>
<td>.01</td>
<td>0.05</td>
<td>.959</td>
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**AFTER REMOVAL**

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<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of Friendship Network</td>
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<td>.11</td>
<td>.18</td>
<td>.24</td>
<td>2.27</td>
<td>.026</td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>.23</td>
<td>.11</td>
<td>.25</td>
<td>.24</td>
<td>2.18</td>
<td>.032</td>
</tr>
</tbody>
</table>

Multiple r = .37; R² = .13; Adjusted R² = .10
.005), and "My spouse says nice things about me" ($r = -0.41; p = .008$).

**Social Class and Social Restrictiveness**

The relationship between role restrictiveness and poor mental health among women varies by social class. Indicators of social restrictiveness are strongly related to demoralization only among low SES women. Women in lower socioeconomic groups who are not in the labor force, report low contact with friends and report problems of physical illness are more likely to report low morale. Among women in higher SES groups, this model does not apply. Women in these strata who report family stress and large friendship networks are more vulnerable to demoralization. Limiting the discussion to the married, this differential effect is also evident in terms of the relationship of spouse support to demoralization. Low SES women who do not receive emotionally validating sentiment from husband or boyfriend are more likely to report high demoralization while the relationship does not hold for high SES women.

The difference in fit between high and low SES women in terms of a model based on social restrictiveness is evident from the data presented in Table 9.8. Table 9.8 presents a breakdown of demoralization scores by a composite measure of social restrictiveness. This measure was constructed by adding the scores of nine items. A person received one point for each negative response to the following items: 1) In labor force? 2) Has spouse? 3) Has children? 4) Reports more than one non-kin acquaintance? 5) Reports more than one kin member in twenty-five mile radius of residence? 6) Reports frequent interaction with non-kin network? 7) Reports frequent interaction with
Table 9.8—Breakdown of Mean Demoralization Scores by Measure of Social Restrictiveness for Three Groups: Males, High SES Women and Low SES Women

<table>
<thead>
<tr>
<th>High Social Restrictiveness</th>
<th>Low SES Women</th>
<th>High SES Women</th>
<th>All Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>1</td>
<td>6.5</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>7.5</td>
<td>8.5</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
<td>10.5</td>
<td>11.5</td>
<td>11.5</td>
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<td>5</td>
<td>11</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>12.5</td>
<td>13</td>
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</tr>
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<td>7</td>
<td>13.5</td>
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</tr>
<tr>
<td>8</td>
<td>14.5</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>9</td>
<td>15.5</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>
kin? 8) Reports having a friend? 9) Reports not feeling lonely or
eremoted from other people?

Scores on this measure could range from 0-9. Actual scores ranged
from 0-8. Because of the small number of respondents reporting extreme
high scores, those with scores of 4,5,6,7, and 8 were combined for
analysis.

Data in Table 9.8 present the breakdown for demoralization scores
and the measure of social involvement for three groups: men in the
community sample, low SES women in the community sample, and high SES
women in the community sample. The data show, for low SES women, an
almost perfect linear relationship between demoralization scores and
social restrictiveness. Men and high SES women do not show a clear
relationship between social restrictiveness and the dependent variable.
High SES women show a pattern of results much more similar to males
than to low SES women. For these groups, demoralization scores
initially decline with increasing restrictiveness, then dramatically
increase, only to fall off again at high levels of social restrictiveness.

Chapter Summary

This chapter has elaborated upon the basic finding of Chapter VII:
the existence of a sex-social class interaction effect in
demoralization scores. In that chapter it was found that lower SES
women were the sub-group with significantly higher demoralization
scores. Previous research has indicated that this group may be
particularly vulnerable to psychological distress, but this issue has
never been couched in the context of sex differences in psychological
distress. This chapter reported that the dual notions of role restrictiveness versus role overload apply differently to women in the community sample depending on SES.

Notions of role overload are partially consistent with the results obtained for high SES women. These women seem more vulnerable to the stresses of involvement in family and friendship networks. Notions of role restrictiveness better fit variations in demoralization among low SES women. Having physical health problems, low contact with friends and being out of the labor force are the strongest predictors of demoralization in this group.

Among men, the most persistent variables affecting demoralization are those having to do with physical health problems. The variable with the largest beta among men in the community sample concerns the physical health problems of other family members. This finding was more characteristic of low SES men and suggests that its relationship to demoralization may be an economic one. Physical health problems of others involving treatment and hospitalization are demoralizing in themselves and additionally because of the added demands placed on the occupant of the provider role.
CHAPTER X

CONCLUSION

Major Findings of This Research

This dissertation research began by asking two questions:
"Has there really been a dramatic decline in female mental health relative to male mental health since 1950?"
"Is this decline magnified among married women and due to the social roles they perform in marriage and family?"

Evidence from a number of sources does not support a "yes" answer to these questions. A review of thirty-six epidemiological studies conducted in the United States and Canada between 1950-1983 and a review of treatment statistics from the United States during the 1970's indicate that asking which sex is more mentally ill is the wrong question to ask. Findings from these sources indicate that, in general, women report more symptoms of sadness, mood variation, and other mild forms of psychological disorder. Men report more serious symptoms of mental illness reflected in higher rates of mental disorganization and disruptive acts. This distinction is reflected in treatment statistics with women more likely to be treated in the community and men more likely to be removed from the community for problems of mental illness.

Most of the evidence supporting a "greater female mental illness" belief is based on responses to symptom checklist scales. These scales have been used in the majority of epidemiological investigations in the
United States since World War II. But even when using these scales, the female excess in impairment begins to disappear when stricter criteria are used to define impairment. As reported in Chapter IV, when 4+ symptoms are used to define impairment on symptom checklist scales, females are two and one-half times more likely than men to score above this point. However, when 10+ symptoms are used as a cut-off point to qualify for the status "impaired", no sex difference in rates of disorder are evident.

I argued in Chapter IV that the belief in "greater female mental illness" is socially useful. It is a belief that is compatible with the prevailing ideologies of a number of groups. Specifically, this belief is useful for at least three reasons: 1) it is useful in discussions of female victimization and critiques of the oppressive nature of marriage and family; 2) the belief helps to avoid characterizing men as more mentally ill than women; and 3) it serves to justify women's use of mental health outpatient services for "family problems".

This research was also concerned with social role interpretations of various forms of psychological distress. In an examination of a sample of 373 users and non-users of mental health services, sex differences in demoralization were examined and several propositions of social role theory were found to be contradictory and unable to explain sex differences in this form of disorder. The shortcomings of social role theory were examined in light of the relationship between demoralization and social class.

**Sex and Social Class Differences in Demoralization**

Thirty-five years of epidemiological research on mental illness
have uncovered few certainties. Two exceptions to this statement concern sex differences in demoralization and social class differences in demoralization. In the most comprehensive review of community studies of mental disorders to date, the authors of MENTAL ILLNESS IN THE UNITED STATES (Dohrenwend et al., 1980) conclude that being female or a member of the lower social classes places one at-risk to demoralization. From the statistical summary of a large number of United States studies of mental illness in general populations, Dohrenwend et al., (1980) conclude that:

the rate of demoralization for women is consistently higher than the rate for men; about 10 percent more women than men are demoralized.

The rate of demoralization is higher in the lowest social class than it is in the highest social class; probably 20-30 percent more of those in the lowest social class are demoralized than in the highest class (1980: 126).

Based on the stability of these findings over an extended period of time, it is curious that attempts to explain sex differences in demoralization have largely ignored the variable of social class. If both sex and social class separately account for demoralization, it is a good guess that in combination they would provide a good starting point in research on demoralization. However, the theoretical literature on sex differences in demoralization has routinely turned its attention to the impact of family statuses and family roles performance on the mental health of men and women. Following World War II, the attempt to understand the large number of mental health casualties of the war led psychiatry to a preoccupation with family type, family structure, and family roles in its search for the causes
of mental disorder. This trend continues to the present day spawning social-psychological explanations of emotional distress with an almost exclusive concern with marital and family roles.

The research agenda on this issue today is largely guided by the specific sex role theory of mental illness. This theory has formalized and encouraged a focus on family relations in explaining sex differences in psychological distress. The research of Gove (1972), Bernard (1972) and Gove and Tudor (1973) all indict family statuses and role demands as the generator of the mental health differential between men and women. In their separate reviews of a large number of studies of sex differences in mental illness, these authors interpret the overall female excess in disorder to a large excess of married women relative to married men. These authors hold that among the never married and among the maritally disrupted there are no consistent sex differences in mental health functioning. Gove and Tudor (1973) have elaborated this finding to argue that the vulnerability of married women has been a trend since after World War II and is due to the increasing stressfulness of the married women’s role since that time. Again, according to these authors, the greater stress and conflict of married women’s roles stems from both the demands of family life and from the difficulties of trying to reconcile the obligations and expectations of family roles with the counter demands of non-family roles, especially those from outside employment. It is not clear from the work of these authors if the frustration and stress of family roles in and of themselves are sufficient to account for the female excess in psychological distress, but it is seen as aggrevated by the role conflict that develops between family and non-family roles.
The use of the supposed vulnerability of the married woman to psychological distress as the basis of a general theory of sex differences in distress is flawed by four major problems:

1) the inability of the specific sex role theory of mental illness to explain why married women show up consistently as less disturbed than women in other marital statuses. The strain of being a married woman seems slight compared to being a non-married woman. Through an exclusive comparison of married women to married men, sight is lost of the protective effect of marriage for both men and women.

2) A close examination of the data used to support the specific sex role theory of mental illness shows that it is comprised almost exclusively of treatment data. Epidemiological data based on non-treatment populations (Chapter II) fails to show a sex-marital status interaction effect in rates of mild psychiatric disorders. In almost all non-treatment based studies, women report more symptoms of distress than men regardless of marital status. The existence of a sex-marital status interaction effect with married women showing high rates of distress is found in treatment population data and may reflect the fact that married women are more likely than other sex-marital status groups to seek help psychological help for family based difficulties and for the problems of other family members.

3) Marital status explains little of the overall variation in psychological distress. In their review article of marital disruption as a major stressor. Bloom et al., (1978) present data to show that marital status, or a sex-marital status interaction effect, accounts for little more than a few percentage points of the total variance in psychological distress (p. 882). Current research cannot give an
accurate reading of the influence of marital status since studies are rarely designed to compare the effect of marital status with a number of other variables.

4) A last problem with the specific sex role theory of mental illness is the lack of attention paid to the concept of mental illness. All forms of disorder are lumped together with little attempt to differentiate between types of functional psychiatric disorders, or even between mild and severe disorders. Women do consistently report higher rates of mild symptomology, while men tend to have higher rates of several severe disorders. For other forms of severe disorder there are minimal sex differences and this has been consistently reported in the literature since 1950 (Dohrenwend and Dohrenwend, 1976)

Evidence for a Sex-Marital Status Interaction Effect

The sample used in this research is composed of both a treatment sub-sample and a community sub-sample. The treatment sample consists of users of four community agencies in two areas of the State of New Hampshire and the community sample consists of persons living in the same geographical area as the treatment sample, but not known to be in treatment themselves. The sample is small, and the treatment sample is not a random sample of users of mental health services, but such a sample makes it possible to examining whether a sex-marital status interaction is present in one or both types of samples.

It was hypothesized that a sex-marital status interaction effect would be found, but only in the treatment sub-sample. Results reported in Chapter VII support this hypothesis. Such an interaction effect was found to explain variations in demoralization. However, it was not
found to be a predictor in the community sample. In this sub-sample, the strongest effect was for a sex-social class interaction effect, with working class women, regardless of marital status, reporting the highest demoralization scores.

The existence of a sex-marital status interaction effect on demoralization in the treatment sub-sample may reflect a selection problem. As part of the responsibility attached to the statuses of wife and mother, married women may show up more often in clinics because of the problems of other family members. Several authors view the help-seeking process as inherently directed toward higher female involvement (Mayer and Timms, 1970; Foss, 1974; 1979; Atwell et al., 1978). The presenting problems of women at clinics are often for the problems of children, the problems of husbands, or the problems of marriage. Foss (1974) in her study of four community mental health clinics sees this other directed help-seeking behavior of women as part of their "emotional manager" role in the family. The overrepresentation of women in outpatient mental health services may be due to a "contagion effect" in which the problems of distressed women is a sign of a disturbed family system. In the data analyzed in this research, more family level problems are reported by married women than are reported by married men or by persons of any other family status.

In the community sample, a sex-social class interaction effect was found to be a good predictor of demoralization scores. This is highly consistent with epidemiological research findings over the past twenty-five years, in the sense that both sex and social class separately have been two of the most stable and consistent variables related to demoralization.
The evidence presented here concerning interaction effects in treatment and non-treatment samples suggests that it is inadvisable to consider such samples equivalent. The inability to find concrete evidence for a sex-marital status interaction effect in either epidemiological studies of general population samples or in the data analyzed here suggests it is an artifact of treatment samples.

In a more general vein, Dohrenwend et al., (1980) in their review of studies of mental illness in the United States warn against failing to distinguish between treatment and non-treatment samples in mental health research:

The evidence strongly suggests that true rates cannot be used interchangeably with treated rates. The sociodemographic variables of age, urban-rural location, and class show consistently different patterns of relations with psychological disorder depending on which rate is chosen....the evidence indicates that the two rates do not measure the same thing and that it would be unwise to consider them to do so (147-48).

The findings here suggest a fundamental problem in interpretations of sex differences in psychological distress. They have relied upon the existence of a sex-marital status interaction effect as real and theorizing has proceeded accordingly. The priority of family status as a predictor of sex differences in demoralization seems misplaced in light of the importance of social class and strains a specific sex role interpretation of sex differences in distress.

Social Roles Versus Socioeconomic Variables

The second part of the empirical analysis presented here has attempted to offer an interpretation of why females in lower
socioeconomic groups account for the female excess in demoralization. To accomplish this task, separate analyses were conducted on four sub-groups within the entire sample: 1) females in the treatment sample; 2) males in the treatment sample; 3) females in the community sample; and 4) males in the community sample. This was done in order to isolate the best predictors to explain demoralization not only in each sub-sample, but for each sex as well.

Chapter VIII presented analyses on men and women within the treatment sample. For men, level of family income proved to be the best predictor of demoralization. The only other variable showing a significant relationship to demoralization was the number of physical health problems of self. The finding concerning income level is consistent with findings reported by Kessler (1982) in his review of eight epidemiological surveys of distress in normal populations. He reports that among men, income level is the strongest predictor of distress. For women, being out of the labor force proved to be the best predictor of demoralization followed closely by the total number of family problems reported. Again, the physical health problems of women were significantly related to demoralization as was age.

Predictors of demoralization in the community sample proved to be different from those in the treatment sample, but more different for women than men. As reported in Chapter IX, among males, the serious physical health problems of other family members is the best predictor of demoralization. Health problems of others in the family group is, in a sense, a "double stressor". Beyond the strain imposed by a sick loved one, illness produces economic strain. Consistent with this interpretation is the fact that the physical health problems of others
is a much stronger predictor of demoralization among lower than among higher SES men.

The strongest predictors of demoralization among women in the community sample are the physical health problems of self, social class, lack of friendship contact, being out of the labor force, and age. Because a sex-social class interaction effect was found to be an important predictor of demoralization in the whole community sample, separate analyses were conducted on lower and higher SES women.

Among low socioeconomic females, social restrictiveness is strongly related to demoralization. Women out of the labor force, with restricted contact with friends and women with physical health problems report high demoralization scores.Analyses in both samples suggest that socioeconomic variables offer a better and more direct interpretation of sex differences in demoralization than factors related to social role performance.

**Future Research Questions**

This research reinforces the continuing importance of separating treatment from non-treatment samples. On both the epidemiological and social psychological levels, a different kind of relationship appears between demoralization and theoretically important variables depending on sample type. In addition to sample type, the specification of the type of mental disorder under investigation is crucial. The findings reported here may be applicable to no other form of psychological impairment but demoralization.

Findings in this research also call for a reexamination of existing sources of data for the presence of a sex-social class
interaction to explain sex differences in psychological distress. Prior research has been guided by a search for a sex-marital status interaction to explain the female excess in distress.

Future research should also be directed to the relationship between physical and mental health. Among both men and women, especially in the community sample, physical health problems were strongly related to demoralization. Most noteworthy, among men in the community sample, the physical health problems of other family members was the best predictor of demoralization.

Lastly, it is hoped this analysis will help to move research away from simplistic notions about gender and mental illness. The relationship is complex, but it has traditionally been examined in a highly stereotyped manner. The characterization of women as sick, unreasonable, crazy and dependent (Chesler, 1972) may be due, in no small part, to the belief that women are more vulnerable to mental illness than men. Similarly, research has neglected the mental illness of men. The disruptive, anti-social behaviors of men have not been extensively studies. In the course of my research, I discovered there has never been a national epidemiological study of personality disorders among males in the United States. Even though this is a common diagnosis of men in treatment for mental illness, no estimate has ever been made of its incidence in a non-treatment epidemiological study. When we consider the number of studies conducted in the United States on female mental illness in the last forty years, the omission is noteworthy.
Table A.1 — Items from the Indik Scale of Psychological Strain (1968)

INDIK SCALE OF PSYCHOLOGICAL STRAIN

1. Has any ill health affected the amount of work you do?
2. Have you ever been bothered by shortness of breath when you were not exercising or working hard?
3. Have you ever been bothered by your heart beating hard?
4. Do you ever drink more than you should?
5. Have you ever had spells of dizziness?
6. Are you ever bothered by nightmares?
7. Do you tend to lose weight when you have something important bothering you?
8. Do your hands ever tremble enough to bother you?
9. Are you troubled by your hands sweating so that you feel damp and clammy?
10. Have there ever been times when you couldn't take care of things because you just couldn't get going?
11. Do you ever have trouble getting to sleep or staying asleep?
12. Have you ever been bothered by nervousness, feeling fidgety and tense?
13. Are you ever troubled by headaches or pains in the head?
14. Do you have loss of appetite?
15. How often are you bothered by having an upset stomach?
16. Do you find it difficult to get up in the morning?

Response categories for these items were: (0) Never; (1) Not very much; (2) Pretty often; (3) Nearly all the time. Respondents were asked to respond to time frame during the last year.
Table A.2 — Items from the Bradburn Scale of Psychological Well-Being (1969)

Bradburn Scale of Psychological Well-Being*  

DURING THE PAST FEW WEEKS DID YOU EVER FEEL:  
1. Particularly excited or interested in something?  
2. Did you ever feel so restless that you couldn't sit long in a chair?  
3. Proud because someone complimented you on something you had done?  
4. Very lonely or remote from other people?  
5. Pleased about having accomplished something?  
6. Bored?  
7. On top of the world?  
8. Depressed or very unhappy?  
9. That things were going your way?  
10. Upset because someone criticized you?  

*Response categories for these items were: (1) yes; (2) no.
Table A.3 — Factor Pattern After Oblique Rotation with Kaiser Normalization on items from Indik Scale of Psychological Strain and Bradburn Scale of Psychological Well-Being

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interested or excited</td>
<td>-.004</td>
<td>.087</td>
<td>.433</td>
</tr>
<tr>
<td>Restless</td>
<td>.130</td>
<td>.454</td>
<td>.086</td>
</tr>
<tr>
<td>Proud</td>
<td>-.005</td>
<td>.160</td>
<td>.393</td>
</tr>
<tr>
<td>Lonely</td>
<td>.051</td>
<td>.639</td>
<td>-.052</td>
</tr>
<tr>
<td>Accomplished something</td>
<td>.099</td>
<td>-.053</td>
<td>.448</td>
</tr>
<tr>
<td>Bored</td>
<td>.005</td>
<td>.580</td>
<td>-.001</td>
</tr>
<tr>
<td>Top of the world</td>
<td>-.056</td>
<td>-.076</td>
<td>.561</td>
</tr>
<tr>
<td>Depressed</td>
<td>.082</td>
<td>.688</td>
<td>-.030</td>
</tr>
<tr>
<td>Things going your way</td>
<td>-.048</td>
<td>-.196</td>
<td>.528</td>
</tr>
<tr>
<td>Upset over criticism</td>
<td>.064</td>
<td>.368</td>
<td>-.006</td>
</tr>
<tr>
<td>Can't sleep</td>
<td>.568</td>
<td>.133</td>
<td>-.026</td>
</tr>
<tr>
<td>Nervous</td>
<td>.482</td>
<td>.350</td>
<td>-.159</td>
</tr>
<tr>
<td>Headaches</td>
<td>.568</td>
<td>.042</td>
<td>-.056</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>.479</td>
<td>.247</td>
<td>.017</td>
</tr>
<tr>
<td>Upset stomach</td>
<td>.536</td>
<td>.092</td>
<td>.001</td>
</tr>
<tr>
<td>Can't get out of bed</td>
<td>.207</td>
<td>.326</td>
<td>.023</td>
</tr>
<tr>
<td>Ill health - can't work</td>
<td>.609</td>
<td>-.003</td>
<td>-.030</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>.735</td>
<td>-.203</td>
<td>.016</td>
</tr>
<tr>
<td>Heart beating hard</td>
<td>.742</td>
<td>-.146</td>
<td>.036</td>
</tr>
<tr>
<td>Drink too much</td>
<td>-.070</td>
<td>.386</td>
<td>-.007</td>
</tr>
<tr>
<td>Spells of dizziness</td>
<td>.662</td>
<td>-.137</td>
<td>.014</td>
</tr>
<tr>
<td>Nightmares</td>
<td>.511</td>
<td>.112</td>
<td>.038</td>
</tr>
<tr>
<td>Lose weight</td>
<td>.334</td>
<td>.186</td>
<td>.074</td>
</tr>
<tr>
<td>Hands tremble</td>
<td>.497</td>
<td>.181</td>
<td>-.099</td>
</tr>
<tr>
<td>Hands sweat</td>
<td>.456</td>
<td>.159</td>
<td>-.057</td>
</tr>
<tr>
<td>Can't get going</td>
<td>.462</td>
<td>.227</td>
<td>-.133</td>
</tr>
</tbody>
</table>

*a* See Appendices A.1 and A.2 for complete item wording.
Table A.4 — Rankings used by Hollingshead and Redlich (1958) for Occupations and Education. Socioeconomic Levels based on Occupation-Education Score.

**Occupational Groups**

1. Executives and proprietors of large concerns, and major professionals
2. Managers and proprietors of medium-sized businesses and lesser professionals
3. Administrative personnel of large concerns, owners of small independent businesses, and semi-professionals
4. Owners of little businesses, clerical and sales workers, and technicians
5. Skilled workers
6. Semi-skilled workers
7. Unskilled workers

**Educational Groups**

1. Graduate professional training
2. Standard college or university training
3. Partial college training
4. High school graduation
5. Partial high school
6. Junior high school
7. Less than seven years of school

Socioeconomic Groups Based on Multiplying Occupation Level by 7; Education Level by 4 and Adding Them.

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Range of Computed Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>11 - 17</td>
</tr>
<tr>
<td>II</td>
<td>18 - 27</td>
</tr>
<tr>
<td>III</td>
<td>28 - 43</td>
</tr>
<tr>
<td>IV</td>
<td>44 - 60</td>
</tr>
<tr>
<td>V</td>
<td>61 - 77</td>
</tr>
</tbody>
</table>
Table A.5 -- List of Husband-Wife Problems, Parent-Child Problems, Family Health Problems, Work-Income Problems and Family Deviance Problems

**Husband-Wife Problems**
- Can't discuss feelings and problems with each other
- Upset over interference in marriage by parents or in-laws
- Involved in extra-marital relationship
- Unwilling or unable to have sex
- Making unacceptable sexual demands
- Disagreements over how many children to have
- Disagreements over how to handle children
- Not managing money well
- Arguments between you and your spouse
- Getting physically violent

**Parent-Child Problems**
- Can't discuss feelings and problems with child(ren)
- Disagreements between parent and child over rules and punishments
- Differences between what parent and child think is important
- Severe physical punishment
- Starts fights with brothers and sisters

**Problems of Family Health**
- Physical disability or handicap
- Long-term physical illness
- Hospitalization

**Work-Income Problems**
- Unemployment
- Spouse spends too much time working
- Not enough family income
- Job is dangerous or physically demanding
- Spending money recklessly

**Family Deviance Problems**
- Drinking too much
- Uses drugs
- Can't get along with people
- Suicide threats or attempts
- Fights where someone gets hurt badly
- Involvement with police
Table A.6 -- Ten-Item Index, Factor Loadings, and Factor Score Coefficients of Amount of Spousal Support Received During Last Year (Straus, 1972)

DURING THE PAST YEAR, HOW OFTEN DID YOUR HUSBAND OR WIFE DO EACH OF THE FOLLOWING?

<table>
<thead>
<tr>
<th>ITEM</th>
<th>FACTOR LOADING</th>
<th>FACTOR SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Says nice things about me</td>
<td>.750</td>
<td>.092</td>
</tr>
<tr>
<td>Likes to have me around</td>
<td>.716</td>
<td>.092</td>
</tr>
<tr>
<td>Is thoughtful when I am tired out</td>
<td>.724</td>
<td>.083</td>
</tr>
<tr>
<td>Helps me with homework, housework, or problems at work if I need it</td>
<td>.593</td>
<td>.055</td>
</tr>
<tr>
<td>Kisses or hugs me</td>
<td>.746</td>
<td>.087</td>
</tr>
<tr>
<td>Praises me</td>
<td>.843</td>
<td>.156</td>
</tr>
<tr>
<td>Does things with me</td>
<td>.776</td>
<td>.126</td>
</tr>
<tr>
<td>Comforts me when I have problems</td>
<td>.886</td>
<td>.209</td>
</tr>
<tr>
<td>Helps me out of difficulties</td>
<td>.838</td>
<td>.109</td>
</tr>
<tr>
<td>Makes me feel I am loved</td>
<td>.866</td>
<td>.170</td>
</tr>
</tbody>
</table>

Eigenvalue = 6.05; 1 Factor
Table A.7---Analysis of Variance for Demoralization Among Men in the Treatment Sample by Number of Family Roles and Labor Force Participation Controlling For Age, Social Class, Family Income, Amount of Friend Contact, and Number of Family Problems

<table>
<thead>
<tr>
<th>Control Variables: Two and Three Way Interactions</th>
<th>N</th>
<th>Mean Squares</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Roles and Age</td>
<td>35</td>
<td>47.3</td>
<td>1</td>
<td>0.92</td>
<td>.34</td>
</tr>
<tr>
<td>Labor Force Part. and Age</td>
<td>35</td>
<td>29.9</td>
<td>1</td>
<td>0.58</td>
<td>.45</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Age</td>
<td>35</td>
<td>312.6</td>
<td>1</td>
<td>6.08</td>
<td>.02</td>
</tr>
<tr>
<td>Family Roles and Social Class</td>
<td>35</td>
<td>0.2</td>
<td>1</td>
<td>0.01</td>
<td>.96</td>
</tr>
<tr>
<td>Labor Force Part. and Social Class</td>
<td>35</td>
<td>211.3</td>
<td>1</td>
<td>3.99</td>
<td>.06</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Social Class</td>
<td>35</td>
<td>141.4</td>
<td>1</td>
<td>2.67</td>
<td>.11</td>
</tr>
<tr>
<td>Family Roles and Amount of Friend Contact</td>
<td>35</td>
<td>1.0</td>
<td>1</td>
<td>0.02</td>
<td>.89</td>
</tr>
<tr>
<td>Labor Force Part. and Amount of Friend Contact</td>
<td>35</td>
<td>257.9</td>
<td>1</td>
<td>4.46</td>
<td>.04</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Amount of Friend Contact</td>
<td>35</td>
<td>4.6</td>
<td>1</td>
<td>0.08</td>
<td>.78</td>
</tr>
<tr>
<td>Family Roles and Family Income</td>
<td>35</td>
<td>24.7</td>
<td>1</td>
<td>0.47</td>
<td>.50</td>
</tr>
<tr>
<td>Labor Force Part. and Family Income</td>
<td>35</td>
<td>0.1</td>
<td>1</td>
<td>0.01</td>
<td>.98</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Family Income</td>
<td>35</td>
<td>3.9</td>
<td>1</td>
<td>0.06</td>
<td>.81</td>
</tr>
<tr>
<td>Family Roles and Number of Family Problems</td>
<td>35</td>
<td>9.9</td>
<td>1</td>
<td>0.16</td>
<td>.69</td>
</tr>
<tr>
<td>Labor Force Part. and Number of Family Problems</td>
<td>35</td>
<td>38.4</td>
<td>1</td>
<td>0.62</td>
<td>.44</td>
</tr>
<tr>
<td>Family Roles, Labor Force Part. and Number of Family Problems</td>
<td>35</td>
<td>8.2</td>
<td>1</td>
<td>0.13</td>
<td>.72</td>
</tr>
</tbody>
</table>
Table A.8---Regression Equation on Demoralization Using Backward Elimination With High SES Men in the Community Sample With Selected Variables Before and After Elimination

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>Se Beta</th>
<th>Correlation</th>
<th>Partial Correlation</th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Removal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Anti-Social Problems</td>
<td>.40</td>
<td>.23</td>
<td>.43</td>
<td>.28</td>
<td>1.71</td>
<td>.096</td>
</tr>
<tr>
<td>Physical Health Problems of Others</td>
<td>.22</td>
<td>.16</td>
<td>.14</td>
<td>.23</td>
<td>1.36</td>
<td>.183</td>
</tr>
<tr>
<td>Number of Work Problems</td>
<td>.15</td>
<td>.21</td>
<td>.31</td>
<td>.12</td>
<td>0.71</td>
<td>.482</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
<td>-.15</td>
<td>.18</td>
<td>-.21</td>
<td>-.12</td>
<td>-0.81</td>
<td>.426</td>
</tr>
<tr>
<td>Amount of Contact with Kin</td>
<td>-.09</td>
<td>.16</td>
<td>-.06</td>
<td>-.10</td>
<td>-0.57</td>
<td>.568</td>
</tr>
<tr>
<td>Satisfaction with Income</td>
<td>.03</td>
<td>.16</td>
<td>-.16</td>
<td>.04</td>
<td>0.21</td>
<td>.839</td>
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<tr>
<td>Physical Health Problems of Self</td>
<td>.03</td>
<td>.15</td>
<td>.11</td>
<td>.03</td>
<td>0.20</td>
<td>.847</td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>-.01</td>
<td>.26</td>
<td>.38</td>
<td>-.01</td>
<td>-0.50</td>
<td>.960</td>
</tr>
</tbody>
</table>

| After Removal                   |        |         |             |                     |     |            |
| Number of Anti-Social Problems  | .43    | .14     | .43         | .43                 | 3.02| .004       |

Multiple $r = .43$; $R^2 = .18$; Adjusted $R^2 = .16$
Table A.9—Regression Equation on Demoralization Using Backward Elimination With Low SES Men in the Community Sample With Selected Variables Before and After Elimination.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Before Removal</th>
<th></th>
<th></th>
<th></th>
<th>T</th>
<th>Sign. of T</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beta</td>
<td>Se Beta</td>
<td>Correlation</td>
<td>Partial Correlation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health Problems of Others</td>
<td>.50</td>
<td>.16</td>
<td>.62</td>
<td>.55</td>
<td>3.06</td>
<td>.006</td>
</tr>
<tr>
<td>Physical Health Problems of Self</td>
<td>.30</td>
<td>.16</td>
<td>.44</td>
<td>.37</td>
<td>1.88</td>
<td>.073</td>
</tr>
<tr>
<td>Number of Family Problems</td>
<td>.24</td>
<td>.23</td>
<td>.39</td>
<td>.21</td>
<td>1.03</td>
<td>.316</td>
</tr>
<tr>
<td>Number of Anti-Social Problems</td>
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<td>.20</td>
<td>-.01</td>
<td>-.18</td>
<td>-0.85</td>
<td>.406</td>
</tr>
<tr>
<td>Number of Work Problems</td>
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<td>.17</td>
<td>.30</td>
<td>.15</td>
<td>0.73</td>
<td>.474</td>
</tr>
<tr>
<td>Satisfaction with Work</td>
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<td>.15</td>
<td>-.23</td>
<td>.12</td>
<td>0.57</td>
<td>.573</td>
</tr>
<tr>
<td>Amount of Contact with Kin</td>
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<td>.15</td>
<td>-.01</td>
<td>-.09</td>
<td>-0.47</td>
<td>.644</td>
</tr>
<tr>
<td>Satisfaction with Income</td>
<td>-.07</td>
<td>.16</td>
<td>-.20</td>
<td>-.09</td>
<td>-0.43</td>
<td>.675</td>
</tr>
</tbody>
</table>

| After Removal                   |         |         |         |          |        |            |
| Physical Health Problems of Others | .56            | .13     | .62      | .62      | 4.14   | .000       |
| Physical Health Problems of Self | .35            | .13     | .44      | .44      | 2.60   | .015       |

Multiple r = .71; R² = .50; Adjusted R² = .47
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