Women, Marriage, Employment and Mental Health

RAYMOND COCHRANE and MARY STOPES-ROE

Summary: This paper reviews explanations of sex differences in mental hospital admission rates, taking account of age and marital status effects. Six propositions derived from the review are tested on data from a nationwide community survey of 259 respondents, using a standardized symptom check list.

Women report more psychological symptoms than men, but this is unrelated to marital status. It is suggested that being married acts to keep a potential patient out of hospital rather than to reduce symptoms. Whether or not a woman is in paid employment outside the home is a major predictor of symptom levels, especially in depression. Women with unemployed husbands are also particularly likely to report high levels of depression. However, there is no reciprocal effect of wives' employment status on the psychological well-being of their husbands.

In Britain, as in the United States, women are very considerably overrepresented among those receiving treatment for mental illness. Figures from the Department of Health and Social Security show that female rates for in-patient mental hospital treatment in England and Wales are almost forty per cent higher than male (DHSS, 1980). This differential is very similar to that observed by Gove (1972) in the United States. A closer analysis of admission rates by diagnosis shows that admissions for depressive psychoses account for a large part of the female excess, twice as many women as men needing in-patient treatment (Table I). Women also predominate in the neurotic category, which includes other forms of depression. There are several diagnostic categories where men are over-represented—alcohol-related disorders and drug dependence, for example—but these tend to account for relatively few admissions.

Two other points are worth noting about these statistics before possible explanations are considered. First, there is the dramatic age reversal of the sex differential at puberty. In the age groups up to 10 years, boys have higher treatment rates than do girls; in the next age group the sexes have equal rates; at 15 years, however, the female excess over males becomes large and consistent (see Table II). This, too, is a phenomenon that has an exact parallel in the United States. Although not too much reliance can be placed on statistics for children's admissions to mental hospitals, it seems that the tendency of young boys to exhibit disturbance in an overt and perhaps aggressive fashion is more likely to lead to hospitalization than is the covert, emotional disturbance more characteristic of girls.

Equally dramatic, and perhaps better known, is the enormous influence that marital status has on mental hospitalization rates. The data in Table III show that, for both sexes, being married is associated with a much lower risk of in-patient treatment than is being unmarried. Those at highest risk are the divorced. What is most important about these data, however, is the fact that the difference in rates between married and unmarried is much smaller for women than for men. Another way of looking at this is to say that, although married women have substantially lower rates of mental hospital admission than single women, marriage affords them less protection than it does to men. In the three unmarried status categories (single, widowed and divorced) men are at greater risk than women—it is only among the married that women have higher rates. Because the vast majority of the adult population is married, the overall sex differences are largely determined by this category.

There are, of course, several objections to the use of mental hospital in-patient admission statistics as the sole basis of an index of the distribution of psychological disorder. On the basis of a detailed review of all psychiatric contacts in one region, Robertson (1974) concluded that reliable inferences about the mental illness patterns of the married and single could not be made from hospital admission statistics alone. Specifically he suggested that single people were more likely than married to be admitted to hospital, rather than be treated as out-patients or on some other basis. However, his analysis of rates of all contacts (in-patient, out-patient, day-patient, emergency and domiciliary) confirmed the general pattern.
of higher female contact rates among the married but not the other status categories.

Further evidence supporting the existence of sex differences in psychological disturbance comes from the increasing use being made of community surveys to establish sociodemographic correlates of psychiatric impairment (e.g. Schwab et al., 1979; Cochrane and Stopes-Roe, 1980). Several recent reviews of large numbers of studies of this kind have also confirmed that women have more psychological impairment than do men (Dohrenwend and Dohrenwend, 1976; Goldman and David, 1980; Gove and Tudor, 1973).

Given that sex differences in psychiatric disorder are not an artefact of in-patient treatment statistics, what other explanations are available? The most obvious proposition is one based upon biological differences in susceptibility. At first glance this is an attractive approach, especially in the case of depression. However, Weissman and Klerman (1977), after a thorough review of a variety of possible biological agents which may cause sex differences in depression (premenstrual tension, oral contraceptives, post-partum depression, menopause), conclude that "while some portion of the sex differences in depression, probably during the childbearing years, may be explained endocrinologically, this factor is not sufficient to account for the large differences" (p 106). The huge variations in the rate of psychological disturbance associated with changes in marital status also militate against a biological explanation by itself being sufficient.

More plausible, perhaps, is an explanation based upon the traditional sex role definitions of men and women. These may be seen as operating in a number of ways to increase the relative vulnerability of women. First, the feminine role, encompassing as it does dependence, passivity and low self-esteem, may make women less able to cope adequately with life stress and hence more likely to respond pathologically. Second, in a variety of contexts women who accept traditional sex role definitions will experience only a relatively low capacity to influence their environment. Girls may be more protected than boys and more affected by hormonal changes at puberty. They may be
taught to identify the opposite sex as instrumentally more effective than their own. Women may experience more discrimination in employment and more disruptive changes associated with marriage, over which they have less control than their husbands (for example in mate selection, geographical and social mobility, standard of living, and adjusting to motherhood). All these factors may contribute to a condition of 'learned helplessness' which, it is suggested by Seligman (1975) and others, may lead to depression. Third, women possibly find it easier to admit to symptoms and seek help from others than do men, for whom admitting to emotional problems may be taken as a sign of weakness or inadequacy. This, if so, would make women appear to have more psychological problems than men even though actual symptom levels were comparable. On the other hand, it may be more socially acceptable for men to show aggression and to indulge in heavy drinking than it is for women—a suggestion strongly borne out by the respective crime and alcoholism rates of the sexes.

Like the biological propositions, this social sex-role proposition is seriously weakened by its inability to account for the marital status interaction—indeed, a literal application of the proposition would predict that, as it is traditionally believed women need marriage more than men in order to provide identity, status, and a role, marriage should provide women greater protection than men and should mean that they would be more affected by the loss of a spouse through divorce or death than would men. The opposite is true in both cases (see Table III).

A suspicion also remains that the general sex role explanation is very much post hoc. Had the figures indicated that men had more psychological problems than women then an equally convincing explanation, based on the greater stress of the male sex role, could have been developed, incorporating features such as pressure of work, the need to provide for a family, the need to be aggressive and dominant and so on. In fact, Waldron (1976) has made just such a case to explain depression. This, if so, would make women appear to have more psychological problems than men even though actual symptom levels were comparable. On the other hand, it may be more socially acceptable for men to show aggression and to indulge in heavy drinking than it is for women—a suggestion strongly borne out by the respective crime and alcoholism rates of the sexes.

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in this area. Radloff (1975) specifically looked for an interaction between sex, marital status and employment in self-reported depression. She found that although women were more depressed than men, and married women more depressed than married men, controlling for employment status did not eliminate these differences. Working married women were less depressed than non-working married women, but still more depressed than working men. Two further findings from this study merit note. First, women were just as likely to find their jobs satisfying as were men; and second, the highest depression score, in any group, was recorded for unemployed men.

Subsequently Rosenfield (1980) took this analysis a step further by looking at the reciprocal effects of the employment of one spouse on the extent of depression in the other. She found that women had higher levels of depressive symptoms in families with the traditional division of labour (i.e. husband working, wife at home) but that the position was reversed in the non-traditional families (both spouses at work). This reversal was caused partly by the lower depression scores of working wives compared to housewives and partly by the higher depression scores of husbands with working wives compared with husbands whose wives did not work. These differences held up even when educational level and family income were controlled. Rosenfield, however, did not look at families where the husband was unemployed. There is reason for believing that this situation has adverse psychological consequences for both spouses (Stokes, 1981).

This brief review of the literature leads to several propositions:

1. Women will report more psychological symptoms than will men and this will be most marked for depression.
2. In general, the unmarried will report more psychological symptoms than the married.
3. Unmarried women will have fewer symptoms than unmarried men, but among the married the position will be reversed, with women having more symptoms.
4. Women in employment will have fewer symptoms (especially of depression) than women not in employment.
5. Unemployment of married men (as distinct from not working through retirement, etc) will be related to higher symptom levels in their wives.
6. Husbands will report fewer symptoms in families where wives do not work than where they do work but married women who work will have fewer symptoms both than married women who do not work and married men with working wives.

Method

Sample

Samples of English-born men and women aged 20 to 60 years living in large towns in England (London, Birmingham, Coventry, Manchester, Slough) were taken by the random walk method. This method is based on a random selection of dwellings within a given area, and means that the interviewers effectively play no part in the eventual selection of respondents as they follow a predetermined 'random' map covering the sample area. This method is much cheaper than true random methods and avoids many of the potential biases associated with quota sampling. In terms of age, marital status, employment and dwelling type the samples obtained were representative of the total population of England in these age ranges. A total of 304 people were approached and interviews obtained with 150 men and 109 women, a response rate of 85 per cent. The field work was carried out by Opinion Research Centre in the autumn of 1978, after detailed briefing of interviewers by the authors. Interviews were conducted in the respondents' homes and all questions were read aloud by the interviewer to prevent exclusion of the non-literate. Only one respondent from each dwelling was interviewed. Interviews were systematically back-checked and discrepancies accounted for (see Cochrane, 1979, for a detailed account of procedure).

Measures

The questionnaire on which this report is based consisted of three parts. Basic demographic details were elicited by simple questions on facts (age, sex, employment and so on). A series of questions on interaction patterns was included but is not reported on here. The dependent variable—psychological disturbance—was measured with the Symptom Rating Test (SRT) devised by Kellner and Sheffield (1973). This instrument is a simple symptom check list, respondents being asked whether or not they have experienced each of 30 symptoms within the last month or so. Each symptom is rated by respondents as being experienced often, sometimes or never. Scores are obtained by summing the weighted response to each symptom (never = 0, sometimes = 1, often = 2).

In addition to a total scale score the originators of the SRT describe four specific subscales: Anxiety (eight items), Somatic (seven items), Depression (eight items) and Inadequacy (seven items). The original authors demonstrated the validity and reliability of this measure (Kellner and Sheffield, 1967, 1973) and these have been independently confirmed since (Cochrane, 1980). The total SRT can therefore be accepted as a psychometrically sound measure of
mild psychopathology, but the subscales have not received independent verification on non-clinical samples (Cochrane, 1980). They do, however, have considerable face validity. The Depression subscale of the SRT, for example, is made up of symptoms such as guilt, failure, hopelessness, poor appetite and tiredness, while the Anxiety subscale contains items referring to nervousness, panic attacks, restlessness and tension.

**Results**

The propositions suggested at the end of our review of the literature directed the analysis of data obtained from the survey in several ways. The tests of the first three propositions are reported in Table IV, which contains the means on each of the SRT subscales broken down by sex and marital status.

Proposition one is supported, as women do have higher symptom scale scores than men overall, but this occurs on each of the subscales (except the somatic) and is not confined to depression. However, there is no support for propositions two and three because marital status is not significantly related to psychological symptom levels on any of the scales, either simply or in interaction with sex.

Proposition four, that women in employment will have fewer symptoms than women not working, was borne out on each subscale except that for inadequacy (Table V). The difference between working and non-working women on the depression subscale was somewhat larger than on the other scales.

The same is true, but to a lesser extent, of proposition five. Married women whose husbands are out of work have conspicuously higher symptom levels than women with husbands in employment, accounted for by differences partly in anxiety and partly in depression (Table VI).

In passing, it might be noted that the unemployed

<table>
<thead>
<tr>
<th>Table IV</th>
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</thead>
<tbody>
<tr>
<td>The relationship between sex, marital status and symptom levels</td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Men</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Unmarried</td>
</tr>
<tr>
<td>All</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Unmarried</td>
</tr>
<tr>
<td>All</td>
</tr>
<tr>
<td>All</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Unmarried</td>
</tr>
<tr>
<td>P *for sex</td>
</tr>
<tr>
<td>P *for marital status</td>
</tr>
<tr>
<td>P *for interaction</td>
</tr>
</tbody>
</table>

* Based on F ratio

<table>
<thead>
<tr>
<th>Table V</th>
</tr>
</thead>
<tbody>
<tr>
<td>The relationship between paid employment and psychological symptoms in women</td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Employed</td>
</tr>
<tr>
<td>Not employed</td>
</tr>
<tr>
<td>P *</td>
</tr>
</tbody>
</table>

* Based on t-test
men who fell into our sample also had very high rates of symptomatology. Because only eight of our married women had unemployed husbands, it was not possible to do a further breakdown on whether or not they themselves were working.

Finally, the propositions relating to the traditional versus non-traditional division of labour suggested by Rosenfield (1980) are tested in Table VII. As was found earlier for all women (Table V), married women who worked had lower SRT scores than housewives, but in their case the only significant sub-scale was the depression scale. However, whether or not their wives were in paid employment outside the home did not appear to affect men. Presumably families with both spouses at work were on average richer than those where only the husband worked, but as we had no information on income it was not possible to control for this variable.

**Discussion**

The discussion of the results will be structured around the propositions in the introduction, but perhaps a word is in order about the measurement of the central dependent variable in this study. Obviously a simple questionnaire measure of psychological symptoms involves a considerable compromise between clinical precision and economy. In most cases large scale community surveys have to rely on this kind of measure, but their results are only as good as the measurements employed. The SRT has been demonstrated as being reliable (test–retest correlation over 1 week being 0.91 and alpha 0.94) and valid as judged by the criterion groups method (Cochrane, 1980). The exact meaning of the scores on the scale is not defined by the latter. However, it can be asserted with some confidence that those who score highly on the SRT have many symptoms in common with people diagnosed clinically as being mentally ill, though not necessarily the most important or defining symptoms. The scale is probably not sensitive enough to be used as a case identifier, but is useful as a measure of mild psychological disturbances.

**Proposition one**

Women will report more psychological symptoms than will men and this will be most marked for depression. This proposition is a straightforward extrapolation from the mental hospital admission

### Table VI

**The relationship between psychological symptoms in married women and husbands' employment status**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Total</th>
<th>Anxiety</th>
<th>Somatic</th>
<th>Depression</th>
<th>Inadequacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband employed</td>
<td>79</td>
<td>11.43</td>
<td>3.79</td>
<td>2.00</td>
<td>2.56</td>
<td>3.10</td>
</tr>
<tr>
<td>Husband unemployed</td>
<td>8</td>
<td>19.50</td>
<td>6.38</td>
<td>3.40</td>
<td>5.73</td>
<td>4.00</td>
</tr>
<tr>
<td>P*</td>
<td></td>
<td>&lt;0.01</td>
<td>&lt;0.05</td>
<td>NS</td>
<td>&lt;0.01</td>
<td>NS</td>
</tr>
<tr>
<td>* Based on t-test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

### Table VII

**The effect of wife’s employment status on psychological symptoms for married men and women, in families where the husband is in employment**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Total</th>
<th>Anxiety</th>
<th>Somatic</th>
<th>Depression</th>
<th>Inadequacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wife employed</td>
<td>59</td>
<td>7.24</td>
<td>2.15</td>
<td>1.25</td>
<td>1.90</td>
<td>1.93</td>
</tr>
<tr>
<td>Wife not employed</td>
<td>31</td>
<td>8.42</td>
<td>2.58</td>
<td>1.61</td>
<td>2.07</td>
<td>2.16</td>
</tr>
<tr>
<td>P*</td>
<td></td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At work</td>
<td>42</td>
<td>10.38</td>
<td>3.55</td>
<td>1.76</td>
<td>2.07</td>
<td>3.00</td>
</tr>
<tr>
<td>Not at work</td>
<td>36</td>
<td>13.14</td>
<td>4.19</td>
<td>2.31</td>
<td>3.28</td>
<td>3.36</td>
</tr>
<tr>
<td>P*</td>
<td></td>
<td>&lt;0.05</td>
<td>NS</td>
<td>NS</td>
<td>&lt;0.05</td>
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<tr>
<td>* Based on t-test</td>
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respondents did in fact report more symptoms than did the male respondents but this was no more true for symptoms of depression than for anxiety and inadequacy. Only on the somatic subscale was there no significant sex difference. This result is not entirely unexpected, for two reasons. First, although recent attention has mainly been focussed on sex differences in depression, it appears from the most recent statistics available that women also have very much higher rates of treatment for neuroses than do men, and this should be reflected in symptoms of anxiety and inadequacy. Second, the SRT subscales may be relatively insensitive to different forms of psycho-neuroses in a non-clinical population, as was shown by correlations of +0.81 between the depression and anxiety subscales and +0.73 between the depression and inadequacy subscales.

Propositions two and three

Although mental hospital admissions clearly show that marital status is a determinant of hospitalization for both sexes and that there is a strong interaction between marital status and sex, no evidence along these lines was produced by this community survey. None of the SRT subscales showed any significant effect by marital status, alone or in combination with sex. It seems likely, therefore, that the reason married people are less likely to be admitted is because they have more social resources to fall back on rather than because they show fewer psychological symptoms. Marriage does not necessarily provide a protection from psychological disturbance, but may offer some people an alternative method of coping with problems, which is often unavailable to the unmarried.

Although this explanation may go some way to resolving the apparent contradiction between the admission statistics and the survey results, it cannot, on its own, account for our failure to find an interaction between sex and marital status as predicted by proposition three. Here a more complex set of factors needs to be invoked. The unresolved problem is that the more dramatic effect of marital status on men, illustrated by their hospital admission figures is not compatible with our survey results, which show that both married and unmarried women have more symptoms than men either married or unmarried. If, as suggested previously, when a married person has psychological problems some of the burden of coping with these problems falls on the spouse, then it is likely that wives will care for husbands at home more often than the other way around. This is because care giving is traditionally considered a feminine role and also because married men are more likely to be prevented by work commitments from giving support in a crisis than are married women. The wife of a man with problems will either not be working full time, or be more likely to give up employment if necessary, than will a husband with a disturbed wife. For a man in this position, giving up work will either be considered impossible or very much a last resort after hospitalization. Again, it appears possible that an important determinant of hospitalization is to be found in social definitions of appropriate responses.

There is also a substantial body of evidence (e.g. Brown and Harris, 1978) that the nature and quality of the marital relationship is all-important in psychological terms, rather than the simple fact of being married. It may be that only certain kinds of marriage have a protective effect. As no assessment was made of the marital relationship it was not possible to examine this proposition, but it remains a viable alternative explanation for our failure to show any effect of marital status.

Proposition four

As has been suggested previously, women who worked outside the home reported fewer psychological symptoms than women who were not in paid employment. This tendency was most strongly evident on the depression subscale of the SRT. Only for inadequacy was the trend not statistically significant. There remains the question of the direction of causality, if any, but these results are certainly compatible with the suggestion of Brown and Harris (1978) and others that employment affords a protection against depression for women in much the same way as it does for men.

Proposition five

It is equally true, however, that the extent of psychological symptoms reported by married women is influenced by their husband’s employment status. In fact the overall differences between the symptom levels of women with employed and unemployed husbands were somewhat greater than the differences between working and non-working women. Again, this effect is most clearly marked on the depression scale. In this analysis only women whose husbands were seeking work are included, so the number involved is small (about ten per cent). It is perhaps not surprising that women should be affected by unemployment of their spouses, as this is likely to lead to material hardship and status decline even if the woman herself has a job.

No previous British study has reported the psychological consequences on another family member of the head of the household’s being unemployed, nor the relationship between a woman’s employment status and her mental health. With the current high, and increasing, levels of unemployment it is obviously
important to look beyond the unemployed person himself for possible psychological sequelae. It would also be interesting, for example, to look at the consequences of parents' unemployment on children.

**Proposition six**

The results in Table VII largely confirm the finding that paid employment offers a protection for married women (as opposed to all women—proposition four), but the protection only operates for depression, at least as measured by the SRT. However the suggestion by Rosenfield that the husbands of working wives would suffer more symptoms was not borne out. In Britain, it appears that the employment status of a woman has no significant impact on the psychological well-being of her husband. Husbands in non-traditional families in our survey had marginally, though not significantly, fewer symptoms than men whose wives did not work. It is possible of course that family structure and family income are confounded here, as families with two wage earners are likely to be better off than those relying on one income. As we did not find out family income from our respondents we were unable to control for this possibility. But it would in any case be a spurious control, as it would rule out a real difference in the situation of the two types of families. Although we confirm Rosenfield's finding that work is associated with fewer symptoms for married women there is certainly no evidence from our study that husbands are adversely affected when their wives go out to work.

In general this study shows that employment, both for themselves and their husbands, is a stronger predictor of psychological well-being for women than is marital status. The apparent marital status differential is probably a result of numerous factors, other than psychological well-being, influencing mental hospital admission.

These findings obviously flatly contradict Gove's theory, and are perhaps closer to the findings of Radloff (1975) and Brown and Harris (1978). Although Gove cites evidence from community surveys in the US supporting the existence of a real marital status difference in psychopathology these studies pre-date the changes in role definitions, the trends towards a less rigid division of labour in marriage and the fuller participation of married women in the labour force that have undoubtedly occurred in the last decade.

It is still, however, true that many fewer women than men are in employment, and it is towards unemployment, rather than marital status, that we should be looking as a major determinant of sex differences in psychopathology.


Women, marriage, employment and mental health.
R Cochrane and M Stopes-Roe
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