The Impact of the Family on Health:
The Decade in Review

How does the family affect the health of its adult members? It is in the family that the macro-level social and economic order affects individual physical and emotional well-being. This review presents a general model of understanding family and health that describes patterns of well-being, and then asks, “what explains these patterns?” Explanations are found in causal chains, conditional effects, and “structural amplification.” The review summarizes and synthesizes ideas and findings about four factors: marriage and parenthood (which define the family), and the wife’s or mother’s employment and the family’s social status (which connect it to the larger social order). Overall, the married are in better health than the nonmarried, but parents are not better off than nonparents. Women’s employment and high family socioeconomic status tend to be associated with good physical and psychological health. Under what circumstances are these basic patterns found, and what explains these patterns—what links structure to individual health? Economic well-being and social support are considered as the basic explanations. Concluding comments point to the need for more studies of the impact of family on the sense of control, which could be an important link to health.

How does a family promote or hinder the well-being of its individual adult members? A family is more than just a collection of people who might expose each other to infections and pollutants. A family is an economic unit bound together by emotional ties. The larger social structure impinges on individuals through the family (Ross and Huber, 1985). Does the family nurture health by cushioning against an impersonal and sometimes threatening social order, and by encouraging responsible and temperate behavior? Or does it erode health with an unceasing flow of demands?

To answer these questions, we begin by defining family and health. Next we describe a general mode of understanding family and health—a format evolved from research of the past decade. Then we detail the ideas and findings about two pairs of factors: marriage and parenthood (which define the family), and the wife’s or mother’s employment and the family’s social status (which connect it to the larger social order). Finally, we discuss the need for more studies of the impact of family on the sense of control, which could be an important link to health.

What is a family? The U.S. Bureau of the Census defines a family as two or more individuals related by blood, marriage, or adoption who reside in the same household (Cherlin, 1981). This definition, which combines household and kin, is appropriate for a study of the American family today, because of the low degree to which kin outside the household rely upon each other. The Census Bureau definition encompasses a great variety of family household structures, including married adults with or without children, single-parent families headed by either a woman or a man, families with three or more generations in the household, and stepfamilies, to name a few. Nearly 80% of all American families are formed

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The World Health Organization defines health as a state of physical and mental well-being, not simply the absence of disease. This broad definition of health focuses on the physical and emotional quality of people's lives, more than on rates of diagnosed illness. Well-being varies along a continuum (Mirowsky and Ross, 1989). At one extreme, people feel tired, sick, and run-down. They are physically unable to climb stairs or walk, have many short-term illnesses like colds or the flu, have ongoing problems like arthritis that interfere with activity, or feel depressed, anxious, and demoralized. At the other extreme, people feel healthy and energetic, rarely spend a day sick in bed, and feel happy and hopeful about the future. Most people fall somewhere between these two extremes. People who qualify for medical or psychiatric diagnoses tend toward the sick end of the continuum, whereas those who do not qualify for diagnoses tend toward the health end. Nevertheless, people who qualify for diagnoses differ considerably among themselves in their degree of sickness or health, as do people not qualified for diagnoses.

Physical and mental health correlate highly (Aneshensel et al., 1984; Bruce and Leaf, 1989; Mechanic and Hansell, 1987; Verbrugge, 1986). They share common causes, they affect each other, and signs of one often are signs of the other.

Physical well-being consists of feeling fit and able, unrestricted by discomfort or disability. Physical distress includes feeling unhealthy, tired, run-down, having no energy, having headaches and stomach aches, feeling faint, having trouble breathing, being in pain, having difficulty with activities such as walking, lifting, carrying, bending, and so on, feeling unable to get out of bed, and being disabled by acute and chronic health problems (Verbrugge, 1983; Waldron and Jacobs, 1988). Physical distress is indicated by self-reported symptoms, poor health, dysfunction, and sick days, but not necessarily by the number of visits to the doctor. Although feeling sick increases the likelihood of visiting the doctor, other factors such as income, insurance, time, and inclination make doctor visits a problematic measure of health.

Emotional well-being consists of feeling happy, hopeful, and energetic, with a zest for life. Psychological distress includes moods of depression or anxiety, and physiological symptoms associated with these moods (Mirowsky and Ross, 1989; Pearl, Lieberman, Menaghan, and Mulvan, 1981). Depression and anxiety correlate highly with each other and afflict everyone to some degree from time to time. They correlate with other affective problems such as anger; with cognitive problems such as paranoia; and with substance abuse such as heavy drinking (Mirowsky and Ross, 1989). (Heavy drinking decreases depression in the short run but increases it in the long run; Aneshensel and Huba, 1983; Parker, Parker, Harford, and Farmer, 1987). Depression consists of feeling sad, demoralized, lonely, hopeless, and worthless; wishing you were dead; having trouble concentrating; having trouble sleeping; not feeling like eating; crying; and feeling run-down and unable to get going. Anxiety consists of being tense, restless, worried, irritable, afraid, and having "fight or flight" symptoms such as acid stomach, sweaty palms, and cold sweats, as well as your heart beating hard and fast, shortness of breath, or feeling hot all over when not exercising or working hard. (Notice that one of the ways physical and mental health correlate is through psychophysiological symptoms of depression and anxiety.)

It is important to distinguish well-being from certain things that may affect it but are not one and the same thing. In particular, satisfaction with one's lot does not necessarily indicate well-being. Satisfaction implies a convergence of aspiration and achievement that reflects resignation as much as it does accomplishment. Whereas distress often results from deprivation, dissatisfaction results from deprivation relative to one's expectations. Although the two often go together, sometimes they diverge in meaningful ways. For example, among people with the same family income, higher levels of education reduce satisfaction but increase psychological well-being (Mirowsky and Ross, 1989).

The sense of control over one's own life also is not the same as well-being. Well-being is feeling pleasant rather than unpleasant, good rather than bad, up rather than down. The sense of mastery, efficacy, and control is a belief rather than a feeling. People respond emotionally to their perceptions of themselves, but the perceptions and the
emotions are distinct. For example, it is one thing to consider oneself attractive and another to feel happy because of the belief, the consequences of the belief, or the consequences of the reality the belief presents.

A General Model of Family and Health

Structural Analysis: A Mode of Understanding

How can we describe and talk about the ways that health or sickness depend on family arrangements and situations? Obviously, health and sickness occur within the family. We want to know how the family itself generates health and sickness, or alters the impact of things that generate it. The family exists within a social context and is itself a social context. Patterns of physical and mental health, things that explain the patterns, and things that modify them all flow from the "structural arrangements in which individuals are embedded" (Pearlin, 1989: 241). Pearlin and his colleagues laid the foundation for a decade of research on social structure and well-being that focuses on durable, structured experiences that people have as they engage in their various social roles, such as economic, occupational, family, and parental roles (Pearlin et al., 1981). The research of the 1980s produced a general format for thinking about and studying how such durable, structured experiences generate and regulate variations in well-being.

The paradigm, which we call structural analysis, searches for two types of patterns. In causal chains, intermediate links explain patterns of well-being. Causal-chain models divide the overall correlation between family and health into component links that explain the correlation. In conditional effects (or interactions), one element of the social context modifies the impact of another on well-being. Conditional-effect models specify the conditions that increase, decrease, eliminate, or reverse a correlation between family and health. Both causal chains and conditional effects provide means of explaining why and how family affects well-being (Wheaton, 1985). When causal chains and conditional effects combine, they produce what we call structural amplification, in which an aspect of social structure erodes the barriers that would otherwise reduce its correlation with well-being.

In the sections that follow we examine research of the past decade for patterns and explanations of the association between family and health. We begin each section by describing the pattern of well-being related to one of four aspects of family: marriage, parenthood, the wife's employment, and the family's social and economic status. Next we ask, What explains the pattern? To answer, we look for links in the causal chain, conditional effects, and their combination in structural amplification.

Marriage

Patterns

Marriage is associated with physical health, psychological well-being, and low mortality. Compared to people who are divorced, separated, single, or widowed, the married have better overall well-being. This overall positive effect is strong and consistent. Compared to married people, the nonmarried have higher levels of depression, anxiety, and other forms of psychological distress (Bowling, 1987; Gore and Mangione, 1983; Gove, Hughes, and Style, 1983; Mirowsky and Ross, 1989), they have more physical health problems as indicated by acute conditions, chronic conditions, days of disability, and self-reported health (Anson, 1989; Berk and Taylor, 1984; Riessman and Gerstel, 1985; Tcheng-Laroche and Prince, 1983). The nonmarried have higher rates of mortality than the married: about 50% higher among women and 250% higher among men (Berkman and Breslow, 1983; Litwack and Messeri, 1989). Compared to married people, the divorced and widowed have higher death rates from coronary heart disease, stroke, pneumonia, many kinds of cancer, cirrhosis of the liver, automobile accidents, homicide, and suicide, all of which are leading causes of death (Berkman and Breslow, 1983; Kaprio, Koskenvuo, and Rita, 1987; Tcheng-Laroche and Prince, 1983). The ratio of nonmarried to married mortality is particularly high for causes of death that have a large behavioral component, such as lung cancer and cirrhosis, or that kill young and middle-aged adults, such as suicide and accidents (Litwack and Messeri, 1989; Smith, Mercy, and Conn, 1988). The highest mortality ratios are among persons from 35 to 44 years old (Litwack and Messeri, 1989). Widows have higher levels of depression and anxiety and higher death rates.
than the married (Bowling, 1987; Helsing, Moysen, and Comstock, 1981). Death rates are greatest immediately after the death of one’s spouse (Kaprio et al., 1987) but remain elevated until the widowed remarry (Bowling, 1987; Helsing et al., 1981).

Some researchers claim that selection of the healthy into marriage accounts for the association of marriage and health, but the evidence cited is equivocal. For example, Brown and Giesy (1986) find that people with spinal cord injuries are less likely to be married. They interpret this as the consequence of selection, arguing that people with severe health problems have difficulty finding and keeping marriage partners. It is just as likely that marriage protects against spinal cord injuries, because married people engage in fewer risky activities than unmarried people. Although there may be some selection effect keeping or taking the unhealthy out of marriage, the protective effects of marriage on health probably account for more of the association.

Although marriage generally protects and improves health, it protects men’s well-being more than women’s. Marriage protects men from death more than it does women (Helsing et al., 1981; Litwack and Messeri, 1989), it protects men’s physical health more than it does women’s (Bird and Fremont, 1989), and it protects men’s psychological well-being more than it does women’s (Gove, 1984) (although there is some counter evidence that men’s advantage over women in mental health is as large or larger among the single, divorced, and widowed; Fox, 1980). The protective effect of marriage may be declining somewhat. In terms of reported happiness, the positive effects of marriage have declined slightly between 1972 and 1986, especially for women (Glenn and Weaver, 1988), and recent studies show a weaker association between marriage and well-being than did earlier studies (Haring-Hidore, Stock, Okum, and Witter, 1985). Nonetheless, marital happiness is still the largest contributor to overall happiness (Glenn and Weaver, 1988). For men and women, now as before, marriage is associated with physical and psychological well-being.

**Explanations**

The literature focuses on three explanations of why marriage protects well-being: living with someone rather than alone, emotional support, and economic well-being. Of the three, emotional support and economic well-being explain much, but not all, of the positive effect of marriage on health.

**Living with someone.** At first researchers thought the simple presence of another adult in the household might explain why marriage improves well-being. Since unmarried people often live alone but married people almost always live together (often with children), this might explain why unmarried people are more distressed. A person who lives alone may be isolated from an important network of social and economic ties: the privileges and obligations centered on the home and family. These ties might help create a stabilizing sense of security, belonging, and direction. Without them a person may feel lonely, adrift, and unprotected. To test this theory, Hughes and Gove (1981) subdivided three types of unmarried people (never married, divorced or separated, and widowed) according to whether they lived alone or with another adult. Contrary to what Hughes and Gove expected, they found that unmarried people who live alone are no more distressed than those who live with other adults. The big difference is between married people and others, not between people who live alone and others. The unmarried, living alone or with others, are significantly more distressed than the married. The mere presence or absence of another adult in the household does not explain the patterns of marriage and well-being.

**Social support.** Social support is the commitment, caring, advice, and aid provided in personal relationships. It has several dimensions, including emotional and instrumental support. Marriage typically provides social support of all forms—particularly the emotional element (Gerstel, Reissman, and Rosenfield, 1985; Ross and Mirowsky, 1989). Emotional support is the sense of being cared about, loved, esteemed, and valued as a person, and having someone who cares about you and your problems. Married people are more likely to report that they have someone they can turn to for support and understanding when things get rough, and that they have a confidant they can really talk to. Emotional support decreases depression, anxiety, sickness, and mortality (Blazer, 1982; Gerstel et al., 1985; Han-

On the other hand, when a spouse expects more than he or she is willing to give back, acts like the only important person in the family, and cannot be counted on for esteem and advice, men and women feel demoralized, tense, worried, neglected, unhappy, and frustrated. Marriages characterized by an unequal division of decision-making power are associated with high levels of depression on the part of both spouses, as compared to marriages characterized by equity (Mirowsky, 1985). It is not enough just to have someone around. It is better to live alone than in a marriage characterized by a lack of consideration, caring, esteem, and equity. Gove, Hughes, and Style (1983) show that the emotional benefits of marriage depend on the quality of the marriage. The 62% of married people who report being very happy with the marriage are less distressed than unmarrieds. The 34% who only say they are pretty happy with the marriage are no less distressed than the unmarrieds. The 4% who say they are not too happy or not at all happy with the marriage are more distressed than unmarrieds of all types (Gove et al., 1983).

Support from one's spouse may improve physical health several ways: by improving emotional health, by reducing risky behavior, by aiding early detection and treatment, and by helping recovery. The first impact is through the direct effect of psychological well-being on physical well-being. Social support, especially emotional support, decreases depression, anxiety, and other psychological problems (Cohen and Syme, 1985; Kaplan, Robbins, and Martin, 1983; Kessler and McLeod, 1985; LaRocco, House, and French, 1980; Mirowsky and Ross, 1989; Wheaton, 1985). Over time, psychological well-being improves subsequent physical well-being (Aneshensel et al., 1984; Mechanic and Hansell, 1987). A 15-month follow-up of people aged 50 and over finds that the severely depressed are four times more likely to die than others, with adjustment for history of hypertension, heart attack, stroke, cancer, or limitation of physical functioning (Bruce and Leaf, 1989). By protecting and improving psychological well-being, social support also improves physical health and survival. The second way support from one's spouse improves physical health is by encouraging and reinforcing protective behaviors. Marriage provides a stable, coherent, regulated environment (Hughes and Gove, 1981; Umberson, 1987). Compared to single, divorced, and widowed people, the married experience more social control and regulation of behavior (Anson, 1989; Umberson, 1987). For the most part, married people live a healthier lifestyle than the single, divorced, or widowed. Married people are more likely to quit smoking, to eat diets low in cholesterol and high in fruits and vegetables, and to eat balanced meals (Hayes and Ross, 1987; Umberson, 1987; Venters, 1986). Married people are less likely to drink heavily, to get into fights, to drive too fast, and to take risks that increase the likelihood of accidents and injuries (Umberson, 1987; Venters, 1986). Wives, in particular, often discourage smoking, drug use, or heavy drinking in the house, cook low-cholesterol meals and keep fattening food out of the house, and schedule checkups. The fact that women generally have a healthier lifestyle than men may explain why marriage improves men's health behaviors (Umberson, 1987) and survival (Litwack and Messeri, 1989) more than women's.

The effects of marriage on a healthy lifestyle are generally positive but not completely consistent. A few healthy behaviors are not increased by marriage. Married people are more likely to be overweight, and they are less likely to engage in physical activity and exercise than the nonmarried (Hayes and Ross, 1986; Ross and Mirowsky, 1983; Venters, 1986).

On the whole, marriage produces a net improvement in avoiding the onset of disease, which is called primary prevention. There is little argument over the benefits of primary preventive behavior (Abbott, Yin, Reed, and Yano, 1986; Graham and Mettlin, 1979; Hovell, 1982; Lipid Research Clinics Program, 1984; Magnus, Matsuo, and Strackee, 1979; Multiple Risk Factor Intervention Trial Research Group, 1982; Paffenbarger, Hyde, Wing, and Steinmetz, 1984; Sagan, 1987; Stamler, 1981; Surgeon General, 1982). Quitting smoking (or never smoking) decreases the risk of lung cancer, emphysema, stroke, coronary heart disease, and respiratory infections, including pneumonia. A balanced diet low in calories and cholesterol and high in fruits and vegetables decreases the risk of coronary heart disease, adult-onset diabetes, atherosclerosis, high blood pressure, and colon cancer. Driving safely and not drinking and driving decreases the risk of
car accidents. *Avoiding heavy drinking* decreases the risk of cirrhosis of the liver, accidents, and injuries, and even suicide and homicide. All of these primary preventive behaviors are more common among the married and decrease the risk of leading causes of death in the United States: heart disease, cancer, stroke, accidents, emphysema, pneumonia and influenza, diabetes, suicide, cirrhosis of the liver, atherosclerosis, kidney disease, and homicide (Litwack and Messeri, 1989; National Center for Health Statistics, 1989).

A third way marriage may improve health, in theory, is by helping to catch and treat disease early, which is called secondary prevention. Married people are more likely to see the doctor for checkups, screening, and other early detection than the nonmarried with the same symptoms, functioning, and general level of health (Berkman and Breslow, 1983; Neale, Tilley, and Vernon, 1986). Yet, the benefits to overall health of uncovering and treating disease early are uncertain. Yearly checkups appear to have no effect on maintaining health (Sagan, 1987). Screening tests such as X rays and mammography entail some risk with the exposure to small amounts of radiation (Bailar and Smith, 1986). The risks and side effects of treatment often outweigh the benefits for low-level disease, which often gets better, or no worse, if left untreated. False alarms lead to treatments that carry risks to survival, such as septicemia or drug reactions, without providing counterbalancing benefits (Sagan, 1987).

Cancer statistics provide an example of the questionable benefits of finding and treating diseases before symptoms appear. Cancer is the second leading cause of death. Despite trends toward much earlier detection and treatment, cancer deaths in the United States have been stable or increasing over the past 40 years (NCHS, 1989). According to Bailar and Smith (1986) and Cairns (1985), early detection and treatment of cancer is largely ineffective. (Hodgkin's disease [1% of cancer deaths] and leukemia [4%] are exceptions.) For lung cancer (30% of cancer deaths) and breast cancer (10%), screening creates an illusion of improved survival because many of the small cancers detected by X ray would not be fatal even if untreated (Bailar and Smith, 1986). Also, X rays, breast examinations, and mammograms detect cancers at an early stage. The earlier cancers are detected, the longer the average time between detection and death, which gives a false impression of longer survival (Sackett, Haynes, and Tugwell, 1985). Neale, Tilley, and Vernon (1986) find that married women seek treatment sooner than do widows after noticing symptoms like a lump or change in the breast. When adjustments are made for age, SES, and stage of the disease at diagnosis, the length of time between noticing symptoms and seeking treatment does not affect 10-year survival. However, married women do live longer than widowed women with breast cancer detected at the same stage. Thus, the salutary effect of marriage on subsequent length of survival is not explained by finding the cancer at an earlier stage.

A fourth way that support from one's spouse may improve physical health is by aiding recovery. Intimacy between partners, as opposed to marital conflict, promotes emotional recovery from myocardial infarction (Waltz, Badura, Pfaff, and Schott, 1988). High levels of emotional support from one's husband reduces depression and anxiety among women with breast cancer (Neuling and Winefield, 1988). Low levels of family conflict are associated with better control of diabetes (Edelstein and Linn, 1985).

In summary, marriage has large, significant, consistent, positive effects on physical health by increasing social support. The effect of social support on health appears to be mediated by improved psychological well-being, healthier lifestyle, and better recovery, more than by earlier detection and treatment of disease.

**Economic well-being.** Married people have higher household incomes than the nonmarried. In a representative sample of Illinois residents interviewed in 1985, married people had average household incomes of about $33,500. Nonmarried females had average household incomes of $21,500, and nonmarried males, $28,600 (Ross, 1989). Roughly speaking, being married increases the average household income of women by $12,000; for men the amount is about $7,000. The economic benefits of marriage hold for both women and men, even with adjustment for age, minority status, employment status, and education (Ross, 1989), although the economic benefits of marriage (and losses of nonmarriage) are greater for women than for men (Bianchi and Spain, 1986; Cherlin, 1981). Household income drops precipitously after divorce and remains close to the new low for as much as five years, especially for...
women (Weiss, 1984). Economic well-being, in turn, has a large effect on health and mental health (Kessler, 1982; Kessler and Cleary, 1980; Pearl et al., 1981: Ross and Huber, 1985).

The two main health benefits of marriage—social support and economic well-being—may weigh differently for men and women. Gerstel, Riessman, and Rosenfield (1985) looked at the ways in which divorce increases the psychological distress of men and women. They found that, when divorced, women suffered more of a loss of household income than did men, whereas men suffered more of a loss of social support than did women. Both men and women gain economic well-being and emotional support from marriage, but marriage may be more of an economic benefit to women and an emotional-support benefit to men.

**Unexplained effects.** Social support and economic well-being explain some of the effect of marriage on depression, but not all. At the same levels of emotional support and family income, the married still have significantly lower levels of depression than the nonmarried (Ross and Mirowsky, 1989). The question of why married people have higher levels of physical and psychological well-being than the unmarried is still not completely answered empirically.

One possibility is that nonmarried people have less protective forms of social support, as well as less social support overall. People who live alone get a higher proportion of their social support outside the household than do people who live with others (Alwin, Converse, and Martin, 1985). Almost all people who live alone are unmarried (although not all people who are unmarried live alone). Having the providers of one’s social support in the household may be more comforting and protective, perhaps simply because of greater availability.

Even though the nonmarried have a larger number of supportive relationships of other kinds, those relationships typically do not provide as much emotional support as a good marriage. Among the elderly, the married get most of their support in close personal relationships, whereas the nonmarried get a larger proportion of their support from agencies or people not personally close (Longino and Lipman, 1981). The less personal relationships specialize more in instrumental support, whereas the personal ones provide more emotional support. The latter is more important to health and mental health (Kessler and McLeod, 1985).

**Parenthood**

**Patterns**

People have strong beliefs about the positive effects of having and rearing children. Without children, women especially are said to feel empty, lonely, and demoralized. Although the strict sanctions against staying childless have abated somewhat, norms about the desirability of having children are still strong. The strength of these norms is seen partly in the fact that over 90% of all married people eventually have children. In 1980, only 7% of ever-married women reached age 44 without having any children (Bianchi and Spain, 1986). Nonetheless, a number of theorists and researchers challenge the view that children increase well-being. They argue the opposite, that children decrease the physical and psychological well-being of parents, especially mothers.

**Emotional well-being.** Children do not generally improve the psychological well-being of parents (Cleary and Mechanic, 1983; Gore and Mangione, 1983; Kessler and McRae, 1982; Lovell-Troy, 1983; McLanahan and Adams, 1987; Ross, Mirowsky, and Huber, 1983). People with children at home do not have higher levels of well-being than nonparents. In some instances, parents—especially mothers—are more psychologically distressed than nonparents, but in most, the effect of children on mothers’ well-being is insignificant or inconsistent. Children at home either increase psychological distress or have an insignificant effect. In general, they do not decrease distress.

The studies that find a positive impact of children on well-being tend to look at the total number of children, not the number living at home (Aneshensel, Frerichs, and Clark, 1981; Kandel, Davies, and Raveis, 1985). Kandel and her colleagues, for instance, find that positive effects of children (if any) on the health and well-being of their parents appear only after the children leave home. Children at home increase depression, but parents whose children have left home are less depressed and in better health than the childless of the same age (Kandel et al., 1985),
probably because of emotional support from adult children. However, elderly parents are not happier than the elderly who are childless (Glenn and McLanahan, 1981; Rempel, 1985), and giving or receiving aid from children does not affect the morale of the elderly (Lee and Ellithorpe, 1982). Overall, the evidence shows that children at home either decrease psychological well-being or have no impact on it. The positive effects of children may appear after they leave home, although studies that measure well-being as happiness find no evidence for any positive effects.

**Physical well-being.** Children at home have small, inconsistent, or insignificant effects on parents’ physical health, too. Verbrugge (1983) looked at physical health in a comprehensive way, measuring self-reported health, number of chronic problems in the past year, number of days of restricted activity in the past year, job limitations, and a number of health measures taken from daily diaries, including physical feeling, number of health problems, and so on. In no case does the presence of children in the home significantly affect health, although the trends tend to be positive. Some researchers find that the presence of children, many children, and preschool children are associated with worse health for women (Gove, 1984), while others find insignificant effects of the number of children and the number of hours spent in child care on self-reported health (Bird and Fremont, 1989). Children at home do not significantly improve health. Marriage clearly improves health, but parenthood does not.

**Explanations**

Why would children at home decrease well-being, especially psychological well-being? Children tend to be valued and loved (although the disturbing facts about the prevalence of child abuse undermine our myths somewhat). How could children be loved and still increase distress levels, especially among mothers? Two explanations stand out: children increase economic hardships on families, and children decrease the amount of emotional support that spouses receive from each other. Economic well-being and social support reduce the detrimental impact of children on the health and well-being of parents, but children deplete those very resources (providing an example of structural amplification).

**Economic well-being.** Children increase economic strains on the family. At the same level of family income, a family with children feels more economic pressure than one without children (Ross and Huber, 1985). Each dollar must go farther—must buy more food, clothes, and medical care. Children often mean that the current house or apartment is too small. People in crowded housing conditions feel more harassed by their children (Goldsteen and Ross, 1989; Gove, Hughes, and Galle, 1979). Young children increase the pressures to acquire more living space, which requires larger rent or mortgage payments. However, the presence of young children often means the mother does not work outside the home. She may quit her job while the children are young, thus magnifying the family’s economic hardship. If she continues her employment, family funds often are needed for day care. Economic hardship increases depression among both men and women. The chronic strain of struggling to pay the bills and to feed and clothe the children takes its toll, making parents feel run-down, hopeless, and worried (Pearlin et al., 1981; Ross and Huber, 1985).

Children are most detrimental to the health and well-being of single and divorced mothers (Alwin, Converse, and Martin, 1985; Aneshenshel et al., 1981; Kandel et al., 1985; McLanahan and Adams, 1987), in large part because of greater economic hardships (Moen, 1983). Nonmarried mothers and their children are the new poor in the United States. In 1980, 18% of all births were out of wedlock; and another 43% of all children born in wedlock in 1980 will experience parental separation before they are 16 years old (Preston, 1984). By 1982, 23% of all children under age 14 were living in poverty—most in female-headed households (Preston, 1984). If these mothers can find work, it tends to be poorly paid, and they must struggle to find and pay for child care. Both the children and their mothers are in extremely disadvantaged positions. For the mothers this disadvantage often has psychological consequences of depression and anxiety.

**Social support.** Children decrease the quality of the marriage and the amount of support the spouses get from each other. Emotional support and satisfaction with marriage decrease with the birth of the first child and do not return to preparenthood levels until all the children have
Left home. Both husbands and wives are most satisfied with their marriage when there are no children at home, either because they are childless or because the children have left home. As the number of children, especially young children, increases, satisfaction decreases (Pleck, 1983; Veroff, Douvan, and Kulka, 1981). Parents of preschool-age children report the lowest levels of support from spouses; people whose children have left home, and the childless, report the highest levels of marital support. Both voluntarily and involuntarily childless women report more support from husbands than do women with children (Callan, 1987). The involuntarily childless report the most loving marital relationships. The voluntary childless report the most time spent with husbands, exchange of ideas, and consensus with husbands (Callan, 1987). Richman, Raskin, and Gaines (1989) find that both spouses feel a decrease in mutual support following childbirth. Husbands and wives spend less time together when they have young children, and the time they do spend together is often focused on the child. Husbands feel they are getting less emotional support from their wives, whose energies now go into caring for the child. And wives, too, feel they get less support from husbands, who often distance themselves (sometimes literally) from the difficult care of young children. Women, especially those in the working class, report that their husbands are less likely to be confidants—to be there to talk to when needed—after the birth of the first child. In sum, couples with children, especially young children, report less support from and satisfaction with marriage.

Children tend to keep unhappily married couples together. Couples dissatisfied with their marriage are less likely to get divorced if they have young children, especially first children. Dissatisfied couples with no children or grown children are more likely to separate and divorce (Goetting, 1986; White and Booth, 1985; White, Booth, and Edwards, 1986). Thus, married couples without children are more satisfied than those with children partly because the dissatisfied without children get divorced.

Employed and unemployed mothers. For women, the relationship between parenthood and health may depend on employment status, child care arrangements, and the husband's participation in child care. Women with young children are less likely to be employed than those with older children and the childless. Research indicates that children create more burden for women who are exclusively housewives than for employed women (providing another example of structural amplification). Children put strain on these mothers, apart from the quality of the marriage. Young children put constant demands on mothers who are home all day with the children. Young children separate mothers from other adults and make them feel they are stuck in the house, at the same time decreasing their privacy and time alone (Gove, 1984; Gove and Peterson, 1980). Housewives who are not employed are much more likely to feel that others are making demands on them than are employed mothers or fathers. Housewives feel more burdened by their children—feel their children are making too many demands, get in their way, are too noisy, and interfere with their privacy; and wish they could get away from their children—than do employed mothers (Goldsteen and Ross, 1989). In turn, mothers who feel burdened by their children have low levels of psychological well-being compared to mothers who feel fewer demands (Umberston, 1989).

Kotler and Wingard (1989) found an increased risk of mortality among mothers who are exclusively housewives, but no increased risk among working mothers. Employed mothers report better health than nonemployed mothers on a number of measures, including self-rated health, chronic conditions, and days of restricted activity (Verbrugge, 1983).

Clarey and Mechanic (1983) make the opposite argument, that children distress employed women more than housewives because of role strain. Many employed wives are largely responsible for child care. Role overload results from the sheer amount of effort it takes to perform in both arenas, and role conflict results from trying to meet the expectations of people who do not take each other into account (i.e., one's boss and one's children).

Employment may improve a mother's well-being under some conditions but degrade it under others. What are the conditions? Ross and Mirowsky (1988) concluded that the effect of children on a married woman's depression depends on her employment, child care arrangements, and husband's participation in child care. Two conditions are associated with the lowest levels of depression among women:
employment and no children, or employment coupled with either easy and available child care for the children while the parents are at work or with the husband’s shared participation in child care. Staying at home with children is associated with higher levels of depression than these alternatives. The most stressful situation occurs if a wife is employed, has young children, has difficulty arranging child care, and gets no help from her husband with child care. These mothers are twice as depressed as employed mothers who have no difficulty arranging child care and whose husbands share the child care responsibilities with them. Thus, children seem to have very different effects on employed mothers, depending on the availability and affordability of child care and the husbands’ participation in child care.

External support. Support from people in the household other than the husband also can reduce the burden of children (Goldsteen and Ross, 1989). However, help with child care by neighbors and relatives outside the household carries costs as well as benefits. Receiving support in the form of aid incurs the costs of mutual obligation (Belle, 1982; Rook, 1984). When friends and neighbors provide child care, mothers apparently have specific obligations to provide child care in return, which increases their sense of burden (Goldsteen and Ross, 1989). In a study of low-income women, Belle and her colleagues found that involvement with neighbors in caring for children is a strategy of desperation, not choice. It helps with basic survival but does not imply emotional support. When relatives in the area provide child care, mothers have more diffuse obligations that impinge on their ability to be by themselves when they want to be (Goldsteen and Ross, 1989). For women who can afford it, paying for formal child care service carries fewer emotional costs than using informal exchange networks. Paid employment sometimes frees women from demanding and restricting networks of reciprocity (Belle, 1982). People who can afford to pay for services such as child care do not need to rely on networks for aid. Instead, they benefit from intimacy, caring, and trust, without incurring burdensome obligations.

Summary

Overall, children at home decrease adult well-being. However, in the best circumstances children do not decrease well-being and may improve it. These circumstances include (a) enough family income so that there are no felt economic hardships, (b) the mother’s paid employment, (c) available and affordable child care services, and (d) support from husbands, or other relatives in the household, in the shape of emotional support and shared participation in child care. The combination of children and these circumstances is uncommon, however, because children increase economic hardship, make it more difficult for women to be employed, and strain marital relationships. The result is a classic example of structural amplification. Children at home decrease health and well-being by eroding the very things that are necessary to cope successfully with children—economic well-being and supportive relationships.

Women’s Employment Patterns

For most Americans, employment improves physical and psychological well-being. Few ever questioned that this is true for men, and evidence continues to accumulate that unemployment is detrimental to men’s health (Kessler, House, and Turner, 1987). However, it was not until the 1970s that Gove and his colleagues claimed similar benefits of employment for women. Most research finds that employed women have less depression, anxiety, and other forms of psychological distress than do housewives (Gore and Mangione, 1983; Gove, 1984; Gove and Peterson, 1980; Hall, Williams, and Greenberg, 1985; Kessler and McRae, 1982; Rosenfield, 1980; Ross, Mirowsky, and Ulbrich, 1983).

Employed women are physically healthier than nonemployed women (Lewin-Epstein, 1986; Marcus, Seeman, and Telesky, 1983; Nathanson, 1980; Verbrugge, 1983; Waldron and Jacobs, 1988; Woods and Hulka, 1979). Among women, the employed report the best physical health, housewives report lower health, and the unemployed report the worst health (Brenner and Levi, 1987; Jennings, Mazaik, and McKinlay, 1984). Death rates of women in the labor force are substantially lower than those of housewives (Passannante and Nathanson, 1985).

Interestingly, before current results were available, many speculations were pessimistic
about the impact of women's employment on their health (Mortimer and Sorensen, 1984). Many thought employment would expose women to the stress and hazards of work, and thus worsen health. Accumulating evidence shows the opposite to be true. This trend is most striking in the literature on employment and pregnancy. Early work warned against possible adverse effects of employment on pregnancy. Research evidence accumulated since 1970 shows a positive association between employment and good perinatal outcomes (Saurel-Cubizolles and Kaminski, 1986).

The benefits of a wife's employment to her husband's well-being is less clear than the benefits to her own. Some studies find that the wife's employment increases her husband's psychological distress by reducing his power in the family and thus threatening his self-esteem (especially if they hold traditional sex-role attitudes), by reducing the wife's attention to him or by increasing his housework load (Kessler and McRae, 1982; Rosenfield, 1980). Others find that the wife's employment decreases her husband's psychological distress by improving or maintaining the standard of living (Ross and Huber, 1985; Ross, Mirowsky, and Ulbrich, 1983). Some find no effect (Roberts and O'Keefe, 1981). A meta-analysis by Fendrich (1984) concludes that the wife's employment generally does not increase her husband's distress. Although there is less research concerning the effect of a woman's employment on her husband's well-being than on her own, the evidence is beginning to show that it is not as detrimental as first believed.

Selection versus causation. The association of women's employment with good physical and mental health could be causal, because something about employment improves health, or it could be selective, because healthy women work outside the home whereas unhealthy women do not. Waldron and Jacobs (1988) concluded that most of the effect was due to selection. Their latest work, with better health measures, shows a large causal effect. Waldron and Jacobs (1988) used longitudinal data of a national sample of women interviewed in 1977 and again in 1982. They used a more reliable and valid health measure than was available in earlier studies. The measure assesses physical difficulties with a number of activities including walking, using stairs, standing for long periods, kneeling, lifting, using hands and fingers, seeing, hearing, and so on; it assesses activity limitations due to poor health, such as using public transportation, personal care, and so on; and it assesses psychological symptoms, including pain, tiring easily, low energy, weakness, aches, swelling, feeling sick, dizziness, and so on. Waldron and Jacobs (1988) find that participation in the labor force improves health on these dimensions over time. The association is not simply due to the selection of healthier women into the labor force. Follow-up studies of mortality support the causal interpretation (Passannante and Nathanson, 1985).

Explanations

Economic well-being. Women's employment decreases economic hardship, thereby improving the psychological well-being of the family members. Employed wives provide about 31% of the family income (U.S. Bureau of the Census, 1986). Ross and Huber (1985) looked at wives' earnings ranging from 0 (not working for pay) to over $30,000. The more a wife earns, the higher the family income, which decreases her and her husband's perception of economic hardship, which decreases their levels of depression. The wife's earnings decrease her husband's depression almost as much as hers. Thus, Ross and Huber show that a wife's employment and earnings benefit both spouses' mental health by decreasing economic strain on the family. For nonmarried women, economic well-being accounts for even more of the beneficial effect of employment (Waldron and Jacobs, 1988). About half of employed women are not married. A nonmarried woman's earnings typically constitute her total family income (U.S. Department of Labor, 1986). Waldron and Jacobs speculate that the woman's employment is more beneficial, the more critical her earnings to her family's economic well-being. Thus, employment is more beneficial to the health of nonmarried women, black women, and women in blue-collar jobs than to married women, white women, and women in white-collar jobs (Passannante and Nathanson, 1985; Waldron and Jacobs, 1988).

Social support. The second way employment improves a wife's mental health is by increasing support from her husband in doing the household chores. A wife's employment, and higher earnings
if she is employed, increase the likelihood and extent of her husband's sharing housework and child care (Ross, Mirowsky, and Huber, 1983; Saenz, Goudy, and Lorenz, 1989). Although only about 20% of the husbands of employed wives share the housework and child care equally with their wives, this is almost triple the 7% that do so if their wives are not employed (Ross, Mirowsky, and Huber, 1983). The more a wife earns compared to her husband, the greater his share of the housework and child care (Maret and Finlay, 1984; Ross, Mirowsky, and Huber, 1983). The more husbands share the household work, the lower their wives' depression (Kessler and McRae, 1982; Ross, Mirowsky, and Huber, 1983; Saenz et al., 1989). The husband's help with cleaning, cooking, dish washing, shopping, and caring for children significantly decreases a wife's depression and improves her self-rated health (Bird and Fremont, 1989; Ross, Mirowsky, and Huber, 1983; Saenz et al., 1989). The extra housework and child care done by husbands of employed women does not increase the husbands' distress (Kessler and McRae, 1982; Ross, Mirowsky, and Huber, 1983). There is no evidence that a move toward 50:50 division of housework and child care worsens a husband's mental health.

The effect of a wife's employment on the quality of the marriage, spouse support and communication, and marital satisfaction may be changing. Early studies found that wives' employment decreased marital satisfaction (Gove and Peterson, 1980). Studies of more traditional families, such as Mexican Americans, found that when a wife is employed, both she and her husband are less satisfied with the marriage, possibly because the wife resents the fact that the husband does not share the housework and child care, and because her work overload leaves less time for companionship (Ross, Mirowsky, and Ulbrich, 1983; Saenz et al., 1989; White, 1983). Reduced marital satisfaction increases psychological distress. It appears that wives' employment reduces marital satisfaction only under the following conditions: the family is a traditional one in which the husband and wife believe the wife's place is in the home, but she needs to work for economic reasons, and she retains full responsibility for the home. This would explain why older studies and studies of Hispanics find a negative relationship between wives' employment and marital satisfaction, whereas more recent studies and studies of less traditional families do not (Houseknecht and Macke, 1981; Ladewig and White, 1984; Locksley, 1980; Spitz, 1988). It is the inequality in total work load that creates marital tension and dissatisfaction.

Summary

The woman's employment decreases economic strains on the family, which is unambiguously good. However, in a large minority of families (39%), the wife is employed but she and her husband prefer that she not work. In a large majority of families in which the wife is employed, her husband does not share the housework and child care equally (80%) (Ross, Mirowsky, and Huber, 1983). Such conditions reduce, and sometimes reverse, the beneficial impact of the wife's employment. Her employment improves well-being most when her earnings are high enough to clearly improve the family's economic well-being, she and her husband prefer her employment, and he shares the household tasks. In the ideal healthy marriage (which is rare—less than one in five hundred), the husband and wife both earn good pay, both contribute about the same amount to the total family income, and both share the housework and child care equally.

Family Socioeconomic Status

Patterns

The association of socioeconomic status with mental and physical health appears consistently in the literature. Socioeconomic status, as indicated by education, income, and occupation, is associated with decreased depression, anxiety, physiological malaise, and other forms of psychological distress and demoralization, and with less schizophrenia (Kessler, 1982; Kessler and Cleary, 1980; Kohn, Naoi, Schoenbach, Schooler, and Slomczynski, 1990; Pearlin et al., 1981; Ross and Huber, 1985; Ross and Mirowsky, 1989). Longitudinal analysis supports a causal interpretation: differences in the demands and resources of various socioeconomic positions produce differences in psychological well-being and distress (Pearlin et al., 1981). Link and his colleagues show that occupation has a large causal effect on depression and schizophrenia; it is not simply that people with psychological problems are selected.
into low-level occupations (Link, Dohrenwend, and Skodol, 1986).

The same pattern exists for physical health. As Syme and Berkman say, “a vast body of evidence has shown consistently that those in the lower classes have higher mortality, morbidity, and disability rates” (1986: 28). Low socioeconomic status is associated with high rates of infectious and parasitic diseases, infant mortality, many chronic noninfectious diseases, disability, self-reported poor health, lower life expectancy, and higher death rates from all causes (Gortmaker, 1979; Hayes and Ross, 1986; Leigh, 1983; Litwack and Messer, 1989; Syme and Berkman, 1986). People in the lower social classes are more likely to get sick and less likely to survive if sick. (Of course these general patterns are not always true of every disease.)

Education is the aspect of social status most important to health. Education produces and protects physical health in many ways. It shapes knowledge and behavior, determines the kind of job a person can get, and strongly affects the amount a person earns. The well-educated are more likely than the poorly educated to quit smoking, exercise, and avoid obesity (Hayes and Ross, 1986; Leigh, 1983; Syme and Berkman, 1986), and they score higher on an index of overall health practices that includes exercising, not smoking, not being overweight, not drinking heavily, and so on (Berkman and Breslow, 1983).

Low education often leads to working at hazardous, risky, and physically noxious jobs characterized by noise, heat, fumes, cold, humidity, physical dangers, exposure to carcinogens, and so on (Leigh, 1983; Link, Dohrenwend, and Skodol, 1986), in addition to working at jobs that do not pay well. The effects of education on behavior and exposure, more than on access to medical care, explain the beneficial impact of education on health (Syme and Berkman, 1986).

The poorly educated who work at low-status, poorly paid, hazardous jobs are also the ones most at risk of losing their jobs in an economic downturn (Elder and Liker, 1982). On the aggregate level, the unemployment rate is associated with morbidity and mortality, including heart disease mortality, infant mortality, and suicide (Bunn, 1979; Marshall and Hodge, 1981). Studies that follow individuals are more direct tests of the effect of unemployment on health. Most find that the people who are unemployed have worse physical and mental health than the employed (Frese and Mohr, 1987; Kasl and Cobb, 1982; Linn, Sandifer, and Stein, 1985; Pearl et al., 1981). Kessler, House, and Turner (1987) find that the unemployed have worse self-reported health and higher levels of somatization, anxiety, and depression, none of which can be explained by selection of sicker people out of the workforce.

When other aspects of status are held constant, education is the single most important aspect of status for women’s well-being, whereas personal earnings are the most important for men’s (Ross and Huber, 1985). Kessler (1982) and Kessler and McRae (1982) find that, for women, employed or not, education has the largest net effect on distress. Occupation has the smallest. An analysis of eight surveys, Kessler (1982) finds that personal earnings have the largest net effect on men’s distress. Family income and education have smaller net effects and occupation has none. Of course, net effects are somewhat mythical, given that education leads to a better job with higher pay, a spouse who has a better job with higher pay, and thus higher family income.

Explanations

Why is low socioeconomic status associated with poor mental and physical health? We focus on economic hardship and social support as two basic explanations. Then we introduce perceived control over life as an important explanatory mechanism on which more research is needed.

Economic hardship. Economic hardship explains much of the effect on depression of low family income and loss of family income (due to being laid off, fired, or downgraded) (Pearlin et al., 1981; Ross and Huber, 1985). A family is an economic unit bound by emotional ties. It is in the household that the larger social and economic order impinges on individuals, exposing them to varying degrees of hardship, frustration, and struggle. The struggle to pay the bills and to feed and clothe the family on an inadequate income takes its toll in feeling run-down, tired, and having no energy, feeling that everything is an effort, that the future is hopeless, that you can’t shake the blues, that nagging worries make for restless sleep, and that there isn’t much to enjoy in life. When life is a constant struggle to get by, when it
is never taken for granted that there will be enough money for food, clothes, and shelter, people often feel worn down and hopeless, and they are susceptible to disease (Pearlin et al., 1981; Ross and Huber, 1985). Low generalization resistance increases the risk of infectious disease and of chronic diseases such as cancer (Syme and Berkman, 1986). Low family income is obviously the major cause of economic hardship, but the translation is not one-to-one. At the same income levels, those who are poorly educated feel greater hardship than the well-educated (Ross and Huber, 1985). Not only are low levels of education associated with low incomes, but lack of education makes it more difficult to cope with an inadequate income. Ross and Huber (1985) find a synergistic effect of poverty and lack of education on economic hardship, each making the effect of the other worse. A poorly educated person needs more money to fend off economic hardship than does a well-educated person. Education provides skills, information, a sense of mastery, and well-educated friends that help a person deal with the stresses of life, including a low income. People who have not finished high school or have barely finished high school are doubly disadvantaged because their low education translates into low earnings and it increases the difficulties of coping with low earnings.

Economic hardship affects women more than men (Ross and Huber, 1985). Women and their children in female-headed households are the new poor in the United States (Moen, 1983; Preston, 1984). Even in the intact families, the wives often are more acutely aware of economic strains. Usually it is the wife's responsibility to do the shopping, make sure there is food on the table, take the children to the doctor, and pay the bills (Huber and Spitze, 1983). This arrangement is especially prevalent in working-class families, where there is just enough money to get by, but the budget must be juggled to pay the bills and still have enough money for food.

Social support. Low socioeconomic status is associated with lower levels of social support (Mitchell and Moos, 1984; Ross and Mirowsky, 1989). Middle-class women consider their husbands confidants more frequently than do working-class women. The poorly educated mobilize social support less effectively than the well-educated (Eckenrode, 1983), and generally are less likely to agree that "I have someone I can turn to for support and understanding when things get rough" (Ross and Mirowsky, 1989). The unemployment and economic hardship associated with low status decrease the sense of having a supportive and confiding spouse (Gore and Mangione, 1983; House, 1981).

The strain that low status puts on social support represents a particularly destructive instance of structural amplification. Social support reduces the distress associated with unemployment, but unemployment erodes social support (Gore and Mangione, 1983; House, 1981; Pearlin et al., 1981). Atkinson, Liem, and Liem (1986) find that long-term unemployment of both white- and blue-collar workers reduces the perceived quality of marital support and of the spouse's role performance, and increases the number of arguments between the partners. The impact of unemployment on social support magnifies the negative effects of unemployment on health. The strain of unemployment is reduced in couples who manage to maintain a high level of mutual support. Under the circumstances, few can.

Many people buckle under the strain of providing social support, particularly in difficult circumstances. Spouses of chronic pain patients have an elevated incidence of pain problems (Schaffer, Donlon, and Bittle, 1980) and depression (Shanfield, Heiman, Cope, and Jones, 1979). Noh and Turner (1987) report substantial psychological costs for families of ex-hospitalized psychiatric patients. Low socioeconomic status increases the likelihood of disability and disease, which in turn exacts a toll on the physical and mental health of the spouse. Low education, poverty, and low support feed each other, magnify each other's impact on sickness in the family, and magnify the impact of sickness in the family.

Directions for Research

The Sense of Control

Not everyone in difficult circumstances breaks under the pressure. Some manage to gain control of their situation, using whatever resources are available. However difficult the circumstances, the spouses and parents who fare the best take an attentive, active, instrumental approach to solving family problems (Pearlin et al., 1981; Ross and
Mirowsky, 1989). Such an approach improves well-being and health directly (Rodin, 1986) and also indirectly by improving family welfare over the long run (Kessler and Cleary, 1980; Kohn and Schooler, 1982). Many studies explore the ways that low status or old age reduce instrumentalism and the sense of control, and thereby produce distress or disease (e.g., Krause, 1986; Pearl et al., 1981; Rodin, 1986; Ross and Mirowsky, 1989). Only a few explore the ways that marital, parental, and work roles combine to shape the sense of responsibility and control.

Beliefs about personal control appear under a number of other names, including the sense of personal efficacy (Downey and Moen, 1987; Kohn and Schooler, 1982), self-efficacy (Gecas, 1989), self-directedness (Kohn and Schooler, 1982), mastery (Pearlin et al., 1981), helplessness (Elder and Liker, 1982; Garber and Seligman, 1980), fatalism versus instrumentalism (Wheaton, 1980, 1983), and powerlessness (Mirowsky and Ross, 1983; Seeman, 1983).

Consequences of the Sense of Control

The sense of not being in control of one's own life can diminish the will and motivation to actively solve problems. Attempts to solve problems seem pointless: "What's the use?" The result is less success in solving problems and adapting (Wheaton, 1980, 1983). The reactive, passive person fails to prepare, prepare for, and limit the consequences of problems. In contrast, instrumental people search the environment for potentially distressing events and conditions, take preventive steps, and accumulate resources or develop skills and habits that will reduce the impact of unavoidable problems. For example, Seeman and Seeman (1983) find that people with a high sense of control know about health, initiate preventive behaviors, quit smoking on their own, avoid dependence on doctors, and feel healthy more than those with a low sense of control. When undesired events and situations occur, the instrumental person is better prepared and less threatened. Thus, the instrumentalist is constantly getting ahead of problems, whereas the fatalist is constantly falling behind.

In the long run, the sense of control can lead to a change in status that further reinforces a high or low sense of control. People who feel responsible and instrumental improve their conditions with time, which reinforces the sense of control in the long run (Downey and Moen, 1987; Kohn and Schooler, 1982; Pearlin et al., 1981). Unfortunately, the long-run feedback works both ways. People who feel powerless and fatalistic, or who are cognitively rigid, can wind up in tedious jobs that do not pay well, and sometimes lose their jobs. Little success over long periods discourages and demoralizes people, reinforcing the sense of powerlessness and fatalism.

Work, Family, and the Sense of Control

How does family shape a persons' sense of control? Research is just beginning to provide an answer. Sometimes dependency or family obligations erode the sense of control. People whose mothers were overprotective have a lower sense of control than other adults, and are more depressed as a consequence (Richman and Flaherty, 1986). Employed mothers with most of the responsibility for housework and child care have a low sense of control that reflects their role overload (Rosenfield, 1989). However, people who meet the demands of family roles successfully can benefit in the long run. Middle-class women who saved their families from economic ruin during the Great Depression by taking jobs are more instrumental 40 years later than those who did not take jobs (Elder and Liker, 1982). The sense of control may prove to be a major link between family and health (Sagan, 1987).

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Sickness and Health 1077


