Chapter 2
Twenty Years of the Sociology of Mental Health: The Continued Significance of Gender and Marital Status for Emotional Well-Being

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2.1 Introduction

The formation of the Mental Heath Section of the American Sociological Association in 1992 heralded a period of considerable excitement, energy, and creativity in theory and research on the social determinants of mental health. The availability of a new institutional identity had a galvanizing effect on section members, who welcomed greater opportunities for social interaction with scholars working on similar substantive issues and ideas. Two areas in which this wave of enthusiasm and synergy is particularly evident pertain to gender and marital status differences in emotional well-being. Over the past couple of decades, sociologists have made significant theoretical, analytical, and substantive progress in our understanding of *how* and *why* people's gender and marital status—two axes of social inequality in the United States—influence their mental health. Building on theory and research from the 1970s and 1980s, when research on the relationships between gender, marital status, and mental health first gained traction, the last 20 years of scholarship has produced an impressive body of work elucidating a multitude of social—including social structural, social psychological, and sociocultural—factors that contribute to persistent gender and marital status differences in emotional well-being.

In light of profound social changes in the nature and organization of both gender and marriage that have been evolving in the U.S. since the last quarter of the 20th century, it is not surprising that much of this research compares the emotional consequences of major adult social roles and relationships for women and men. In the last decades of the 20th and first decades of the 21st centuries, women's

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labor force participation was at an all time high as were dual-earner families (Bianchi and Milke 2010). Moreover, although the divorce rate leveled off during this period, it continued to be high as were rates of single-parenthood, remarriage, and non-marital heterosexual cohabitation (Cherlin 2010). Additionally, while an increasing number of women were the primary breadwinners of their families, the recent downturn in the economy led to a growing number of un- or under-employed men—many of whom are husbands and fathers (Cherlin 2010). On top of changes in men's and women's social roles and relationships, the revolution in longevity has resulted in an increase in the proportion of older adults in the population living as both couples and single persons; cultural shifts in Americans' views about homosexuality have also led to a recent upsurge of men and women who are openly in same-sex intimate relationships—many of which involve minor children (Powell et al. 2010). A result of these and other social changes is that there is an unprecedented number of men and women in the U.S. today living outside of traditional marriage that includes an employed husband/father, a homemaker wife/mother, and the minor children they had together; the 2010 Census indicates that less than one-third of all American households represent this type of family (United States Census Bureau 2010).

Armed with an arsenal of high quality data, sophisticated analytic techniques, and nuanced hypotheses based on insights from several substantive areas within sociology and cognate disciplines, sociologists of mental health have been shedding light on how men and women are coping with these new social forms and arrangements. The past 20 years of research reveals that while some of these social changes have created new opportunities for men and women and are associated with increased emotional well-being, others are highly stressful and detrimental for their mental health. Indeed, the stress process paradigm—which focuses on the mediating and moderating role of personal resources such as financial and psychosocial resources including social support—continues to be the dominant framework for explaining observed gender and marital status differences in mental health. At the same time, researchers have been paying closer attention to the larger social, economic, and cultural context in which men and women's lives are embedded, the proximate social conditions under which their social roles and relationships are emotionally beneficial or harmful as well as the different ways they express mental health problems. By identifying macro- and meso-level social causes of micro-level emotional processes, this new wave of research on gender and marital status disparities in mental health exemplifies the unique strength of the sociological perspective.

In this chapter, I summarize some broad themes that have emerged over the past two decades of scholarship on gender, marital status, and mental health, broadly defined—highlighting important theoretical continuities and new developments, methodological innovations as well as key substantive findings. However, because these are highly prolific areas of scholarship, I will not discuss all studies on these separate yet highly interrelated topics that have appeared in print since the early 1990s. A recent count indicates that 45 articles on gender and mental health, and another 32 articles on marriage and mental health, have been published

in the *Journal of Health and Social Behavior* between 1992 and 2012; many more articles have appeared in other specialty sociology and health journals—including the new section journal *Society and Mental Health, Social Science and Medicine*, *Journal of Marriage and Family, Gender and Society, Social Psychology Quarterly* as well as sociology's generalist journals such as the *American Journal of Sociology, American Sociological Review, Social Forces*, and *Social Problems*. My review is, therefore, highly selective and reflects my own idiosyncratic scholarly interests in gender variation in the emotional impact of adult social roles and relationships—particularly work and family roles and intimate (including, but not limited to, marital) relationships. In addition to taking stock of what we have learned about these status inequalities in emotional well-being since the formation of the ASA Mental Health section, I discuss some promising new directions for theory and research that would further social science knowledge about the continued significance of gender and marital status for mental health during this historical period of social change.

2.2 Twenty Years of Theory and Research on Gender, Marital Status, and Mental Health

2.2.1 Gender and Emotional Well-Being

One of the most vexing social problems that has long preoccupied sociologists of gender and mental health is that women have higher rates of depressive disorders than men. Recent epidemiological studies based on non-clinical populations of adults indicate that women are twice as likely as men to experience this mental health problem (Kessler 2003). Moreover, the gender gap in depressive disorder has been fairly stable over the past four decades (Dohrenwend and Dohrenwend 1977; Weissman and Klerman 1977) despite greater educational and employment opportunities for women since the last quarter of the 20th century along with their more expansive roles in the family, workplace, and society, women continue to meet criteria for affective disorders at a rate that is double that of men's. The female excess of depression in the adult population is an intractable social problem that has both personal and society-wide impacts; not only is it the leading cause of disease-related disability among women but it is associated with a host of other social and economic consequences for themselves, their families, and their communities (World Health Organization 2000).

Decades of sociological research based on community and national surveys have produced similar results for self-reports of depressive symptoms in the general population of adults; in most studies conducted from the 1970s to the present, women report significantly more symptoms of depression than men (Rosenfield and Mouzon 2013). Recognizing that depression is only one of many dimensions of emotional distress (see Simon 2007 for a review), researchers over the past two decades have also assessed gender differences in the experience of a variety of

everyday emotions. Paralleling findings for depressed affect, these studies reveal that women report significantly more frequent negative emotions including anger as well as significantly fewer positive emotions such as happiness than do men (Ross and Van Willigen 1996; Simon and Nath 2004; Simon and Lively 2010; Stevenson and Wolfers 2009, but also see Yang 2008 for an exception). The gender gap in these indicators of emotional distress represents a challenging paradox for gender and mental health scholars across many disciplines who assumed there would be greater gender parity in mental health as women's social roles and relationships began to resemble those of men.

Sociologists have developed three main hypotheses about this mental health disparity. The first is the exposure hypothesis, the second is the vulnerability hypothesis, and the third and most recent is the gendered-response hypothesis. These hypotheses differ with respect to the etiology of women's greater emotional distress—including the structure and nature of their social roles and relationships, the personal resources they are able to mobilize in the face of life stress as well as the ways in which they express emotional upset relative to men.

2.2.1.1 The Exposure Hypothesis: Women are More Exposed than Men to Role-Related Stress

It is now 40 years since (Gove 1972; Gove and Tudor 1973) introduced his highly influential sex-role theory of mental illness that argues that the higher rate of emotional disturbance among women in the U.S. is due to their roles in society, which are presumably less satisfying and more stressful than are men's. Gove attributed women's relatively greater distress to their role as homemaker, which he claimed is a restrictive, socially isolating, and devalued social position that offers modern women little opportunity for self-fulfillment, social interaction with other adults, and financial independence. In contrast, men's social roles are expansive, interesting and self-affirming, providing greater financial rewards, adult interaction, and marital power. While he recognized that combining employment with marriage and parenthood is likely be more stressful for women than men, the implication of Gove's sex-role theory is that women's mental health would improve once their social roles and relationships were more like men's.

Gove's seminal insights were the catalyst for much empirical research on gender and mental health in the 1970s and 1980s, which I noted earlier was a period marked by the steady rise in female employment—particularly the employment of wives and mothers. Much of this research compared the mental health of men and women who hold similar numbers and types of roles, especially the roles of spouse, parent, and worker. In essence, these studies evaluated the *exposure hypothesis*, which posits that gender inequality in mental health is due to gender inequality in exposure to role-related stress. Interestingly, this research produced equivocal findings with respect to the emotional benefits of employment among married women; for example, while some studies found no distress differences between employed wives and homemakers (Aneshensel et al. 1981; Cleary

and Mechanic 1983; Gore and Magione 1983; Pearlin 1975), others showed that employed wives are significantly less distressed than their non-employed peers (Kessler and McRae 1982; Rosenfield 1980). Findings were, however, unequivocal with respect to differences in psychological well-being between men and women in dual-earner families; in numerous studies, employed wives reported significantly more symptoms of psychological distress than their male counterparts (Kessler and McRae 1982; Menaghan 1989; Rosenfield 1980; Thoits 1986). Another interesting finding from this body of work is that husbands of employed wives reported significantly more distress than husbands of homemakers (Kessler and McRae 1982; Rosenfield 1980, 1992; Ross et al. 1983).

Sociological research on gender and mental health over the past two decades has continued to evaluate the exposure hypothesis but in contrast to earlier studies, recent studies have gone beyond comparisons of the well-being of women and men who hold the same configurations of social statuses. This research focuses on elucidating the larger *social conditions* under which combining work and family roles is more or less stressful and distressing for women and men. Scholars have identified a number of social structural factors that contribute to women's greater distress in dual-earner families. Wives' relatively lower incomes, limited access to high quality, affordable child-care outside the home as well as husbands' failure to participate more equitably in the division of household labor have emerged as pivotal structural factors that contribute to the persistence of gender inequality in emotional well-being in these families (Bird 1999; Glass and Fugimoto 1994; Lennon and Rosenfield 1995; Lively et al. 2010; Ross and Mirowsky 1988; Ross et al. 1983). Although the gender gap in time spent in paid and non-paid work has narrowed over the past two decades (Bianchi et al. 2007), a recent study shows that multitasking—more common among mothers than fathers in dual-earner families—is a continued source of chronic strain, negative emotions, and psychological distress for working mothers (Offer and Schneider 2011). Hochschild's (1989) formative work on dual-earner families shows that wives' perceived inequity in the division of household labor between themselves and their husbands, and the unpleasant interpersonal dynamics and emotions it gives rise to, not only have negative consequences for their mental health but also for marital quality.

Other studies find that social psychological factors such as women's low sense of control, particularly in the face of high work and family demands, also help explain the gender gap in depressive symptoms among employed spouses residing with minor children (Lennon and Rosenfield 1995; Rosenfield 1992). A sense of powerless to alter the structurally unequal and subsequently stressful situations to which they are disproportionately exposed plays an etiological role in employed wives' poorer mental health as well (Lennon and Rosenfield 1995; Simon and Lively 2010). Still other research reveals that sociocultural factors—including gendered beliefs about men's and women's work and family identities—also contribute to male-female differences in well-being. For example, I found that a reason why combing work and family is less advantageous for women's than men's mental health is because work and family roles have fundamentally different meanings for the genders; whereas men's family roles are based on the provision of

economic support to their families, employment detracts from women's ability to provide care and nurturance to their spouse and children (Simon 1995, 1997). The emotional benefits of combining work and family identities are greater for men than for women because employment contributes to men's identity as a "good" father and husband but interferes with women's identity as a "good" mother and wife.

In short, while social change in women's social roles and relationships has created greater opportunities for themselves and their families, it has also been met with some new forms of structural inequality, which are both stressful and distressing. The failure of husbands to engage more fully in the home, wives' relatively lower incomes, the lack of high quality affordable child-care outside the home as well as deeply held cultural beliefs about the nature and meaning of men's and women's family identities continue to play a pivotal role in employed married mothers relatively higher levels of emotional distress. However, while I focused on gender differences in mental health in dual-earner marriages, research also indicates that the stress women experience from combining work and family roles is even greater in families in which they are single-parents (Avison et al. 2007; McLanahan 1983; Simon 1998). This finding suggests that the gender gap in emotional well-being may be even greater among non-married than among married employed parents—a point to which I return in the section on marital status and mental health.

Although this body of research clearly indicates that gender inequality in exposure to certain types of stressors helps explain gender inequality in emotional distress, sociologists recognize that there is no single explanation of the complex and seemingly intractable disparities in mental health. That is, structurally based gender inequality in the family and workplace are necessary but not sufficient for explaining the persistence of women's greater distress. To more fully understand the gender gap in mental health, sociologists have turned to the *vulnerability hypothesis*, which posits that women are also more vulnerable than men to the adverse emotional effects of stress.

2.2.1.2 The Vulnerability Hypothesis: Women are More Vulnerable than Men to the Impact of Stress

Pearlin and Schooler (1978), Kessler (1979a), and Thoits (1982) were among the first to argue that members of socially disadvantaged groups in the U.S. are not only more exposed to life stress but also possess fewer personal resources, which enhance emotional well-being as well as reduce (i.e., buffer) the negative impact of stressful life circumstances. Whereas the exposure hypothesis locates the etiology of psychological distress in structurally-based social inequality, the vulnerability hypothesis attributes disparities in mental health to the *social psychology of inequality*—particularly inequality in the possession of psychosocial resources. With respect to gender, these and other scholars surmised that women's insufficient social support and coping resources (a by-product of structural gender

inequality) renders them more vulnerable or reactive than men to the psychological impact of both acute and chronic stressors; women's greater stress-reactivity, in turn, helps explain their relatively poorer mental health. In his influential study using a novel analytic technique, Kessler (1979b) found that differential impact is a more important determinant of the relationships between gender and distress than differential exposure.

Sociological research over the past several decades investigated gender differences in personal resources and psychological vulnerability, though with mixed results. Studies consistently find that men and women have different coping styles and strategies for dealing with stress. For example, while men tend to have an inexpressive coping style and are more likely to control their emotions, women tend to have an emotional and emotionally expressive style of coping (Simon and Nath 2004; Thoits 1991). These studies also show that men are more likely to use problem-focused coping strategies, whereas women are more likely to use emotion-focused coping and seek social support. Additionally, a large body of work documents gender differences in perceptions of control (or mastery), which also play an important role in gender differences in mental health (Mirowsky and Ross 2006; Thoits 1991, 1995). As I noted earlier, studies indicate that women's low sense of control in the face of high demands from combining work and family responsibilities contribute to the gender gap in depressive symptoms in dual-earner families (Lennon and Rosenfield 1995; Rosenfield 1989). Women's lower sense of personal control no doubt reflects their continued unequal status, power, and resources in the family, workplace, and larger society (see Simon and Lively 2010).

Interestingly, research is somewhat more equivocal with respect to gender differences in self-esteem. While some researchers find little evidence of women's lower self-esteem (Miller and Kirsh 1989; Thoits 1995)—which may be a positive outcome of women's increasingly expansive role in the workplace, family, and society—others show that women continue to report lower self-esteem than do men (McMullin and Cairney 2004; Robins and Trzesniewski 2005; Rosenfield and Mouzon 2013; Thoits 2010; Turner and Marino 1994; Turner and Roszell Turner 1994). At the same time, however, women report more rather than less social support than men (Thoits 1995; Turner and Marino 1994; Turner and Turner 1999). Moreover, despite the abundance of studies documenting that efficacious coping resources and perceived social support reduce the negative impact of eventful and chronic stressors (Thoits 1982, 1987; Turner and Turner 1999), gender differences in the possession of psychosocial resources do not explain gender differences in emotional distress (see Aneshensel 1992 and Thoits 1995, 2010 for reviews).

Additionally, with the exception of Turner et al. (1995) study, which finds greater female vulnerability to the depressive effects of acute and chronic stress, there is little evidence that women are more vulnerable than men *in general* (Aneshensel et al. 1991; Lennon 1987; Newman 1986; Simon 1998; Turner and Avison 1989). Rather, studies reveal that certain stressors are more distressing for women and others are more distressing for men. While women tend to be more reactive to family-related and interpersonal stress, men tend to be more reactive

to employment-related stress (Conger et al. 1993; Pearlin and Lieberman 1979; Kessler and McLeod 1984; Simon 1992, 1998, Simon and Robin 2000; Simon and Lively 2010 but also see Ensinger and Celentano 1990, Lennon 1987, and Newman 1986 for exceptions with respect to the greater impact of work-related stress on men). Scholars have attributed these findings to gender socialization that begins in childhood as well as the different adult role-responsibilities that are socially assigned to women and men. By continuing to hold men responsible for their family's economic support, and women responsible for providing nurturance to loved ones and maintaining interpersonal relationships within and outside the family, it is reasonable to conclude that stress in work and family domains differentially effect the well-being of women and men.

Taking these findings one-step further, Thoits (1991, 1992) argues that stressors may not have the same meaning and emotional significance for the genders; stressors that threaten peoples' valued identities and self-concepts (i.e., identity-relevant stressors) are more harmful for mental health than identity-irrelevant stressors. These important insights suggest that observed gender differences in vulnerability to work and family-related stress reflect differences in the salience of work and family identities for women and men. In support of this argument, I found that the impact of children's health and behavior problems on emotional distress is greater for mothers than fathers because the parental identity is more important for women's self-conception than it is for men's (Simon 1992). Gender differences in vulnerability to work and family stress also depend on marital status, which alters the meaning of work and family roles for women and men. For example, in a study that included symptoms of both depression and substance abuse, I found that married mothers are more vulnerable than married fathers to chronic marital and parental strain, but married fathers are more vulnerable than married mothers to the effects of financial strain (Simon 1998). There were, however, no gender differences in the impact of financial strain among unmarried parents; moreover, unmarried fathers were more rather than less vulnerable to parental strain than their female peers. These findings indicate that *marital status* is an important part of the *social context* that shapes the meaning and emotional significance of work and family roles and identities for women and men. One further point: These complex patterns of male and female vulnerability were evident for symptoms of depression among women and symptoms of substance problems among men.

Indeed, in her seminal work on differential vulnerability, Aneshensel (1992, Aneshensel et al. 1991) argued that gender differences in stress-reactivity are highly specific and depend not only on the stressor involved but also on the mental health problem considered. She notes that because most studies are based on mental health problems that are more common among women (i.e., symptoms of depression and generalized distress) and do not include those that are more common among men (e.g., antisocial behavior and substance abuse/dependence), they tend to *over*estimate female vulnerability and distress and *under*estimate men's. Aneshensel's theoretical insights are the basis for the third major hypothesis about the relationship between gender and mental health.

In sum, the past several decades of research on gender and mental health have produced inconsistent but nonetheless important results regarding gender inequality in both the possession of psychosocial resources and psychological vulnerability. In contrast to earlier claims that women's insufficient coping and social support render them more vulnerable to the deleterious emotional consequences of stress in general, it appears that some stressors are more distressing for women while others are more distressing for men. The stressors that are most harmful for men and women tend to be those in role domains for which they are responsible. However, while theory and research on differential vulnerability has expanded our knowledge about social psychological factors that mediate and moderate the relationship between sex, stress, and distress, the vulnerability hypothesis does not explain persistent gender differences in mental health.

2.2.1.3 The Gendered-Response Hypothesis: Men and Women Express Distress and Respond to Stress with Different Types of Mental Health Problems

The inability of the vulnerability hypothesis to account for the gender gap in mental health led to the development of the third main hypothesis about the relationship between sex, stress, and psychological distress. Over the past two decades, sociologists have increasingly turned their attention to the *gendered-response hypothesis*, which argues that women are not more distressed and vulnerable than men, but that males and females express emotional distress and respond to stress with different and gendered-types of psychological problems. Animated by Aneshensel's (1992) (Aneshensel et al. 1991) pivotal insights about the highly specific ways in which stress affects women and men, researchers have been examining the effects of different stressors on a range of mental health problems—including those that are commonly found among men. As I noted above, the failure of studies to examine male-typical expressions of psychological disturbance has resulted in overestimates women's distress and psychological vulnerability and underestimates of men's. As their starting point, advocates of the gendered-response hypothesis point to epidemiological estimates of rates of specific types of mental health problems among men and women in the U.S.

Epidemiological research on both lifetime and recent prevalence rates of mental disorders conducted from the 1970s to the present consistently document that although women have higher rates of affective and anxiety disorders (and their psychological corollaries of symptoms of non-specific distress, anxiety, and depression), men have higher rates of antisocial personality and substance abuse/dependence disorders (and their psychological corollaries of antisocial behavior and symptoms of substance abuse/dependence) (Dohrenwend and Dohrenwend 1977; Meyers et al. 1984; Robins and Regier 1994; Kessler et al. 1993, 1994). Interestingly, research on adolescent mental health conducted over the past two decades also documents gender differences in these mental health problems; studies that compare boys' and girls' emotional well-being reveal that by mid- to

late-adolescence, girls report significantly more symptoms of depression, whereas boys report significantly more symptoms of antisocial behavior and substance problems (Avison and McAlpine 1992; Gore et al. 1992; Rosenfield 1999a, b). Hagan and Foster's (2003) study provides insight into gendered pathways or trajectories of mental health problems from early adolescence to emerging adulthood; based on the National Longitudinal Study of Adolescent Health, they find that angry emotions experienced in early adolescence—a result of stressful family circumstances—increase the likelihood of rebellious or aggressive behavior in middle adolescence and the development of depressive symptoms among females and substance problems among males in young adulthood. In other words, males and females tend to respond to a similarly stressful childhood situation with different mental health problems as adults.

On the basis of these and other studies (including the National Co-Morbidity Studies, Kessler et al. 1993), mental health scholars agree that although there are gender differences in the prevalence of specific types of mental disorders, there are no gender differences in the *overall* prevalence of mental health problems (see Rosenfield and Mouzon 2013 and Simon 2007 for reviews). Females tend to manifest distress and respond to stress with *internalizing* problems such as depression, whereas males are more likely to express emotional disturbance and react to stress with *externalizing* problems including antisocial behavior and substance abuse/dependence. Because gender differences in rates of these specific types of problems are evident in adolescence—years before males and females acquire adult social roles—sociologists of mental health now argue that we cannot continue to attribute male-female differences in mental health in adulthood solely to differences in the structure and meaning of men's and women's adult roles.

The past 20 years of research provides empirical support for the gendered-response hypothesis. An accumulating body of work (including Hagan and Foster's 2003 study) reveals that the impact of some types of stress does not differ for men and women when gendered expressions of distress are considered. Much of this work is based on longitudinal analyses of the mental health consequences of marital-status transitions for women and men. Several studies indicate that while women tend to respond to the stress associated with divorce and widowhood with elevated symptoms of depression, men tend to respond to these same sources of stress with increases in symptoms of substance problems (Horwitz et al. 1996; Simon 2002; Umberson et al. 1996; Williams 2003). These studies also find that the emotional benefits associated with becoming married accrue to women and men; the transition to marriage (and remarriage) significantly reduces depressive symptoms among women and substance problems among men. These findings are consistent with epidemiological research as well as Aneshensel's (1992) argument about gender differences in stress-reactivity. They are not, however, consistent with Gove's early sex-role theory of mental illness that I discussed earlier (1972), which posits that marriage improves men's emotional well-being but harms women's (also see Bernard 1982).

In addition to studies that reveal no gender difference in vulnerability to these types of eventful stressors, studies find no gender difference in the mental health

impact of certain types of chronic stress. In an earlier study, Lennon (1987) found that stressful job characteristics—including a lack of control, autonomy, and creativity in one's occupation—are associated with more depressive symptoms among women and substance problems among men. Although women disproportionately find themselves in jobs that have these emotionally unhealthy characteristics (Roxburgh 1996), neither men nor women are more vulnerable to emotional effects of this source of chronic stress.

However, other studies document gender differences in vulnerability to other types of chronic stress—even when gender-typical expressions of distress are examined. As I noted above, one of my earlier studies showed that the association between both marital and parental strain with depressive symptoms is greater for married women than married men, but there is no gender difference in the association between these sources of stress and substance problems among the married (Simon 1998). In contrast, although there is no gender difference in the association between financial strain and depressive symptoms among the married, the association between this source of stress and substance abuse is greater for married men than married women. In a more recent study, Simon and Barrett (2010) found that certain dimensions of non-marital romantic relationships in early adulthood are differentially associated with young men's and women's mental health. Status dimensions of these relationships (e.g., being in a current romantic relationship and a recent romantic breakup) are more depressing for women than for men, whereas dimensions of an on-going relationship (i.e., partner support and strain) have a greater impact on symptoms of alcohol problems among men. Together, these findings indicate that certain stressors do *not* equally affect the mental health of women and men.

Not surprisingly, sociologists have developed provocative and compelling explanations of why males and females tend to express emotional upset and respond to stress with different types of mental health problems. Drawing on insights from sociological social psychology and cognitive psychology, Rosenfield attributes gendered-expressions of distress to gender-differentiated structures of the self (or self-schemas) that develop in adolescence. She argues that a result of female socialization in childhood—which emphasizes the importance of others for self-development—is that females tend to develop an "other-focused" self that privileges the collective over the self in social relations. In contrast, a result of male socialization in childhood—which emphasizes the importance of independence for self-development—is that the males tend to develop an "ego-focused" self that privileges the self over others in social relations. In a systematic program of research on adolescents and emerging adults (Rosenfield et al. 2000, 2005, 2006), she finds that these different self-schema increase the risk of different types of mental health problems; persons with other-salience schema (i.e., adolescent girls) are predisposed to internalizing problems including depression, while those with self-salient schema (i.e., adolescent boys) are predisposed to externalizing problems such as antisocial behavior and substance abuse. She also demonstrates that gender differences in self- and other-salience mediate gender differences in internalizing and externalizing mental health problems.

It is worth noting that the concepts of self- and other-salience closely correspond to the concepts of agency and communion, which have long been discussed in the literature on gendered personality (e.g., Parsons 1955). Although its not yet been tested, gender differences in self- and other-salience may also help explain why "self-events" (i.e., undesirable events that occur to oneself) tend to be more distressing for men, whereas "other-events" (i.e., negative events that occur to people in one's social network) tend to be more distressing for women (Aneshensel et al. 1991; Kessler and McLeod 1984; Turner and Avison 1989). Future research testing these ideas should, of course, include male and female typical expressions of distress.

Viewing these observed gendered-patterns of distress and vulnerability through a somewhat different though closely-related lens, I attribute gender differences in rates of internalizing and externalizing mental health problems to the larger emotional culture of the U.S. and gender-linked norms about the appropriate experience and expression of emotion for males and females (Simon 2000, 2002, 2007; Simon and Nath 2004). Drawing on theoretical insights from the sociologies of gender and emotion, I argue that embodied in Americans' emotional culture are beliefs about the "proper" emotional styles of males and females as well as emotion norms that specify "appropriate" feeling and expression for men and women (also see Hochschild 1979, 1983, Smith-Lovin 1995; and Thoits 1989). Because feelings of depression signal weakness to self and others—and weakness is a permissible personality characteristic for females but not for males in the U.S.—it is an acceptable emotion for females but a sanctioned emotion for males. A consequence of gender-linked emotional socialization throughout the life course is that females learn to express emotional upset with internalizing emotional problem including depression, while males learn to express distress vis-a`-vis externalizing emotional problems such as substance abuse. Men's higher rate of substance problems reflects their tendency to manage (i.e., suppress) culturally inappropriate feelings of depression with mood-altering substances in order to avoid being labeled "weak" by others and one-self.

However, while the gendered-response hypothesis begins to unravel the complex set of social factors that contribute to sex differences in both the experience and expression of emotional upset, other factors also appear to be involved in the female excess of depressed affect. Recently, Simon and Lively (2010) argued that intense and persistent subjectively experienced anger—more common among women than among men—play a role in their higher levels of depression. Although most sociologists of mental health have focused on anger as an outcome of women's social disadvantage (Mabry and Kiecolt 2005; Ross and Van Willigen 1996), our study showed that anger mediates the relationship between sex and depressive symptoms. In other words, women's more intense and persistent anger—an emotional response to their unfair and unequal work and family roles and relationships—also help explain their higher level of depression relative to men.

Before leaving the topic of gendered-responses to stress, it is important to mention that sociologists are also beginning to examine the links between male and

female typical mental health problems and male and female typical physical health problems. A recent study (Needham and Hill 2010) showed that internalizing emotional problems are closely associated with chronic health conditions such as arthritis, headaches, and seasonal allergies, which more common among women. In contrast, externalizing mental health problems are closely associated with life threatening health conditions such as stroke, heart disease, and high blood pressure, which are more common among men. This study also revealed that gender differences in the expression of emotional upset help explain gender differences in physical health problems.

In sum, research that includes male and female typical expressions of distress is a corrective to research that focused exclusively on mental health problems that are more common among females. An examination of internalizing and externalizing emotional problems in tandem allows researchers to assess the degree to which females are more, less, or similarly distressed relative to males. This approach also allows researchers to identify those stressors that have a greater impact on males, those that have a greater impact on females as well as those that take an equal toll on males' and females' mental health. As such, the gendered-response hypothesis—and the body of research evaluating its efficacy—offers a richer and more nuanced picture of the relationship between sex, stress, and psychological distress than either the exposure or vulnerability hypotheses. The socialization experiences of males and females—and the cultural (including emotion) norms upon which gender socialization is based—play an important role in persistent gender differences in mental health.

2.2.1.4 What Have We Learned About Gender and Mental Health Over the Past Two Decades?

Taken together, research on gender and mental health conducted over the past 20 years has made significant progress in our understanding of the social determinants of emotional well-being and gender differences therein. The culmination of research evaluating the exposure, vulnerability, and gendered-response hypotheses indicates that social structural, social psychological, and sociocultural factors are *all* involved in gender differences in mental health. The persistence of gender inequality in the workplace and family continues to play a role in the gender gap in mental health. However, to the extent that current cohorts of women continue to define themselves first and foremost as nurturers and caregivers, and current cohorts of men continue to define themselves primarily as breadwinners, structural changes that have occurred in male's and female's social roles and relationships alone will not produce greater parity in mental health. A focus on emotional well-being reveals that while some aspects of men's and women's lives have changed dramatically over the past decades, other aspects have remained essentially the same.

Two decades ago, Hochschild (1989) referred to this phenomenon as the "stalled revolution" and findings from the past 20 years of research is consistent with this idea. Changes in attitudes about gendered practices in the family have

not kept pace with structural changes in the economy. More recently, Gerson (2011) refers to this phenomenon as the "unfinished revolution." Her qualitative research on young men and women indicates that they have more egalitarian views about work and family roles and identities than their parents; current cohorts of young men and women embrace the reality that they will have to combine employment with parenthood and expect to share work and family responsibilities with their future partners. However, Gerson notes that unless there are fundamental changes in workplace that would allow men and women to *balance* employment with parental responsibilities, young women will also experience more stress from combining work and family than young men.

Ridgeway (2011) offers a more theoretical and admittedly even less sanguine account of this contradiction in women's lives—an account that emphasizes the social psychology of gender, particularly the role of deeply entrenched cultural beliefs about women and men. She argues that despite structural changes that have paved the way for gender equality, nominal differences between men and women become infused with traditional gendered beliefs, which in turn maintain and reproduce gendered expectations and practices in both the workplace and family. Whether the recent downturn in the economy, which has disproportionately affected men, will fuel traditional gender beliefs or marshal in a shift in beliefs about men's and women's social roles is currently unknown but is a worthy topic for future research on gender and mental health.

2.2.1.5 Some Current Gaps in Knowledge About Gender and Mental Health

While the past 20 years of scholarship has made significant inroads into our understanding of an array of social factors underlying persistent gender differences in mental health, there are nevertheless several important gaps in knowledge about the relationship between sex, stress, and psychological distress. Page limitations preclude me from discussing all issues that need more scholarly attention so I will touch on what I consider to be two of the most pressing gaps.

The first is that we currently do not know whether the gendered patterns of distress and vulnerability I discussed are evident in minority populations in the U.S. Most studies of gender and mental health have been based on the general population of adults (and more recently adolescents and emerging adults) and have not assessed the degree to which gender inequality interacts with other axes of social inequality to produce different gendered patterns of distress among minorities. Sociologists have increasingly called for an "intersectional" approach to gender research that considers the ways in which race, ethnicity, socioeconomic status, age, and sexual orientation shape the life experiences of males and females. In response to this call, researchers have been examining the intersection of gender, race, and class for mental health (Rosenfield et al. 2006, Rosenfield 2012), gender and mental health over the life course (Barrett 2005; Caputo and Simon 2013; Mirowsky 1996) as well as gender differences in the mental health impact

of LBGTQ sexual identities (Ueno 2010); this research has produced interesting results. For example, in a study that included male and female typical mental health problems, Ueno (2010) finds that emerging awareness of same-sex attraction in late adolescence is more distressing for young women than for young men. There has not, however, been much research on gender differences in exposure and vulnerability to work and family stress among African, Hispanic, and Asian Americans. The lack of research on this issue is surprising since there may be greater gender equality in mental health among some minority groups and greater gender inequality in mental health among other minority groups than among white Americans.

As a case in point, our nation's legacy of discrimination against African American men resulted in higher unemployment rates among black men and higher employment rates among black women than their white counterparts throughout the 20th century. A consequence of their shared history of social inequality and disadvantage is that African American men and women tend to have less traditional views about gender and the division of household labor than their white peers (Hill and Sprague 1999; Ladner 1995). It is, therefore, possible that the gender difference in distress and vulnerability in today's dual-earner families is narrower among blacks than among whites. Conversely, because they adhere to more traditional views about gender, the gender difference in distress and vulnerability may be greater among Hispanics and members of lower socioeconomic status groups than among whites and members of higher socioeconomic status groups. We will not know the answer to these and other questions until more mental health research takes an intersectional approach to the study of human health. Springer et al. (2012) recent special issue of *Social Science and Medicine* devoted to this topic represents a positive first step in this direction. Because norms about the "appropriate" experience and expression of emotion may vary by race, ethnicity, age, socioeconomic status, and sexual orientation, studies investigating variations in the relationship between sex, stress, and distress should include multiple—including both mental and physical—indicators of health.

The second important gap in knowledge is that we currently do not know the degree to which potential biological predispositions of males and females are involved in gender differences in emotional distress and vulnerability. Without going into details, recent research in neuroendocrinology and psychophysiology indicates that there is a biological basis for gender differences in anger, depression, and substance abuse (see Simon and Lively 2010 for a brief review). Scholars who study the biology of emotion also recognize that biological factors interact in complex ways with social factors to produce distinct mental health trajectories for males and females. However, while there has been increase in genetics informed sociology, which examines the joint influence of social and genetic factors on happiness and alcohol dependence (Schnittker 2008; Pescosolido et al. 2008), sociologists have been noticeably (and understandably) silent about the potential ways that biology interacts with social circumstances to produce sex differences in mental health (however, see Bird and Rieker 1999; Rieker and Bird 2008; Hopcroft and Bradley 2007; Simon and Lively 2010; and Springer

et al. 2012 for exceptions). Fausto-Sterling (1992), an eminent feminist biologist, argues that the failure to acknowledge the complex interactions between the biological and social environment impedes scientific understanding of sex and gender. Sociological research that focuses on the interplay between biological and social factors would expand our knowledge about the relationships between sex, stress, and mental health. As a start, an examination of whether transgender individuals express emotional distress and vulnerability in ways that are consistent with their current or former gender may shed light on the interplay of biological and social factors that shape mental health. Of course, research on members of this highly vulnerable social group must also take into account the stigma and discrimination to which they are routinely exposed.

2.2.2 Marital Status and Emotional Well-Being

In addition to the abundance of sociological theory and research on the relationship between gender and mental health, sociologists have produced an extensive and rich body of theoretical and empirical work on the relationship between marital status and mental health. In fact, one of the most consistent and oft-cited findings from the sociology of mental health since the 1970s is that marriage is associated with significantly higher levels of emotional well-being. This robust finding is evident in community and national samples, cross-sectional and longitudinal analyses, across a variety of household types as well as for several dimensions of mental health. In dozens of studies, married individuals report less emotional distress than their non-married counterparts.

While earlier studies focused on marital status differences in symptoms of depression and non-specific psychological distress (Kessler and McRae 1984; Marks and Lambert 1998; Pearlin and Johnson 1977; Thoits 1986), the past two decades of research on this topic has expanded its focus to include other dimensions of mental health—including substance problems as well as negative and positive affect. This research documents that in addition to reporting significantly fewer symptoms of depression and generalized distress, the married report significantly less substance problems, less frequent negative emotions including anger as well as more frequent positive emotions such as happiness than non-married persons (Caputo and Simon 2013; Simon 2002; Simon and Nath 2004; Umberson et al. 1996; Williams 2003). Marital status differences in emotional well-being in the U.S parallel epidemiological studies, which find lower prevalence rates of psychiatric disorders among married than non-married adults (Williams et al. 1992).

Although these patterns are unequivocal, the direction of the marital status-mental health association has long been a topic of debate; while most sociologists agree that social causation is responsible for married persons' greater emotional well-being, some concede that social selection may underlie the link between marital status and mental health. In contrast to the social causation hypothesis, which argues that marriage improves mental health, the social selection hypothesis posits

that persons who enjoy better mental health are more likely than less emotionally healthy persons to become married in the first place; they are also less likely than their less emotionally healthy counterparts to become divorced. However, because they tended to be based on cross-sectional data, earlier studies on this topic were unable to adjudicate between these two competing hypotheses of the relationship between marriage and mental health.

2.2.2.1 Social Causation or Social Selection?—Marital Transitions and Mental Health

Over the past 20 years, sociologists have evaluated the social causation and selection hypotheses by assessing the degree to which marital status transitions result in *changes* in mental health. This research also examines whether individuals' prior mental health predicts marital status change. Several longitudinal studies find that becoming married (and remarried) results in a significant decrease in symptoms of depression and substance abuse, whereas becoming divorced and widowed results in a significant increase in these symptoms of distress (Barrett 2000; Booth and Amato 1991; Marks and Lambert 1998; Simon 2002; Umberson et al. 1996; Williams 2003). These findings clearly support the social causation hypothesis of the relationship between marital status and mental health. At the same time, there is also some support for the social selection argument with respect to marital loss. For example, based on national data, I found that although prior mental health does not predict selection into marriage, persons who reported more symptoms of depression and alcohol abuse were significantly more likely to experience a subsequent divorce than persons who reported lower levels of these symptoms of distress (Simon 2002). These and other findings (Forthofer et al. 1996; Mastekaasa 1992; Menaghan 1985; Wade and Pevalin 2004) indicate that complex social causation and selection processes are *both* involved in the relationship between marriage and mental health.

The past two decades of research on the mental health impact of marital status transitions also sheds light on another issue that has long captured the attention of sociologists: that is, whether the emotional advantage of marriage is greater for men than for women. In contrast to Gove's (1973) early sex-role theory of mental illness, which argues that marriage is advantageous for men but disadvantageous for women (also see Bernard 1982), an accumulating body of work indicates that the advantage of becoming married and disadvantage of becoming divorced and widowed are evident among men and women when gender-typical expressions of distress are considered. The positive impact of marriage and remarriage, and the negative impact of divorce and widowhood, tends to show up in depressive symptoms among women and substance problems among men (Horwitz et al. 1996; Simon 2002; Umberson et al. 1996; Williams 2003). My study further revealed that there are no gender differences in selection into or out of marriage on the basis of prior mental health (Simon 2002). In other words, emotionally robust women are neither more nor less likely to become or remain married than their male peers.

2.2.2.2 Current Explanations of the Mental Health Advantage of Marriage

Why does marriage have positive effects on adults' mental health? For over a century, sociologists have attributed this pattern to a multiplicity of social factors. In his classic study of suicide, Durkheim (1951) argued that married persons' greater emotional well-being (measured by their relatively lower rates of suicide) is due to their greater social integration in society. Influenced by Durkheim's early insights, sociologists generally believe that similar to other adult social relationships, marriage connects individuals to a broad array of people, which is essential for the development and maintenance of emotional well-being in adulthood (House et al. 1988). Empirical research is, however, inconsistent about marital status differences in social integration; for example, Putnam (2000) and Gerstel and Sarkisan (2006) find that marriage is a "greedy" institution, and that the married report less rather than more engagement in the community than their non-married peers. At the same time, other studies indicate that one of the reasons why divorce and widowhood have deleterious mental health consequences is because they disrupt individuals' social networks (Gerstel et al. 1985; Umberson et al. 1992). It is likely that these inconsistent findings are due to the different ways social integration is conceptualized and measured across studies. While the married are not more involved in the larger community than the non-married, they are more likely than the non-married to have an intimate partner they could confide in and from whom they receive emotional, instrumental (or practical), and financial support (Turner and Turner 1999).

In the 1980s, Kessler and Essex (1982) argued that the married enjoy greater emotional well-being than the non-married because they have more psychosocial resources (i.e., greater social support, mastery and self-esteem), which not only improve mental health but also render them more resilient than the non-married to the negative emotional effects of acute and chronic stress. Drawing on insights from symbolic interaction, Thoits (1986) argued that marriage also provides individuals with a sense of purpose and meaning in life and an important social identity, which have positive effects on mental health as well as buffer the negative emotional impact of life stress. Indeed, studies show that in addition to reporting higher levels of emotional well-being, the married are less vulnerable than the non-married to undesirable life events (Kessler and Essex 1982; Thoits 1986) and chronic strains (Pearlin and Johnson 1977; Simon 1998). Though not yet explored, it is possible that in addition to their greater social support, psychosocial resources and sense of purpose in life, the married experience lower levels of distress and vulnerability because they feel that they *matter* to others—particularly their spouse. Of course, the married also tend to have greater financial resources than the non-married—a pivotal factor that helps explain why single-parents, especially those headed by women, are among the most stressed and distressed social groups in the U.S. (Avison et al. 2007; Carr and Springer 2010; McLanahan 1983; Pearlin and Johnson 1977).

2.2.2.3 Variations in Mental Health Among Married and Non-married Adults

While much of the earlier research focused on documenting marital status differences in distress and vulnerability, studies over the past two decades tend to focus on identifying the social conditions under which marriage is more or less emotionally beneficial; not surprisingly, this research shows that the mental health advantage of marriage is greater for men and women in more than less equitable marriages (Lennon and Rosenfield 1995; Lively et al. 2010; Ross et al. 1983) as well as in higher than lower quality marriages (Hawkins and Booth 2005; Umberson et al. 1996; Williams 2003). In a highly innovative study, Wheaton (1990) found that under certain conditions (i.e., a high level of prior on-going stress), divorce and widowhood actually improve mental health; Wheaton argues that for this group of people, divorce and widowhood represent "stress relief." In view of these findings, it is possible that non-married adults are less distressed than persons in highly stressful marriages; persons who are "single by choice" may also enjoy the same high level of emotional well-being as their married counterparts. Since they are a growing population (Klinenberg 2012), it is important for future research on marriage and mental health to assess whether this is the case.

There is some indirect evidence that persons who choose to be single are not more distressed than their married peers; Simon and Marcussen (Simon and Marcussen 1999) found that persons who hold strong beliefs about the importance of marriage derive a greater mental health benefit from the transition to marriage and remarriage than persons who do not hold strong pro-marriage beliefs. On the flip side, the negative impact of divorce is greater for persons who attach more than less importance to marriage. Although we focused on beliefs about the importance of marriage as moderators of the marital status-mental health association, pro-marriage beliefs may help explain why the marital status gap in mental health is greater between currently and formerly than between currently and never-married persons (Umberson and Williams 1999).

In addition to documenting variation in emotional well-being among the married that is due to variation in marital equity, marital quality, marital stress and marital beliefs, sociologists have been examining heterogeneity in the mental health of non-married adults. In response to increases in non-marital heterosexual cohabitation over the past several decades, researchers have investigated the extent to which these marriage-like relationships offer the same mental health benefit as conventional marriage. Marcussen (2005) finds that men and women in non-marital cohabiting relationships report significantly more depressive symptoms and substance problems than married persons, which is partially explained by their poorer quality relationships (see Brown 2000 for similar results). In her study of social attachments and mental health, Ross (1995) shows that while persons in cohabiting relationships report more depressive symptoms than the married, they enjoy better mental health than single adults. Unfortunately, Ross did not compare the mental health of romantically involved persons who are not

co-residing with their partner to persons living with their romantic partner as well as non-romantically involved adults. In a study that focused on emerging adults, Barrett and I (Simon and Barrett 2010) found that young men and women in a romantic relationship report fewer symptoms of depression and substance problems than their non-romantically involved peers. Recent trends in marriage—including the delay of first marriage, non-marital childbearing and increasing rates of non-marital heterosexual cohabitation—as well as cultural shifts undergirding these changes in marital patterns in the U.S. among current cohorts of young adults may narrow the marital status gap in mental health in the next decades of the 21st century. Potentially foreshadowing these trends, a very recent study (Uecker 2012) indicates that married young adults exhibit levels of distress that are similar to those of young adults in any kind of romantic relationship.

Although we have a great deal more to learn about the mental health of the increasingly diverse population of unmarried adults, research is clear about the mental health of single-parents who, due to a number of social and cultural factors, are disproportionately women. Studies consistently document that single-mothers living with dependent children report significantly more depressive symptoms than their married counterparts (Avison et al. 2007; Evenson and Simon 2005; McLanahan 1983; Pearlin and Johnson 1977; Simon 1998). Single-mothers greater distress is due in large part to their greater exposure and vulnerability to a variety of chronic stressors, including the stress of combining work and family responsibilities as well as financial stress (Avison et al. 2007; Pearlin and Johnson 1977; Simon 1998). In fact, social scientists argue that the persistence of the gender gap in earnings, coupled with the increase in female-headed single-parent households, are responsible for the feminization of poverty—a mounting social problem in the U.S. (Christopher et al. 2002; McLanahan and Kelly 2006). Single-mothers' higher levels of emotional distress, especially among those who are poor, have consequences for children's mental health. Studies show that there is an intergenerational transmission of emotional distress and that children growing up in poor single-parent families are significantly more likely to have internalizing and externalizing mental health problems in childhood, adolescence, and young adulthood than children who grew up in two-parent families and female-headed single-parent families that are not poor (Amato and Cheadle 2005; McLeod and Shanahan 1993, 1996).

At the same time that research is clear about the mental health of single-mothers and their children, we know far less about the emotional well-being of both custodial and non-custodial single-fathers as well as non-custodial mothers. Because they continue to be perceived by self and others as "deviant," non-custodial mothers may be even more distressed than single-mothers. In support of this idea, Evenson and I (2005) found that non-custodial mothers of young children report significantly more depressive symptoms than single-mothers residing with their minor offspring. Moreover, despite the preponderance of depression among women, we found that non-custodial fathers actually report significantly more depressive symptoms than custodial single-mothers and fathers residing with their young children. We attributed these findings to non-custodial fathers' lack

of involvement in their children's everyday lives, which is highly stressful. Given the recent increase in non-martial childbearing among highly educated women (Cherlin 2010), researchers should compare their level of stress and emotional well-being relative to their less educated and affluent counterparts. Although studies show that parents are more distressed than non-parents (Evenson and Simon 2005), this particular group of single-mothers may enjoy higher levels of well-being than their less educated and solvent peers; they may also enjoy better mental health than working mothers in non-equitable marital relationships.

2.2.2.4 What Have We Learned About Marital Status and Mental Health Over the Past Two Decades?

In sum, sociological research over the past decades consistently documents that marriage confers a number of psychological benefits to men and women, which contribute to their higher levels of emotional well-being. Although they are not necessarily more socially integrated than the non-married, the married do report more social support and both psychosocial and financial resources that improve mental health as well as protect them from negative effects of life stress. At the same time, studies over the past 20 years reveals considerable heterogeneity in mental health among the married that reflects variations in marital equity, marital quality, marital stress and marital beliefs; recent research also documents considerable heterogeneity in mental health among the increasing diverse population of non-married adults—which includes both formerly and never-married adults who have and do not have dependent children, single-parents residing with dependent offspring, non-custodial parents of young children, persons in a variety of non-marital intimate relationships as well as adults who are single-by-choice. The take away message from this body of work is that intimate social relationships—including but not limited to—marital relationships, are associated with improved mental health among women and men.

However, while this body of work has undoubtedly increased our understanding of an array of social factors underlying the relationship between marital status and mental health, there are nonetheless several important gaps in knowledge about the link between intimate social relationships and emotional well-being. Once again, due to space limitations I will only comment on a couple of gaps that I think are most critical for future research to address.

2.2.2.5 Some Current Gaps in Knowledge About Intimate Relationships and Mental Health

In addition to the need for more research on age, race, ethnic, and socioeconomic status variations in the marital status-mental health association among women and among men, we need more research on the ways in which recent social changes in marriage and marriage-like relationships affect individuals' emotional well-being.

A question based on very recent social change that begs for more theoretical and empirical attention is whether men and women in same-sex intimate relationships (including non-marital cohabiting as well as state-sanctioned marital relationships) enjoy the same mental health benefit as their heterosexual peers. At the time this chapter was written, 13 states have extended legal marriage rights to gays and lesbians, which provides a unique opportunity for researchers to compare the emotional well-being of men and women in heterosexual and homosexual marriage (as well as men and women in hetero- and same-sex non-marital cohabiting relationships). Umberson (2012) is taking the lead on this important and theoretically rich topic and has recently collected data on these different types of partnered women and men. Although only time will tell, I strongly suspect that the mental health advantage of marriage is as great, if not greater, for persons in same-sex than in heterosexual relationships because they have fought so long and hard for this privilege. Borrowing Wheaton's concept that I discussed above (Wheaton 1990), the transition to marriage may represent "stress relief" for married gay and lesbian persons who had been denied this civil right relative to their heterosexual peers. At the same time, researchers should also assess the mental health of the LBGTQ community in states that are openly hostile to sexual minorities—particularly in states that have constitutional bans on same-sex marriage and adoption. Recent theory and research on the mental health consequences of perceived stigma and discrimination (Link and Phelan 1999) would provide a useful model for such research.

We also need more prospective studies on the mental health of current cohorts of young adults who, due to a confluence of broad social, economic and cultural forces, are transitioning to adulthood in a context that is different than the context in which their parents came of age. Sociologists note that the transition to adulthood is now a more prolonged period in the life course than it was in the past (Furstenberg et al. 2004). Given the need for more training and education to be competitive in an economy that provides limited employment opportunities for young people, current cohorts of young adults are postponing marriage until their late twenties. At the same time, young women are obtaining higher levels of education than young men, while rates of unemployment are higher for males than females (Kimmel 2009). These social changes, along with the upsurge in non-marital childbearing, are altering the meaning of marriage for young men and women in ways that are not currently well understood; although we do not yet know what their marriages will look like, we do know that marriage is no longer a marker of adulthood and the period of experimentation with non-marital intimate relationships is occupying a longer period of young adults' life course. What these social changes portend for men's and women's mental health before and once they marry is still unclear but it is likely that their marriages will be different from those of their parents. These and other recent social changes in gender and marriage will require sociologists of mental health to rethink some of their assumptions about the emotional advantage of marriage and disadvantage of unmarried statuses in the 21st century. Rather than continuing to focus on marital status differences in emotional well-being, changing marriage patterns in the U.S. behoove researchers

to examine the mental health of adults who are and are not in an intimate social relationship—including those who are legally married, those in a committed marriage-like relationship and those not residing with their romantic partner. The marital status gap in mental health may be narrower for current than previous cohorts of adults as new forms of non-marital intimate relationships become the norm.

2.3 Conclusions

As I noted at the beginning of this chapter, the past two decades of sociological research on mental health has made significant theoretical, analytical and substantive progress in our understanding of *how* and *why* people's gender and marital status influence their emotional well-being. Building on but also going beyond theory and research from the 1970s and 1980s when scholarship on the relationships between gender, marital status and mental health first gained momentum, the last 20 years of scholarship has increased our knowledge about social structural, social psychological and sociocultural factors that contribute to persistent gender and marital status differences in emotional well-being. In light of profound social changes in gender and social relationships that have been evolving in the U.S. over the past several decades, I attempted to take stock of the state of current knowledge about the impact of social roles and intimate (including, but not limited to, marital) relationships on men's and women's emotional well-being. Overall, the large body of work on this topic indicates that although some social changes have created greater opportunities for men and women and are associated with increased emotional well-being, others are highly stressful and detrimental for their mental health.

The stress process framework, which first appeared in the late 1970s and early 1980s (Pearlin 1989; Pearlin and Lieberman 1979; Pearlin and Schooler 1978), has stood the test of time and continues to be a dominant explanation of observed gender and marital status differences in emotional well-being during this period of rapid social change. At the same time, researchers have been paying close attention to the larger social, economic and cultural context in which men and women's lives are embedded, the proximate social conditions under which their social roles and relationships are emotionally beneficial or harmful for them as well as the different ways they express mental health problems. By identifying macro- and meso-level social causes of micro-level emotional processes, this new wave of research on gender and marital status disparities in mental health exemplifies the power of the sociological perspective.

With regard to gender inequality in mental health, this research indicates that despite women's increasingly expansive roles in the workplace and family, they continue to report more depressive symptoms than men. The higher rate of depression among women in the U.S. is partially due to persistent gender inequalities in the workplace and family—including the relatively lower wages they receive for the work they do outside the home, the inequitable division of labor within

the home, their perceived lack of control over life circumstances as well as their continued responsibility for providing primary care to others while holding a job. Indeed, it appears that current cohorts of employed women are struggling to reconcile their responsibilities and identities as paid workers and mothers.

However, the inclusion of multiple dimensions of mental health in recent studies—particularly male and female typical mental health problems—provides new insight into men's sources of emotional distress and vulnerability. In my view, one of the most important findings from sociological research on mental health over the past two decades is that males and females express emotional upset in different ways and that women are neither more distressed nor more vulnerable than men in general. Indeed, it appears that stressors associated with caregiving tend to be more distressing for women, while stressors involving breadwinning tend to be more distressing for men—at least among the married. Still other stressful life experiences (e.g., divorce and widowhood) are equally distressing for women and men. Thus, rather than continuing to focus exclusively on the social determinants of depression among women, these nuanced gendered patterns behoove sociologists to continue identifying which stressors that are more distressing for women, which are more distressing for men, and which are equally distressing for women and men. The findings of this research are important in their own right but also provide insight into relative importance of work and family identities for women and men.

A critical issue going forward is whether these gendered patterns of distress and vulnerability vary by race, ethnicity, socioeconomic status, age, sexual orientation and LBGTQ identity. Our understanding of the significance of gender for mental health will be greatly enhanced when we focus on the intersection of gender with these other social statuses as well as the interplay between social and biological factors that may contribute to gender differences in the expression of emotional upset. The observation that gender differences in rates of internalizing and externalizing mental health problems first emerge in adolescence require sociologists to look beyond the structure, nature and meaning of men's and women's adult social roles for keys to the complex relationship between gender and mental health.

With regard to the relationship between marital status and mental health, the past two decades of scholarship indicate that for current cohorts of adults, marriage—particularly high quality, low stress and equitable marriage—continues to be associated with higher levels of well-being. In addition to having more financial and psychosocial resources and social support, the married may have a greater sense of purpose and meaning in life than the non-married, which improve mental health and buffer the negative emotional effects of life stress. One of the most important findings from this research is that the advantages of marriage and remarriage, and disadvantages of unmarried statuses, are evident among both women and men and reflect both social causation and selection processes. At the same time, this research also reveals that while they do not confer the same emotional advantage as marriage among current cohorts of adults, persons in non-marital intimate relationships (including but not limited to cohabiting relationships) enjoy better mental health than persons who do not have an intimate partner.

Indeed, social changes in marital patterns that were nascent at the close of the twentieth century—including increases in heterosexual and same-sex marriage-like relationships, same-sex marriage, female headed single-parent households as well as persons who are single-by-choice—are creating greater heterogeneity in the population of unmarried adults in the U.S. today; increasing heterogeneity among the non-married requires sociologists of mental health to go beyond simple comparisons of the emotional well-being of married and non-married adults—particularly as the next cohorts of men and women transition to adulthood. Armed with more nuanced theories, sophisticated data analytic techniques and recent panel data, sociologists of mental health are in an excellent position to track the continued significance of gender and social (including marital) relationships for mental health in the early decades of the 21st century as new cohorts of men and women come of age and as our population becomes increasingly diverse.

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