

Monika Frąckowiak-Sochańska  
Institute of Sociology  
Adam Mickiewicz University in Poznań  
monikafs@amu.edu.pl

## Family life as an area of emotional work and investments: an analysis from the perspective of sociology of mental health

### Abstract

The purpose of this paper is to analyse and interpret family life as an area of individuals' emotional work and investments. The perspective of the above mentioned analysis is designated by the sociology of mental health. Relationships within a family have undeniable influence on the state of people's mental health. These relationships can be a source of support as well as emotional burden. Families can either compensate for the social stress individuals experience due to processes at the macro level or enhance the emotional tension resulting from social stress. The main method used in this study is meta-analysis of epidemiological and clinical data concerning the mental health of the global (WHO) and Polish population (EZOP-Poland) and my own research – a nationwide, representative survey (N=1,000) carried out in Poland, which was part of a broader theoretical and empirical project devoted to the process of social construction of the categories of mental health, disease and disorder in late modern society. I also refer to my qualitative research including twenty in-depth interviews with psychologists, psychiatrists and psychotherapists who had experience in carrying out family, couples and individual therapy. The research objective was to find out whether and in what way some issues described from the socio-cultural perspective manifest themselves in the form of problems with which people turn to psychotherapists.

The analysis and interpretation of data from the above mentioned sources enable us to put forward a thesis that living within a family entails not necessarily an alternative (either emotional burden or support), but a conjunction (both emotional burden and support). In this context the practical solutions that enable families to protect and strengthen the individual's mental health should be searched for.

**Keywords:** mental health, mental disorders, family, marital status, gender

---

## Introduction

Studies in the field of sociology of mental health designate an important research area nowadays. In the global scale, mental health problems have become one of the most common reasons for people's disabilities and poor quality of life. These problems affect a growing number of people around the world – currently estimated at between one-quarter and one-third of the world's population (WHO, 2013; 2014). Polish epidemiological data confirm these tendencies (Moskalewicz, Kiejna & Wojtyniak, 2012). Moreover, mental health problems entail costs – both in economic and social terms. For example, it is estimated that the costs of depression in Poland incurred by the Social Insurance Institution due to disability certificates are almost 4.5 times higher than the costs of its treatment borne by the National Health Fund. At the same time, social costs of depression resulting from lost productivity range from PLN 1.0 to 2.6 billion per year (Gałązka-Sobotka, 2014). The social costs of mental disorders go far beyond measurable economic parameters. The reduced quality of functioning applies not only to the labour market, but also to family roles and functions (including partnership, parenting and caring) as well as broadly understood social and civic activity.

The purpose of this paper is to analyse and interpret family life as an area of individuals' emotional work and investments. The primary research problem sums up to the question: to what extent family and other intimate relationships are a source of support that protects the individual's mental health resources, and to what extent are they determinants of emotional burden experienced by males and females of different marital status. The secondary research problem addresses the relationships between the objective state of mental health and the subjective concerns about one's mental health declared by men and women differing in their marital status. The tertiary research problem is an attempt to understand the socio-cultural foundations of common mental health disorders experienced by contemporary individuals.

I assume that in certain circumstances the family may perform a protective function toward their members' mental health, whereas in other conditions family life

can be a significant source of stress resulting from unequal investments and division of emotional work. These ambivalences of family life may result in the discrepancy between the individual's subjective perception of mental well-being and the objective state of mental health perceived from psychiatry's point of view. I also hypothesise that support and stress are experienced differently by men and women of different marital status, which is the result of the socio-cultural construction of gender.

The main method used in this study is meta-analysis of epidemiological and clinical data concerning the mental health of the global (WHO) and Polish population (EZOP-Poland) and my own research – a nationwide, representative survey (N=1,000) carried out in Poland, which was part of a broader theoretical and empirical project (habilitation thesis) devoted to the process of social construction of the categories of mental health, disease and disorder in late modern society (Frąckowiak-Sochańska, 2019). I also refer to my qualitative research including 20 in-depth interviews with psychologists, psychiatrists and psychotherapists who had experience in carrying out family, couples and individual therapies.

I begin my analyses with an overview of global epidemiological data concerning mental disorders and Polish pioneering studies on the prevalence of these disorders in the context of which mental health problems appear as a global and local challenge. Next, I confront the results of empirical studies on subjective concern about one's mental health declared by the representatives of contemporary Polish society with the objective data on the prevalence of certain mental disorders (and broadly understood – mental health problems) of men and women of different marital status. Confrontation of these results contributes to understanding the patterns of gendered subjective-objective mental well-being experiences. Afterwards, I deal with empirical data concerning social support (within and outside a family) and the mental health of men and women of different marital status according to Polish epidemiological research *EZOP Poland*. In the end, I refer to the qualitative research whose objective was to find out whether and in what way some issues described from the socio-cultural perspective manifest themselves in the form of problems with which people turn to psychotherapists. The qualitative data enable us to illustrate the micro social context of the mechanisms captured in the broader scale.

## Mental health problems as a global and local challenge

According to the World Health Organization's data about a quarter to a third of today's world population suffers from mental disorders (particularly common are depression and anxiety disorders, which are mostly derivatives of stress). Mental disorders are

currently in the 2nd place of diseases causing disability in people's life, and by 2030 they are to be in the first place. 350 million people in the world suffer from depression. It is estimated that depression affects about 15% of Europeans (WHO, 2013; 2014).

Polish epidemiological data confirm these tendencies. According to the research EZOP Poland – the first and the only so far epidemiological study carried out in 2012 on a representative random sample of 10,000 people – at least 23.5% of Poles at the age between 18 and 65 meet the formal criteria of at least one mental disorder.<sup>1</sup> The extrapolation of these data allows us to estimate that about 6 million representatives of contemporary Polish society suffer from at least one mental disorder and about one third of Polish families faces their members' mental health problems. Moreover, the cited studies allow us to determine the prevalence of many symptoms that are not sufficient to diagnose specific mental disorders included in diagnostic systems (ICD-10 and DSM-V), but significantly reduce the quality of life and may herald the appearance of certain mental disorders in the future. It was found that 20%–30% of the Polish population aged 18–65 experience such problems as: lowered mood, mood swings, lowering activity, specific avoidance symptoms, chronic anxiety, irritability, anxiety attacks, social anxiety and anger attacks (Moskalewicz et al., 2012). Such prevalence of mental health problems is interpreted as the result of the tension connected with functioning on the labour market, the difficulties in combining professional and family roles, lack of control over one's life and poor social relations (WHO, 2014).

According to my own research (representative, nationwide survey) carried out in 2012 (the same year in which the epidemiological studies EZOP – Poland were conducted), 26.7% of Poles aged 15–65 agreed with the statement “sometimes I worry about my mental health”.<sup>2</sup> Although the subjective declarations of anxiety about one's mental health differ from the self-observation of certain symptoms of mental

---

<sup>1</sup> EZOP Poland was carried out in accordance with the WHO's methodology, in cooperation with the World Mental Health Survey Consortium. The survey used the WMH-CIDI, a fully structured diagnostic interview, to assess disorders and treatment. Disorders considered include anxiety disorders (agoraphobia, generalised anxiety disorder, obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder, social phobia, specific phobia), mood disorders (bipolar I and II disorders, dysthymia, major depressive disorder), disorders that share a feature of problems with impulse control (bulimia, intermittent explosive disorder, and adult persistence of 3 childhood-adolescent disorders, including attention-deficit/hyperactivity disorder, conduct disorder, and oppositional-defiant disorder among respondents in the 18- to 44-year age range), and substance disorders (alcohol abuse and dependence, drug abuse and dependence, nicotine dependence). Disorders are assessed using the definitions and criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) and the ICD-10 Classification of Mental and Behavioral Disorders (ICD-10). The research sample was random and consisted of 10,000 respondents at the age of 18–65. (Moskalewicz et al., 2012) World Mental Health Consortium, <https://www.hcp.med.harvard.edu/wmh/>).

<sup>2</sup> This research was carried out on November 22–25, 2012 on a nationwide, representative, random-quota sample of residents of Poland aged over 15 (N = 1,000) by TNS Polska company owing to the funds

disorders, this anxiety indicates a certain range of perceived mental discomfort and stress that can transform into a chronic state and cause states that meet the diagnostic criteria of mental disorders.

## Concerns about one's mental health versus family status and gender<sup>3</sup>

A comparison of the responses of people who differ in marital status indicates that respondents who are married or live in informal relationships declare concerns about their mental health more often than those who are single, widowed and divorced (these data are presented in Table 1). The results can be interpreted in the context of the specific type of stress experienced by people living in intimate relationships due to the greater frequency and intensity of potential and real conflicts.

The above picture becomes more expressive, if we take into consideration another variable, namely gender. The research results indicate that women who are married or live in informal relationships voice concern about their mental health more often than men of the same marital status (33% vs. 24%). In the case of divorced people 30.6% of women worry about their mental health, whereas only 17.9% of men do so. The opposite proportion was observed in the category of widowers, in which 23% of women and 30.5% of men declared they are concerned of their mental health. No difference regarding analysed declarations was found in the category of singles. These results are presented in detail in Table 2.

Above data may suggest that subjectively estimated emotional costs (investments) resulting from living in a family or intimate relationship as well as from the loss of the relationship are different for men and women (Kwak, 2009). The objective dimension of individuals' investments resulting from living within a family can be analysed regarding time budget of men and women. Women spend on average 1 hour and 45 minutes per day more than men on unpaid household duties, whereas men spend 1 hour and 1 minute per day more than women at paid work. At all stages of the life cycle, the share of duty time in the structure of women's day was higher than in the structure of the men's day.

---

for the statutory activities of the Institute of Sociology and the Faculty of Social Sciences of the Adam Mickiewicz University in Poznań.

<sup>3</sup> I use the term *gender* instead of *sex* in the whole paper because I assume that most men and women have adopted in the process of socialisation culturally defined constructs of *femininity* and *masculinity*. These constructs influence the ways of performing family roles and manifesting the stress resulting in disturbances of mental balance and mental health.

**Table 1. Marital status and anxiety one's about mental health**

Subjective assessment of anxiety about one's mental health	Marital status											
	single		married/in informal relationship		divorced/in separation		widowers		in general			
	n	%	n	%	n	%	n	%	n	%		
Sometimes I worry about my mental health	7	23.9	26	28.6	4	26.0	6	24.7	40	26.7	4.0	
	58	21.3	134	24.4	16	20.8	19	18.8	227	22.7	22.7	
neither agree nor disagree	44	16.2	65	11.8	8	10.4	21	20.8	138	13.8		
rather disagree	97	59.9	229	59.6	33	63.6	35	54.5	394	59.5	39.4	
strongly disagree	66	24.3	99	18.0	16	20.8	20	19.8	201	20.1	20.1	
in general	272	100.0	550	100.0	77	100.0	101	100.0	1000	100.0	100.0	

Source: own elaboration.

**Table 2. Marital status/gender and anxiety about one's mental health**

Subjective assessment of anxiety about one's mental health		Marital status															
		single				married/in informal relationship				divorced/i n separation				widowed			
		M		F		M		F		M		F		M		F	
Sometimes I worry about my mental health	n	1.9	4	3.4	13	4.8	10	3.6	0	4	8.2	2	8.7	4	5.1		
	%	23.2	24.8	24.8	24.0	33.0	35.0	33.0	17.9	30.6	30.6	30.5	30.5	23	17.9		
	n	21.3	25	21.4	52	19.2	82	29.4	5	11	22.4	5	21.7	14	17.9		
neither agree nor disagree	n	18.7	15	12.8	34	12.5	31	11.1	4	4	8.2	7	30.4	14	18		
	%	58.0	62.4	62.4	63.5	44.6	48	55.9	67.8	61.2	46.9	39.1	39.1	59	23.1		
	n	33.5	45	38.5	121	44.6	108	38.7	10	23	46.9	7	30.4	28	35.9		
rather disagree	n	24.5	28	23.9	51	18.8	48	17.2	9	7	14.3	2	8.7	18	23.1		
	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0		
	n	155	117	100	271	1000	279	1000	28	49	1000	23	1000	78	1000		
in general		155	117	100	271	1000	279	1000	28	49	1000	23	1000	78	1000		

Source: own elaboration.

In the case of rest time, there was a reverse relationship – its share in the structure of women's day at all stages of the life cycle was lower than in men's day time budget (GUS, 2015). In the context of these data we can put forward a thesis that women tend to have less time for regeneration of physical and mental power, which can lead to concerns about one's mental health (Frąckowiak-Sochańska, 2011).

## **Social support and mental health of men and women of different marital status according to Polish epidemiological research *EZOP Poland***

The family (as well as a close relationship) may be a source of support in the face of difficulties, however – as shown by the results of the *EZOP Poland* research, it does not always perform such a function. Approximately every third respondent (36%) aged 18–64 declared that he or she can count on the support of family members while struggling with a serious problem, while slightly more than one in fourth of the respondents (27%) cannot count on such support. Women can count on their families' help more often than men (38.25% vs 34.65%). About 29% of people (35.6% of women and 22.7% of men) can openly talk about their worries to their family members, whereas about the same number of people have very limited opportunities of such talk, but in their case the proportions by gender are opposite – it is 36.3% of men and 25.2% of women (Moskalewicz et al., 2012). Over 70% of people living in relationships (both formal and informal) can always or usually talk about their problems with their spouses or partners. At the same time almost 10% of people living in relationships never (or very rarely) talk to their partners about their problems (Moskalewicz et al., 2012). The *EZOP Poland* research also revealed that being married can limit the possibilities of receiving support in a wider social environment. While grappling with a serious problem, persons who are married can count on help from their friends and acquaintances less frequently than those who are in an informal relationship. Similarly, married respondents could significantly less often talk openly about their worries to their friends and acquaintances than those who lived in informal relationships. Married respondents significantly more often than those living in informal relationships declared that they cannot have such open conversations or they can – but only to a small extent (Moskalewicz et al., 2012).

The analysis of indicators allowing for diagnosing certain mental disorders among persons differing in terms of gender and marital leads to a conclusion that the relationships between these variables are ambiguous. It is not possible to determine the causal relationship between gender, marital status and symptoms of mental disorders.



The interactions between these variables can be diverse. Specific experiences of men and women of certain marital status can affect their mental health in many ways (as well as positive as negative). At the same time, mental health problems can influence individuals' marital status in a number of respects. Some symptoms can result in barriers to developing intimate relationships or cause a crisis in a relationship that can lead to its breakdown. However, in some cases certain symptoms can strengthen the motivation to live in a relationship that is a source of support and protection. It is also likely that some other variables influence an individual's mental health as well as his or her marital status. For example, the experience of unemployment, somatic illness or any critical life event can lead to worsening one's mental condition. Simultaneously, those experiences can cause conflicts within a relationship that may result in its disintegration.

Depressive disorders<sup>4</sup> more often affect women and singles of both sexes, but those who were in a formal or informal relationship in the past. Significantly lower prevalence of depression is observed between singles who did not declare living in a relationship in the past and married people (Moskalewicz et al., 2012). In case of mania,<sup>5</sup> higher prevalence of symptoms is observed among men and women who are divorced or living in an informal relationship. The difference in comparison to married people is statistically significant (Moskalewicz et al., 2012). In the case of mania, occurring in the course of bipolar affective disorder,<sup>6</sup> the symptoms and the secondary life complications related to them may contribute to the breakdown of the

---

<sup>4</sup> According to the *International Statistical Classification of Diseases and Health Related Problems* (ICD 10) in typical *depressive episodes*, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by the so-called *somatic* symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe (WHO, 2016).

<sup>5</sup> In the course of *manic episode* mood is elevated out of keeping with the patient's circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech, and a decreased need for sleep. Attention cannot be sustained, and there is often marked distractibility. Self-esteem is often inflated with grandiose ideas and overconfidence. Loss of normal social inhibitions may result in behaviour that is reckless, foolhardy, or inappropriate to the circumstances, and out of character (WHO, 2016).

<sup>6</sup> *Bipolar affective disorder* is characterised by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression) (WHO, 2016).

relationship. The prevalence of the panic anxiety disorder<sup>7</sup> among men was conformed the most often by widowers (1.9%) and the divorced (1.1%). Among women this disorder was observed most often in those living in informal relationships (1.1%), however, the differences were not significant statistically. The authors of the *EZOP Poland* study put forward a thesis that marital status was connected with suffering because of panic anxiety disorder only in the case of men after the breakdown of their marriage. The occurrence of this disorder can be related to reasons or results of disintegration of the matrimony (Moskalewicz et al., 2012). Similar relationships were found for specific phobias.<sup>8</sup> These disorders are the most common among divorced men (4.3%) and in women living in informal relationships (7.4%). They are least common among widowed men (1.8%) and married women (5.4%). According to the authors of the study, “Although these differences have not reached the level of statistical significance, it can be hypothesised that among women the type of partner relationship – formal or informal – is associated with the frequency of phobic symptoms” (Moskalewicz et al., 2012, p. 208). The symptoms of social phobia<sup>9</sup> are most common in men and women in constant informal relationships, respectively 2.0% and 3.5%. The prevalence of this disorder among people in an informal relationship is statistically higher than among those in married couples. The authors, therefore, hypothesise that marital relationships may have a protective function or that stable

---

<sup>7</sup> The essential feature of *panic anxiety disorder* are recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances and are, therefore, unpredictable. As with other anxiety disorders, the dominant symptoms include a sudden onset of palpitations, chest pain, choking sensations, dizziness, and feelings of unreality (depersonalisation or derealisation). There is often also a secondary fear of dying, losing control, or going mad. Panic disorder should not be given as the main diagnosis if the patient has a depressive disorder at the time the attacks start; in these circumstances the panic attacks are probably secondary to depression (WHO, 2016).

<sup>8</sup> In the whole group of *phobic anxiety disorders* classified in ICD 10, anxiety is evoked only, or predominantly, in certain well-defined situations that are not currently dangerous. As a result, these situations are characteristically avoided or endured with dread. The patient's concern may be focused on individual symptoms like palpitations or feeling faint and is often associated with secondary fears of dying, losing control, or going mad. Contemplating entry to the phobic situation usually generates anticipatory anxiety. *Specific (isolated) phobias* are the phobias restricted to highly specific situations such as proximity to particular animals, heights, thunder, darkness, flying, closed spaces, urinating or defecating in public toilets, eating certain foods, dentistry, or the sight of blood or injury. Though the triggering situation is discrete, contact with it can evoke panic as in agoraphobia or social phobia. Phobic anxiety and depression often coexist. Whether two diagnoses, phobic anxiety and depressive episode, are needed, or only one, is determined by the time course of the two conditions and by therapeutic considerations at the time of consultation (WHO, 2016).

<sup>9</sup> *Social phobias* are connected with fear of scrutiny by other people leading to avoidance of social situations. More pervasive social phobias are usually associated with low self-esteem and fear of criticism. They may present as a complaint of blushing, hand tremor, nausea, or urgency of micturition, the patient sometimes being convinced that one of these secondary manifestations of their anxiety is the primary problem. Symptoms may progress to panic attacks (WHO, 2016).

informal relationships are burdened with the risk of symptoms of social phobias or their exacerbation (Moskalewicz et al., 2012). A significant relationship between marital status and gender occurs among persons who experience symptoms of agoraphobia<sup>10</sup> as well. Married women confirm these symptoms more often than married men (0.8 compared to 0.4). Similar trends were found in people who were in a steady informal relationship (0.9% in women compared to 0.5% in men). Among the respondents living in an informal relationship or in a marriage this disorder occurs more often than among the divorced ones. This may suggest the impact of agoraphobia on the greater pursuit of staying in a stable relationship than in the case of persons who do not suffer from this disorder. (Moskalewicz et al., 2012). In case of the generalised anxiety disorder,<sup>11</sup> declaration of symptoms appeared most often in women who were divorced or in separation (3.8%) and widowed (3.1%) and less often in single (1%) and married women (1.3%) – the difference is statistically significant. These percentages are similarly distributed in the case of men: divorced or separated (2%) and widowers (2.2%) confirm the symptoms of generalised anxiety disorder significantly more often than bachelors (0.3%) and married ones (0.4%). According to the authors of the study, “this could be a sign of a correlation between this disorder and the chronic stress reaction caused by the breakup of a marriage – in the form of a divorce or the death of one of the partners” (Moskalewicz et al., 2012, p. 220). Similar interrelations were found in the case of post-traumatic stress disorder (PTSD),<sup>12</sup> whose symptoms are significantly more often identified in persons who are divorced or in separation

---

<sup>10</sup> *Agoraphobia* is a cluster of phobias embracing fears of leaving home, entering shops, crowds and public places, or travelling alone on trains, buses or planes. Panic disorder is a frequent feature of both present and past episodes. Avoidance of the phobic situation is often prominent, and some agoraphobics experience little anxiety because they are able to avoid their phobic situations. ICD 10 distinguishes *agoraphobia without history of panic disorder* and *panic disorder with agoraphobia*. Depressive and obsessional symptoms and social phobias are also commonly present as subsidiary features (WHO, 2016).

<sup>11</sup> In *generalised anxiety disorder* anxiety is persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances (i.e., it is *free-floating*). The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, light-headedness, palpitations, dizziness, and epigastric discomfort. Fears that the patient or a relative will shortly become ill or have an accident are often expressed (WHO, 2016).

<sup>12</sup> *Post-traumatic stress disorder* arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Typical features include episodes of repeated reliving of the trauma in intrusive memories (*flashbacks*), dreams or nightmares, occurring against the persisting background of a sense of *numbness* and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected

(3.1%) than in married (1.0%) or single ones (0.6%). These differences are on the verge of statistical significance. According to the authors of the *EZOP Poland* study, it can be hypothesised that a divorce can be, for both sexes, one of the stressors which cause the risk of the occurrence of post-traumatic stress disorder symptoms (Moskalewicz et al., 2012). This statement is coherent with the Holmes's and Rahe's concept of Social Readjustment Rating Scale (SRRS) in which divorce is the second most stressing situation – after a loved one's death (Holmes & Rahe, 1967) and the updated study on SRRS carried out by Hobson et al. (1989) in which divorce located itself in the seventh position of the most stressing life events. It has to be noted that in many cases divorce is preceded by a crisis and conflicts that accumulate and may lead to the disturbance of an individual's emotional balance. That is why we should consider not only divorce itself but also complex factors leading to the disintegration of the relationship in terms of stressing experiences. The symptoms of intermittent explosive disorder<sup>13</sup> are most often experienced by divorced (2.4%) and widowed (2.1%) men as well as women in informal relationships (1.9%). These symptoms are less often observed in married men (0.3%) and widowed women (0.2%). The authors of *EZOP Poland* research put forward a thesis that in the case of men marriage has a protective function. In the case of women, however, determining the direction of the causal relationship between staying in an informal relationship and symptoms of intermittent explosive disorders requires further analysis (Moskalewicz et al., 2012). Since it is impossible to establish a cause-effect relationship on the basis of the cited data, the above statement applies to all relations between symptoms of specific disorders and marital status of men and women discussed in this paper.

The manifestations of behavioural disorders<sup>14</sup> are observed in the highest regularity in men and women in an informal relationship (respectively 6.7% and 5.9%) as well

---

in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (WHO, 2016).

<sup>13</sup> According to the *Diagnostic and Statistical Manual of Mental Disorders*, *intermittent explosive disorder* is a behavioural disorder characterised by explosive outbursts of anger and violence, often to the point of rage, that are disproportionate to the situation at hand (e.g., impulsive screaming triggered by relatively inconsequential events). Impulsive aggression is not premeditated, and is defined by a disproportionate reaction to any provocation, real or perceived. Some individuals have reported affective changes prior to an outburst (e.g., tension, mood changes, energy changes, etc.) (McElroy, 1999).

<sup>14</sup> *Conduct disorders* are the disorders characterised by a repetitive and persistent pattern of dissocial, aggressive, or defiant conduct. Examples of the behaviours on which the diagnosis is based include excessive levels of fighting or bullying, cruelty to other people or animals, severe destructiveness to property, fire-setting, stealing, repeated lying. In adolescence this disorder can manifest itself by truancy from school and running away from home, unusually frequent and severe temper tantrums, and disobedience. Any one of these behaviours, if marked, is sufficient for the diagnosis, but isolated dissocial acts are not. ICD-10 distinguishes several subcategories of conduct disorders: (1) *conduct disorder confined to the family context* – involving dissocial or aggressive behaviour entirely, or almost entirely,

as in divorced men (6.2%). These disorders are most rarely observed in married men (2.5%) as well as in married and widowed women (0.6%). The prevalence of these disorders among married people of both sexes is significantly lower in comparison to those living in informal relationships as well as divorced ones. This trend may indicate the protective role of marriage, but also the destructive impact of behavioural disorders on the durability of the relationship (Moskalewicz et al., 2012). It should be noted that the presented data do not allow us to determine whether the symptoms of the disorder appeared before or after the breakdown of the relationship.

Another disorder considered in the *EZOP Poland* research was neurasthenia,<sup>15</sup> occurring with a similar frequency in men and women of the majority of analysed marital statuses, with the exception of people living in informal relationships, amongst whom neurasthenia symptoms were declared by ten times more women than men (2.3% and 0.2%, respectively) – the difference was statistically significant. In addition, the symptoms of neurasthenia appear more often in men who are divorced (1.5%, which was almost double the ratio recorded in divorced women) and widowed (2.5%, which was three times more than in the case of widowed women). However, these differences are not significant statistically (Moskalewicz et al., 2012).

*EZOP Poland* also analysed the frequency of behaviours that could be classified as suicidal attempts (which are usually a consequence of severe, chronic mood disorders). The highest rate of these behaviours was reported by divorced persons (1.9%) and those in an informal relationship (1.5%), whereas the percentage of those who confirmed suicide attempts amounted 0.5% (Moskalewicz et al., 2012).

---

confined to the home and to interactions with members of the nuclear family or immediate household; (2) *unsocialised conduct disorder*, which is characterised by the combination of persistent dissocial or aggressive behaviour with significant pervasive abnormalities in the individual's relationships with other people; (3) *socialised conduct disorder* – occurring in individuals who are generally well integrated into their social environment; (4) *oppositional defiant disorder* – a constant pattern of behaviour characterised by behaviours that are in contrary to applicable social norms; this disorder is usually diagnosed among adolescents and according to the common assumption – can lead to the antisocial personality disorder in adulthood (WHO, 2016).

<sup>15</sup> Considerable cultural variations occur in the presentation of *neurasthenia*. According to ICD 10 two main types occur, with substantial overlap. In one type, the main feature is a complaint of increased fatigue after mental effort, often associated with some decrease in occupational performance or coping efficiency in daily tasks. The mental fatigability is typically described as an unpleasant intrusion of distracting associations or recollections, difficulty in concentrating, and generally inefficient thinking. In the other type, the emphasis is on feelings of bodily or physical weakness and exhaustion after only minimal effort, accompanied by a feeling of muscular aches and pains and inability to relax. In both types a variety of other unpleasant physical feelings is common, such as dizziness, tension headaches, and feelings of general instability. Worry about decreasing mental and bodily well-being, irritability, anhedonia, and varying minor degrees of both depression and anxiety are all common. Sleep is often disturbed in its initial and middle phases but hypersomnia may also be prominent (WHO, 2016).

As the authors of the study claim, this would confirm the thesis (originally put forward in classic Durkheim's study and partially confirmed in contemporary research projects) that the disintegration of social ties is a factor conducive to suicidal attempts (Moskalewicz et al., 2012; Durkheim, 2011; Jarosz, 2013; Kołodziej-Sarzyńska et al., 2019). Interesting is the fact that apparently it is not only about emotional, intimate social ties, but also those of a formal nature. (Moskalewicz et al., 2012). Since causal reasoning is not possible on the bases of the analysed data, we can consider at least two alternative interpretations. The first one indicates the protective role of steady, formalised relationships. The second one allows assuming that in some cases mental health problems can appear primarily and be one of the reasons for divorce or barriers that prevent formalisation of the relationship.

Among the analysed disorders there were also addictions – to nicotine, alcohol and drugs. In the case of cigarettes dependency, it was observed that married women smoke significantly less frequently than those living in informal relationships, divorced and widows. Among people in informal relationships, smoking is similarly widespread between men and women. In the other categories of marital status proportions of smoking men are significantly higher than smoking women (this applies especially to marriages). The highest rates of smokers were observed among people who were divorced. Divorced men smoke significantly more often than the representatives of all other categories of marital status (Moskalewicz et al., 2012). Marital status and gender are the variables that differentiate the prevalence of alcohol abuse. In all the categories of marital status men experience alcohol problems more often than women. The highest prevalence of alcohol abuse was observed in divorced men (over 40% which is twice as much as in all other categories except for men living in informal relationships). Among the individuals living in informal relationships the prevalence of alcohol abuse is higher comparing to all other categories of marital status – alcohol related disorders were observed in over 10% of women and 23% of men. In this group the difference between the rate of women and men who abused alcohol was lower than in all the other categories. Women living in informal relationships declared alcohol abuse almost six times more often than the married ones, whereas in the case of men this difference was on the verge of statistical significance (Moskalewicz et al., 2012). Marital status also differentiates the frequency of using drugs. The highest prevalence of drug abuse was noticed among men living in informal relationships (over 6%). This rate was almost ten times higher than in the case of women of the same marital status. The lowest prevalence of drug abuse (0.5%–0.7%) was observed in women living in stable relationships – both informal and formal. These differences were statistically significant (Moskalewicz et al., 2012).



The analysis of the above data leads to a conclusion that the relationships between gender, marital status, social support and the state of mental health are multilateral. These variables interact within the entire network of connections with other socio-demographic variables (such as age, level of education, place of living, etc.). When we consider the relationship between the experience of living in formal and informal relationships and the state of individuals' mental health, we have to take into account the quality of these relationships and social ties in a broader social environment. Mental disorders have a diverse character, though most of them are a reaction to social stress that exceeds the individuals' coping abilities. Disorders discussed above are in many ways related to culture in which different norms and patterns of behaviours are assigned to individuals who differ in gender and marital status. In other words, individuals who are burdened with social stress can manifest different symptoms in accordance with socio-cultural norms regulating psycho-social functioning of people who differ in gender and marital status in particular culture (Frąckowiak-Sochańska, 2010; 2016).

## **Family and socio-cultural context of mental health problems in psychotherapists' narratives (qualitative approach)**

The issues discussed in the context of quantitative research results presented above became also visible in my qualitative research (the interviews with the experts in mental health). Individual in-depth interviews have been carried out on a purposive sample of 20 psychologists, psychiatrists and psychotherapists working with adults, children and adolescents, having experience in individual, group, couples' and families' therapy, working in different specialist units such as: psychiatric and somatic hospitals, mental health clinics, psychological and pedagogical counselling centres, addiction treatment clinics, centre for domestic violence victims, rehabilitation centres for children and adolescents, socio-therapeutic community centres and private psychotherapy centres. Some of the interviewees combined the therapeutic work with scientific, educational and training activities as well as with the role of a supervisor in psychotherapy. The research participants represented different schools in psychotherapy: psychodynamic, cognitive behavioural, systemic, narrative. Some of them declared the eclectic approach. The respondents practised in Wielkopolskie province: in Poznań, Kościan, Leszno and Gniezno. Their professional experience ranged from 2 to 45 years (the average: 16.65 years and the median: 12 years). I conducted the interviews in person between January 2016 and May 2017. The interview questionnaire included a series

of open questions divided into thematic blocks.<sup>16</sup> Depending on the direction of the narrative, it was possible to ask additional questions deepening the issues discussed by the respondents.<sup>17</sup> One of the purposes of the interviews was to check whether (and how) some trends observed at the socio-cultural level and described in the context of epidemiological data manifest themselves in form of problems with which clients turn to psychotherapists. These problems are often connected with some significant interactions within a family or other intimate relationships. We can assume that some of these problems are the background of the phenomena described in the categories of mental disorders (especially the stress – related depressive and anxiety disorders). The research material from the interviews was analysed in accordance with the constructivist grounded theory methodology (Charmaz, 2009).

The most important categories distinguished on the basis of the data concerned: (1) tensions connected with the deconstruction of traditional family role patterns and the absence of unambiguous principles of constructing contemporary family and gender roles; (2) difficulties in functioning within relationships resulting from the strong sense of individualism and being self-centred; (3) being overloaded with duties resulting from the necessity of joining various spheres of life and high cultural standards of performing certain social roles; (4) the sense of being lost, overwhelmed and feeling guilt in the face of being overloaded by contradictory concepts of *good life, good parenting, good relationship, etc.*

The shift of family life patterns is experienced differently by men and women. Transformation of gender and family roles leads to openly manifested conflicts which are an inevitable part of the process of constructing the acceptable family model. This thread is addressed by the author of the following statement:

“Women come because they are tired and overwhelmed, whereas for men it is rather a way to explain why something is not going well (*I don't make a career because I'm depressive, because I'm sick*). When couples come, they often present a symmetrical model – they argue about everything and shift the responsibility and guilt on the

---

<sup>16</sup> The interview scenario contained questions concerning: (1) context of the therapeutic work in which the respondents were asked to define the categories of mental health, mental disorders and mental disease, (2) potential changes in the way of understanding the above categories along with the development of the respondents' professional experience, (3) potentially observed relationships between sociocultural factors and problems with which people turn to psychotherapists (“signs of our times” which manifest themselves in the form of certain emotional and mental health problems), (4) the respondents' opinions about relationships between mental condition of a psychotherapist and the perception of categories of mental health, disease and disorder and perceiving persons who turn to therapists with their problems.

<sup>17</sup> Likewise my nationwide, representative survey research, the interviews were part of my habilitation dissertation (Frąckowiak-Sochańska, 2019).



other person – *who of them brought up the child wrongly*, etc. This is a fight rather than complement and cooperation (...). Besides, I'm thinking about the messages about raising daughters and sons. Parents, especially mothers instilled their daughters that they were to be independent, resourceful, etc., while boys were often dismissed from many duties, and therefore, there are now many men who have not enough practical everyday life skills. There are also many women who have certain expectations for men who do not meet them, so women are dissatisfied with them" [interview no. 3, psychologist, psychotherapist with 35 years of experience].

The author of the above narrative explains why the process of family life patterns transition is not a simple linear change:

"The role division used to be simple in the past: men provided goods, women were in charge of managing them and taking care of social relations of the family. Right now, it is not completely clear. The change is in progress (...) The previous order went out of date and the new one is not yet established. I am not sure if the change is so easy because, I think, if it was so easy, it would mean the lack of respect for the previous order, that it was worthless, but it had certainly its significance" [interview no. 3, psychologist, psychotherapist with 35 years of experience].

Another category of narratives addresses the difficulties in functioning within relationships experienced by contemporary young adults. This is an exemplary narrative's fragment which is representative for this category:

"There is another thing I think, something that the parents from my generation did, maybe not all of them (...). This is instilling into the child the belief that he or she is important (how the role of a child has changed from the times before the Second World War, when a child was almost "owned" by his or her parent and he/she could do whatever he/she wanted to with a kid; and now I have an impression that parents are often "owned" by a child; this is like the transition to another polar). And when the child was told: *you are important and your needs are important and you have to look after yourself to ensure that* and it was still time when there were many things that came to the market that were once a dream and the kids got it all. I don't know if it was more the children's or the parents' need to let the children have it all (...). And now if two people enter a relationship, both of them convinced of their reasons and their needs, both not having much skills in fact, I am not surprised that they are unable to function together (...). And besides, as it is said, these young ones are *the instant generation*. Everything has to be immediate. And the concept of making money from scratch does not exist at all. Parents are to ensure a *good start* in life and if they do not, it is a great harm" [interview no. 3, psychologist, psychotherapist with 35 years of experience].

The above thread manifests itself as well in the context of intergenerational relations:

“There is a thread of various claims to parents, which are not really a grudge against them, but only claims to the internal representations. This is visible when emigrating from the countryside to the city, when the parents are in the countryside, in that cultural context, in that community, in those customs. It sounds a bit like it used to be in the old days, but (...) it is quite real now and applies to such 30-year-olds, whose parents are 50 plus (...) and live somewhere else. This is more in women, this kind of anger that hides sadness, because some things happened then in that parents-children relation and *I wasn't the most important for them, but in my way* (but they want to be the most important in their own way, not in their parents' way). This is visible from the position of culture and consciousness that she has now, because she emigrated somewhere, finished her studies and she is a humanist today, she's heard of various cultural messages about ties, closeness and loving parents. The way her parents live, their imperfect, harsh customs are like a kind of heritage park for her. All this makes her angry and this anger hides the longing for a perfect childhood and the sadness because this imaginary perfect childhood would never come true. As a matter of fact, she has to leave the childhood mentally” [interview no. 6, psychologist, psychotherapist with 45 years of experience].

The symbolic role of a child is played not only towards parents, but towards a partner as well. This role contains the demanding attitude as well as the unwillingness to accept commitments. High expectations combined with lack of readiness to invest one's effort in a relationship almost inevitably lead to grief and frustration which are the emotional background of depression (Schwartz, 2013). On the basis of the interviewees' statements we can put forward a thesis that the difficulties appearing in relationships within families reflect individualism and its limitations. One of the problems experienced by the psychotherapists' clients is the selectivity of empathy (most often we expect that others will understand us empathically, while we are not ready to do the same). As a result, individuals have an impression of a lack of understanding and support, which increases the tension and generates the emotional feedback loop resulting in the impression of overall life crisis. Some mechanisms described above can be interpreted in the context of Giddens's concept of *the reflective project of the self* which relates to the process of construction of self-identity in the late modernity society (Giddens, 2001). During this process, the individuals experience tension between the pursuit of self-fulfilment and the need for emotional affinity with others.

Another issue that occurs in the analysed narratives addresses everyday stress and exhaustion resulting not only from the necessity of combining different spheres of life (family, work, etc.), but also from the high cultural standards of fulfilling the

social roles (for example parental roles). Here is the exemplary narrative dealing with this issue:

“Sometimes I am horrified when I see mothers who come with their children from outside of the city because they don’t have access to a psychologist where they live. And they say: I am on one shift with the child and the father is on the other shift. And I say: Do you have any grandma? And they say: No, we have to deal with it on our own. Then I ask: And how is it when you come here? And they answer: I have to take a day off. And they practically spend their holidays to come to a specialist with their child (...). Where is some rest? Any closeness? The child is practically once with his/her mother once with father. (...) Nowadays children are in the schoolroom until 5 p.m. every day, then, of course, some additional sports activities because parents want to rise to the challenge. And they are so tired at the end of the day. Many families always want to come to me for the last hour, because they cannot come earlier and I can see that they are so tired that they can hardly focus, but they still feel the need to come and consult something about the children” [interview no. 17, psychologist with 42 years of experience].

Living within a family entails many everyday logistics problems described by Carolyn Aldwin et al. (2014) as *daily hassles*, which cause everyday moderate stress that entails the relatively highest risk of depression. Time spent with relatives is nowadays conditioned by the rhythm of professional work (consuming most of the day) and the rules of functioning of caring and educational institutions. Tensions experienced by individuals in these contexts affect the relationships with the loved ones, which makes it difficult for individuals to synchronise emotionally in the relatively short time that they have remaining. Family members often have different interests and incompatible outside-family obligations. The family, thus, becomes an area of a struggle with other family members. The individuals can fight for example for the respect for one’s work (both professional and household), the conditions for exercising it, and for recognition of their right to development and rest. Both adults and children can feel overloaded by the tension resulting from multiple duties. At the same time, they can feel frustration because in the face of exhaustion, their effort does not bring the expected effect in the form of a sense of fulfilment and life satisfaction. In this context depression develops.

The problem of excessive expectations, aroused by specific cultural ideas, including consumption patterns, is addressed in the following narrative:

“People have growing difficulties in making good, rational decisions *how to live well*. The growing number of offers and opportunities leads to for example women who come with a very strong feeling of guilt because they don’t satisfy their children the

way they think they should. They get information from different places that they should attend 1-year olds' club, 2-years olds' club, swimming classes, yoga, thousand possible things they cannot cope with anymore (...). These are the moments when the culture probably activates the narcissistic personality structure with the need of perfection or the masochistic structure or obsessive-compulsive tendencies (...). Is it the individual's problem or culture's problem? Is it the excess of information, goods, options, etc. with which the individual cannot cope anymore" [interview no. 9, psychologist with 10 years of experience].

The interview ends with the question which is crucial from the perspective of contemporary sociology of mental health: to what extent are the phenomena that meet the formal criteria of mental disorders a manifestation of individual psychopathology, and to what extent are they indicative of adaptation to specific socio-cultural norms?

In this context, we can put forward a thesis that some forms of social adjustment give rise to an individual's behaviour and/or emotional state that are further interpreted as symptoms of mental disorders. It means that the borders between adjustment, maladjustment, and categories of mental health and disorder are not unambiguous.<sup>18</sup>

## Conclusion

The above analyses lead to a conclusion about the multilateral relationships between family life, gender role patterns, subjective mental well-being and objective state of mental health. The incoherence of epidemiological data (reflecting the objective perspective of psychiatry) and the data concerning the subjective apprehension about one's mental health can be interpreted in the context of the ambiguity of family life experiences. Living within a family entails emotional costs, but at the same time family ties provide social and emotional resources.

In the contemporary society social ties are not imposed, rigid or unchangeable. In order to maintain them, individuals have to invest their time and energy in order to take care of them. Even in the primary groups, individuals have to put effort into maintaining relationships, because in the psychological sense they cannot be taken for granted. The engagement in family life requires certain skills – of dealing with one's own emotions, readiness to bear frustration, an ability to cooperate with others and the expectation of a deferred gratification. These skills are necessary in building the *pure relationships*, which are, according to Giddens (2001), the autotelic, reflexively constructed close relationships, based on trust and mutual commitment. As Giddens

---

<sup>18</sup> This issue was discussed in more detail in my habilitation thesis (Frąckowiak-Sochańska 2019).

(2001) wrote, these relations involve a free choice, so they can go beyond family ties. However, they can be built on the basis of family ties (or partner ties) as well.

Family life manifests itself as an area of emotional work – meaning managing emotions and struggling with one's own, often strained mental condition and confronting with the emotions and mental condition of others (Hochschild, 1979; Livingston, Judge 2008; Strazdins 2000; Strazdins, Broom 2004). The patterns of emotional work are strongly connected with gender and family roles' schemes, which is why men and women of different marital status experience a specific sort of stress which in some circumstances leads to the psychological and psychosomatic consequences that meet formal criteria of certain mental disorders.

Summarising the considerations contained in the paper, we can put forward a thesis that living within a family entails emotional costs, but at the same time family can be a source of support. This is not necessarily an alternative (either emotional burden or support), but a conjunction (both emotional burden and support). In this context practitioners should focus on searching for the solutions that support family so that it can support mental health of the individuals. The areas in which it is worth investing for the good of families and individuals should focus on psychoeducational support for parents and partners as well as on building a system in which work-life balance is viable and achievable for everyone.

## References

- Aldwin, C., Jeong, Y.J., Igarashi, H., Choun, & S., Spiro, A. (2014). Do hassles mediate between life events and mortality in older men?: Longitudinal findings from the VA normative aging study. *Experimental Gerontology*, 59, 74–80.
- Charmaz, K. (2009). *Teoria ugruntowana. Praktyczny przewodnik po analizie jakościowej*. Warszawa: Polish Scientific Publishers PWN.
- Durkheim E. (2011). *Samobójstwo. Studium z socjologii*. Warszawa: Oficyna Naukowa.
- Frąckowiak-Sochańska, M. (2019). *Konstruowanie kategorii zdrowia, choroby i zaburzenia psychicznego w społeczeństwie późnej nowoczesności*. Poznań: Adam Mickiewicz University Press.
- Frąckowiak-Sochańska, M. (2010). Rodzinne i społeczno-kulturowe uwarunkowania zaburzeń psychicznych – analiza z perspektywy płci społeczno-kulturowej. *Roczniki Socjologii Rodziny*, XX, 153–185.
- Frąckowiak-Sochańska, M. (2011). Czas wolny kobiet i mężczyzn. Ilość i jakość czasu wolnego jako wymiar nierówności społecznych. In: D. Mroczkowska (Ed.), *Status i znaczenie czasu wolnego. Refleksje, dylematy, polemiki*. Warszawa: Difin.

- Frąckowiak-Sochańska, M. (2016). Psychoterapeuci o klientach i klientkach. Płeć społeczno-kulturowa jako kategoria analizy wzorów funkcjonowania kobiet i mężczyzn w procesie psychoterapii. *Rocznik Lubuski*, 42(1), 193–211.
- Gałązka-Sobotka, M. (Ed.) (2014). *Depresja – analiza kosztów ekonomicznych i społecznych*. Warsaw: Lazarski University. Retrieved from: [www.institut.lazarski.pl/izwoz/wydawnictwa/raport-nt-depresji/](http://www.institut.lazarski.pl/izwoz/wydawnictwa/raport-nt-depresji/) (accessed: 19.06.2017).
- Giddens, A. (2001). *Nowoczesność i tożsamość. „Ja” o społeczeństwo w epoce późnej nowoczesności*. Warszawa: Polish Scientific Publishers PWN.
- GUS (2015). *Budżet czasu ludności 2013*. Warszawa: Central Statistical Office.
- Hobson C.J., Kamen J., Szostek J., Nethercut C.M., Tiedmann J.W. & Wojnarowicz S. (1998). Stressful Life Events: A Revision and Update of the Social Readjustment Rating Scale, *International Journal of Stress Management*, 5(1), 1–23.
- Hochschild, A.R. (1979). Emotion work, feeling rules, and social structure. *American Journal of Sociology*, 85(3), 551–575. doi:10.1086/227049.
- Holmes, T.H., & Rahe, R.H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research*, 11(2), 213–218. [http://dx.doi.org/10.1016/0022-3999\(67\)90010-4](http://dx.doi.org/10.1016/0022-3999(67)90010-4).
- Jarosz M. (2013). *Samobójstwa. Dlaczego teraz?*. Warszawa: Polish Scientific Publishers PWN.
- Kołodziej-Sarzyńska M., Majewska M., Juchnowicz D. & Karakuła-Juchnowicz H. (2019). Czynniki ryzyka samobójstwa w kontekście teorii integracji społecznej według Émile’a Durkheima, *Psychiatria Polska*, 53(4), 865–881.
- Kwak, A. (2009). Niedokończony proces indywidualizacji kobiet – czy Ulrich Beck ma rację? In: M. Frąckowiak-Sochańska, S. Królikowska (Eds.), *Kobiety w polskiej transformacji 1989–2009. Podsumowania, interpretacje, prognozy*. Toruń: Wydawnictwo Adam Marszałek.
- Livingston, B. A., Judge, T. A. (2008). Emotional responses to work-family conflict: An examination of gender role orientation among working men and women. *Journal of Applied Psychology*, 93(1), 207–216.
- McElroy, S.L. (1999). Recognition and treatment of DSM-IV intermittent explosive disorder. *Journal of Clinical Psychiatry*, 60(15), 12–16.
- Moskalewicz, J., Kiejna, A., Wojtyniak, B. (red.) (2012). *Kondycja psychiczna mieszkańców Polski*. Raport z badań „Epidemiologia zaburzeń psychiatrycznych i dostęp do psychiatrycznej opieki zdrowotnej – EZOP Polska”. Warszawa: Instytut Psychiatrii i Neurologii.
- Schwartz, B. (2013). *Paradoks wyboru. Dlaczego więcej oznacza mniej*. Warszawa: Polish Scientific Publishers PWN.
- Strazdins, L. (2000), Integrating Emotions: Multiple Role Measurement of Emotional Work, *Australian Journal of Psychology*, 51(1), 41–50. <https://doi.org/10.1080/00049530008255366>.
- Strazdins, L., Broom, D. H. (2004). Acts of Love (and Work): Gender Imbalance in Emotional Work and Women’s Psychological Distress. *Journal of Family Issues*, 25(3), 356–378.

- WHO (2013). *Fact sheet – mental health*. World Health Organization, Regional Committee for Europe – 63 rd session Copenhagen. Retrieved from: [www.http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/215275/RC63-Fact-sheet-MNH-Eng.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0004/215275/RC63-Fact-sheet-MNH-Eng.pdf?ua=1) (accessed: 10.05.2017).
- WHO (2014). *Health for the world's adolescents*. Geneva: World Health Organization. Retrieved from: <http://www.who.int/mediacentre/news/releases/2014/focus-adolescent-health/en/> (accessed: 30.09.2014).
- WHO (2016). ICD-10, Version: 2016. Retrieved from: <https://icd.who.int/browse10/2016/en#/F30> (accessed: 14.07.2019).
- World Mental Health, without date, *The World Mental Health Survey Initiative*. Retrieved from: <https://www.hcp.med.harvard.edu/wmh/> (accessed: 11.07.2019).