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Neurosis and Marital Interaction III. Family Roles and Functions

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In this paper we consider another aspect of the marriages of male neurotic patients and their wives, namely the pattern of role-playing within the marriage and the family. Though no formal predictions were made regarding the differences that might be found between the marriages of the patient and control groups, it was hoped that examination of the role-activity patterns would illuminate the data already reported in Part I and II on health, personality, time-sharing and social activity.

Method

The subjects used in the study comprised 60 consecutive male neurotics referred to an out-patient clinic, with 60 control husbands and their wives: the design has already been presented in detail in Part I. Here it is necessary to indicate how we approached the elusive problems of concept, measurement and analysis of role-playing.

General considerations

We decided to concentrate on a small number of family functions which are either necessary for survival or are widespread customs in our culture. These were child rearing, choice of dwelling, financial arrangements, maintenance of social relationships, holidays, and entertainments. Our interest was focused on patterns of behaviour in the execution of these functions and how the necessary decisions were made, rather than how individuals perceived their roles. We recognized that each of these functions involved a number of subsidiary activities, so perhaps it would be preferable to refer to them as 'role-playing areas'.

We found it necessary to distinguish three levels of activity within each area. The first, 'executive activity' is what is actually done. Secondly, 'executive decision-making' is deciding what is to be done: thus a housewife must not only make purchases but must decide which goods to buy. Note that a husband sent out with a shopping list is functioning at the first level but not at the second. Lastly, there is the process of policy decisions which determines how responsibility for executive decisions in any given area is to be allocated: this is analogous to the 'metarules' described by Haley (1963).

The second level, that of executive decision-making, was used for all our assessments of role playing practices, even though forfeiting the higher level occasionally resulted in seeming anomalies. For example, a wife who alone decided where the family would spend the summer holiday would be considered the primary partner in the holiday 'area', even though it was her husband who insisted that she make the choice and accept all responsibility for it.

Categorization of role-playing

The process of decision-making, as just defined, was thus central to our interest. Eight descriptive categories were used. Of these five related to degrees of domination by one or other partner, ranging from those where the decisions rested exclusively with the husband to the opposite situation where they were taken only by the wife. The mid-point of this spectrum referred to joint decisions, where both members collaborated with equal authority. The sixth category was labelled 'divided', where the partners actually acted in opposition to each other, having failed to achieve a binding common policy. This pattern will be described in more detail below. A 'not applicable' class

was used only when it was not physically possible for a role-function to be discharged. Thus a childless couple would be scored as 'not applicable' in the child-rearing area only if infertility was reported, and not if a decision by either or both partners to have no offspring had been made. Finally, 'not known' was used only when despite repeated probing the interviewer remained in doubt.

The behaviour subsumed in each role-playing area was explored by the interviewer in a semi-structured manner in the conjoint session (see Part I), and the final rating for any area was made only after all the information on all the areas had been obtained. Questioning was directed to the couple's usual pattern, which in general proved to be surprisingly stable, with little change following the onset of the patient's illness.

Certain aspects of the husband's participation in household affairs were treated separately: the details will become apparent.

Reliability of Categorization

The reliability of the interviewers' ratings was assessed during the two reliability studies (see Part I), each based on 16 couples.

Details are given in Table I for agreement over the six role-areas, plus the two specially concerned with the husband's activity at home. The 'other' column of the Table refers to (a) a two-point discrepancy on the continuum husband only, husband mainly, both, wife mainly, wife only, or (b) where one rater has scored 'divided', 'not known' or 'not applicable', while the second rater has used another category. Least agreement was attained in the 'social relations' and 'outside entertainment' areas. Five of the eight areas show minor improvement in reliability on the second study, and one a slight decline.

In general, of the 96 judgements required over the six main areas for the 16 couples rated in each study, exact agreement was obtained in 79 per cent, and approximate or exact agreement in 93 per cent of ratings in the first study, with corresponding figures of 87 per cent and 99 per cent in the second study. These figures

TABLE I
Reliability of role categories

	First reliability study			Second reliability study		
	Exact agreement	± 1 point	Other	Exact agreement	± 1 point	Other
Conjoint roles						
Money	12	14	2	14	16	0
Holidays	14	16	0	14	16	0
Childbearing ..	13	14	2	15	16	0
Household arrangements ..	15	16	0	15	16	0
Social relationships	11	14	2	11	16	0
Entertainment ..	11	13	3	13	15	1
Total	76	87	9	82	95	1
% of all ratings (N = 96) ..	79%	91%	9%	85%	99%	1%
Husband-only roles						
House care ..	13	16	0	15	16	0
Child care	16	16	0	15	16	0
Total	29	32	0	30	32	0
% of all ratings (N = 32) ..	91%	100%		94%	100%	0
All roles						
Total	105	119	9	112	127	1
% of all ratings (N = 128) ..	82%	93%	7%	87%	99%	1%

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are slightly improved if the two special areas are also included. We concluded that the reliability of the ratings was satisfactory.

Analysis of role-patterns

A preliminary and purely statistical analysis led us to adopt a typological classification of role-playing into four patterns. Marital patterns were first divided into those where one partner dominated the other ('dominated' marriages) and those where domination was not a feature ('non-dominated' marriages). The former group was divided into husband- or wife-dominated, while the non-dominated marriages were split into (a) those where both partners collaborated equally in a co-operative manner (termed 'co-operative' marriages) and (b) those where although both partners played an equally active part, specific roles were taken over by each individual, so that distinct areas of responsibility were demarcated for each spouse (termed 'segregated' marriages). In classifying a marriage within this scheme, role areas which were conflictual and scored as 'divided' were set aside for later consideration, and the categorization effected on the remaining data. The definitions used were as follows.

Wife-dominated: At least 3 areas coded as mainly or exclusively the domain of the wife, and none mainly or exclusively that of the husband.

Husband-dominated: At least 2 roles mainly or exclusively the province of the husband, and not more than one mainly or exclusively that of the wife.*

All remaining marriages were classed as non-dominated, and divided into:

Co-operative: At least 4 roles scored as 'joint' role-activity.

Segregated: The remainder.

The omission of "divided" roles, as well as those coded as "not applicable" or "not known" means that less than six roles could be used with some couples (15 patient and 8 control): special definitions, analogous to the above were drawn up for such examples.

Results

Marital type

The distribution of the types of marriage in the patient and control groups is shown in Table II. There is a significant difference between the groups ($p < \cdot 02$): the commonest pattern among the controls is clearly that of co-operation, while among the patient pairs it is that of segregation, though other patterns are also prominent.

Some authors, e.g. Pond *et al.* (1963) have suggested that husband-dominance tends to be

* The definitions of 'wife-dominated' and 'husband-dominated' marriages are not numerically equal in terms of the coding of areas. This was because the particular areas rated in the study were subsequently found to reflect the wife's activity rather more than the husband's, so that the average family emerged as slightly wife-dominated on mean scores. The effect of this skew was offset by setting a higher cut-off point for the classification of 'wife-dominated' marriages.

Table II

Distribution of marital role patterns in patient and control couples

	Dominated marriages			Non-dominated marriages			
	H.-Domin.	W.-Domin.	All	Co-operat.	Segregated	All	Total
Patients (P) ..	14	10	24	16	20	36	60
Controls (C) ..	6	14	20	29	11	40	60
Total	20	24	44	45	31	76	120

Comparison of P/C v.	χ^2	d.f.	p <
Dominated/non-dominated	0·574	1	—
Husband/wife domination	3·532	1	(·10)
Co-operative/segregated	6·175	1	·02
Each marital pattern (4)	10·235	3	·02
Husband domination/other patterns ..	4·301	1	·05

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a feature of the marriages of neurotic patients. This pattern when compared with all other in Table II emerges as significantly associated with the patient group ($p < \cdot 05$), among whom it is appreciably commoner, though it characterizes barely a quarter of the patient couples. Domination *per se* (irrespective of who is dominating) is not a special feature of either group.

Co-operation and conflict

(a) *Joint decisions*

An indication of the amount of shared decision-making can be obtained by examining the distribution of joint roles in the patient and control marriages. Each couple could score a maximum of six: couples for whom role areas were considered to be inapplicable or ratings could not be made were approximately equally distributed between the two groups. The results are shown in Fig. 1: control couples have significantly ($p < \cdot 01$) more 'joint' ratings than patients and their wives.*

Moreover, as Table III illustrates, with increasing impairment of the husband's health there is a decreasing number of joint roles.

Table III also indicates equal correlations between the health of the husband and the number of joint roles, and between the latter and the health of the wife. Nevertheless, it is probable that the health of the husband is the more important determinant of joint role activity, since small but significant correlations were also found between the number of joint roles in the marriage and the *husband's* score in the M.P.I. N scale ($p < \cdot 05$), the M.R. section of the C.M.I. ($p < \cdot 01$) and total C.M.I. score ($p < \cdot 02$), while no significant associations on these measures were found for the wives.

TABLE III

Health ratings of husbands and wives, and number of joint roles

Health ratings	Mean number of joint roles: Husbands	(N)	Wives	(N)
1	3·26	(35)	3·09	(44)
2	3·22	(41)	2·87	(56)
3	2·44	(36)	2·44	(18)
4	2·42	(7)	—	(2)
5	—	(1)	—	(0)
	$r = -\cdot 25$	($p < \cdot 02$)	$r = -\cdot 24$	($p < \cdot 02$)

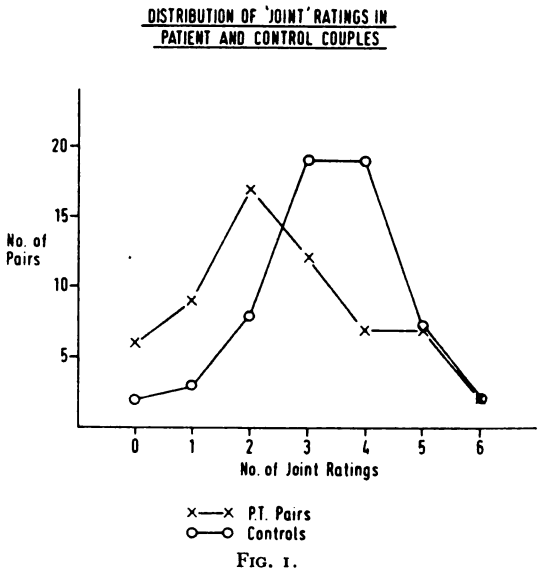

FIG. 1.

Mean ± S.E. joint ratings for patient-spouse pairs = 2·57 ± ·205.
Mean ± S.E. joint ratings for control pairs = 3·32 ± ·165.
$t = 2 \cdot 852$, $p < \cdot 01$.

As regards specific role areas, we found that joint ratings were made least often in both groups for finance (35 per cent controls, 25 per cent patients). However, two other areas differentiated significantly between the groups (comparing the number of joint roles against *all* other ratings).

One of these was child-rearing, for which 77 per cent of controls but only 51 per cent of patient couples received a 'joint' rating ($\chi^2 = 8 \cdot 202$, $p < \cdot 01$), the latter tending instead to show either wife-dominated or 'divided' activity. This is a finding of some importance and will be referred to again. The other area

* Our patient group included some men with only minor symptoms, and on the other hand, despite our screening during sampling, some of the controls showed appreciable psychological impairment. To eliminate this misclassification, we redefined the husbands as 'sick' and 'well' according to their health ratings (see Part I). Comparison of these redefined groups in terms of the number of joint ratings of role function led to results essentially similar to those obtained with the original clinical groups. Thus patient status *per se* might be associated with a deficit of joint role activity.

of interest was that of outside entertainment, covering excursions not only to cinema and theatre but also to clubs, pubs and social gatherings. Here too the patient couples had fewer joint ratings than the controls (42 per cent compared with 70 per cent, $\chi^2 = 9{\cdot}766$, $p < {\cdot}01$) but showed instead an excess of husband-dominated behaviour. A rather similar result emerged for the area of external social relationships, covering arrangements about joint visits to and from friends and family. Here there was no difference between the groups on the number of joint ratings, but the patient couples showed a clear excess of husband-domination (24 per cent compared with 5 per cent controls, $p < {\cdot}01$). Both these role areas concerning socialization reflected the marked reluctance of the husband to engage in conjoint social activity and the effect of his veto on the couple's behaviour. This accords well with the earlier observation (Part II) that the patient's wife typically spends less time in the company of others than the control wife, and suggests an explanation for that finding.

(b) *Divided role functions*

The 'divided' category was used in rating a role area only when the partners failed to agree on what should be done and proceeded to act independently and usually in opposition to each other. Thus, one parent might punish a child for something the other condoned, or one might acquire new possessions while the other insisted they should save money. No marriage could survive if many family functions were carried out in such a style, and only three couples scored two 'divided' ratings. (One at least of these later proceeded to divorce action.)

Among the patient pairs, there were 12 (20 per cent) displaying divided activity in at least one role area, compared to five (8 per cent) of the controls. This difference is not statistically significant ($p < {\cdot}10$). If, however, the couples are divided according to the health ratings of the husbands (see Part I), then 'divided' couples are found to represent 25 per cent of the 'sick husband' group compared to 8 per cent of the 'well husband' group, a difference which is highly significant ($p < {\cdot}01$). Thus role division is apparently related more to the husband's incapacity than to his formal patient-status, though the examples are too few to test this distinction critically.

Our original classification of dominant and non-dominant marriages and their subtypes was made quite without reference to any role areas rated 'divided', and it is thus possible to examine the frequency with which divided role activity occurs in the different types of marriage. Table IV gives the details for the combined patient and control samples. It can be seen that divided roles occur significantly more often in dominated marriages, and among those is a particular feature of the husband-dominated subgroup. The category next most likely to contain divided couples is the role-segregated one. Thus conflict appears to arise when a wife rebels against her husband's domination, or where agreement on how role activities should be partitioned in the segregated pattern breaks down; it is less likely to occur in situations of wife domination (which implies that husbands are more acquiescent than their spouses in the corresponding situation) or where couples generally adopt a co-operative relationship. The relative excess of divided ratings obtained by the patient couples is presumably a reflection of the higher frequency among them of both husband domination and role segregation, and more detailed inspection of the data fully bears this out.

TABLE IV

'Divided' role areas and type of marriage

(Patient and control groups combined)

Type of marriage	N	Percent with divided roles	Sig. of diff.†
Dominated	44	23	$p < {\cdot}05$
Non-dominated	76	9	
Husband-dominated	20	45	$p < {\cdot}001$
Wife-dominated	24	4	
Co-operative	45	4	$p < {\cdot}09$
Segregated	31	16	

† Tests of significance based on either Yates modification of χ^2 or Fisher's Exact Probability Test.

The role area for which 'divided' ratings distinguished most clearly between the patient-spouse pairs and the controls was child-raising. Excluding couples where such a role was not

relevant, there were 14 per cent and 2 per cent respectively in the two groups ($p < \cdot 05$).

The figure for the neurotic couples is disturbing, especially when it is recalled that our definition of 'divided' roles covered only major conflict. That such conflicts should occur principally in connection with child-rearing must also occasion concern.*

Small but significant correlations were found between the number of divided roles in the marriage, and two measures of the husband's health, namely his health rating ($r = + 0 \cdot 20$ $p < \cdot 05$) and total C.M.I. score ($r = + 0 \cdot 22$, $p < \cdot 05$); the other indices of health were also positive. On the other hand, there were no significant correlations between the number of divided roles and measures of the wife's health, all the coefficients being approximately zero. This recapitulates other findings in the study on the relative prepotence of the husband's characteristics on the marital pattern.

Domestic roles of the husband

In addition to the general role-playing pattern of the married couples we were also interested in the contribution of the husband to two specific areas of domestic activity, namely housework and child care. These were considered quite separately from the role activities already discussed, and were assessed quite differently. Instead of 'executive decision-making' we were here concerned with manifest behaviour, and in particular with the regularity of the husband's contribution. Attention focused on behaviour during the few weeks preceding the interview, but in nearly all cases the couple reported no change from their habitual mode. For each role separately, the husband's activities were classified in three grades:

(a) Regular. The husband routinely and regularly took on duties such as bathing the children (either daily or at weekends) or assisting with the shopping or washing up.

(b) Occasional. The husband would sometimes carry out these functions but without doing so regularly.

(c) Never. The husband never made a contribution to those family activities.

Inter-observer agreement on the use of these categories, plus one for 'not applicable', e.g. with childless couples, was shown in Table I and seen to be statisfactory.

From Table V it is evident that for both roles patient-husbands contribute significantly less than the controls—despite the fact that they tend to spend more time about the house (see Part II).

When the domestic roles of the husbands are analysed by the overall pattern of the marriage, rather striking differences emerge. Table VI shows the proportional distribution of the ratings. For housework contributions,

* We made an assessment of the health of the children from their parents' account and found that thirteen of the patient families compared with five of the controls (representing 29 per cent and 11 per cent respectively of those with children under 16) contained at least one disturbed child. Details have not been given, since with the numbers available the difference is not statistically significant, nor could disturbance in a child be convincingly linked with other variables.

TABLE V

Domestic roles of husbands in patient and control groups

	Regular	Occasional	Never	
Household duties				
Patients ..	16	31	13	
Controls ..	32	23	5	
	48	54	18	$\chi^2 = 10 \cdot 074$ d.f. 2 $p < \cdot 01$
Child care				
Patients ..	10	32	6	
Controls ..	26	22	1	
	36	54	7	$\chi^2 = 10 \cdot 790$ d.f.* 1 $p < \cdot 01$

* Combining occasional and never categories.

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TABLE VI

Domestic roles of husband by type of marriage: percent distribution
(Patient and control groups combined)

	N	Regular	Occasional	Never	
Housework					
(a) Co-operative ..	(45)	51	40	9	χ^2 (a + b) v. (c + d)
(b) Wife-dominated ..	(24)	46	42	12	= 6·748
(c) Segregated	(31)	29	48	33	d.f. 2
(d) Husband-dominated	(20)	25	55	20	p < ·01
Child care					
(a) Co-operative	(39)	54	41	5	χ^2 (a + b) v. (c + d)
(b) Wife-dominated ..	(19)	37	53	10	= 7·701
(c) Segregated	(25)	20	68	12	d.f. 1
(d) Husband-dominated	(14)	21	79	0	p < ·01

the co-operative and wife-dominated marriages have a high proportion of husbands in the 'regular' category and few in the 'never' group. Husband-dominated and segregated marriages have fewer regularly helpful husbands and more who are quite unhelpful. A similar pattern is found for child care, though rather fewer husbands are scored 'never' (in any type of marriage).

Thus both patient or control status (Table V) and the type of marriage (Table VI) influence the regularity with which husbands assist in traditionally feminine activities. When both these variables were held constant in further analyses it was found that the patients on the whole show less variation by marital pattern than the controls. It also emerged, despite the small numbers available, that among marriages formally designated as co-operative patient-husbands help less than controls both with housework and child care ($p < \cdot01$ and $< \cdot05$, respectively). For the patients, co-operation was evidently a matter of sharing decision-making rather than the actual chores.

Lastly, we considered the domestic participation of husbands in conflict-laden marriages, represented by one or more 'divided' role activities as already defined. Unfortunately there were too few control couples in this category to make detailed analysis possible, but if all divided couples are compared with the remainder (Table VII), it emerges that divided couples have lower scores, i.e. the husbands have less regular domestic commitments: however, the difference is significant only for child care.

TABLE VII

Mean values for domestic roles of husbands of 'divided' and 'other' marriages
(Patient and control groups combined)

	Household	Child care
Divided (N = 17)	1·06 ± ·20	1·00 ± ·13
Other (N = 103)	1·32 ± ·06	1·36 ± ·07
t =	1·14	2·47
p <	·20	·02

DISCUSSION

We do not intend to comment here on the techniques employed, apart from noting that, given close specification of which aspects of role function are being rated and a period of training for the interviewers, it is evidently possible to achieve reasonably reliable assessments.

Our findings show that male neurotics and their wives lead a very different kind of married life from matched control pairs, with relative excess of patterns of segregation and husband domination and a deficit of the co-operative mode. It appears that the neurotic husband and his spouse avoid co-operation (Fig. 1) either by splitting the family roles into more or less autonomous areas or by adopting a style in which the wife's role activity is subordinated to the husband's decisions. Both methods ensure that there are relatively few areas in which conjoint decision-making is required.

Data have been presented to suggest that the degree of deviation from 'normal' in a patient's marriage, as reflected in a deficit of

joint decision-making, is proportional to the severity of illness, measured by both clinical and psychometric assessments, in both spouses (Table III) but particularly in the husband. This finding recapitulates those obtained for time analysis and social integration presented in Part II, where it was shown that the activities of both the (neurotic) husband and his wife were associated primarily with the severity of illness of the husband. But quite apart from the severity of the husband's impairment, the very fact of his being a patient may be of some consequence. To be defined as sick by a hospital out-patient department and in need of continuing attention must carry substantial implications for the marital relationship, quite apart from specific psychological incapacity. Our data do not readily permit the dissection of the two components (i.e. of severity and patient status), but the matter would repay investigation in a specially designed study.

Neurosis in husbands, then, is associated quantitatively as well as qualitatively with patterns of role behaviour which involve minimal co-operation, but the alternatives to co-operation necessarily carry an appreciable risk of conflict. In the segregated pattern, friction may ensue along the frontiers, so to speak, of each partner's territory, while with husband domination it seems that there are areas where the wife resists her husband's directives.

These findings suggest that neurosis in the husband leads to the adoption of deviant role patterns, and these in turn tend to lead to conflict. It is, however, also possible that given a critical level of conflict, originating no matter how, particular role patterns are developed in an attempt to contain it. Such possibly 'defensive' aspects of the role patterns will be returned to later.

One important role area on which the patient and control marriages differed was that of child rearing. Here the neurotic patients and their spouses were rated significantly less often as making conjoint decisions and more often as showing overt conflict than were the controls. Among the children, disturbed behaviour was reported twice as commonly by the patient as by the control pairs. Although the difference is not statistically significant, the findings are generally in line with those reported by others, such as Rutter (1966); Kellner (1963); Ryle (1967) and perhaps most of all by Hare *et al.* (1965), whose data clearly indicate the importance of the father's as well as the mother's psychological health for the well-being of the child.

In Part II considerable attention was devoted to the restricted social life of the patients' spouse. In this context the other role areas in which our patient and control series differed, namely external social relationships and external entertainment (including social gatherings), becomes particularly relevant. For 70 per cent of control couples decisions about their joint social activities were taken conjointly, but this was true for only 42 per cent of the patient pairs ($p < \cdot 01$). Conversely the husbands were rated as mainly responsible for this area in 23 per cent of the patients but only 3 per cent of the controls, and, as we previously noted, his influence was generally one of veto. The social outlets for the patient's wife would therefore tend to be curtailed, and since she evidently enjoys no compensatory social activity (see Part II) an increase in face-to-face contact at home with the patient must ensue, with consequences discussed in the earlier paper.

All the findings discussed so far refer to decision-making about various family functions. We have, however, also assessed how much practical help the husband gives his wife with domestic chores and child rearing. The main finding was that the patients contribute significantly less than the controls, so that even on a manual level the patient's wife is at a relative disadvantage. Patient marriages contain an excess of segregated and husband-dominated marital patterns, and these have been shown to be significantly associated with poor husband co-operation in domestic tasks (Table VI). It might be supposed, therefore, that the observed lack, among the patients, of husband participation in domestic activities, simply reflects the prevailing marital pattern. But this is not the whole story, for even in marriages which are rated as co-operative the neurotic husband does less housework and gives less help with the children than the normal husband from a similar type of marriage. Moreover, any conflict in the marriage

is also associated with low levels of husband participation, especially regarding child care (Table VII), and conflict is demonstrably commoner in the patients' marriages. In general terms, we have evidence of a deficit of domestic involvement by the neurotic husband. The significance of this finding, we would suggest, lies less in the extra physical labour which falls to the wife than in the loss of support and lessened experience of sharing.

Throughout the various parts of this study the health of the wife of a neurotic husband has been a major concern. In this paper we have shown that such a wife is often involved in unusual patterns of role-playing, and is exposed to more marital conflict and receives less practical help than control wives. It was shown in Part I that patients' wives are themselves more ill than control wives* and the results of Part II, as well as the present paper, illustrate that the patients' wives are in a psychological, interpersonal and social environment which to an important degree is not of their own making, and which on commonsense grounds may readily be considered conducive to neurosis. However, with regard to the role patterns with which we are currently concerned, the interesting possibility arises that deviant patterns come about because they serve *inter alia* as a protective mechanism for the wife. As Ehrenwald (1963) has commented, withdrawal from contact may be the simplest and most ubiquitous mode of 'psychosocial defence' that one individual can display in relation to another. It is conceivable that with an irritable and self-absorbed husband a wife might prefer to assume certain domestic roles herself leaving others to the husband, thus producing a segregated marital pattern in which she can maintain her distance. Similarly she may find husband domination preferable to continuous strife, except in areas where she finds herself vitally concerned and where her resistance, manifest as conflict, represents a defence against undermining, devaluation and the development of symptoms in herself.

Such speculations cannot be usefully pursued in the present state of knowledge, and we have not even attempted to test them with our existing data. Our concern, rather, has been with the general structure of the neurotic's marriage, and to outline some of the problems awaiting further study. The replicability of the findings is clearly one important consideration, and although we have not tried to review the voluminous literature on family function, one study might be mentioned which came to our notice only after the work was completed and fully analysed. Oeser and Hammond (1954) reported on a group of normal urban Australian families, relying largely on accounts by children of their families' activities. Using a highly complex Lewin-type framework, these authors grouped their families according to both decision-making and activity patterns, producing a final classification rather similar to the one we have used. They also derived a tension index which, like our measure of conflict, was found to be most obviously related to disagreements over child care. They concluded that marital tension was more closely related to disagreements in decision-making than over role activities, and it is of great interest that maximum tension was found in husband-dominated, and minimum tension in co-operative families. Again, tension was correlated with a deficit of joint decisions and was prominent in families showing what we have termed the segregated pattern. Considering the wide differences in the samples studied and the methods of analysis, these similarities are encouraging.

* Unfortunately with the numbers available it was impossible to test for duration of marriage effects in the present section.

Summary

1. A method of analysing role-playing activities in marriage is described which focuses on decision-making processes. Evidence is produced from two reliability studies indicating adequate inter-observer agreement.

2. From the analysis of ratings made on 120 married couples (60 male neurotics and their spouses and 60 matched control pairs) a typology of marital patterns was derived. Patient and control couples differed significantly on the distribution of marital patterns, the patient-spouse pairs showing an excess of segregated and husband-dominated marriages,

and a deficit of co-operative marriages. Joint decision-making was significantly less common in the neurotics' marriages. The number of joint decisions decreased in proportion to the severity of the husband's pathology, as reflected in several indices; a similar correlation was less often demonstrable for the wives.

3. Patient and control pairs differed most conspicuously in the areas of child rearing and extrafamilial social contacts.

4. Conflict over role functions was commoner in patient marriages than in controls ($p < \cdot 10$), and more obviously so if the husbands were classified by their level of impairment rather than by patient or control status ($p < \cdot 01$). Husband-dominated and segregated marriages were particularly likely to be associated with conflict; child raising led to friction more often than other roles.

5. Participation by the husband in domestic activities such as housework and child care was significantly less for the neurotic males than the controls ($p < \cdot 01$). Low levels of domestic involvement were also shown to be characteristic of husband-dominated and segregated marriages, though even within marriages classified as co-operative the patients were less helpful than the controls.

6. The findings are reviewed with reference to the clinical, psychological and social data from earlier stages of the study. The deviant role patterns in which the patient's spouse operates may explain in part her development of neurotic symptoms, though it is also possible that segregation and husband-dominance serve some protective functions for the wife.

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