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PRESIDENTIAL ADDRESS

WOMEN AND MENTAL HEALTH*

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Honorable delegates and guests from India and abroad, fellows and members of the Indian Psychiatric Society and dear friends,

I am indeed honored by the trust that you have reposed in me for having elected me to this highest office of the Indian Psychiatric Society. It is with a great sense of responsibility that I assume charge of this office of the apex body of Mental Health Professionals in the country. My predecessors have all been illustrious persons and some of them were my esteemed teachers. I shall sincerely try to achieve the high standards already established by them and come up to your expectations.

Working in Lady Hardinge Medical College, New Delhi, gave me a unique opportunity to focus and reflect on the mental health problems affecting women. As you know, this institution was primarily meant to train women doctors for our country and thus, caters to a large number of women patients from all strata of society.

Contemporary women of our society are at cross-roads in terms of traditionality vs. modernity, dependence vs. autonomy and changing familial and economic roles. An understanding of the impact of gender on psychopathology either from a biological or psycho-social stand point has long been neglected. It is with this background in mind that I have chosen "WOMEN AND MENTAL HEALTH" as my theme for today's Presidential address.

WOMEN AND MENTAL HEALTH

"If you want to know more about femininity, enquire from your own experiences of life or turn to the poets or wait until Science can give you deeper and more coherent information" (Sigmund Freud, 1933).

The far reaching differences between men and women have inspired curiosity, poetry, romance and polemics for centuries, but only recently have they been the subject of scrutiny by medical and social scientists. Earlier, social lives of men and women used to be more predictable, fitted as they were in stereotyped roles. With society in transition, options expanded for both sexes and men and women began to vary more in their roles, attitudes and behaviors.

What are women's health issues? The following definition was developed by Public Health Task Force on women's health in U.S.A. (DHHS, 1985).

1) Diseases or conditions unique to women or some subgroups of women.
2) Diseases or conditions more prevalent in women or some subgroups of women.
3) Diseases or conditions more serious among women or some subgroups of women.
4) Diseases or conditions for which the risk factors are different for women or some subgroups of women.
5) Diseases or conditions for which the interventions are different for women or some subgroups of women.

Women live longer than men. At every point of development, females live longer and maintain a biological advantage over males. Mortality is higher for males at all ages and there are more men in all leading causes of death. However, health statistics regarding morbidity show higher rates for acute conditions and non-fatal chronic diseases for women. They also have more short-term disability, medical service use and medical drug use.

While mortality is higher in men, chronic conditions like rheumatoid arthritis, SLE, auto-immune liver disease and minor psychiatric morbidity are more prevalent in women. Further, perhaps due to their close contact with children and their roles as health workers and care-takers, they experience more respiratory and digestive conditions. Men have higher injury rates, partly because of occupational and recreational exposure to dangerous situations. As roles change in our society as well, the emerging picture is likely to be different.

Some long term disabilities are more prevalent among women. More women in middle and older ages report trouble carrying out their secondary activities like shopping and recreation due to chronic health problems than men of the same age. Sex differences in health service use is largest for young adults and narrows as age advances.

In our country, women tend to somatise or develop 'fits' for which they may seek help. Some senior psychiatrists from our country like Drs. Venkoba Rao, Nandi, Neki & Wig were perceptive early enough to report on these aspects. Women have more frequent illness and disability but the problems are typically not serious or life threatening ones. In contrast, men suffer from more life threatening diseases and these cause more permanent disability and earlier death for them. One sex is sicker in the short run - the other in the long run.

Only a small part of the 'iceberg of morbidity' is visible in health statistics or clinical practice (White et al, 1961). It's gender hue varies, most likely being deeply feminine at the bottom and gradually fading until it is intensely masculine at the very top. The bulk of the iceberg is of a feminine shade.

BIOLOGICAL RISKS:

There are intrinsic differences between males and females based on their genes or reproductive physiology which confer differential risks of morbidity. It is generally thought that males are less durable biologically than females, offset only during females' reproductive years by

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pregnancy related and breast-genital tract morbidity.

Specific Hypotheses Are:

1. Women have greater genetic resistance to infectious diseases and also some rare X-chromosome linked diseases.
2. Women are protected from cardiovascular morbidity by sex hormones until menopause.
3. The reproductive events of pregnancy, child birth and puerperium give women unique morbidity risks not experienced by men. In addition they have female specific disorders such as those related to breast, genital and genito-urinary areas [eg: cervicitis, menstrual or menopausal symptoms].
4. The pathology of some diseases, their symptoms and developmental course may differ for men and women.

ACQUIRED RISKS:

Men have more risks from their jobs, household tasks, life style behaviors, self imposed stress, social ties and reaction to stresses over a life time. Women have more risks in two respects - from more contact with young children and from more emotional distress.

a) Men encounter more risks of serious injury than women.
b) Men's choice of hobbies and sports boosts their risks of injury.
c) Men tend to drink, smoke and drive more than women - these behaviors elevate their risks of some chronic diseases and injuries.
d) Women adopt more preventive health practices - vitamin supplements, drug prescriptions, less alcohol consumption and frequent consultations for minor symptoms.
e) Women feel more psychological distress (anxiety, depression, guilt, conflicting demands) on a day-to-day basis and over their life-times than men do, and this may decrease their physiological resistance to acute and chronic conditions.
f) Women tend to be less delighted about life than men and this may make them more vulnerable to stress-related illnesses, but women also buffer the route from stress to disease by reacting to disrupting life events and upsets in more benign ways. They turn to other people and to medical drugs for relief whereas men opt for quiet brooding or resort to alcohol, cigarettes and illicit drugs.
g) Over their lifetime, women maintain stronger emotional ties with more people. Intimate ties with friends, colleagues and neighbors offer social support and deter loneliness. This may act as a buffer for disease - reducing its occurrence, severity and especially, its duration.

The most popular reason offered for greater female distress concerns women's social roles in traditional cultures. Home-makers of this era are thought to feel unchallenged, bored and undervalued, whereas employed women are believed to have excessive demands on their time and attention since they relinquish few responsibilities for child care or home-management when they work. It is thus argued that contemporary women have more stressed lives than men, no matter what they do.

EATING:

Obesity in women is generally defined as body fat content greater than 30%. Obesity is a health hazard because it is linked to an increased likelihood of hypertension, atherosclerosis and diabetes which are major risk factors for coronary artery disease.

Exercise and dieting are the common means of weight reduction, but calorie restricted diets that do not account for a woman's nutritional needs, coupled with excessive exercise pose serious health risks to women. (Dazzi & Dwyer, 1984; DHHS, 1988). The anti-obesity clinics in many cities are being run by unqualified persons and more on a commercial basis.

ALCOHOL & DRUG ABUSE:

Alcohol is consumed in lesser quantities by women in our country as compared to others, but in those who drink, Fetal alcohol syndrome is of significant concern. Prescription drugs and over the counter drugs are consumed more by women. Two thirds of prescriptions for psychotropic drugs such as Diazepam and Alprazolam are for women. Multi centered sample surveys in schools and colleges carried out by Dr.Mohan and others have, over the last two decades, found similar trends.

DRUG TRIALS:

Women subjects are conspicuously absent or under represented in drug trials. Thus, the possible gender differences in therapeutic response do not receive adequate attention.

ILLNESS BEHAVIOR:

Hypotheses of psychological differences proposed are:

1. Perception: Women are more sensitive to bodily discomforts than men are. This may be because of childhood socialization - discouragement for boys to complain about bumps and bruises; and in girls, more attention given to menarche and puberty and the body awareness that menstruation and reproduction provoke.
2. Evaluation: Women are more apt to label their symptoms as physical illness and after such labelling, assess their illnesses and injuries as more severe and serious than men. On the other hand it is not 'masculine' to be ill and men ignore the implication of symptoms for their usual activities.
3. Behavior: Women take action by adopting a sick-role. This occurs through both their willingness and ability and may have numerous factors, some of which may be that it is more socially acceptable. They also have more dependent and help seeking behavior and have more trust in authority.

- The concept of learned helplessness is more typical of women than men.
- In addition, bed rest, activity restriction and turning to

others/medical attention is believed by them to be helpful

Looking at ability factors, women have more flexible time schedules and fewer time constraints to accommodate health problems. They may even drop out of a job while men continue to work more often even when ill.

Whereas response to serious or life threatening illness is of a uniform pattern in terms of hospitalization and medical care, the minor psychiatric morbidity seen more often in women offers a variety of possible responses. This may be in the form of neglecting it, talking about it to neighbors and friends, turning to faith healers and traditional health care systems, visiting religious places or seeking professional help. This provides plenty of discretion to the individual and family members. The more discretionary a health action is, the more it allows psychosocial factors to operate leading to gender differences in help seeking behavior.

HEALTH REPORTING BEHAVIOR:

-Women are more willing to talk about their symptoms to others whether they are friends, employees, interviewers or physicians.

-Women recall minor health problems and minor health actions better than men do. A presumed reason is that women are more interested in health matters and also more often involved in them as a health helper for children and kin and this greater salience enhances their memory.

-Vocabulary of illness differs for women and men. They may elaborate more and their presentation includes both somatic and psychological content more often.

VIOLENCE AGAINST WOMEN:

The scope of violence against women is of a stunning magnitude when crimes by intimate perpetrators and strangers are considered.

They do not come to public attention because of 'cover ups' facilitated by forced secrecy demanded by perpetrators of abuse, or due to closed family boundaries.

Family members committed 90% of the physical & sexual assaults recalled by psychiatric patients (Carmen et al, 1984). We have no figures from India, but are we enquiring about them in our case histories?

Exposure to sexual violence fails to be included in standard sexual history in clinical medicine, even in the developed countries. Standard psychiatric assessments routinely fail to detect histories of sexual assault among inpatients. Thus when psychological variables are ignored in diagnosis, somatic complaints which are the ticket of admission to a medical system may be inaccurately or inappropriately diagnosed as organic in aetiology. While somatic complaints place a burden on the health service delivery system, opportunities are missed to facilitate simple confiding in a caring person which has a demonstrated therapeutic response on the immune system. Furthermore, the psychiatric aspects of the perpetrators and victims of dowry deaths also needs to be explored.

GENDER DIFFERENCES IN TREATMENTS RENDERED AND RECEIVED:

Physicians distinguish the characteristics of 'difficult patients' along gender lines (Schwenk et al, 1989). Physicians' perception of difficult patients mainly involve two factors:

1. Medical uncertainty (vague, difficult to describe symptoms - frequently changing symptom picture).
2. Interpersonal difficulty: Difficult physician- patient relationships result in poor health care delivery as well as in patient dissatisfaction.

OCCUPATIONAL STRESS:

A working woman performs multiple roles in life including that of a wife, mother, employee, maintainer of extended family ties and caretaker of elderly relatives. This trend has raised questions even in the West whether the prevalence of heart disease amongst women would begin to rise as a response to occupational stress and multiple role tensions. However, data from Western countries indicates that working women have a slight health advantage over housewives. The changing scene of Indian society provides a good opportunity for studying this phenomenon and its mechanisms.

Contrary to the notion that executive jobs produce high stress, heart disease is more common among women in clerical or low status jobs. In an eight year prospective study reported by Eaker (1989) clerical workers who reported having an unsupportive boss were at increased risk of developing coronary artery disease. Also, meta-analysis studies of job involvement among women have indicated that it is unrelated to a type A personality - a constellation of personality traits that have been linked to heart disease in men (Booth & Friedman, 1987).

Women who smoke have two or four times the risk of heart attack of non-smoking women (DHHS, 1988). Further, the risk factors for Coronary artery disease (lipid disorders, hypertension, diabetes and smoking) tend to cluster in the same patients. In our country, even though women commonly do not smoke, they are subjected to passive smoking due to constraints of living space and traditional subservience.

SEX DIFFERENCES IN THE BRAIN:

The bulk of the evidence, as reviewed by Kumra (1992), suggests that the effect of sex hormones on brain organization occurs so early in life that, from the start, the environment is acting on different wired brains in girls and boys.

Major sex differences in intellectual functions seem to lie in patterns of ability rather than in overall IQ. In laboratory experiments, researchers have found that women tend to remember land-marks such as a well on the lower right or a tree at an intersection. Men appear to learn routes faster but cannot recall landmarks as readily. They may rely preferentially on spatial cues such as distance or direction.

Men on an average perform better than women on certain spatial tasks. In particular, men have an advantage in tests that require the subject to imagine rotating an object or manipulating in some other way. They outperform women in mathematical reasoning tests and in navigating their way through a route. Further, men are more accurate in tests of target directed motor skills; that is, in guiding or intercepting projectiles. Women tend to do better at rapidly identifying matching items- a skill called perceptual speed. They have greater verbal fluency, including the ability to find words that begin with a specific letter or fulfill some other constraint. Women also outperform men in arithmetic calculation and recalling land-marks from a route. Moreover, women are faster at a certain precision manual tests such as placing pegs in designated holes on a board.

Marion Hals and Irwin Silverman of York University, USA, studied the ability to recall objects and their location within a confined space - such as in a room or a table top. Women were better able to remember if an item was displaced or not. They also were able to replace them in their exact position more accurately than men.

The life long effects of early exposure to sex hormones are characterized as organizational because they appear to alter brain function permanently during a critical period. Administering the same hormone at a later stage has no such effect. Hormonal effects are not limited to sex or reproductive behavior but to all known behavior in which males and females differ. For example, Michael Meaney of Mc Gill University found that Dihydrotestosterone working through the amygdala rather than the hypothalamus gave rise to play-fighting behavior in juvenile male rodents. However, the area in the brain that organizes female and male reproductive behavior is the hypothalamus. Roger Gorki and his colleagues at University of California at Los Angeles have shown that a region of the pre-optic area in the hypothalamus is visibly larger in male rats than female rats. Laura Allen in Gorki's lab has found a similar sex difference in human brain.

In 1991, Simon LeVay of the Salk Institute for Biological Studies in San Diego reported that the interstitial nucleus of the anterior hypothalamus is larger in human males than females and smaller in homo-sexual men. Sexual preference may thus have a biological substrate. It is a well documented fact that exposure to androgens in girls makes them grow tomboyish .

In 1991, DeLacoste and her colleagues reported that the right cortex was thicker than left in men. Jane Stewart of Concordia University in Montreal, working with Bryan Kolb in Alberta think postulate that androgens appear to suppress the left cortex. It is widely assumed that two hemispheres are more asymmetrically organized for speech and spatial function in men as compared to women.

PSYCHOSIS:

A review of literature on sex differences reveals that the psychiatric focus has swung from questionable assertions of 'anatomy' (or perhaps evolution) as destiny to a relative neglect of sex as relevant at all. The vast majority of follow-up studies of schizophrenic patients since 1980, continue to ignore the gender factor. Perusal of the literature on sex differences in affective and schizo-affective disorders reveals even less recognition of the issue.

SCHIZOPHRENIA:

Strenuous attempts to define onset have been made by some authors (Hafner et al, 1989). Others have chosen to record the age at first psychiatric contact, admission or treatment. Whichever way onset is defined, the earlier appearance of symptoms in men than women is a well replicated finding. This was found in early studies (reviewed by Lewine et al, 1981) and has been reported across several cultures (Sartorius et al, 1986) and with different diagnostic systems. Typical findings are that 50-60% of men but only about a third of women have their first admission by the age of 25. Goldstein et al (1989) studied the age of onset and found that the mean age was 24.3 for males, and 27.9 for females. Onset at age forty occurred in 8% of females and only 1% of males.

Differences in age at first admission do not seem to reflect sex differences in illness behavior nor greater social tolerance of bizarre behavior for females (Lewine et al, 1981; Hafner et al, 1989). Other aspects of onset may also show sex differences; life events heralding onset seem to be more commonly reported by females (Bardenstein & McGlashen, 1990). The season of onset may also differ; Takei et al (1992), found that schizophrenic females, like male and female manic patients showed a significant seasonality of first admission with a peak of July. In contrast, schizophrenic men showed an admission peak in January. A winter peak was most pronounced for males with early onset schizophrenia [first admission before the age of 25].

COURSE AND OUTCOME OF SCHIZOPHRENIA:

Angermeyer et al (1990) reviewed the world literature on the effect of gender on the course of schizophrenia. There is a tendency for attenuation of these gender differences in very long outcome studies. Almost all studies found the outcome of Schizophrenia to be better in females, at varying lengths of follow-up. Thara & Rajkumar (1992) from SCARF, Madras, have also reported a better outcome in females. McGlashan & Bardenstein (1990) found that the gender differences in outcome were more pronounced in schizophrenia than schizo-affective and affective disorders.

Suicide in schizophrenia is more common in men (Brier & Astrachan, 1984). Part of the better outcome in females in the short and mid-term may be explained by a better response to both drug treatment and family interventions (Seeman & Lang, 1990; Haas, 1990).

PREMORBID FUNCTION:

There is now good evidence that, on a range of measures, antecedent deficits are more common and more severe in boys going on to develop schizophrenia than in

girls. If we accept Kraeplin's views that childhood behavior deficits are really the first evidence of a continuous disorder, these results suggest the gender effect at onset not only for psychotic symptoms, but for pre-psychotic signs as well.

INCIDENCE:

Conventionally, men and women are at equal risk of developing schizophrenia. The introduction of operationalised diagnostic criteria has changed all this. The life-time morbid risk of schizophrenia does appear to be slightly higher in men even when broad RDC criteria are used.

PHENOMENOLOGY:

Several studies & reviews (Goldstein & Link, 1988; Bardenstein & McGlashan, 1990; Castle & Murray, 1991) have concluded that there are differences in the non-nuclear symptoms of schizophrenia between the two sexes. Overall, men are more prone to express negative defect symptoms such as social withdrawal and blunted affect. Females are more likely to present with dysphoria and depressive symptoms. Substance abuse and anti-social behavior are more common in schizophrenic men (Bardenstein & McGlashan, 1990).

These sex differences in symptoms could imply differences in Neuropsychology.

FAMILIAL RISK:

Goldstein et al (1990) found that the age corrected life-time risk of DSM-III schizophrenic men was 2.2% compared with 5.2% in relatives of schizophrenic women - a significant and surprising difference. Relatives of schizophrenic men were significantly more likely to show schizotypal personality disorder. Interestingly, both male and female relatives of female probands had a higher risk of schizophrenia. This is not explainable on any known genetic models.

Interestingly, increased risk to relatives of female probands in also found in Neurodevelopmental disorders such as stuttering and epilepsy. Goldstein et al interpret these findings as support for the existence of a subgroup of severe, poor prognosis schizophrenia arising predominantly out of non-genetic factors - a sub-type which appears mainly in men.

BRAIN STRUCTURE:

There is evidence that schizophrenic men more often show structural brain abnormalities which are more clearly of neurodevelopmental origin. Studies using MRI have reported reduced coronal brain area, enlarged ventricles, and small left hippocampal formation in men with schizophrenia, but not women. Other studies have found ventricular enlargement in both schizophrenic men and women (Lewis, 1992).

To conclude, these differences are already being used to try and tease out possible sub-types of schizophrenia. The advantage of using gender as a subdividing variable with which one can look for heterogeneity is that it is completely reliable, stable and valid in its definition - what Lewine (1988) has called an immutable sociodemographic variable.

Thus, men are more likely to have early onset, negative, process, sporadic schizophrenia. In addition, women schizophrenic patients are different in terms of treatment response : antipsychotics, family interventions as well as increased compliance with treatment (Zito et al, 1985). Goldstein et al (1990b) reported that there was a sub-type twice as common in men with poor pre-morbid history, blunted affect and winter birth - (early neural damage). Furthermore, these men had the fewest relatives with schizophrenia.

AFFECTIVE DISORDERS:

Male bipolar patients have worse outcomes than male unipolar patients, whereas outcomes for female unipolar and bipolar patients are comparable (Loyd et al, 1985). Such evidence warrants consideration of each sub-type separately.

BIPOLAR DISORDER:

This disorder seems to occur at a similar age and rate in men and women. Schizophrenia-like symptoms, if present, are equally distributed. By the time they are hospitalized, female patients have had more episodes and less precipitating factors. The outcome scenario is somewhat equivocal and even contradictory. On the one hand, bipolar women are rehospitalized less frequently, healthier at last contact, and less episodic post discharge. They also control drug and alcohol abuse better then their male counterparts. At outcome, bipolar women function better with respect to occupation, living situation, and global recovery. On the other hand, studies show that bipolar women commit suicide more often, remit less frequently, die earlier, and comprise a majority of the 'rapid cyclers' who have the worst outcomes. Compared to schizophrenic cohorts, bipolar men and women are comparable pre-morbidly and exhibit more differences at outcome.

UNIPOLAR DISORDER:

Most unipolar sex differences concern premorbid and baseline characteristics. A female to male prevalence ratio of 2:1 is consistently noted in epidemiological surveys. Current discussions of gender and unipolar disorder focus on hypothesized male equivalents of depressive symptoms which may skew results, especially the possibility that depression is expressed in men as antisocial behavior or alcoholism. Including such depressive equivalents when determining prevalence would more than even the male/female ratio of 1:2.

SUICIDE:

In India, the pioneering work by Dr. Venkoba Rao on depression and suicide is worthy of note. He has highlighted not only the gender differences but also the

transcultural aspects.

SCHIZO-AFFECTIVE DISORDERS:

In the Chestnut Lodge Follow-up Study (McGlashan & Bardenstein, 1990), the schizoaffective cohort weakly echoed the findings in the schizophrenic probands; namely, gender differences in the same direction but in fewer categories. Schizoaffective women were married more often than the men at index hospitalization. Schizoaffective males presented with higher IQs and greater anti-social behavior; in contrast to the schizophrenic cohort, schizoaffective men displayed greater affect than women. The study also found no differences in global outcome, although the males achieved more education than the females. Marital rates were not found to differ in another study. Additional differences noted are a higher prevalence, older age of onset and greater suicidal tendencies in women.

POST-PARTUM PSYCHIATRIC DISORDERS:

Pitt in 1968 alerted psychiatrists that 1 in 10 post-natal women experience clinical depression. Most research on post-partum depression has been done in Great Britain and Scandinavia and only recently (after 1980) in North America & Europe. Scientific studies from developing countries are lacking.

Several prospective studies have found that post-partum period is a time of greater risk for depression than pregnancy (Kumar & Robson, 1984). Post-partum depression, when it does occur, interferes with the developing mother-infant relationship and causes disruption of family life (Cox et al, 1984). Cox et al have developed the Edinburgh Post-Natal Depression scale to study post-natal depression. At any rate, depression is very common in the child bearing age and it has been postulated that aetiology of post-natal depression may well be biological [hormonal]. The incidence of post partum psychosis has been reported as 1-2/1000 deliveries. Kendell and colleagues (1987) have noted that for primipara, the relative risk in the first month for psychotic breakdown is very high. Perplexity and confusion are very frequently encountered symptoms in phenomenology. Our findings from Lady Hardinge are also similar. Those with a past history of bipolar depressive illness are at greater risk of post partum breakdown than unipolar depressives.

MENOPAUSE:

For many years it was believed that there was a specific depressive syndrome occurring in perimenopausal years. However, articles over the past 25 years show a paucity of evidence for any separate depressive entity occurring in the menopausal years. Milder psychiatric syndromes may occur between the ages of 45-49, although there may be no association between these syndromes and biological menopause.

The only comparative recent evidence suggesting that major mood symptoms may be linked to menopausal years comes from studies demonstrating a decrease in serotonin measures (either plasma free tryptophan or platelet serotonin) in the perimenopausal and menopausal years. This time period correlates with peak suicide rates for women - a peak not found in men. It has been suggested that low 5 HIAA, the final by-product of the tryptophanin-doleamine pathway, may be low in suicidal patients - particularly those who commit violent suicide. Although purely speculative at this point, it is possible that decreased serotonin during menopause temporarily causes a greater susceptibility to suicides in vulnerable women who may also be depressed.

HYSTERECTOMY:

Based on the more recent well designed studies, there is a little evidence that hysterectomy is followed by a higher rate of post-operative psychopathology or depression. The subgroup at a higher risk is composed of women with pre-operative psycho-pathology. Recently, Indian studies on Family Planning and Mental Health have been reviewed by Bhatia and Malik and they point out that the physical and psychological symptoms that appear show a decline with passage of time. There is also a need for pre-operative counselling in this area.

STUDIES ON GYNECOLOGICAL PATIENTS:

Most of the studies on gynecological patients, including ours (Agarwal et al, 1990), show that (a) patients with gynecological disorders had a high rate of emotional disorders, and (b) the highest proportion of emotional disorders were found in patients with uterine bleeding.

VULNERABILITY FACTORS & SOCIAL SUPPORT:

In a community study, Brown & Harris (1978) described four vulnerability factors, which increased the chances of a woman developing stress in the form of depression in the presence of a life-event or difficulty. They were:

-lack of good marital relationship
-lack of full-time or part-time employment
-the presence of three or more children under fourteen years at home
-parental loss before seventeen years of age.

Women's status and reality in the authoritarian patriarchal society of India may further exacerbate life-stresses, anxiety or depression. In India, Agarwal et al have drawn attention to the fact that women staying with psychiatrically ill husbands in nuclear families show more psychiatric disturbance. In the Indian study by Mayamma and Sathyavathi (1987), it was seen that neurotics and their spouses appeared to have more conflicts with regard to finance, household tasks and companionship, and to a lesser extent with child rearing. This probably highlights the clash between traditional and modern values as women take up careers and increasingly emerge as individuals in their own right. Points of conflict may arise in various circumstances if the norms and personal preferences of the husband are opposing those of the wife or vice-versa. Such

findings are usually interpreted in two ways: firstly, maritally distressed individuals may produce such marked discrepancies primarily as the function of their unrealistic attitudes, needs and expectations. Secondly, distressed and non-distressed individuals may differ only in the degree to which similarly held expectations are actualized, which in turn may be related to differences in personality traits, communication abilities or social skills repertoire. The marriages of normal couples on the other hand are characterized by a relative absence of conflicts and discrepancies between expectations and performances of both spouses.

In a study of 120 women by Avinash Virk (1990), it was found that the number of desirable and undesirable events experienced by a single woman is almost the same but a trend towards an increase in undesirable events is seen with marriage. He also found that personal events contributed towards greater stress in married women. Marriage contributed to the development of greater symptoms in women. Work appeared to have a protective effect, but to a small extent.

Bernard (1976) suggests that women are dependent for satisfaction of affiliative needs on their husbands who lack training in being expressive. Dependence is related to helplessness. It could also mean that dependent women relate to their husband in a child-parent way or remain excessively involved in their families of origin to the detriment of their marriages. The picture gets complicated because dependency may become worse by a depressive illness. Seligman believes cognitions of helplessness to be the core cause.

Brown (1973) emphasizes the protective function of the ability to have confiding and intimate relationship with spouse/boy friend against developing depression. This however, may itself be a function of a stable personality. The role of a housewife played by married women is relatively unskilled, undemanding, boring and low in status. In addition, this role is invisible, unstructured and allows the occupant to brood and become involved in personal problems in a way that working women in a more structured role cannot.The 'daily hassles' of a housewife may have a cumulative effect; similarly, frustrations or strains from on-going problematic situations at work, e.g. with a co-worker.

Vanfossen (1981) has emphasized the role of affirmation and support received from their husbands as important regarding their work. Researchers have pointed out that even among professional women who perceived their careers as being just as salient or integral to their lives as their spouse, their family interests superseded their career concerns (Hardesty & Betz, 1980).

The housewife's role identity is particularly dependent on family responses because she has no external evaluators to turn to for contrary opinion when her husband and/or children do not perceive her work as worthwhile. Unfortunately, a negative evaluation of her role by her family is quite frequently the case, since the status of a housewife in our society is relatively low. In a money based economy, a job that engenders no income has a lessened status value.

"Our definitions of work", writes David Reisman, "also mean that the housewife, although producing a social work-product does not find her work explicitly defined and totalled either as an hour product or as a dollar product in the national census or in people's minds. And since her work is not defined as work, she is exhausted at the end of the day without feeling any right to be, insult thus being added to injury".

CONCLUSION:

To conclude, it is high time that the medical profession in our country became more aware about women's health issues. Psychiatrists can take a lead by impressing upon the government and other scientific bodies like the ICMR to conduct scientific studies in the form of a Task Force on Women's Mental Health. This will be quite befitting in the 'Decade for the Woman' as declared by the SAARC countries.

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