

Summary

There is increased recognition that many women suffer from postpartum depression. In addition to the personal distress suffered, this disorder causes marital disharmony, interferes with the woman's attachment to her child and may lead to child abuse. If untreated, depression may persist. The aetiology is not clear, but is thought to reflect an increase in physiological vulnerability in combination with other factors - biological, psychological and social.

As many of the determining and risk factors can be identified, there is the possibility of intervening in order to maximize postpartum psychological adjustment. Possible interventions for the mother at risk include psychological and/or social techniques such as increased social support and marital counselling. Evaluation of these interventions is needed. Increased recognition and earlier treatment is needed to help promote mental health and prevent sequelae both for the woman and her family.

Mother-infant relationship

Current figures suggest that at least 1 in 10 babies born will be cared for over the first 6 to 9 months by a mother passing into and usually through a bout of clinically significant depression. There is concern (see Editorial, 1989) about the long term effects of a temporarily depressed maternal psychiatric state on the development of the child. These could persist in various elements, including language development and cognitive functioning. Further, the links between postnatal depression and other factors such as the quality of the relationship between the mother and her child may also impact on the child's development. Research has shown 2 to 3 month old babies to be sensitive to and discriminatory of the quality of maternal behaviour and that inappropriate maternal behaviour elicits signs of distress in the infant which then shows signs of withdrawal. Coghill et al (1986) found lower scores in the general cognitive index for children of mothers who had experienced a period of depression in the child's first year. The Australian prospective study (Janson, 1991) did not find a relationship between depression (BDI Scores) and child's cognitive development. Independent reports of child behaviour disturbance by both mothers and fathers correlated significantly with maternal depression scores. Maternal depression may be more likely to impact on child's behaviour than on cognitive functioning. More studies are needed although there are many methodological problems inherent in this type of research.

Mother-infant interaction disorders may or may not coexist with psychiatric illness such as depression.

These disorders may be classified as follows (see Kumar & Brockington, 1988):

1. **Delayed Attachment (1/10 births).**
Some mothers experience delay in the development of affectionate feelings for their infants. This may or may not be associated with depression.
2. **Obsessional Thoughts of Hostility to the Infant (1/100 births).**
Intrusive and distressing thoughts about the baby including impulses to inflict bodily harm may co-exist with a normal mother-infant relationship.
3. **Rejection of the Infant (1/100 births).**
In this condition there is lack of feeling for the infant, persistent hostility and a determined effort to avoid the maternal role.
4. **Child Abuse and Neglect (1/1000 births).**
This may occur outside the context of severe mental illness. Abuse may occur in a setting of impulsive violence on the part of an inadequate or unsupported parent. There may be a history of familial violence, marital disharmony, lack of kinship support or isolation, low self-esteem, poor models for motherhood and lack of maternal skills.
5. **Infanticide (1/50000 births).**
 - a) **Neonaticide**, the murder of the child within 24 hours of birth (mothers usually under 25, unmarried, without evidence of depression or psychosis or suicidal behaviour. Child unwanted and mother fearful of reaction of families to pregnancy).
 - b) **Filicide** is murder of child more than 24 hours after birth and is usually associated with mental illness. There may be associated suicidal behaviour, acute psychosis, and/or ideas of the necessity to relieve real or imagined suffering. Some babies are killed as consequence of child abuse, others in revenge against a husband.

Pregnancy Loss

Although grief has been understood and documented for many decades, only recently have the full impact and consequences of pregnancy loss become appreciated. Unique aspects of pregnancy losses surrounding miscarriage and ectopic pregnancy, stillbirth or neonatal death include: real (actual) loss of a person; threatened or impending loss of a person; loss of status (motherhood); and symbolic loss (of the future). In addition there is a crucial loss of self-esteem resulting from the woman's inability to rely on her body and give birth. For postneonatal loss, numerous social institutions support the bereavement process. Social rituals have not yet been accorded to pregnancy loss "celebrated only in the tears of women" (Friedman & Cohen, 1982). Emotional responses described include those of initial emotional numbness and denial, shock, feelings of loss, sadness, emptiness, anger, inadequacy, blame and jealousy. The final stage of the mourning process is characterized by a diminution of feelings of self-reproach, loneliness and emptiness (Woods & Esposito, 1987).

Despite the large proportion of pregnancies which end in miscarriage (between 15-20% of pregnancies), there has been a seeming inattention by health care professions to this distressing experience (Reinharz, 1988). The lack of sympathy for a woman who has miscarried has been evidenced by societies past and present. In the Middle Ages, women were sometimes burned alive after miscarrying. In some societies repeated miscarriage represents grounds on which a man may divorce his wife. Reinharz (1988) relates the invisibility of miscarriage amongst other reproductive concerns for women to a general fear of death in our society and Western society's obsession with success and discomfort with failure. Although the prevailing view of the medical profession is that the trauma is not great (Reinharz, 1988), miscarriage is experienced as a loss by most women and is therefore likely to be stressful. Losses involved include those of: this particular child; investment of time and energy in a particular pregnancy; a sense of control about life, health or fate. Lack of community support and rituals deny women comfort and lead to feelings of isolation. Early pregnancy loss may mean that there is no recognizable body to visualize, and this further complicates the mourning process. Borg & Lasker (1981) suggest that doctors should meet several times with couples who have suffered miscarriage to provide information and an opportunity to address questions. Mothers of babies who have died should not be placed in maternity wards, visiting hours should be unrestricted and funeral/burials should be offered. Social support and community support may positively influence the woman's adjustment to miscarriage.

There is a growing literature on the long term psychological effects of stillbirth and neonatal death. Longer term sequelae of continuing psychological symptoms and disturbed family relationships have been reported by a number of authors. Symptoms suffered by families include depression, sleep disturbances, social withdrawal, anger, guilt and marital disturbance (Dyregrove & Matthieson, 1987; Vance et al, 1991). Mothers have more symptoms than fathers, and parents affected by Sudden Infant Death Syndrome have the most symptoms of anxiety and depression (Vance et al, 1991). Studies have identified the following factors as influencing the progress and severity of mourning: lack of parental support (Tudehope et al, 1986); lack of contact with the ill or dead infant (Tudehope et al, 1986); length of time the child lived (Dyregrove & Matthieson, 1987); communication between parents (Laroche et al, 1984); reaction of hospital staff and hospital practices (Laroche et al, 1984); and time since the death (Murray & Callan, 1988).

7.3 Menstrual Cycle Linked

Of particular importance when examining women's mental health is menstruation (O'Rourke, 1984). This biological phenomenon has been the subject of myths and taboos within and among various cultures. These myths distort the reality surrounding menstruation and create ambivalent feelings about the value and usefulness of this function outside of its necessity as a means of reproduction. Thus studies concerning menstruation need to take into account cultural and psychosocial factors that define the meaning, values and behaviour associated with this biological phenomenon. Research on the biopsychosocial

aspects of menstruation may help explain psychological well-being in women, exacerbation of psychological distress, choices of contraception, the interrelationship of belief systems and health behaviour. For the female menstruation is a major life event.

O'Rourke (1983) studied factors affecting the well-being of 633 healthy employees aged between 21 and 44. Demographic factors (age, ethnicity, income) and perceived general health status significantly affected perceived general well-being. The number of premenstrual and menstrual symptoms also significantly affected personal well-being as did the type of symptoms. The symptoms of negative affect and arousal accounted for most of the effect. Specific menstrual symptoms did not adversely affect personal well-being suggesting a greater acceptance of menstrual rather than premenstrual symptoms.

Mood and behavioural changes have been observed to be associated with the menstrual cycle since ancient times. Most women are probably aware of cyclical changes in mood and behaviour. The findings of 24 prospective studies of affective fluctuations during the menstrual cycle were summarized in an earlier review (Dennerstein & Burrows, 1979). The majority of studies reported negative moods characterized by irritability, restlessness, anxiety, tension, migraine, sleep disturbance, impaired concentration, depression occurred more frequently during the premenstrual and menstrual weeks. Although positive moods were not assessed as frequently as negative moods, the review found that increased feelings of well-being, elation, pleasantness and activation occurred during follicular and mid-cycle phases. From a variety of studies the incidence of premenstrual symptoms ranged from 25%-96% depending on the criteria, timing, type of measurements and characteristics of the women studied. The incidence rates of premenstrual symptoms amongst general practice attenders in Britain were reported as varying from 25% (Kessel & Coppen, 1963) to 75% (Clare, 1977); factory workers in the USA - 36% (Bickers & Woods, 1951); hospital personnel and students in the United Kingdom 33% (Sutherland & Stewart, 1965); wives of American university graduates 52% (Moos, 1969); and French women in a community sample 64% (van Keep & Lehert, 1981).

Janiger et al (1972) compared symptoms experienced by women in Athens, Tokyo, Istanbul, northern Nigeria with Apache Indian women and Californian women. There are a number of methodological problems as the study was based on retrospective recall and the groups were not strictly comparable. For example the samples varied from students to outpatients. Premenstrual symptoms were found in all cultures examined. Several symptoms showed marked variations in frequency between the various cultural groups. For example there was a paucity of breast complaints among the Japanese, but a high incidence of headache symptoms in the Nigerian group. Japanese had fewer symptoms than the other groups, with American women intermediate, and Turkish and Nigerian women showing the highest incidence and symptom scores. Thus symptoms suggestive of premenstrual distress are

present in diverse cultural groups but are subject to individual variation in the incidence, nature and severity of symptoms.

Hasin et al (1988) compared menstrual and premenstrual complaints among 152 women of different ethnicity in Australia. None of the women were using the oral contraceptive pill. 50.8% reported menstrual symptoms which were mostly somatic, with a range of 37% (Vietnamese) to 73% (Greek). 69% reported premenstrual symptoms, but the percentages varied from 88.5% for Greek women to only 42% for Vietnamese women. Turkish, Greek and Vietnamese women complained mainly of somatic symptoms, while 60% of the Australian and 53% of the Italian women's complaints were of psychological and behavioural symptoms. Symptoms were evaluated as significantly more severe by the Greek women and significantly less severe by the Vietnamese women. More research is needed to identify whether the differences observed between the ethnic groups are due to physiological changes in the cycle (longer cycles in the Vietnamese and shorter cycles in the Turkish women) or represent psychosocial differences between the ethnic groups.

Vallings (1987) in a retrospective study, compared premenstrual symptom experience of Maori, Polynesian and Pakeha women attending an Auckland family planning clinic. Severe symptoms were more likely in both Maori and Pakeha women to be experienced by nonhormonal contraceptive users. The symptoms reported were similar in all groups studied. The most severely rated symptoms were depression and headache. Most frequently reported symptoms were tension; irritability; depression; fluid retention; breast tenderness and headaches. 11% of Maoris, 14% of Polynesians and 18% of Europeans rated at least some of their symptoms as severe. When asked how they coped with premenstrual symptoms most of the Maori and Polynesian women answered: "more rest"; "eating watercress"; "extended family help" whereas the European women were more inclined to read books and attend courses on premenstrual syndrome. This small study found that premenstrual symptoms did appear to occur across all groups. A greater number of Polynesian women experienced no symptoms at all (29%). European women showed the greatest incidence of symptoms (84%), the highest incidence of severe symptoms (18%) and considered such symptoms as problems whereas the Maori and Polynesian women were more accepting of their lot and did not really expect any advice or treatment.

In a World Health Organization study (Snowden & Christian, 1981), the incidence of negative mood changes varied from 38%-71% across different cultures. Mood changes were more noticeable in the women of the United Kingdom (71%) reference group. About 60% of the women claimed to have physical discomfort prior to or during menstruation with no significant cultural topology. These findings may indicate that cultural relativity may affect the perception of symptoms and determine what is regarded as important and acceptable.

An outstanding feature of many of these studies is that though large proportions of women report symptom experiences, the actual number who find

these changes problematic and seek treatment is much smaller. It is not clear whether treatment seekers experience a greater magnitude of symptoms than does the wider population; or whether treatment seekers may be women who give more serious attention and meaning to cyclic changes than do others (Renaer, 1983).

The combination of affective, behavioural, cognitive and physical changes occurring premenstrually have been designated as a syndrome - the premenstrual tension syndrome (PMS). PMS research in the past has suffered from the failure to adequately define this syndrome with an overinclusion of symptoms without due regard for the cycle phase in which symptoms appear. This led to difficulties in the comparison of findings and has also contributed to the appearance of separate methodologies that compounded the problem. Recognition of the need to reach consensus on the features of this disorder led to the American Psychiatric Association including PMS as a special category disorder called Periluteal Phase Dysphoric Disorder (PPDD) in the appendix of the revised edition of the Diagnostic and Statistical Manual (DSM-III-R, 1987). Diagnostic criteria included a history of multiple symptoms (in most menstrual cycles) in the premenstrual week, with relief from symptoms by the week post-menstruation. The symptoms had to be severe enough to cause marked distress or interfere with social or occupational functioning and temporal linkage of symptoms to the premenstrual phase of the cycle had to be confirmed by prospective daily-ratings of at least two cycles. The contemporary use of clearly defined diagnostic symptoms linked to specific cycle phases has resulted in more parsimonious estimates of PMS prevalence, of approximately 5% of women of reproductive age (Clare, 1985).

There appears to be a clear hormonal basis at the premenstrum for breast swelling and nipple sensitivity, water fluid redistribution and diuresis, alterations to specific categories of efficient behavioural and cognitive abilities (Philips & Sherwin, 1991) and some cyclic changes in mood and sexual responsivity. All of these changes occur in non-treatment seeking women. In treatment seeking PMS sufferers, these changes are reported to occur at magnified levels.

Some endocrine abnormality has long been sought to explain why some women are more severely affected than others. Despite a plethora of studies, there has been a failure to confirm any oestrogen progesterone imbalance amongst PMS sufferers. A number of studies have nevertheless demonstrated that PMS is confined to ovulatory cycles, and the cyclical symptoms are removed by medical or surgical oophorectomy (Casson et al, 1990) but not by hysterectomy (Backstrom et al, 1981). Other biological theories, such as that of nutritional inadequacies, have failed to be supported by recent research. Still other biological theories related to neurotransmitters and neurohormones are still under investigation. Theories of specific personality factors, sex-role conflicts and conditioned learning have been widely reported. An interactive bio-psycho-social approach is proposed and has been detailed in section 6 of this report.

The relationship between the menstrual cycle and psychological morbidity is likely to be complex. Menstrual cycle changes may exacerbate existing

psychiatric disorders. Janowsky et al (1969) noted a significant increase of psychiatric admissions during the premenstrual and menstrual phases. Abramowitz et al (1982) found that 69% of depressed patients were admitted during the eight paramenstrual days ($p < 0.001$). Thirty-seven percent of schizophrenic patients were admitted during the paramenstruum ($p < 0.06$). Research of the relationship between suicide and the paramenstruum have yielded less consistent results (Wetzel et al, 1971).

Gath et al (1980) found that psychiatric symptoms were significantly more common among women complaining of premenstrual tension, dysmenorrhoea, heavy periods and flushes and sweats than among women complaining of other gynaecological symptoms. It is unclear from this type of study whether psychiatric symptoms are primary or secondary to the gynaecological complaints.

However, the two longitudinal studies reviewed in the next section present evidence suggesting that psychological morbidity is more likely to be a sequelae than antecedent to certain menstrual and gynaecological complaints (Slade & Anderton, 1991; Treloar et al, 1991).

7.4 Hysterectomy

Gynaecological surgery poses a unique stress for women because of the identification of the reproductive organs both with sexuality and with the wider concept of feminine identity. This stress is particularly apparent when one considers hysterectomy. Of major concern has been the high incidence of this operation in many Western countries and a long-reputed association with psychological and sexual sequelae.

Several investigators reported that hysterectomy was associated with adverse psychological sequelae as evidenced by an increasing incidence of psychiatric referral (Barker, 1968) and an increased frequency of treatment with antidepressants in a general practice setting (Richards 1973, 1974). These findings from retrospective studies have not been confirmed by the more recent prospective studies, which have highlighted a previously unrecognized strong association between premorbid psychological dysfunction and hysterectomy.

The prospective studies of women undergoing hysterectomy by Martin et al (1977, 1980) in the USA, Gath et al (1982) in the United Kingdom, Ryan et al (1989) in Australia, are of considerable interest. These studies utilized structured psychiatric interviews and psychological rating scales pre- and post-operatively. Before operation these studies reported a similar and high prevalence of pre-operative psychiatric morbidity (55%-58%). The type of diagnosis varied. In the US study of Martin et al (1977), there was a 27% incidence of Briquet's syndrome (a somatising disorder) and a 30% prevalence of depression. The UK and Australian studies found that of those diagnosed on the PSE as having a psychiatric disorder, around 61% were depressed and the remainder suffered from anxiety states. The outcomes also differed. The US study did not demonstrate any reduction in psychiatric morbidity after surgery.

This would be consistent with the high incidence of somatization disorder in the USA sample. The UK and Australian studies found a marked diminution in psychiatric morbidity at long term follow-up, 14 to 18 months later. There was a marked improvement in general well-being in the UK and Australian studies, where at long term follow up, up to 84% reported their general health to be better. The post-operative prevalence of psychiatric disorder in the Australian sample was 32%, which compares with a community prevalence rate for Australian women of 15% (Henderson et al, 1981). There was no evidence that hysterectomy led to greater psychological distress. There were few women who developed new psychiatric syndromes which had not been present pre-operatively. In the Australian study, each of the three women concerned related significant life events which had occurred in the intervening period to their current depressive mood. The principal risk factors of poor psychological outcome were the previous psychological morbidity as evidenced by mental status and personality inventory scores. The Australian study found that involvement in the research process did not affect the psychological outcome but did affect the sexual adjustment achieved. This study (Ryan, 1985) provided good evidence that even the minimal intervention of a pre-operative research-based interview could positively enhance sexual outcome.

What remains unclear from the above prospective research, are the reasons for the high prevalence of psychological dysfunction in women who are scheduled for hysterectomy. Gynaecology populations have been shown in many studies to contain a high incidence of women with, or at risk of, psychiatric disorder. Gath et al (1987) found a strong relationship between gynaecological and psychiatric symptoms in a community sample of middle aged women. These authors suggested that either gynaecological symptoms may produce psychiatric symptoms in a vulnerable population or alternatively psychiatric disturbance may reduce tolerance of minor physical changes. In a study of 81 consecutive gynaecology admissions for a variety of elective surgery, Hrasky and Morris (1986) found a minimum prevalence rate of psychiatric caseness using the present state examination of 37%. This rate is more than double the prevalence rate for women in Australian community samples but not as high as the rate for a hysterectomy sample.

In a longitudinal study of the relationship between gynaecological symptoms and psychological distress, Slade and Anderton (1991) found that emotional symptoms in gynaecological outpatients rapidly reduce to normal levels after consultation and that persisting anxiety symptoms are related to gynaecological outcome. Chronic gynaecological symptoms may lead to an increase in depressive symptoms. These findings are in keeping with those from a longitudinal study of twin pairs in Australia (Treloar et al, 1991). 3,808 twin pairs were surveyed in 1980 - 1982 and again in 1988 - 1990. New hysterectomies performed in the intervening time interval were predicted by genetic factors (66% of the variance). How much of the genetic variance in hysterectomy is due to the genetics of menstrual dysfunction needs to be established. Risk factors for later hysterectomy from the earlier survey data included reports of: degree of limitation associated with menstrual periods, number of days of menstrual bleeding, menstrual pain, total period of oral

contraceptive use and (retrospectively reported) interference by premenstrual symptoms in usual activities. None of the psychological variables scored in the earlier survey were predictive of later hysterectomy. These variables included: anxiety index, depression index, extraversion and neuroticism scores, life events, experience of rape or sexual assault.

In summary these findings suggest that chronic gynaecological symptoms lead to psychological distress and disorders and to hysterectomy. There is a marked reduction in psychological symptoms following improvement in gynaecological complaints. Counselling is needed to ensure optimal sexual outcome for women undergoing hysterectomy.

7.5 Menopause

Women naturally cease menstruation between the ages of 50 and 52 years on average in Caucasian populations. As overall life expectancy now approaches 80 years in Western countries, women can expect to live more than a third of their lives beyond menopause. The relationship of psychological symptoms to the occurrence of menopause has been controversial. Gynaecologists have concentrated on determining which symptoms can truly be attributed to an estrogen-deficient state and are thus amenable to hormone replacement therapy. Social scientists have maintained the view that the symptomatology of midlife is more affected by the expectations of a particular sociocultural group or by other factors such as life stress. Women in their middle years experience a great deal of personal change or major life events. It is usually assumed that these are negative: such events include onset of a major illness in self or spouse or close relative, death of spouse or close relative, midlife crisis of spouse or retirement, own retirement, employment uncertainty, care-giving to frail older parent, children leaving or returning home. Others such as Ballinger (1979) refer to the positive counterbalances such as arrival of grandchildren, freedom from unwanted conception, and the opportunity (with freedom from the nurturing role) to pursue other activities or plans.

McKinlay (1989) in a community-based prospective study of 2,300 premenopausal Boston women, found that the overwhelming majority of women report positive or neutral feelings concerning cessation of menses and the shift in attitudes is towards positive or neutral feelings as women experience menopause. The percentage of women reporting relief was just slightly higher than that found in a Japanese sample (Lock, 1986). The cessation of menses had almost no impact on subsequent perceived health, physical or mental. The one major exception is the surgical menopause group which exhibits poorer health and higher use of health services before the surgery as well as subsequently. Current health status was consistently explained by prior health status (65-80% of explained variance). Small independent contributions were also made by education, employment and marital status. Becoming unemployed recently was associated with increased subsequent ill-health.

Negative attitudes towards menopause were related to general symptom reporting and depression. Additionally negative attitudes prior to menopause

were related to subsequent symptom reporting during menopause. Educated women had somewhat more positive attitudes. Employment, better health and education were associated with agreement with the statement that women with interests hardly notice the menopause (Avis & McKinlay, 1991). These findings are in agreement with considerable social psychological research which has demonstrated that a person's behaviour can be affected by his or her expectations.

In order to determine whether the frequency of depression was increased around the menopause, Winokur (1973) studied psychiatric admissions. He found no significantly greater risk of developing depression at the menopause when compared with other phases. High rates of depression are found amongst women attending menopause clinics and middle aged women attending gynaecology clinics. However psychiatric symptoms are increased among all hospital outpatients. Four general population samples in Sweden, England, USA and Canada did not find an increase in depressive disorder at the menopause.

In the Boston study (McKinlay, 1989), those with a recent surgical menopause were the most depressed group. When this group were removed, factors contributing to depression were: previous poor health status, women reporting at least two physical symptoms, worry caused by a family member and sociodemographic factors. Women with a lower education level, and who were widowed, separated or divorced had a depression rate more than twice that of college educated women of the same marital status. There was a low rate of depression for never married women. Further, in refutation of the empty nest syndrome, women with children at home for a longer period or whose children had returned home, were more likely to report stress than those with no children at home. Stress was also reported by those who cared for a parent whether or not the parent lived in the home. Work may alleviate the stress of nurturing roles and thus help prevent morbidity. Work, with its clear expectations, may provide a sense of satisfaction and self-worth not equalled by the familial nurturing roles, for which expectations are implicit and more ambiguous. Current employment served to substantially reduce the impact of other roles and accompanying stress on health and utilisation behaviour - thus work outside the home appears to play a protective effect on health in the midlife years.

Cooke (1984) studied a population of Scottish women. Menopausal status was enquired about as well as chronologic age. They found that the severity of psychologic complaints began to rise in the late 30s, reaching a peak in the early 40s, and began to decline in the late 40s. Cooke found an increase in life events during the climacteric years. Cooke also found that nonexit stress was associated with mood complaints (such as depression, crying spells, panic attacks, and worrying), whereas exit stress was not. Both exit and nonexit stress were required to produce elevation in "somatic" symptoms (faintness and dizziness, headaches, and tingling or numbness in the body). Using a hierarchical regression analysis, Cooke found that the loss of one's mother before the age 11 and employment status act as vulnerability factors for life event stress, influencing the occurrence of mood complaints. The degree of

involvement with children was directly associated with the occurrence of psychologic complaints. The number of confidants available to the patient was directly associated with the lessening of psychologic symptomatology and had a synergistic effect with life event stress. Thus the availability of confidants may help to diffuse life stress. Neither the level of confiding in the spouse, the number of children at home, nor the quality of communication with the children had any effect. Similar results were found for the "somatic" complaints, except that the degree of involvement with the children no longer had any effect. Van Keep (1983) reported that women who were well-integrated into their environment and surrounded by friends reported fewer climacteric symptoms than those who were lonely.

Hunter and co-workers (1986) used a multiple regression analysis to determine which of the following background factors were associated with the presence of symptoms: menopausal status, age, current illness, marital status, social class, and employment status. Vasomotor symptoms and sexual problems were best predicted by menopausal status alone. Menopause status was also a strong predictor of depressed mood. Lower social class also predicted depressed mood, anxiety/fears, cognitive difficulties, sleep problems, and somatic symptoms. Absence of employment was a predictor of somatic symptoms and anxiety symptoms.

Depression in the menopausal years may be associated with feelings that the menopause means loss of fertility and/or femininity. Such reactions are uncommon in Western societies. The research findings summarized above suggest that depressive disorder and depressed mood may relate more to the vicissitudes of life than to the menopause per se.

Changes in mood are sometimes claimed to be secondary manifestations of disabling vasomotor symptoms, such as hot flushes and sweating. The vasomotor symptoms and those of atrophic vaginitis are held by some to be the only "true" symptoms of ovarian failure (Utian, 1972). Psychologic complaints are then explained by a "domino-theory". That is, if the flushes cause the woman to stay awake and the night sweats cause her to change the bed linen, she will report insomnia and fatigue, which may lead to irritability and nervousness.

A number of the studies reviewed have reported a peaking of depression symptoms in the immediate premenopausal years (McKinlay, 1989; Cooke, 1984). These findings suggest underlying endocrinological changes, which begin some years prior to menopause, may affect mood, although this effect seems to be temporary. Evidence of the specific effects of steroid hormones on mood derives largely from clinical trials. Both the two largest double-blind, placebo-controlled, cross-over studies that have been published report improvements with estrogen therapy over placebo for a variety of psychologic symptoms. Campbell and Whitehead (1977) compared two months therapy of 1.25 mg conjugated estrogens (daily) with placebo in a short-term cross-over involving 64 patients with severe symptoms. Estrogen was found to be significantly more effective than placebo in alleviating 12 symptoms (hot

flushes, insomnia, vaginal dryness, irritability, poor memory, anxiety, worry about age, headaches, worry about self, urinary frequency, optimism, good spirits) and produced increased coital satisfaction. In order to determine whether this improvement reflected relief of hot flushes, an analysis was made of the 20 patients who had not reported hot flushes. Vaginal dryness, poor memory, anxiety, and worry about age and self continued to be significantly improved by estrogens, indicating a direct positive effect of estrogen on some aspects of mental status.

The other large double-blind, placebo-controlled cross-over study, Dennerstein et al (1979, 1980) also found a beneficial effect of estrogen on mood. However all the 49 women had undergone hysterectomy with bilateral oophorectomy. This study set out to measure the effects separately of an estrogen and a progestin and compare these with placebo. The study used a cross-over design. Ethinyl estradiol given alone was found to have the most beneficial effect on mood as measured by Hamilton Depression Rating Scale scores and interview ratings of general well-being, depression, fatigue, anxiety, irritability and insomnia. This study also found that ethinyl estradiol had a beneficial effect on female sexual desire, enjoyment, and vaginal lubrication (all measured by ordinal scales) and on orgasmic frequency (recorded daily). There was a trend toward norgestrel being more inhibitory. The combination pill was less beneficial than estrogen alone. Finally, when the relationship between headaches and the administration of hormones was examined, it was found that an increase in headaches occurred when therapy was changed from estrogen-containing compounds to the nonestrogens (norgestrel or placebo) (Dennerstein et al, 1978). It is not possible to extrapolate from these treatment studies to the community-based studies. Longitudinal community-based studies will provide needed information on the risk of hormone therapy for perinatal mood changes.

Cross-cultural Differences

Menopause is a complex transition involving biological, psychological, sociological and cultural variables. Menopause should be viewed as a process and not an event, as something which is shaped by historical factors and environmental and cultural context, and by each individual's personal history, both biological and social. In this life cycle transition powerful symbolic meanings (individual and social) are attached. The menopause is not merely the end of menstruation, nor even an inevitable part of aging; it also leads to a moral discourse in which ideas about gender and especially the roles of middle aged women are raised (Lock, 1991).

Griffen (1977) reviewed the Human Relations Area Files in order to find documentation for different customs relating to menopause in differing cultures. In eight cultures it was specifically noted that no behaviour changed for menopausal women. Changed behaviour did occur in some cultures. For example elderly Tiv women put on the snail shell as an insignia that they are no longer sexually available and return to live with brothers. The rural Irish believe that menopause can induce insanity and at least 3 contemporary Irish women

confined themselves to bed from their mid-40s until death some years later. In two African cultures menopause was viewed as a disorder. For example a Yoruba woman believes that cessation of menses is a pregnancy prevented by witchcraft from terminating normally. In other cultures menopause results in greater freedom for women. Women are then able to eat foods previously forbidden or to get drunk or indulge in other behaviours, such as appearing at public dinners normally only attended by men. In China after reaching 60 years, women were released from male domination. In New World cultures menopause signalled accession to increased social and sometimes supernatural power. Thus the loss of roles of reproducer - mother - wife signalled access to role of curer. Thus the behaviour of any female is a product of the interplay between her unique biological heritage, her shared sociocultural environment and the choices she as an individual makes from among the alternatives available to her in her culture.

Some apparently contradictory results are beginning to emerge from cross-cultural research. Among Mayan Indians, north African residents of Israel, the Rajput of India and Japanese the occurrence of somatic symptoms is either low or absent. In contrast studies in North America and Europe, Zimbabwe and Varanasi, India elicited much higher somatic symptom reporting. It is unclear whether these findings represent real differences or merely reflect artifacts of research design and methodology. Lock believes there are probably some differences, both biological and socio-cultural, but also that some of the reported variation may indeed reflect poor research design. Intensive small group interviews have revealed that the meaning of menopause is subject to a wide degree of interpretation and may not coincide with the norm of that society. Also in societies where women have numerous births and long periods of amenorrhoea it is extremely difficult to assess the onset of the menopause.

Lock (1986) found that menopause is regarded as a natural life-cycle transition in Japan in which the biological marker of cessation of menstruation is not considered to be of great importance. Symptom reporting is low regardless of menopausal status. Symptoms such as hot flushes and sweats are lower (12.6% of perimenopausal women) than from other areas. Shoulder stiffness, while frequently reported (54.8% of perimenopausal women), is not linked to menopausal status. Feelings of depression and melancholy were low but significantly higher in the premenopause than peri and postmenopausal groups. Changing family norms in this and other societies means that the present generation of women entering their fifties are the first where the majority must face later life in a nuclear family. What was apparent in the minds of most of the informants was how they would get on, living by themselves with husbands whom they may never have come to know very well given the organisation of contemporary Japanese life.

There are obviously many problems in such cross-cultural research. These include possible bias introduced by the investigators, language problems, and the possibility that some cultures express emotional changes in masked ways.

No studies appear to have compared the endocrine status of women from different cultures, on the presumption that the duration and severity of endocrine changes are similar in different cultures. This may not be the case. Surprisingly little is known of the relationship of genetics, the environment and diet to circulating and stored estrogen nor about the interrelationship of psychosocial variables, estrogen levels and the objective measurement or the subjective experience of menopausal symptoms. Nevertheless, there is evidence to suggest that cultural factors may be important in determining a woman's response to biologic changes and the expression of perceived changes.

7.6 Mental Health of Aging Women

The problems of old age are largely the problems of women. In Western societies at the age of 75 years, most women are widowed. Large numbers live alone often without a network of available family resources. For every 100 women aged 80 and over in Australia, there are only 47 men (Kane, 1991). Research in several countries suggests that a large proportion of the longer life span women can expect is actually spent in pain and ill-health (Kane, 1991). The increase in the aging population has profound political, and economic implications as this group has greater needs for health care, social welfare and economic support. Only a small segment of the elderly (5%) are institutionalized. Of the 5% living in nursing homes 3/4 are women. Thus it is a myth that the elderly are a helpless, disease ridden group. Negative images of the elderly woman as unattractive, dependent, and physically ill have significant psychological and social repercussions.

Russo (1990) in her review noted that 25% of persons over 85 years of age have Alzheimer's disease or a related disorder, and most are women. There must also be concern for the well-being of those who care for them. In the USA, 72% of the 2.2 million people caring for the elderly without pay are women. In a review of recent research, Morris et al (1991) showed that the demands of the care-giving role are experienced differently by men and women. Both the subjective and objective strain appear to be greater in female carers of dementia sufferers. Factors that influence this include differences in role expectations and coping strategies.

Women account for more than 70% of the chronically mentally ill in nursing homes, and family support systems for these women may be virtually nonexistent. Elderly women are amongst the poorest of the US population. Major diagnoses are depression, organic brain syndromes and the dementias. Depression is the single most pressing problem affecting elderly women's mental health. Older women are also vulnerable to alcohol and drug abuse particularly those: isolated and depressed women living alone; women trapped in unhappy marriages; those institutionalized in nursing homes or psychiatric settings; those culturally isolated; and those lacking the resources to enter treatment programmes. Anxiety is another common problem for elderly women and social and economic factors are the primary contributing factors. Yet older women are often underrepresented in the use of mental health services. There is

also concern about the use of psychotropic drugs in elderly women because of harmful side effects and drug interactions.

For women the emotional quality of their social activities and the degree of satisfaction with social relationships are the important predictors of morale (McCallum). Psychological well-being has been found to be predictive of morbidity, mortality and institutionalisation in the elderly. McElmurry & LiBruzzi (1986) report that the older woman without a connection to others and social activities is at risk for emotional discomfort. Well-being in old age is associated in a cumulative way with the amount of expressive social supports and their range. These relationships provide acceptance, reassurance of worth and participation in leisure activities (Mugford & Gibson).

8. SUMMARY

Both community-based studies and studies of treatment seekers indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with marital status, work and roles in society.

Women's mental health cannot be considered in isolation from social, political and economic issues. When women's position in society is examined, it is clear that there are sufficient causes in current social arrangements to account for the surfeit of depression and anxiety experienced by women. Women experience and respond to stress quite differently than do men. In addition, the routine of women's lives render them at risk to experience more stress than do men. This reflects the greater number of social roles women fill as wife, mother, daughter, employee and carer of others. Beyond that, women's reproductive role of bearer, producer, feeder and nurturer of children produces unique potential for stress related effects.

Thus, the well-documented higher morbidity in women's health across the lifespan has a clear biosocial underpinning to explain the burnout rates. It is not surprising that the health of so many women is compromised from time to time. Rather, what is more surprising is that stress-related health problems do not seriously affect more women.

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