Depression – a socio-cultural way of manifesting women's psychological crises

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Abstract
In the context of the anthropology of health, in this article depression is discussed as the most common form of the manifestation of women's psychological crises. The outline of the history of such crises indicates that we should search for commonalities between depression and hysteria in the comprehension and understanding of the phenomenon as well as in the reinforcement of the unequal relation between the genders and stigmatisation. The classic feminist theoretical starting points for the understanding of women's social status in this article are completed by the analysis of ethnographic material that illustrates and confirms the theoretical statements about the androcentric construction of the modern Slovenian social space and the relations in it.

KEYWORDS: anthropology of health, depression, hysteria, women's mental health, androcentric culture

Introduction
From the beginning of modern psychiatry, the gender stereotype discourse was supplemented by a medical discourse. The result of the mutual intertwining is visible in the phenomenon of hysteria. In the 19th century, women's hysteria became the most visible product of psychiatric help. Within the medical theories, on the basis of the distinction between the emotional and passive woman and the rational and active man, the belief in the labile and unhealthy female nature and the strong and healthy male nature was introduced.

The fact that the function of the binary structure between the two genders also works within the concept of mental health is shown in the work of Brovermann and her colleagues (Brovermann, Brovermann, Clarkson, Rosenkrantz & Vogel 1970). The research took place among American therapists who spoke about their conceptions about a psychologically healthy man, a psychologically healthy woman and a psychologically healthy adult. The research results confirmed that the images of a psychologically healthy man and woman follow the stereotypical images of masculinity and femininity in today's European and American societies. If a psychologically healthy man is active, rational, psychologically stable, a psychologically healthy woman is more passive, emotional and labile. The therapists' answers about their idea of a psychologically healthy adult were the same as the

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answers about their idea of a psychologically healthy man. A healthy adult man has to be sufficiently aggressive, active, controlling, and strong and without fear; he has to control his emotions and has to follow his purposes. In contrast, a "psychologically dysfunctional" man had a great deal of the qualities that were earlier attributed to a psychologically healthy woman (passivity, too much sentimentality, irrationality, adventurism, feelings of fear and weakness, no aggressiveness, and no dominance). The qualities composing the stereotypical female image can also be a starting point for the search of a man's psychological problems; the concept of the psychological health within the psychiatric-medical and psychotherapeutic practice is regulated to the cultural stereotype of a healthy man (Zaviršek 1991: 19–20).

Psychiatry's politics, as a part of the social control's apparatus, strengthens the normal/abnormal, health/illness with the specific sexual diagnosis that is shown in an output of different criteria and on the basis of which the woman comes into a psychiatric institution.

The division and the valuation of the genders in the opposition of better-worse means an imminent stigma that is carried by the gender stereotypes, regarding which the stigma stays in a latent form, as shown by Goffman (1981), in negative stereotypes; it activates itself with an individual's wilful determination in personal interest. Goffman's theory of the stigma emphasises that the stigma is a discrediting identity in which the "abnormal" difference covers all the other characteristics and marks them to the extent that puts the owner of this attribute in an inferior position in society. It is a relationship that is dependent on society's normative expectations.

The stigmatisation process, in which the stigma realises itself in the form of a negative identity, is almost inevitable within the medical model. Society's image of a mental illness, as well as of psychiatry, has a negative influence on the individual's self-image. Society responds to someone who is labelled as a mentally ill person in accordance with the stereotype and judges all his actions through this stereotype's prism. The stigmatisation becomes an additional source of degeneration for mentally ill persons in our society.

The history of hysteria

Hysteria, the woman's illness, allegedly caused by a wandering uterus, was known in ancient Egypt. The uterus was living organism whose movements were indicated by different diseases and symptoms: eye problems, ear problems, toothaches, speech impediments, menstrual anomalies, neck pain, etc. Women with these kinds of problems were treated with herbs, baths, inhalations, massages and magical-religious techniques in order to return the wandering uterus to its normal anatomical position.

The conviction of the wandering uterus persevered until the 2nd century, when the conception of hysteria (the name comes from the uterus's anomalies, *hysteria,* the Greek word for the uterus) appeared for the first time in Hippocrates's texts, where it is mentioned in an observation about asphyxiation caused by the uterus. He defines hysteria as one of women's most common diseases, especially typical of infertile and sterile women, young widows and old virgins. In Hippocrates's opinion, the two main causes of a wandering uterus were the lack of moisture and peculiarities in the menses; the symptoms of the

disease depend on which organs the uterus touches and puts pressure on (the liver, the stomach or the head). A woman could lose the ability to talk, but the greater danger was asphyxiation. Hippocrates's sexual aetiology of hysteria was also shown in his therapeutic procedure; for curing the disease, he prescribed entering into marriage and a pregnancy, and as a support to these therapies also a forced fixing of the uterus, its cleaning and moistening (Braun1988: 35–6).

Plato also followed Hippocrates's tradition for whom the moving and the wandering of the uterus was caused by an unrealised maternity. The uterus longs for and wants a baby, the non-realisation of its natural need releases a plethora of female diseases (ibid.: 45–7). The theory of the wandering uterus and its animal nature was contested by Soranus and Galen, although they were still connecting the causes of hysteria with the uterus. For Soranus, the best remedy for hysteria was pregnancy; other therapies that he suggested were walks and gymnastics, reading aloud and vocal exercises, baths and nutrition. Galen labelled hysteria as a completely somatic disease; he prescribed sexual intercourse, because (in his opinion) sexual abstinence was dangerous, especially to young widows and single women (ibid.: 36).

At the beginning of the 17st century, Edward Jorden, an English doctor, developed a new theory about vapours that rise from the uterus to the head and that way damage memory and intelligence, and cause blackouts, which are symptoms of hysteria. According to this theory, hysteria began to be treated as a disease that needs therapeutic treatment (consultancy, etc.). Hysteria also began to be attributed as the cause of melancholic mental states characteristic of virgins, nuns and widows. Even in the 17th century, the therapy recommended for these women was matrimony, because melancholy was caused by illegitimate intercourse, sexual abstinence, life in a convent or virginity (ibid.: 47–8).

Hysteria's appearance among men become possible to appear when Charles Lepois (1563–1633) designated it as a nervous disease whose cause can be found in the head; its principal symptom being pain in the head (ibid: 50–1). Sydenham, an English doctor, saw the causes for hysteria in the emotional instability, which is shown in the physical symptomatology (ibid: 49). Hysteria thus became a mental disease. In the 18th century, the causes for hysteria were finally transferred to the head, and it found its place among many other diseases that fit the concept of neurosis. At the end of the 18th century, hysteria was consequently transferred to psychiatric hospitals.

The second half of the 19th century was characterised by discussion about the simulation of hysteria. A hysterical woman was a liar and her hysteria a non-disease, because she was just simulating it. Hysterical women were considered the subjects of their own disease. Jean-Martin Charcot, a French neurologist, disputed the concept of lying hysterical women and attempted to prove the cause to be excessive suggestibility and loss of one's own will, which are the caused by a damaged psyche. He organised theatrical performances in the Salpetriere psychiatric hospital, where female patients showed the symptoms valid at that time. Charcot affirmed that the automatic reflexes of the nervous system activated a hysterical formation of the symptoms that originated in a trauma. He believed that these reflexes loosened under hypnosis, causing muscle cramps, contortions, screaming and scolding, hallucinations, insensitivity to the touch and the complete incapacity of sensory

comprehension with all that have been under hypnosis. In his opinion, hysteria was an inborn disease; therefore, he recommended that hysterical mothers be separated from their children, especially from their daughters, and vice versa hysterical daughters from their mothers (ibid.: 56–62, 446–51).

Later, Charcot's student, Sigmund Freud, developed the theory that hysterical symptoms were the result of a conflict between the individual's social and ethical standards and her unsuccessfully repressed needs.

The ideology of woman's hysteria is a typical social construct that was put into effect in the 19th century. With the capitalistic ways of production, professional and private spheres had become separated at that time. The work that needed to be done in the family circle, to make it function normally, belonged to women, who were to ensure the on-going stability of functions, such as taking care of everyday life, giving birth and educating children. The women who had these roles had some positive qualities attributed to them, such as kindness and sacrifice for others. However, women were considered more prone to diseases and to pathological kinds of behaviour because of their sensitivities.

This image of woman was quickly grasped by the culture-forming institutions of that time, which consolidated the conviction that women, because of their specific nature, are prone to develop women's diseases, among which hysteria was primary.

Hysteria, which has been connected with women more frequently than men, started to be treated by psychiatry in the end of the 19th century; it had been determined to be a women's disease with scientifically proven evidence, and it was treated and studied in this sense.

The anthropologist Darja Zaviršek states that the branched hysteric symptomatology in the medical and non-medical records suits a defined social reality. Furthermore:

> The objective definition of hysteria never existed, it always depended on the social reality and on the fact how was the woman and the woman's body looked at by people who took the right to write about and to define it (1990: 182–3).

Hysteria in the Slovenian territory

In this way, some Slovenian women also "became hysterical"; their hysteria was attributed to their gender, followed by ideological discourses about the 'perfect mother' that prevailed in the Slovenian territory in the 19th century.

The initial medical, church and laic discussions about female hysteria were mixed with deliberations about nervousness. The doctor Edvard Šavnik (1877) explained women's predisposition to nervousness as originating in the gender's difference regarding the different number of sensory receptors. The smaller female body contains more receptors, especially if the woman prevails over the man, which causes the agitation of the woman and of her imagination. Šavnik saw the cause of the female nervousness in women's lifestyles. The nervousness caused by the abandoning of the physical health care, doing work that belonged exclusively to the male domain, causing an overwhelming agitation of the woman's receptors, which led to nervousness and other mental disorders. Moreover,

giving birth was also dangerous for women. Their emotional and labile nature posed many dangers, from which they could be saved only by men.

Among all the causes that could trigger a disease Šavnik mostly cited heritability, too much or too little food, the influence of coffee, tea and alcohol, a non-hygienic dwelling, uncontrolled passions, overly difficult work, children's education, religious ecstasy, etc.

In this way, Šavnik started the Slovenian discussion of nervousness that continued with the deliberation of different authors about hysteria and mental disorders. Some years later, Fran Göstl (1893)saw drunkenness as one of the basic causes of insanity causing the epilepsy in men and hysteria, epilepsy, and pathologies in menstruation and pregnancy, in women.

In line the women's natural predisposition to diseases and insanity, Arnšek (1926) introduced the idea of men with some external symptoms that show the danger of an unhealthy young woman and a bad bride. In Arnšek's opinion, the nature of a person and a healthy soul are reflected in the eyes, the face and the body. He also asserted that:

> a well-formed robust bony cheek, a particularly lower jaw comparing to the skull indicates the lack of a woman's spiritual life… A crooked figure, a crooked mouth, a crooked walk, a curved writing (now left, then right, then up) indicates a crooked, inconsequential, cunning, capricious thinking and a nature full of internal opposites.

From the end of the 19th century to the beginning of the 20th century, the discussion about women ranged from the adoration of the women and their mission to warnings against their cunning, their inclination towards infidelity, their secrets and sensitivity. A cultured woman, the holder of the ideal female nature has to suppress her passions, to suppress her emotions, to have control over her body and soul.

Typically, such malice was applied women's diseases. Many people thought that a woman's hysteria was caused by her single life,which does not enable her to satisfy her sexual desires, or by an unhappy married life. Most frequently, hysteria was seen as manifesting itself in women that had hysterical mothers. The priest Skubic (1909) also acknowledged other, social causes of hysteria, besides heritability, like a bad education and an early leaning toward sexuality. He warned priests and doctors about the danger shysterical women. He described them as frequently inclined to suggestion, domineering, anxious, of unsteady temper and mainly desirous of attention. He talked about hysteria as a both disease and a simulation. He thought that hysterical women exaggerated, lied and simulated disease to gain their doctor's and priest's attention.

Arko (1935) also followed this ambivalence, because in his opinion hysteria wasa hereditary disease, caused by the inflammation especially of the woman's genitals, by poisoning, fear; but he also deemed hysterical women to be lying fakers. Arko also introduced a description of hysterical attacks of the Charcot type, composed of different occurrences that point to hysteria. The most common being blinking, snorting, yawning, hiccupping, sneezing, stammering, muteness, vision and hearing hallucinations, vomiting, trembling, dizziness, fainting, cramps, rapture, anger and delirium.

In Slovenia, the definition of hysteria also depended on the observer's perspective, which is why we cannot talk about an objective, scientific definition of hysteria as a state of

disease. Definitely, throughout the history of hysteria women become the main objects of control. They were expected to care for morality, children and housekeeping. Later, these cares started to become increasingly determined as "female" and as having an important role in women's mental health.

Depression and other traditional forms of mental suffering's manifestation in the context of gender stereotypes and medical discourses of current psychiatry

In line with societal expectations, bound to gender, there are also acceptable forms of the manifestation of psychological crisis. Within the regular gender roles and the determined cultural context, depression and other forms of mental anguish manifestations, especially addiction, become an answer to the personal distress and anguish.

In Slovenia, there are two culturally acceptable examples of manifesting emotional distress: excessive consumption of alcohol, and suicide[1] or attempted suicides. The most common diagnosis among men is alcoholic psychosis, while among women neurosis and depression prevail. Therefore, it is about the forms of the manifestation mental suffering that are attributed to women and that, with its forms, emphasises a typical woman's behaviour. Such manifestations are the consequence of the woman's socialisation and of the latest life experiences connected with it. Women expresses their personal dissatisfaction with silent, inconspicuous women's behaviour.

In the Western world, depression is considered a "woman's diagnosis". The research done in Ljubljana's psychiatric hospital confirms this, stating that among all the patients with depressive symptomatology, 83.2% were (84 patients) and 16.8% male (17 patients) (Zaviršek 1994: 199, 202).

The forming of depressive mental states is influenced by aggravating, traumatic life incidents, and (according to the data of different research) they are the main cause in more than 85% of cases. Disappointment in the family, marriage disputes, a change of the place of residence or working place, a disease or the death of a family member, financial problems or the loss of a certain social status – in 30% of the cases these kinds of events are the precursors of a mental disorder, according to the research of Brown and Harris (1989) who focused on the causes of the mental disorders. They showed that the type of event does not determine the period of illness as much as the meaning the person affected attributes to it and its subjective transformation. The research showed that a woman who has a strong, intimate relationship with her husband, relative or friend is less susceptible to depression than a woman who does not have this kind of support in a relationship. The meaning of satisfying relationships, a strong and abundantly intertwined social net, is increasingly indicated as being the basis of strong mental health.

The study of the Italian anthropologist, Donatella Cozzi (1992), reveals the causes of depression in women who live in the Slovenian populated province of Karnija. This

[1] Hanging is still the most common form of suicide in Slovenia, followed by poisoning and drowning, especially among women.

province was marked by a century of emigration caused by poverty. The people leaving were mostly men who returned home after a few years of work in foreign countries. Because of this situation, the culture of Karnija is based on the women's physical work in the fields, producing crops and dairy-farming. Consequently, throughout Italy people believe the image of the physically strong women from Karnija. Recently there have been some sudden lifestyle changes, states Cozzi, which is why the women's role in this environment is changing, while the traditional values are still very strong. The women in Karnija express depression, the extreme version of women's emotional state, as physical pain. They express their distress as tiredness, inability to work, headaches or lower back pain. This is a somatisation of the psychological distress, defined differently by every culture. This kind of expressing problems (with tiredness or body weight) is the most acceptable and consequently the more common. People from Karnija think that an emotional expressing of the problems (with anger or agitation) is not appropriate, while the tiredness is culturally acceptable. Cozzi is convinced that this culture defines a woman as one that has to keep her moral posture, for this reason she cannot directly express her problems. In this context, depression obtains different, additional meanings. Social pressure is very strong, because all the social reproduction forms – the care for the children's education, agriculture, animals and different artisanal work – are on the woman's shoulders. She is the cultural guarantor for a society's continuity, but she has no authority, which is why she persist in this situation. The only culturally acceptable way of expressing her dissatisfaction and problems is tiredness, which manifests itself through physical pain.

Among the adult female population in Slovenia, alcohol addiction is very common, in addition to physical pains (especially headaches). In the alcoholic section in the Centre for Mental Health in Ljubljana, there were four times more men than women among the first treatment for alcohol addiction. Among the women admitted for the first time, alcoholism was at second place, following neurotic disorders (Zaviršek1994: 199). It is impossible to talk about a specific type of alcoholic, because the problem of alcohol addiction appears in different age brackets and the different social and economic conditions in which the women live. Alcoholic women are subjected to different social, emotional and physical risks than men. It is necessary to emphasise that differences remain between the genders in the field of alcoholism and drug abuse, because a man's drinking is often tolerated, whereas for a woman it is strongly criticised.

The research demonstrates that women drink because of different reasons than men. Women's alcoholism is connected to their emotions, and to concrete events in their lives, their pasts and life patterns, that they acquired while growing up, to the inferior role of women in the family and the society, and to traumatic experiences in their childhood and adolescence.

One addiction frequently intertwines with another. Alcohol and pharmaceutical additions[2] are frequently connected to eating disorders. Food, coffee, cigarettes and tranquilisers are substances women are more frequently addicted to, especially because they are

[2] In Slovenia women in particular consume regularly all kinds of pharmaceuticals. Most commonly, they are medicines that reduce anxiety and internal tension, and painkillers (Žmuc Tomori 1995: 36).

socially acceptable. Food addiction (food refusal, excessive eating, binging and purging, and the combinations thereof) have many individual causes in the opinions of experts: searching for one's identity, compulsory control of feelings and sensations, achieving better results, corresponding to an ideal body-form, etc.

We can conclude that somatisation, which manifests itself in chronic "illness",[3] is a more socially acceptable way of manifesting the emotional dissatisfaction. Manifesting daily dissatisfactions with addictions, attempting suicides, etc. is less stigmatising than other forms of psychiatric diagnosis. Regarding the cultural characteristics connected to traditional ideas about health and illness, physical illness is socially more acceptable than emotional distress that (in the experiences of the psychiatric services users) especially brings stigma.

On the method

My ethnographic work was based on an important principle of qualitative methodology – to research people as individuals, groups and communities as totality in their real context. A holistic view of a person can see single aspects of a person's operation in connection with the whole human action. People's experience and behaviour are inseparably connected to the environment, creating a social-cultural context. The context includes the individual's past, because if a person's history is known, we can understand the phenomena occurring in her life as a totality. The life story enables the researcher to see the social world from the social agent's point of view, which can refute the presumptions and prejudices of external observers.

In my research, I explored the individuals' subjectivity, their special and different ways of experiencing their life situation, and the interpretation of the event's meanings and behaviour. Mainly, I wanted to discover their relations with the important questions about their lives, their distress and strategies for controlling their burdensome life situations.

Regarding the qualitative research, the method used for gathering the empirical material is the questioning method; in one case, there is also a personal journal, i.e. a personal unofficial document. I used a non-structured or partially structured interview, a so-called open interview. This technique made it possible for the interviewees to structure the interview by themselves, to indicate what was important to them. They told their stories with their interpretations and with their addition of values and this enabled my understanding of the complex continuity of their life stories and the connection between their hospitalisation and their life events.

I limited the study to patients of the Clinics for Mental Health in Nova Gorica and in Tolmin. I carried out the interviews with the prior approval of the National Medical Ethics Committee, in Ljubljana.

The women cooperating in the medical discussion had obtained a diagnosis for depression and they were hospitalised in a psychiatric clinic. The selection, which is coincidental within the stated limits, confirmed that middle-aged women are more susceptible

[3] The medical terminology (disease, disorder) reinforces the stigmatisation of the differences and accentuates the biological component of the arisen problems, which is why we place it within quotation marks.

to psychological distress because of a lack of emotions, a small social network outside the family circle, and bad intimate relationships. Otherwise, the women I included in my research did not belong to a homogeneous group. They came from different social levels and groups; they had different professional statuses, marital statuses, etc.

Sixteen interviews were not sufficient to demonstrate a representative pattern, yet they did add some knowledge to the social and emotional status of the female users of psychiatric and psychosocial services.

On the general findings

The stories of the interviewees[4] are stories of loss, suffering and limited opportunities. They are stories about a lack of encouragement, self-confidence, a negative self-image, about numerous burdens and losses in the daily life. The identification with the concept of womanhood caused a feeling of inferiority, guilt, incompetence, uselessness to many women, which aided the occurrence of emotional distress. The basic starting points for the development of the symptoms diagnosed as depression are a negative self-image with a low self-confidence and self-esteem.

Among the totality of their life events, they spoke most frequently of their economic problems, social jeopardy, loneliness, lack of quality intimate relationships, loss of a loved person, war experience, rape, and illnesses. They frequently spoke of hard work, material poverty and unpleasant family situations, and the loss of life objectives.[5]

From the written stories, we can understand that the depression is frequently caused by a traumatic event such as the loss of a loved person, physical violence as a traumatic event, the surgical removal of the breasts, the feeling of loss after a hysterectomies and similar surgeries. It is linked to the social experiences and the social realities in which these women live, along with sudden losses, social and emotional deprivation. Their psychological suffering is the expression of difficult life conflicts, such as overloading, division between work outside and inside home, a sense of inferiority, disagreements in a marriage and in a family, rape, psychological and physical violence, etc.

These stories indicated that the social status is correlated to the level of probability that the person becomes a victim of mental stress. The more these people were being socially undervalued, the greater the possibility they had to experience depression. Research shows that the people who are more prone to becoming mentally stressed particularly include elderly people, poor people, women and some ethnic minorities.

The combination of stigmas also contributed to social exclusion. Most frequently, it was about unwed mothers, poor women, those of another nationality, and also users of

[4] We are introducing just a rough socio-anthropological perspective of the stories, which represents interesting material for psychotherapeutic analysis..

[5] The psychiatric diagnosis augments the initial distress; it additionally stigmatises the person, subordinates her socially and economically and by doing so it prevents her social inclusion, which is essential for the preservation and restoring of her mental health. By that we mean the inevitability of a disability retirement. Brown and Harris' study about depression among women (1989) states that a paid job is one of the four protective factors against depression. A paid job increases the possibilities for gaining self-confidence and a sense of self-esteem, a sense of safety, and it enables greater opportunities for social contacts.

a psychiatric hospital. Among the users, the ones with uncertain social status, belonging to the middle and lower classes prevailed.

Their social network was small and barely interconnected; most frequently, it was composed of family members. They mostly searched for an emotional support outside the family circle, among the few friends they had. Their stories have proved every time that it would have been easier for them to surmount their distress with other's social and emotional support.

The somatisation of everyday suffering as a socially more acceptable manifestation of emotional dissatisfaction's was typical of the women that took part in the research. The interviews showed that people usually manifest their dissatisfaction in culturally acceptable forms of behaviour. Different cultures manifest their suffering and stress in different ways; their methods of solving difficult life situations[6]are also different.

Women expressed also their mental suffering in a culturally and sexually acceptable way, within legitimate social limits; they adjust their mental distress to a certain social-cultural environment.[7] A message about what is right, wrong, acceptable and what is desired instils the ideals of a culture already in a child; this is indicated in the ways of surmounting crisis – they represent a specific sexual manifestation of distress.[8]

These individual stories uncovered the psychiatry's users' needs. They would need different community services that would help them change their burdening social situation. At the same time, a question emerged of whether psychiatric institutions' services within the established medical model are really adequate for the women's specific problems and needs.[9]

Most of the interviewed women returned to the psychiatric clinic according to the syndrome of "revolving doors" – they had been hospitalised before but just for several short periods. Many of them noticed that people changed their attitude towards them when they heard that theyhad been hospitalised – they were stigmatised by the institution's social status itself.

The stories of these women show that patriarchal relations in Slovene society still predominate and that a woman's role determined by society is the role of a mother and wife, caretaker and caregiver. Most of the women run the household by themselves, without help. Many of them realise themselves through housekeeping and they identify with their role of housekeeper. Most of the interviewed women had (in addition to their unpaid care work) production jobs and jobs ascribed to women and their "nature", such as

[6] The culturally acceptable forms of mental disorder's manifestation in Slovenia are alcohol abuse and suicide attempts. This is why on the level of biomedical classification in Slovenia one of the most common diagnosis among men is psychosis and neurosis and depression among women. Hysteria as a woman's diagnosis was substituted by depression (Zaviršek1994: 40–1).

[7] A person adjusts her problems to the cultural norms and behaviour patterns and also to the regular sexual behaviour within a definite social group in a culture. A culturally defined behaviour pattern like depression is attached to the female sex; it develops different sexual ideologies and it causes many women with an acceptable behaviour pattern to identify and to adjust the psychical distress expressions to it (Zaviršek 1993: 104,105).

[8] The women cited crying, sleeping, resting, tablets and isolation as the most important acts of surmounting crisis situations.

[9] The discussions with these women showed that their needs are not always merely pharmacological.

sales clerks, hairdressers, nurses, cookers, teachers, cleaning ladies, etc. Some of them also grew up on farms, where the patriarchy as a characteristic of the traditional country society in Slovenian countryside and has not yet completely disappeared among country folk.

Conclusion

The androcentric view of the world was changing gradually through history based on three basic cultural discourses; the greatest role was played by the Judeo-Christian tradition with its idea of a sexual and inferior woman and a superior man, created in God's image. This kind of view is a typical social construct which passed on, with the appearing of industrialisation, the division between man and woman qualities to a capitalistic form of production, where women again received an inferior status compared to men. Furthermore, women's problems in modern society area double strain. By endeavouring for equality with men, they managed to enter the sphere of paid jobs but they still have all the duties that traditionally belonged among their responsibilities, i.e. taking care of the household and the family. Household chores remain a woman's primary responsibility, in a marriage women have less validity and power than their husbands.[10] The sources we followed in this work showed that the structural inequality between the genders still exists. It is reinforced by a patriarchal ideology that reproduces the structural inequality with out a cknowledging a care job as being productive.

Problems, solved with feminist social theory, which are defined as the cause of personal and interpersonal conflicts, proved to be effects of the patriarchal ideology within the wider social context. They are a manifestation of determined social relationships between women and men in a patriarchal society.

Women's mental problems are closely linked to the social role of today's woman, which is a set of past educational patterns and reinforced external expectations, as indicated in this work. In Slovenia, among the women's mental health problems, there are different forms of depression that predominate as a reflection of the stressful burdens and of overloaded women in the personal, familial and employment field. The most frequent answers to women's personal distress and suffering are drug abuse and other forms of addiction. They manifest their mental suffering with forms that are attributed to women and are the consequence of socialisation and later life experiences connected to it. Women express their personal dissatisfaction within the regular sexual roles and the determined cultural context, which proved true also for the interviewed women. They adjusted the expressing of psychological distress to a determined socio-cultural environment and to acceptable behaviour patterns.

Hysteria, as a part of the cultural deliberation about women, from the 19th century onward, became a model of the gender's perception and it reinforced the belief about woman's natural predisposition for diseases. However, as a psychiatric diagnosis along

[10] Research on conjugal roles – the studies done by the sociologists about who does what at home, the number of working hours and the study of the power (decision-making) in a marriage – showed that the pattern of a woman's double burden continues, but the share of men in the entire household is rising. The women in relationships are confronted with the lack of influence on important decisions (especially financial ones) (Haralambos & Horborn 1999: 372–4).

with the symptoms, it still expresses a misogynistic attitude towards everything that can be defined as "female".

One of the effects of the patriarchal ideology and the androcentric view of a woman's needs is the psychiatric medical discourse. The historic memory is preserved in the forms of patriarchy and sexual stereotypes, which can be found in medical descriptions, diagnosis and "treatments". The medical treatments[11] are one of the effects of the patriarchal ideology and the androcentric view of the needs of women who search for help. The medical advices do not consider the social dimensions of everyday life; they are based on the stereotypical convictions of the woman's role in the family and society. Traditional psychosocial services generally do not consider the social context in which the person lives. We can criticise the Western medical model for neglecting the psychosocial component, stigmatising a person and the treatment's elements (psycho-pharmaceuticals, etc.). Frequently, traditional psychiatry denies the connection between the everyday events and the hospitalisation. However, anthropology of health defines medical treatment as a social practice, which realises new psychosocial services that consider the individual's social context, the differences between genders, and the connection of personal and social realms. Through the life stories of women who have had medical treatment, it was possible to view the need to consider the social context in which they lived and the meaning of social factors.

Caution must also be taken regarding interlacing the meaning of negative factors, such as the class one belongs to, the patriarchal sexual pattern, national belonging, physical violence, and a long period of living in threatening and stressful relationship. These are the basis of the women's mental health problems, which is why they have to be recognised and considered in a medical treatment as causes of a mental disorder.

Anthropology of health has brought us through the basic concepts and discourses, such as gender and culture, to the characteristics of the human social systems, to the values and the manifestation of pain. In addition to its position regarding health and disease, it also made it possible to consider the views of the society and culture in which we are.

[11] In the long-term, the medical model is considered as the less efficient, to which people return again and again, by the syndrome of revolving doors. The results of a psychiatric hospitalization are numerous iatrogenic injuries: addiction to medicines, lifelong stigmatisation, reduced self-esteem and self-confidence, consolidation of a false-self, repression of an authentic feeling and expression, changing relationships with the family members, with friends, changing relations in a job and the loss of life goals (Lamovec1995: 34).

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POVZETEK

V kontekstu antropologije zdravja v članku obravnavamo depresijo kot najbolj pogosto obliko manifestiranja psihičnih stisk žensk. Oris zgodovine histerije pokaže, da gre med depresijo in histerijo iskati določene podobnosti, tako v pojmovanju in razumevanju pojava kot tudi utrjevanju neenakega razmerja spolov in stigmatiziranja. Klasična feministična teoretska izhodišča razumevanja družbenega položaja žensk v članku dopolnimo s predstavitvijo raziskovalnega dela – izsledki etnografskih materialov, ki ilustrirajo in potrjujejo teoretske ugotovitve o androcentrični skonstruiranosti sodobnega slovenskega družbenega prostora in odnosov v njem,

KLJUČNE BESEDE: antropologija zdravja, depresija, histerija, duševno zdravje žensk, androcentrična kultura

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