

Original article

Mental health, women and social change: a progressive institutional profile from 1931 to 2000

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INTRODUCTION

The 20th century brought significant changes to humankind, both in scientific and technological areas and in educational and social areas. One of the segments mostly affected by these changes was the female gender. Modernizing changes, after 1930, have allowed the development of a new status of the feminine condition. Women had their social role redefined due to changes that took place within the family and in social and economic conditions. They have conquered political rights, assured access to education and started gaining more space at the work environment. The establishment of a new standard of feminine activity has allowed the passage of women from medium layers of the previous status of wife and mother to a status of working women. The search for women's own identity and social recognition of this identity had a deep impact on the dominant family model based on the provider's ethic. According to Singly: "The extra-domestic work, which had been so far considered a masculine activity, started to be part of women's everyday life, making them accept the challenge of house-work conciliation, which has brought evident consequences to the relationships between genders. Celibacy, 'feminine command,' separations and remarriages have become increasingly more frequent events in women's lives".¹

In Brazil, the rate of women's economic activity has been constantly growing. Statistics related to the 1970's show that the women's participation in the economically active population (EAP) increased from 18.5 to 26.9% by the late 1980's.^{2,3} This tendency is still present nowadays, and in 2004 the women's EAP was 45.4%.³ The number of women in prestigious professions (for example, engineers, physicians, lawyers) increased approximately 400%, from 19,000 in 1970 to 95,800 in 1980.² To date, in states such as Rio Grande do Sul (Southern Brazil), 25.2% of permanent private households are under the responsibility of a representative of the female gender. However, in the municipalities of Santana do Livramento, Pelotas and Porto Alegre, the indexes are even higher, representing 30.3, 31.4, 38.1%, respectively, much above the Brazilian (24.9%) and Rio Grande do Sul average.⁴

The economy of Pelotas is characterized by the specialization of its activities, based on traditional areas, such as agribusiness and production of foods. The latter sector has historically been a productive space concentrating women's labor force. It should be stressed the fact that the production of foods is mainly related to the industrialization of fruit preserves, an activity that is marked by seasonality. This means that changes in this sector directly affect the profile and composition of women's labor force in the industry, with implications on the set of jobs in Pelotas.⁵

Although the women's movement is making some progress, the consequences resulting from this process of changes cannot be hidden. The so-desired "women's freedom" also brings a higher exposure to the risk of taking alcoholic beverages and drugs in general, especially amphetamines. There is a growing increase in alcohol abuse among women, with prevalence rate of 1.3%. Nevertheless, this proportion can be even higher, since the identification of women's alcoholism in primary care services is deficient and receives little attention.⁶⁻⁸

Contrary to what occurs to men, women's insertion in the work market is limited by their household and family chores.⁹ In addition, differences regarding wages and type of activity are still present nowadays, which leads many women to the informal sector of the economy. Another problem faced by women is the increase in the number of unemployed workers, according to data collected by the Survey on Employment and Unemployment in the Metropolitan Area of Porto Alegre.³

This study aims at describing the profile of the female patients admitted to a service of psychiatric hospitalization from 1931 to 2000, relating the data found with the whole process that formed women's identity over the past years.

MATERIAL AND METHODS

This study is based on information collected from a database of a psychiatric hospital in the municipality of Pelotas (RS, Brazil). The research model used was a descriptive study of a historical

series of data from female patients hospitalized since the foundation of the hospital, on May 1, 1931, until December 31, 2000.

The clinical and institutional information is organized in a database structured in a system of case registers. Such information comes from the clinical charts organized by the Service of Medical Filing and Statistics of the hospital. The computer database was created in 1985 and has the following information: name, gender, age, nationality, origin, race, marital status, profession/occupation, hospitalization date, discharge date, diagnosis, discharge conditions, treatment (general reference) and hospitalization conditions (costs). The information above is updated at each hospitalization, originated from the Computerized Patient's Record System (PEP/DADOS-H/COL), which is available in the institutional network and organized so that each hospitalized patient is registered in the database as **case-individual**. Every time the patient reappears in the database (rehospitalization), a **new event** is created, but not a new register or case. The use of this system allows an easy location of the person, besides helping data management when the same individual has multiple hospitalizations.

To first analyze the "cases," we chose to use only the first hospitalizations of all female patients hospitalized between May 1, 1931 and December 31, 2000, in a total of 9,629 individuals/cases. The variables included in the study were: race, age, marital status, social class, nosological status and occupation. For a better progressive analysis of the epidemiological profile of the population being studied, the period was divided by decades, and each one was individually analyzed for each variable. It is worth stressing that the hospital was founded on May 1, 1931; therefore, in the first decade (1931 to 1940), there are no data from January, February, March and April 1931.

The nosological groups are based on the International Classification of Diseases, 9th edition, of the World Health Organization (ICD-9/WHO) and follow the same grouping profile proposed by Gastal,¹⁰ converted and structured into the current nosological groups of ICD-10 (WHO) and described in tables organized according to decade. Both ICD versions were used because the

database was created during the 9th edition, and all diagnoses of previous versions of nosological classifications and from the 9th to 10th edition were converted according to the conversion algorithms proposed by WHO. In case of doubts, clinical histories were reviewed by two specialists to generate a diagnosis in accordance to the above mentioned classification. The database includes the diagnoses according to both systems.

Sociodemographic variables include occupation, professional sector and social class. Those variables were organized using the criteria defined by Bronfman, modified by Lombardi et al.¹¹ and also used by Victora et al.¹²

The information and data from the variables being studied were collected from the database and organized into tables, following a model of descriptive statistical analysis, using spreadsheet software to do so.

RESULTS

The age group profile of patients hospitalized from May 1931 to December 2000 presents a predominance of the age group between 26 and 45 years (47.9%). Women aged between 26 and 35 years account for 25.36% of hospitalizations. There are no registers of hospitalized patients aged 66 years or more during the 1930's. Throughout the years, there is a progressive increase in age group distribution, so that in 1991-2000 the patients aged 66 years or more accounted for 6.78% of all hospitalized women (table 1).

Table 1 - Demographic profile of patients hospitalized from May 1931 to December 2000

Decades	31-40	41-50	51-60	61-70	71-80	81-90	91-00
Age (%)							
< 16	0.77	1.1	2.27	2.78	2.98	2.52	1.53
16-25	24.03	27.7	25.61	23.36	26.87	21.66	15.21
26-35	40.31	25.76	26.65	28.75	24.48	23.82	25.48
36-45	17.82	21.05	20.04	18.77	21.81	19.4	25.22
46-55	10.07	14.95	13.42	13.47	14.47	15.3	15.93
56-65	4.05	6.37	7.64	7.63	6.67	11.03	9.8
66-75	0	1.66	2.68	3.32	1.93	4.71	5.05
> 75	0	1.38	1.23	0.8	0.7	1.42	1.73
MD	2.32	0	0.41	1.07	0.07	0.1	0
Race (%)							
White	97.67	99.16	96.28	92.87	98.27	91.63	88.45
Non-white	2.52	0.55	0	0	0	0	11.54
MD	0.27	0	0	0	0	0.03	0
Marital status (%)							
Single	27.9	30.74	33.67	28.12	36.91	32.84	42.18
Married	58.13	62.6	58.05	63.25	54.68	54.45	39.78
Divorced	0	0.27	0	0.26	1.29	3.36	8.83
Widow	10.85	6.37	8.05	8.26	7.09	9.24	8.98
MD	5.1	0	0.2	0.08	0	0.07	0.2
Social class (%)*							
Subproletariat	96.12	98.61	97.52	86.25	80.36	87.97	89.73
Proletariat	1.55	0.55	2.06	12.75	18.58	11.18	7.91

Petty bourgeoisie	1.55	0.83	0.2	0.8	0.91	0.76	1.17
Technocracy	0	0	0	0	0.07	0	0.3
Entrepreneurial bourgeoisie	0	0	0	0	0.03	0.03	0.56
MD	0.77	0	0.26	0.17	0.03	0.03	0.3

* Subproletariat: salaried workers, liberal professionals, street sellers, civil construction, maids, agricultural workers, liberal professionals without active service; proletariat: salaried occupations in professional sectors: industrial activities, merchandise trade, services, auxiliary services of economic activities, transports and communications, social, public administration, other activities and food industry; petty bourgeoisie: independent traders, owners of active businesses, income lower than nine minimum wages or up to four employees; technocracy (new petty bourgeoisie): technical salaried workers, professionals, directors, executives; entrepreneurial bourgeoisie: owners, employers, income equal or higher than nine minimum wages or five or more employees; MD = missing data.

Table 2 - Occupational and professional sector profile of patients hospitalized from May 1931 to December 2000

Decades	31-40	41-50	51-60	61-70	71-80	81-90	91-00
Occupation (%)							
OCUP1	1.55	0.83	0.2	0.8	1.58	3.65	5.56
OCUP2	0	0	0	0	0.03	0	0.05
OCUP3	0	0	0	0	0.1	0.03	0.76
OCUP4	0	0	0	0.98	1.22	1.35	2.29
OCUP5	0	0	0.41	0.8	0.7	0.65	0.56
OCUP6	0	0	0.2	1.61	2.66	2.15	1.73
OCUP7	1.55	0.27	1.23	7.72	26.27	15.49	5.97

OCUP8	96.12	98.61	96.48	85.08	65.57	74.38	80.54
MD	0.77	0.27	1.44	2.96	1.82	2.26	2.5
Professional sectors (%)							
SET1	0	0	0.2	0.08	0.84	2.95	4.9
SET2	0	0	0	0.44	0	0.03	0
SET3	0	0	0.2	0.44	2.45	3.21	1.17
SET4	0	0	0.82	0.98	20.12	9.86	1.17
SET5	2.32	0.83	0.2	3.5	3.61	2.26	2.5
SET6	0.77	0.27	0	1.25	2.77	2.08	2.8
SET7	0	0	0	0.44	1.12	1.2	2.09
SET8	0	0	0.2	0.17	0.17	0.03	0.3
SET9	0	0.27	1.65	3.95	2.88	3.47	3.42
SET10	0	0	0	0.53	0.28	0.29	0.56
SET11	0.77	0.27	0	0	0	0.14	0
SET12	0	0	0	2.87	0.03	0	0
SET13	95.34	98.33	96.48	85.08	65.64	74.38	80.54
MD	0.77	0	0.2	0.17	0.03	0.03	0.2

OCUP1 = owners; OCUP2 = administrators, managers; OCUP3 = higher level professionals; OCUP4 = office positions: stock brokers, accountants, secretaries, typists, office assistants, cashiers; OCUP5 = specialized manual workers (technicians): those who are middle-level technicians; OCUP6 = semi-specialized manual workers: mechanics, electricians, riggers, welders, drivers, technicians in the transformation and civil construction industry, hairdressers; OCUP7 = non-qualified manual workers: bricklayers, garbage men, helpers, maids, stevedores, fishermen, machine operators, street sellers, police officers (soldiers), gas station attendants, office boys, security guards, night watchers; OCUP8 = housewives, students, pensioners, retired, unemployed, ill; MD = missing data; SET1 = agricultural: farming and cattle-raising, vegetal extraction, fishing;

SET2 = transformation industry: metallurgy, mechanic, furniture, paper and cellulose, leather, clothing (including home-made), chemical, plastic and petrochemical, textile, publishing, graphic, pharmaceutical and veterinary products; SET3 = civil construction industry; SET4 = other industrial activities: mineral extraction, industrial public services (electrical energy, water supply, sewage, public cleaning and garbage removal); SET5 = merchandise trade: supermarkets, warehouses, street markets, stores, wholesale, butchers, gas stations, second-hand stores, junk shop, used glass and paper; SET6 = services: housing and food (hotels, pensions, restaurants, bars, etc.), repair and conservation (mechanic shops), personal and home services (hairdressers, tailors), entertainment, hygiene and building conservation, stowage; SET7 = auxiliary services of economic activities: banks, financial institutions, insurance companies, real estate agencies, registry, accounting, juridical; SET8 = transports and communications: transportation of passengers, loads, mail, telecommunications, press; SET9 = social: community and social activities (social security, unions, social assistance), medical and dental services (public and private), teaching, hospitals, churches; SET10 = public administration: federal, state and municipal administrative services, public companies, legislative, justice, public security services (army, navy, air force, police and firemen); SET11 = other activities; SET12 = food industry: food, beverage, cold storage plants, mills, bakeries; SET13 = not belonging to the economically active population: housewives, pensioners, retired, unemployed.

Table 3 - Nosological groups of patients hospitalized from May 1931 to December 2000

Decades	31-40	41-50	51-60	61-70	71-80	81-90	91-00
Nosological groups (%)							
SEN	3.1	6.92	5.78	6.01	2.07	3.65	5.05
TOP	10.85	8.03	3.3	0.62	1.33	1.05	1.22
COP	0	0	0	0.26	3.09	3.72	5.66
NSYF	1.55	2.21	0.61	0.08	0	0	0

RET	4.65	3.04	6.4	1.61	0	0	0.3
ALC-NEU	0	0	0	0	0.17	0.1	0.81
ALC-PSYC	0	0.83	0	0.26	1.12	2.3	6.38
TOX	2.32	0	0.2	0	0.1	0.87	2.19
SCH	24.8	32.13	31.4	26.5	26.8	24.58	20.58
AFD	25.58	22.16	26.65	28.3	24.76	32.44	31.05
PSYC	3.1	3.87	0.82	3.23	33.86	29.74	20.78
NEUR	3.87	7.2	8.67	10.33	0.42	0.03	0.35
HYST	4.65	3.32	7.02	10.96	4.95	0.36	0.61
OTH	8.52	9.14	7.02	8.35	1.19	1.05	4.85
WDIAG	6.97	1.1	2.06	3.41	0.1	0.03	0.1

AFD = affective disorders; ALC-PSYC = alcoholic dependence with delusional and psychotic or withdrawal syndrom; ALC-NEU = alcoholic dependence without psychotic or delusional disorder or withdrawal syndrome; COP = chronic organic psychoses; HYST = dissociative (or conversive) disorders – hysterical neurosis; NEUR = neurotic disorders; NSYF = neurosyphilis; OTH = other diagnoses; PSYC = nonorganic psychosis; RET = mental retardation; SCH = schizophrenic psychoses; SEN = senile and presenile psychoses; TOP = transient organic psychoses; TOX = drug-related psychosis and dependence; WDIAG = registers without diagnosis.

By analyzing the race profile of the patients, there was prevalence of white (91.3%) in relation to non-white patients. This situation remained through all the decades included in this study, presenting variations between 88.45 and 99.16%. However, there was a progressive increase in the proportion of non-white women, from 0.55% in the 1940's to 11.55% in the 1990's.

As to marital status, married women were prevalent (44.9%) in relation to single women (35.31%). Nevertheless, in the 1990's, this proportion was inverted: single women accounted for 54.45% of the patients, and married women for 39.78%. Moreover, there was a gradual increase in

hospitalizations of separated women. Over the first four decades, they accounted for 0.27% of the patients, reaching 3.36 and 8.83% in the past two decades, respectively. Out of 9,629 hospitalized women, only eight (0.08%) did not present information related to marital status.

Regarding the distribution in terms of professional sectors, there was a clear predominance of patients not belonging to the economically active part of the population (sector 13) throughout the years, especially from 1930 to 1960, when they accounted for 96.71% of hospitalizations. From the 1960's on, there was an increase in the percentage of unemployed women in the industrial sector, going from 0.98% in the 1960's to 20.12% in the 1970's; however, there was a new decrease in the following decades, when the industrial sector collapsed in Pelotas, especially because many industries of food and fruit preserves closed down.

The analysis of the variable social class showed that the subproletariat accounts for 86.8% of hospitalizations. The increase in proletariat (class 2) since 1950 is evident, reaching its highest concentration between 1961 and 1990, accounting for 18.58% of hospitalizations in the 1970's and decreasing in the 1990's (7.91%). Over the first four decades, there were no representatives of technocracy and bourgeoisie among the patients being firstly hospitalized. Over the past decades, however, those classes accounted for 0.30 and 0.56% of hospitalizations, respectively. The losses related to the variable social class were 0.12%.

As to the nosological groups of patients, there was a greater number of hospitalizations due to affective disorders (28.6%) and schizophrenic psychoses (25.2%). Alcoholic psychoses, which accounted for less than 1.5% of hospitalizations over the first five decades, increased in the last decades, accounting for 6.38% between 1991 and 2000. On the other hand, neurosyphilis and mental retardation presented significant decrease, with values lower than 1% over the last three decades. The analysis of neurotic disorders showed that there was an increase until the fourth decade (10.33%), with further decrease, accounting for less than 1% of hospitalizations in the last decade.

DISCUSSION

The reasons for women's admittance to psychiatric services presented a series of changes throughout the years.

The variations were a consequence of women's role in society. Since the 1960's, they have been holding job positions and started having a major role in the economy.¹³ The incorporation of women resulted from a series of factors, such as increase in schooling levels, reduction in fertility rates and expansion of jobs. Such incorporation represented the women's development in distinct social sectors – on the one hand, women with low income, who had to enter the work market to assure the survival of the family group; on the other hand, women from medium and high classes, who entered the economic activity with the aim of searching for professional achievement or of assuring a consumption level threatened by the economic changes occurring in the country.¹ However, women's insertion in the productive process was associated with another major aspect of the feminine identity, related to maternity, family and household chores, resulting in increased social load imposed on them. In our time, it is recommended that a woman should be fully prepared to be responsible for household chores and reach personal achievement in maternal care.¹⁴ The double journey motivates contradictions and conflicts, which are probably involved in the psychogenesis and triggering of psychiatric disorders. Furthermore, economic and social pressures have increasingly led a greater number of women to enter the informal work market, which represents a limited and not recognized opportunity of using their skills.¹⁵ The uncertainty about their work situation, as a consequence of informality, perception of injustice and fewer opportunities in relation to men with formal jobs, may be negatively associated with the women's psychological well-being.¹⁶ Another problem faced by women concerns the growing unemployment rates. Women's labor force has suffered more with the adversities that affected the work market over the past decades, accounting for most of unemployed people in the metropolitan area of Porto Alegre. These results show that women are still facing obstacles to their insertion in the work market. Besides the lack of job positions resulting from the economic situation, there is still a

discriminatory culture in terms of their relationships with the world of work, as a consequence of a traditional sociocultural construction of roles attributed to men and women.³ In industrialized societies, it is established that unemployed people and their families have a worse mental health condition, compared with those who have a job.¹⁶

The prevalence of patients hospitalized during their productive age (26-35 years) reinforces the existence of a strong association between predisposing biological factors and psychological factors related to work overload and maternity and the presence of psychiatric disorders. In addition, professional, family and socioeconomic problems reach their peak in that age group. It is also important to consider the increase in hospitalizations of older patients. This fact is possibly due to an increased life expectancy, especially in Southern Brazil. In Rio Grande do Sul, life expectancy went from 66.7 years in 1972 to 71.6 years in 2000.⁴

Regarding race, there was a clear prevalence of the white over the non-white population, which can be explained by the demographic characteristic of the region where the study was carried out. Nevertheless, in the last decade, there was an increase in the number of non-white hospitalized patients. This is probably due to the growing access of the general population to health services, thanks to the creation of health systems and social security.

The greater proportion of married women during the first decades of the study characterizes the economic dependence and the cultural values of that time. However, after the advent of women's movements and divorce was enacted in Brazil (1970's), this relationship changed. The presence of an independent and dynamic woman in society has become frequent, instead of the submissive character they represented in the early 20th century. According to the Brazilian Census in 2000, 31.5% of houses in Pelotas are under the responsibility of women; of these, 26.5% are single mothers, widows or divorced.¹⁷

As to professional sectors, there was a significant increase in women inserted in the work market, especially in the industrial sector, during and after the 1960's, a fact that may be related to the development of the local food and fruit preserve industry in the 1960's and 1970's.¹³ Work has

been increasingly gaining more importance for women, competing against marriage and maternity as a possibility of achievement and social development.¹⁴ However, there was a decrease in the percentage of employed women in the last decades, which is justified by the economic and social crisis that took place in the 1980's and had a great impact in that region. Restructuring deeply affected job positions in all economic sectors in Pelotas, but it was more incisive on the industry, with reduction in the seasonal contingent of labor force. The reduction in seasonal work, which was less stable and usually taken by women, and the increase in women's employment in other sectors that are more stable show gains as to quality of offered job positions in the economy. On the other hand, they show that the benefits are given to women with higher schooling level and better situated in the market, which means women with lower schooling level are penalized. These women generally come from poorer segments of the population and are submitted to the rough conditions of the seasonal work.⁵

The subproletariat appeared as a prevalent social class in women's hospitalizations. Unequal treatment given to women's work in relation to men's work may be responsible for such prevalence. Data from the Economic Commission for Latin America and the Caribbean, regarding the year of 1996, showed that the average salary for women corresponded to only 68% of men's wages.¹⁸ According to a survey performed by the Brazilian Institute of Geography and Statistics (IBGE) in 2000, the Brazilian reference is 67%, but in Rio Grande do Sul the difference is less considerable: women earn, in average, 29% less than men.¹⁷ The uncertainty presented by women about their work situation, due to informality and perception of injustice and discrimination, may be negatively associated with women's psychological well-being.¹⁶

The prevalence of hospitalizations due to affective disorders is possibly related to the double journey, which causes great suffering and is the psychosocial stressing factor related to the genesis of significant emotional and/or behavioral symptoms that characterize this nosological group. Among women, associations between common mental disorders and work, marital status and parity are highly complex and range according to the specific change in social roles. Such complexity is

clearly demonstrated with regard to work, whose effect is not only strongly dependent on the context, but may also have acquired a different meaning as women entered the work market. Recent studies indicate that married women, with small children and full-time jobs can present higher risk of developing common mental disorders than unemployed married women or employed married women without children, although this effect may be in part incidental or a result of interactions with low socioeconomic level and poor social support.¹⁹

Schizophrenic psychoses are the second most significant nosological group in the study. Some characteristics of women's schizophrenia are late onset and a better prognosis in relation to men.²⁰⁻²²

Female alcoholism has increasingly gained importance in epidemiological terms. Data in the literature show the prevalence of male and female alcoholism ranging from 2:1 to 14:1.^{7,22} The profile presented by alcoholics is that of a woman that starts alcohol consumption later, encouraged by friends or by her husband, especially drinking at home and receiving help from others to acquire the beverage. Biological factors, such as reduced volume of body water and lower amounts of alcohol dehydrogenase, determine earlier deleterious effects.

It is worth stressing that the present study does not aim at surveying or presenting population-based information, data regarding prevalence or incidence of mental disorders in women, since the methodological design does not allow it. The purpose is solely to survey and present a relation between the historical-social process and the data taken from a database with clinical information of a hospitalization service.

Another aspect to be stressed is that this study uses a model of case register, which for some authors could be classified as historical cohort. Therefore, in the descriptive model of analysis, all the patients are included, and not sample subgroups. This type of study is very rare in Brazil; in addition, there are no databases with historical series containing seven decades or more, which compromises the study and avoids comparisons.

CONCLUSIONS

The results observed and their historical evolution corroborate the scenario of deep social changes.

The frequency of mental disorders present in the database and their changes are mainly related to the set of deep changes faced by women in the 20th century. Manifestations of diseases, especially the possible increase in prevalence of alcoholism, suggested by the data regarding frequency of hospitalizations, may confirm the increase in psychosocial tensions and work loads on women.

The results contribute to the construction of a set of references for the development of more appropriate studies in terms of their ability to obtain information about the prevalence and incidence of mental disorders in the population. They also stress the importance of considering gender peculiarities in epidemiology and in health care programs.

Studies using institutional databases have historically played the role of contributing to the formulation of hypothesis and opening new paths for population-based epidemiology, establishing, with their results, relevant scenarios for future action and developments.

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ABSTRACT

Introduction: Along the 20th century, women underwent numerous changes and reached a more active participation in society. This study aims at describing the profile of the female patients admitted to a service of psychiatric hospitalization from May 1931 to December 2000. In addition, it relates the profile of psychiatric morbidity with the historical, social and demographic changes. It also offers a comparison between the epidemiological conditions throughout the historical series and the aspects regarding the environment and the sociocultural status of women from a Southern Brazilian state.

Materials and methods: Descriptive, longitudinal, epidemiological study including historical data and based on data collected from the medical records and statistics of a hospital. The following variables were assessed: age, marital status, race, professional area, occupation, social class and psychiatric diagnosis, all standardized according to the International Classification of Diseases (ICD-9 and ICD-10) criteria. To identify the cases, all first hospitalizations of women were used.

Results: Along 70 years, a total of 9,629 individuals/cases was obtained. There was a predominance of women in the age group between 26-45 years (47.9%), white (91.3%), belonging to the subproletariat (86.8%), not belonging to the economically active part of the population (96.7%) and with diagnosis of affective disorders (28.6%) and schizophrenic psychoses (25.2%). With regard to marital status, married women were prevalent (44.9%). However, in the 1990's, single women represented 54.4%, whereas married women accounted for 39.7% of the patients.

Conclusion: Significant changes were detected in the reasons for admitting women to psychiatric services over the past years. It is suggested that the variations might have been

influenced by biological determinants of severe mental diseases, and especially by the social pressure resulting from the new role of women in society.

Keywords: Mental health, women's health, epidemiological studies, epidemiology, descriptive epidemiology, medical care statistics, hospital statistics, psychiatry.

Title: Mental health, women and social change: a progressive institutional profile from 1931 to 2000

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