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ORIGINAL ARTICLE

Self-Construal among Healthy and Chronically Sick Women

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The nature of self-construal was qualitatively explored among healthy and chronically sick women. Ten healthy women who did not have any major illness in the past 5 years and 10 sick women who had some major chronic health problem in the same period participated in the study. These were middle class, middle age married women residing in Allahabad in north India. These women were interviewed in -depth and narratives of their life events, married life, health history, personal concerns and choices were obtained. The narrative analysis of their life scripts focused on the role of health and life circumstances in shaping self-construal of women. The analysis shows that most of these women construed their selves in terms of role relationships as wife, mother and daughter-in-law. Women with chronic conditions view their marriage as a major discontinuity in their lives and struggle to carve out a new self-identity. In contrast, healthy women experience a sense of continuity and growth, and ~~find~~ some space to express their individuality. The healthy women form new relationships with ease and showed greater acceptance of their present life conditions. The implications of these observations for changing role relationships are discussed.

Keywords: Economics, Human potential, Quality of life (QOL), Life satisfaction, Subjective well being

For centuries, women in India identified themselves with their roles as daughters, wives, and mothers. They have conformed to role-specific responsibilities and expectations, and by the ideals prescribed for them by the society. They remained rooted in social-affiliative system, confining and conforming to a network of social relationships, and thus maintaining the stability of society's cultural institutions (Parikh & Garg, 1989). The aspirations and activities of these Indian women remained family-centred, as they sacrifice their personal needs to fulfill larger social obligations. Though all along the history, women were part of the work force, engaged in a wide range of activities in the outside world, the society continued to identify them with their familial roles only. Literature, religion, and cultural lore eulogized women who lived by the virtues of their social role expectations. Women defined and crystallized their self-identity only in relation to their families. Against this backdrop this study examined the role of health status in organizing women's self construal. The main objective of the study was to understand how chronically sick women ~~understand how these women~~ urban-middle class families background construe their self-identity, discover themselves in different social roles, while dealing with the vicissitudes of every-day life. A comparative analysis of the constructions of self of healthy and sick women was undertaken to provide insights into their struggle to retain a positive self image in a rapidly changing traditional society.

The contours of the world in which Indian women have lived so far are rapidly changing in recent times. Socio-economic changes, as well as, global exposures through television and telecommunication are now heralding new possibilities and new images of womanhood for them. Educated, armed with skills and knowledge, today's woman is rediscovering herself beyond the confines of existing social structures and networks of relationship. "Like their male counterparts, they enter into the world of occupation, career, profession, competition and achievements in their own

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right and create a space where the need to experience themselves and be accepted as autonomous beings is dominated" (Parikh & Garg, 1989, p.25). Even those who are circumscribed by their social roles are also feeling a pressure from within and without to give a new meaning to their self-identity. They never had so much space and freedom to vision themselves in newer roles, beyond the boundaries which society had imposed on them (Chatterji, 1997).

Today, Indian women are caught in cross-currents of a culture in transition. She is facing a major challenge of balancing a traditional and a modern world in her life. The gains of modernization in terms of social liberalism and individual emancipation are at times offset by the negative aspects of the devaluation of the human qualities in urban India (Menon, 2004). Also, the pursuit of independence and achievements creates guilt at not fulfilling the traditional role, anxieties about their inadequacy and apprehensions of being accused or ridiculed. Their lives have already become a battleground between the prescriptive roles based on idealized past and a dream of the future of autonomy and independence. This conflict in internalized more often by educated, urban middle class women. Ghadially (1988), Seymour (1999) and Davar (1998) have discussed at length this dilemma which Indian women are facing today.

Unable to resolve the duality of their existence, many of these women are caught in mid-life crises. Their husbands want them to be traditional at home and modern in public; their children seek nurturance but resent indulgence; they work in office and carry domestic chorus without much support. She is grown up, mature and worldly wise, but is at the same time conscious of the widening gap between her dream image of herself and the real one (Channa, 1997). This is the stage in life when a woman is prone to engaged in self-appraisal and self-reflective exercises.

A woman reaching mid-life has to confront the reality that youth and womanhood has started receding into the past. She is no longer centre of gravity for her husband and children who get busy in their own worlds. As Parikh and Garg (1989) observed, though she is now in a very familiar and predictable surrounding, there is a strange sense of being lost. Many women find it hard to let go their long cherished dreams of a purposeful life and suffer from a feeling of meaningless existence. They become indecisive and confused, angry and reactive, and frustrated, realizing that there is no escape from the expectations of the familial world they were caught in. In a study (Singh & Singh, 1999) many of the middle aged school teachers reported that they were not able to perform now their work with same efficiency as earlier. It causes anxiety and irritation, many times results in unpleasantness with husband and children. It was found that more than three-fourth of the sample expressed negative feelings of depression, frustration, loneliness, anxiety and fear about their aging. Chatterji (1997) reported that health of these women remain neglected because she has never learnt to pay attention to her own well-being.

Many of her conflicts which she had buried in the turbulent period of establishing herself as a wife, mother, and daughter-in-law resurfaces, as she can no longer hold her 'self' in abeyance. She sees a danger of her real self being engulfed by the social networks. In such instances one possibility is that her aggression toward husband and in-laws turn inward, against her own self and internalize cultural devaluation of women as her own feelings of worthlessness and inferiority. Basu (1995) found greater real-ideal discrepancy in self in the case of middle age Bengali women. Isaac and Shah (2004) found that Indian women are less satisfied with their own self and accomplishments. Though, they may find some compensatory reward in their motherhood and in the achievements of their children.

As Peterson, Seligman and Valliant (1987) found in their work that mid-life (35 to 45 years of age) is the most vulnerable age to catch health problems. They conducted a 35-year long follow up study to establish linkages between negative mental states and physical health. As they discovered, in the young age when physical health is robust, it is not much affected by her mental state. As they enter mid-life, their attitudes and expectations play crucial role in shaping their physical health status. People who are pessimistic and helpless are more likely to get into variegated health problems. Those who could find space to express their individuality, or make sense of their social position could be those who remain healthy. In other words, there seems to be a close symbiotic relationship between self construal and physical health status.

It is posited in this study that women's self-construal is a dynamic entity, not just an end product in terms of a given structure. Self-construal is the inclusion of elements of social world in one's self definition (Markus & Kitayama, 1991). The self in this sense is not what one is, but is a system of internalizing social values and traditions. It arises in social interactional process and the manner in which social experiences and events are being interpreted by a person. Gergen (1998) has argued that such social construal of self serves as a referent to make sense of on-going life experiences and events. This is a process through which people come to understand their own selves and the social world they live in. Such self-construal denotes

what they think they are and determine their relationships and participation in social life. This bi-directional causality keeps the self socially grounded, as a relatively stable and continuous entity. More importantly in the present context, it affects and gets affected by one's health status.

Chronic ~~health~~ experience often tempers with woman's self-image. For some it could be a respite from facing hard realities of the life; for others it erodes their sense of respect and self-worth. Her body image and social relationship are undermined by the fact that she is no longer provider of nurturance and care to their family members. It would be enlightening to examine how their material, social and spiritual selves act and interact with each other to compensate for the chronic sickness. The illness, indeed, provides an opportunity to probe deeper into the inner world of a woman.

While attempting to understand women's construal of their own-self, it is important to use appropriate method which had potential to probe into her personal world. An appropriate method is that which can go into the depths of her psyche and can provide an understanding of her existential dilemmas. Parikh and Garg (1989) discovered in their dialogue with more than 2000 women that a women rarely talks about her self. She mostly talks about her social roles, her family and social networks. She may talk about her personal observations once for a while, but keeps her intimate feelings to herself.

Under these conditions, narrative method was found to be the most appropriate choice. Narratives of the lived life experiences are the means to communicating and detailing their lives to others. The way people construct and communicate their life stories is often conditioned by culturally available resources and by the images of their own-self (Williams, 2000). Life narratives thus can be very rich source of material to enhance our understanding of the self and social world of Indian women, as they are impacted by their health status. These narratives are examined and understood without any preconceived categories and theoretical frameworks.

In the narrative approach as employed in this study, without taking recourse to any prepared questionnaire, women were encouraged to free associate with their important life events and share them with the researcher. In informal sessions, these women were asked about their personal experiences, feelings and actions. They were encouraged to reflect back in identifying salient influences on their lives. A narrative construction of personal experiences and events was what constituted research data. In the present study narratives of healthy and chronically sick women were collected and interpreted to establish the potent role of health status in defining and designing one's self identity.

Method

Participants

The study was conducted on 10 healthy and 10 chronically sick women. Healthy women were those who did not have any health problem (except seasonal ailments, like cough, cold) in the past 5 years. The chronically sick were those who suffered one or the other health problem in the same period. Most of the sick women in this study had problems, like peptic ulcer, colitis, spondalitis, high blood pressure. They were constantly under treatment for their illness, causing frequent disruption in their daily routine.

These women participants belonged to urban, middle class families from Allahabad, India. Their age ranged between 35-40 years. They were married for at least 10 years and were living with their husbands, children and in-laws. All of them were educated - a majority of them studied up to graduation and post-graduation. Eight of these women were employed, rest were house-wives. All of them hailed from traditional, upper caste family background, belonging to middle income group. Most of them were from the Bengali community. The demographic break up of the participants is given in Table 1. Care was taken to select the women who were willing to reflect and share their life experiences.

Table 1 Demograp-hic profile of the healthy and chronically sick women.

Demographic Background	Healthy	Sick
Mean Age (in years)	36.7	37.6
Years of Marriage (in years)	15.6	17.9
Education		
Senior Schoo	1	3
Graduation	7	4
Master's degree	2	3
Work Status		
Employed	5	3
Housewife	5	7
No. of Children (mean)	2.1	2.2

Narrative Sessions

Narrative sessions were conducted in the home setting. The second author of this paper visited these women with prior appointment. The preferred meeting time used to be before forenoon when other members of the family were busy elsewhere. The idea was to have some privacy and enough time to engage in conversation. These meetings were not for the purpose of any formal interview, but for what we called 'informal chat sessions'. Some demographic information was obtained at the initial stage, as well as, information about the nature of illness was sought from the chronically sick women. The purpose of the interview was made clear as to know about their life experiences, particularly, to talk about their health experiences. There was no fixed agenda or interview schedule to elicit responses. The researchers only had a list of questions to guide the inquiry. An environment of trust, understanding, and friendship was cultivated during the initial contacts. Since the researcher also belonged to the same age, social class and family background, it was easier to establish a trusting relationship. She talked about her own life experiences, family and health problems to be an active participant in the conversation. This mostly worked well in soliciting cooperation of the respondents.

In subsequent sessions, the respondents were encouraged to reflect on their health experiences. What major changes have occurred in their lives in the past 5 years? What does good health mean to them? How has illness experience changed their lives? The respondents were encouraged to go into their past, think about the major events and their responses to them. Those who were sick were asked to think in terms of their illness experiences. The researcher minimally intervened to maintain the conversational flow.

In fact, the researchers, as well as, the respondents had no prior experience of conducting such narrative inquiry. The first three respondents were taken as practice cases and were dropped from the study. A thorough discussion with colleagues on what really transpired in these practice encounters gave confidence to researcher in handling health narratives. Again, as we discovered, all the respondents were naive in the sense that they had no prior experience of this kind of reflective exercise. Many of these women found it difficult to talk about their personal lives and often avoided talking about themselves directly. They instead talked about other people in their lives. They opened up only in subsequent sessions. The most difficult topic to talk about was husband-wife relationship. There was, of course, variation in self-disclosure of these women. The researcher took detailed noted of whatever respondents said and filled the gaps in subsequent sessions.

It took 3 to 5 sessions with each respondent to get all the information for this study. The respondents were helped to re-examine and re-evaluate the incidences of their lives. For some it was an emotional reliving of the traumatic experiences and cried while narrating their experiences. In such cases, the researcher had to double up as a counselor. On an average, the researcher spent about 8-10 hours with each respondent.

Results and Discussion

Each narrative was read and re-read by both coauthors of this paper to make sense of health narratives of the participants. The main focus was on understanding, how the construal of self differed for healthy and chronically sick women. We looked for the emerging themes and patterns of narrations across all healthy women and compared these patterns with those of the sick women. We focused only on those patterns of narrative scripts which were coherent and consistent, indicative of some salient features of self perception. We could identify some recurring themes that formed the basis of interpreting these narratives.

Location of Identity

Location here means the position from which a woman views herself. It is the reference point from which she comprehends her appearance, relationships, virtues, deficiencies and her life as a woman. Though some of these women described themselves in terms of professional, physical and social attributes, their predominant identity was that of a mother. It is in the motherhood that they ~~find~~ find meaning and purpose of their living. A typical self-description follows as:

I am a teacher and a mother of two daughters. I live with my husband, children and in-laws. I have a small house that I try to keep clean and tidy.

Another self-description of a healthy housewife shows similar pattern:

I am his wife. I have many positive attributed in me. I am mother of two daughters. When I watch TV and realize that women can do a lot, I feel that if I had learnt good tailoring I would have started my own business.

There are though few differences in the narratives of healthy and sick women. One, in the case of sick women there is greater assertion of individuality. They see themselves as a person and maintain a self-object distinction. They are conscious of their appearance. For example, here is self-description of a women suffering from chronic gastric condition:

I am .....I am graduate, a teacher. I am happy go-lucky. I am a tall, fair complexioned, black haired woman. Singing is my hobby. I like clean surrounding, tidy home. I do cleaning, washing, all myself. (Asha)

She is the women who had gone through a very turbulent period. Both she and her husband were short tempered and never got along well. Her husband had high blood pressure and during one of their verbal fight, he got very excited and had the attack of paralysis. He was admitted in the hospital and doctors lost hopes of his recovery. "I was completely stunned but did not cry. I kept praying to the God and nursed him without failure. He recovered in three months time. Now I do not get so much angry but often cry silently. I am very much worried about my children. If something happens to me, who will take care of them. It depresses me."

Another sick woman who is not happy with her life conditions was not interested in talking about herself. She had suffered from multiple illnesses, was withdrawn and her elder daughter was managing most of the household work.

My name is …… I am a housewife. I don't do anything, so there is no point in talking about myself any further.

Its contrast a healthy women considered herself a woman first and a wife later. She is second wife of a doctor and is herself a nurse by profession who viewed herself in a larger social context. Her positive construal is evident in what she had to say about herself.

I am a woman, wife of a doctor. I am a nurse by profession but a social worker by activities. I enjoy helping people in trouble and try to connect with them. I never think of future and am happy with what I am doing.

Another self-introduction of a happy and healthy woman,

I belong to a middle class family. I am an ordinary person, considered myself a happy and successful housewife. I am lucky to have got a good family in marriage that care for me. I am only worried about the education of my three children.

Gender-specific Imageries

The self-image which most of these women had of themselves centered around traditional social roles. The images imprinted in their minds were those of nearest familial roles -that of mother and wife- not of the generalized role base on gender differentiation. However, in all these women a yearning to be unconventional was clearly noticeably. The sick women were, indeed torn between these two contradictory demands. Self-doubt, uncertainty, fear, confusion and other such typical symptoms characterize the self-imagery of these women. On the other hand, physically healthy women were able to strike balance and harmony between these two opposite desires. These women were able to perceive themselves as a unit of a larger social system and their self-concept hinged on a broader domain. The two narratives given here highlight this contrast.

I got married at an early age and had three children one after another. Even then I could complete my studies with family support. My in-laws are also living with us and we all live happily. For me family well-being is foremost and always feed husband and children first. I easily make friends and win trust of others. (Manisha)

Women of poor health had different stories to tell. One of them said:

Wife is devalued in our society. She is burdened with responsibilities and has to tolerate too much in her life. If she does not adjust herself to the demands of her family after marriage she will not be at peace. Her life is suffering and worse, she is not supposed to open her mouth. She suffers silently and faces the consequences. Bengali women, like me, are expected to serve without caring for their health.

Other respondent, Vibha, suffered from peptic ulcer and was hospitalized frequently. She was a housewife and considered it a curse. She observed,

Women keep doing their domestic work till they fall sick. They ignore their disease and hide it till it is intolerable. We have to do strenuous work that is why our illness takes serious turn. I had to please everyone after marriage. In my middle age I had a feeling that I had tortured myself enough.

For the women who were chronically sick, motherhood was not a rewarding or growth experience but is seen as a compensation for her sacrifices. There sense of achievement is reflected in the achievements of their children. If the children are not doing well, it aggravates their personal crises. For healthy women children's performance is one of the many sources of life satisfaction.

Themes of Uprooting

One of the major turning points in lives of all these women was marriage, and more than that to leave their own families and to settle in a place and among people which were unfamiliar. It was like replanting themselves in an entirely new environment. The themes of such uprooting are very much evident in all the narratives.

For the women who were healthy, this transition was smooth and growth- oriented. They succeed in building a bridge between the two worlds and could freely move from

one side to the other. They were accepted by their in-laws with whom they forged a new relationship. One healthy woman mentioned,

We are four brothers and sisters. I got lot of love from my mother. She gave me good upbringing. After marriage, husband and in-laws took good care of me. Outside people think that I take too much attention to maintain my health. My husband thinks that I don't do much for my health. (Vinati)

On the contrary, sense of uprooting is a major theme in the narratives of sick women. When Sharda (name changed) was asked about the saddest time in her life, she mentioned unhesitatingly that was when she realized that her in-laws place was worse than her worst dreams. She stated,

I am least satisfied with my present. There is a big difference in parents house and here – in status, food habits, life style. Here no use abusive language. I had too many problems in adjusting after marriage. My husband is good – he is different. We finally got separated from the in-laws.

Meenakshi's story is a case in point. Her both parents and brother had died in the recent past. She only had distant relatives in her father's house, no one in particular to receive her. She still crave to return to her father's. As she narrated:

Last year my brother died. Same month father died. Mother died later on. I was youngest in the family and I can't forget all of them. This brother gave me blood when I was sick earlier. I always crave to go to my father's house.

In contrast, a healthy woman stated that the worst day in her life was when her sister-in-law died young and she could not do much. Many of these healthy women viewed their marriage as a practical solution to their many life crises. They accepted their present state more sanguinely. Some of these healthy women maintained their close ties with their own family and did not suffer separation. As Meera said:

My husband works in other city and comes home in holidays only. I mostly stay with my parents and it works well in my case. I don't miss them

World of Relationships

Indian women live in a complex web of relationship. They define their identity in terms of relationships. They derive their energy, their vitality from these relationships. These are the close family relationships which are both – the source of pain and pleasure for middle-aged Indian house-wives.

In case of sick women, their relationship with husband and in-laws are always very difficult. There was no evidence to suggest that these women tried to patch up with their in-laws or tried to smoother the relationship, instead the endeavour was to make life a little more tolerable. There is a changing view of husband from indifferent, coercive to that of a little more tolerant person. The healthy women find it easy to form new relationships and find meaning in them.

Kavita who got married at a very age found herself much settled in her relationships with her in-laws and husband. In her words:

People say I keep very good health despite age and grown up children. Still my old fashioned mother-in-law feels concerned about my health and keeps saying that I am week and need to gain some weight. I was strongly attached to me sister-in-law who died few years back. I always regret that I could not do much for her. My mother-in-law and daughters take full responsibility of running the household. I get enough time to read books and play harmonium.

It was quite different experience for Nisha who was teaching in a school and suffered many health problems.

My health problem began with the illness of my son and got aggravated after his death. I stopped taking care of my health, stopped eating properly. In my in-laws house I had to serve every one, a difficult task. I had problem with my husband whose carelessness forced me to abort thrice. My unemployed brother is another source of concern for me.

What comes out from the narratives is that whereas, sick women have a feeling of being stuck up in a relationship, healthy women experience a sense of autonomy. They succeed in carving out a social space for themselves where they can experiment and innovate, and feel their individuality. Vinati likes to visit her friends, Kavita is active in a local NGO, Manisha participates in drama and music competition. The story of Kamla who had a serious health problem in the previous year is rather different.

I was down with rheumatic fever and was hospitalized. My mother-in-law and daughter attended me but my husband did not come to see me. He was annoyed that now he has to spend a good amount of money on my treatment. My husband is attached to his mother and I know nothing about his job, I feel in shackles here.

A significant indicator health and sickness was the relationship with in-laws. Wherever, these relations were strained and health became a major casualty. The themes of being harassed and exploited by in-laws were frequent. Most of these women saw their husband as different from the rest of the family. Kunti who broke away from her husband's joint family after years of recriminations separated and suffered chronic headache stated:

I am not satisfied. It is just sort of o.k., Their (in-laws') behaviour was not what I had expected. There was a big difference in social status, eating habits and living style. Because of all this I faced a lot of problems. And then, after 7 years I got separated from my in-laws. But my husband is a very nice human being. His temperament does not match with anyone in his family. His thinking and friend circle are very different.

This is a healthy woman:

After marriage I got the cooperation and affection of every one, particularly of father and mother-in-laws. I have more freedom here than I had at my mother's place. I never indulge in a situation which may lead to tension. When I get angry, my husband lightens up the whole situation.

Tradition vs. Modernity

Respondents taken in the study seemed to have caught in social transition, trying to balance between the two worlds of tradition and modernity. The demands of these two worlds are different, each pulling the respondents in opposing direction. Whereas modernity calls for independent, self-contained and autonomous mode of self, traditional self is emotionally bound to family and relations. For her personal needs and desires are subordinate to collective interest of the family. Tradition values calls for sacrificing personal well-being before family. Thus whereas traditional model lays emphasizes on social roles (e.g., motherhood) and interdependence, modernity promoted ego-centric functioning of self, the emphasis is on personal achievements and carrier, and builds around individuated selfhood. Thus, whereas traditional self is other-focused, modernity is self-focused. Indian women struggle to reconcile these opposing forces of traditional ideals and modern aspirations in her psyche (Kakar & Kakar, 2007). These two opposing pulls within these women create stress and conflicts, and have implications for their health status.

The narratives revealed that healthy and sick women differed in their resolution to this dilemma. In general, it was observed that whereas healthy women made no efforts to resolve this dichotomy and accepted it as part of living, for the sick this transition proved oppressive and they strived to resolve it.

For most of the healthy respondents life was an orderly transition from one stage to another. They were more tied with the traditional roles and tried to contain their ambitions and greater concern about mental freedom. Many of them believed in the theory of karma and took the life as it came. Though they were craving for freedom and wanted to assert their individuality, they were able to dwell in both the worlds. The sick respondents thought the other way round.

Those who could not fulfill their needs and wishes, like me, tend to fall sick. I was very adventurous before marriage, now nobody appreciates what I do. My son had a hole in the heart. Relations and neighbours kept advising me what to do. It delayed the treatment and my son died. (Vibha)

Believe in God and accept His judgment. I keep worshiping all the time. But my mind wanders and keep asking 'why me? Why do I have to suffer so much? (Meenakshi)

Sharing and Self-Disclosure

Most of the healthy people shared their happiness but not sorrow. They did not share when no solution was in sight. They often shared with their daughters, husband or some friend, as two excerpts given below show.

I share my health problems with everyone – husband, children and in-laws. I can't tolerate when someone ignores me. When my husband, children do not attend to my illness I get very irritated.

I share with my neighbour. She is my guardian and friend. I feel light after talking to her.

The other group of narratives is characterized by low sharing and low self-disclosure. These are from the narratives of four respondents who preferred to keep their suffering to themselves.

I sit alone and brood. Never share my problems with anyone. They are very personal. What's point in sharing it when no one can do anything about it.

I have grudges but no one to talk to. Keep them to myself.

I share only with my daughters. Husband has no time for me; he is not interested in listening anything. In fact, when I talk to him about some problem, he looses his patience and starts shouting.

Share happiness with husband and daughters. I do not share my unhappiness with anyone, except to God. I cry before Him.

This finding that the sick women are lower on sharing and self-disclosure than the healthy women is understandable. Siegel (1991) had noted, "When you put your feelings outside, you may heal inside. And you will certainly heal your life, if not your disease; for emotional repression prevents the healing system from responding as a unified entity to threats from inside or outside" (p.188). Pennebaker

(1991) also opined that sharing one's true feelings and needs helps one to unlock the power of one's healing system. Anger, anxiety, depression, fear and many other feelings are unhealthy when they remain buried inside, unexpressed and not dealt with.

Concluding Comments

This narrative study of married, middle-aged Indian women has clearly evinced that chronically sick and healthy women differ in their self-construal. Healthy people were accepting of their life conditions and had a relatively stable notion about their own-self. They were more in tune with their familial environment and more often resorted to positive construction of themselves and of the negative life events. Healthy women found it easier to relate with people within their social world and at the same time could carve out a personal domain in which they were free to experiment. They could garner a high self-esteem as their self was better grounded in social relationships.

On the contrary, there was greater turbulence in the lives of sick women and they were not able to reconcile with the discrepancy in their ideal and actual self; between dreams and reality. Their lives were much more eventful and they had lot to narrate. They are fighting more with themselves than with the external world. These were the women who were fighting against their destiny and are not prepared to accept their fate. Poor health is the cost which they had paid for asserting their individuality and trying to control own lives and that of others. The sick women rebelled but suffered their agony without much sharing. This comparative scenario profile of healthy and sick women is, of course, not uniform and show general trend.

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