

INTRODUCTION

Since the mid 1970's there has been a turn towards improved health in the United States (Crawford, 2002). The pursuit of health and healthy lifestyles has become an important activity for the American middle class, and a multi-billion dollar industry. Home exercise equipment sales have more than doubled in the past 10 years and health club memberships have seen a 63 percent increase (SGMA, 2006). In addition, life expectancy for Americans has reached an all-time high of 77.6 years (United States Centers for Disease Control, 2005).

As large segments of the population realize their potential to live longer lives, they are actively seeking information to improve the quality of their health over the long term. A recent study revealed that half of American adults have searched online for health information (Fox & Fallows, 2003). Fully eighty percent of adult internet users, or about 93 million Americans, have searched for at least one of sixteen major health topics online (Fox & Fallows, 2003). This makes the act of looking for health or medical information one of the most popular activities on line after email (93%) and researching a product or service before buying it (83%) (Fox & Fallows, 2003). As the population becomes concerned about their health, they are effectively changing their behavior in order to protect or improve it (Muller, 1990).

Conversely, there are also large segments of the population who continue to behave as they always have, with little or no regard to their health choices despite educational campaigns to change behavior. During the late 1990's, for Americans of all ages, obesity continued to rise dramatically. Nearly one third of all adults are now classified as obese (American Medical Association, 2000).

Body mass index (BMI) is a single number that evaluates an individual's weight status in relation to height. BMI is generally used as the first indicator in assessing body fat and has been the most common method of tracking weight problems and obesity among adults. BMI is a mathematical formula in which a person's body weight in kilograms is divided by the square of his or her height in meters. The BMI is more highly correlated with body fat than any other indicator of height and weight. The criteria for obesity are the same for both men and women.

The current data shows that 31 percent of adults age 20 and over, or almost 59 million people, have a body mass index of 30 or greater, compared with 23 percent in 1994 (National Center for Health Statistics, 2002). Among children and teens ages 6-19 the statistics are even grimmer. Almost 9 million children, or 15% of the entire population between the ages of 6-19 are classified as overweight (defined as a BMI-for-age at or above the 95th percentile of the Center for Disease Control Growth Charts). This is triple what the proportion was in 1980. Tragically, these numbers continue to rise annually.

The increase in obesity has profound health implications. Obesity increases a person's risk for other serious health conditions such as diabetes, heart disease, stroke, high blood pressure, and some cancers. For obese children the likelihood of remaining obese throughout adulthood is great (United States Centers for Disease Control, 2003).

Despite the increase in obesity, other markers show dramatic improvements in America's health over the past fifty years. In addition to the rise in adult longevity, fewer babies are dying in infancy, the gap between white and black life expectancy is narrowing

and infectious disease rates have declined (United States Department of Health and Human Services, 2002).

Some researchers have linked more comprehensive and preventative health care to the reduction or even the amelioration of certain health conditions. For example, the proportion of breast cancers detected early increased and the five-year survival rate improved from 75% (1974-1976) to 85% (1989-1995) (Ries et al., 1999). It is a widely held belief that early detection of disease leads to lower mortality rates. Despite the evidence, men and women place very different levels of importance on the procuring of regular health check-ups (Courtenay, 2000).

Health Behavior and Gender

Gender may best be described as a process rather than something that one “has” (Messner & Sabo, 1990). While sex refers to one’s biological classification, gender refers to the socially learned behaviors and expectations associated with each sex. Gender roles, the patterns through which gender relations are expressed, have been observed in health behaviors and outcomes between men and women (Mann & Kato, 1996). Gender roles focus attention on the individual rather than on larger social structures. As such, Mann and Kato (1996) assert that interventions toward improved health are most effective when designed for specific groups because they can account for the unique attributes of certain segments of the population.

In the United States men suffer from more serious chronic conditions, have higher death rates for all fifteen leading causes of death and die nearly six years earlier than women. Health related beliefs and behaviors are important contributors to these differences (Courtenay, 2000). Specifically, American men are more likely than women

to adopt beliefs and behaviors that increase risks and are less likely to engage in behaviors that are linked to health and longevity (Courtenay, 2000). The social practices that undermine men's health are smoking tobacco related products, avoidance of health maintenance check-ups, excessive alcohol consumption, and poor diet. These practices have been linked to the manner in which men perform their masculinity in social settings.

Masculinity and Health

What constitutes "health" in males? Researchers have observed that men's health has long been intertwined with the concept of masculinity. Traditionally, masculinity has been operationalized in a socially constructed arena. This view asserts that most boys (and subsequently men) learn to adopt and adhere to culturally defined standards for masculine behavior (Bergman, 1995). Through routine experiences such as injuring one's self, expressing emotion for pain, crying and receiving negative responses for crying, they are learning unacceptable ways of expression (Good, Sherrod & Dillon, 2000). When coupled with the message, "only girls cry," it denotes that crying and feeling pain are feminine characteristics and associated with vulnerability and weakness. As a result, to be masculine is to repress emotions that might be associated with vulnerability (Good, Sherrod & Dillon, 2000).

When this ideology of masculinity is applied to health care there are wide reaching consequences for men. Through a variety of social interactions, men are taught to be tough, restrict emotions, be competitive and successful, as well as cultivate aggressiveness, fearlessness and invulnerability. In adulthood workaholism, lack of exercise, poor diet and excessive alcohol consumption are manifested as men seek to create a balance between creating success by attaining money and power and what is best

for themselves and their families (Good, Sherrod & Dillon, 2000). Masculinity, or the expression of masculine social roles prevents men from performing those characteristics that would lead them to healthier lifestyles and behaviors.

Femininity and Health

Femininity has also been operationalized in a socially constructed arena. Girls (and subsequently women) adhere to culturally defined standards for feminine behavior. These behavior patterns include stereotypes such as being nurturing, compassionate, more communicative in conversation and dependent (Sigal & Nally, 2004). Other characterizations of women portray them as weak, submissive and passive. Femininity has, in some cultures, become synonymous with vulnerability (Muller, 1990).

From a health care perspective, women comprise larger numbers among the poor and elderly, which inhibits their access to health services, further reinforcing the image of vulnerability. Muller (2004) notes that the women's movement, which emphasized "control over one's body," has been a powerful healthcare theme. Federal legislation that supports the outlawing of discrimination on the basis of sex (Title VII) has had a powerful impact on better jobs and wages for women, and subsequently better health care benefits. However, there is still a long way to go to equalize adequate health care for marginalized at-risk groups.

A Definition of Health

Health is almost always measured against a concept of illness (Read, 1997). The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Health includes how one experiences it (as opposed to illness) as well as how and what one feels (Read,

1997). For the purposes of this study, the WHO definition, which encompasses the physical, mental and social well being of an individual, will be applied.

Health promotion or preventative behavior, or the manner in which we choose to manage and monitor our own health is a learned behavior (Kasl & Cobb, 1966). Specifically, imitation plays a powerful role in the acquisition of conforming behavior (Bandura & Walters, 1963). New responses may be learned or the observer may adopt the characteristics of existing responses. Thus, role models, both positive and negative instruct us, sometimes unknowingly on the health care practices we adopt over our lifetimes.

A National Health Agenda

The establishing of national health objectives has a long history in the United States. Beginning in 1979, the surgeon general's first report on health and health promotion, *Healthy People*, established broad national goals toward improving the health and preventing disease among the American population. It identified 226 objectives in fifteen target areas for public health services, health protection and health promotion.

In 1991, the United States Department of Health and Human Services released *Healthy People 2000*. It was significantly expanded to include several priority areas within the three categories of the original *Healthy People* document and added a fourth category "surveillance and data systems." In its final form, *Healthy People 2000* offered 351 objectives in twenty-two priority areas across four categories (US Department of Health and Human Services, 1995). Clearly the nation's need for health related initiatives was growing.

In January 2000, *Healthy People 2010* was issued. This document provides an ever-expanding plan for nationwide health promotion and disease prevention. *Healthy People 2010* contains 467 objectives that serve as a compass toward directing the increased health care of the United States population throughout the first decade of the 21st century. While its scope is impressive in its detail and insight, critics feel there are too many objectives, many of them unmeasurable, and that federal politics has tainted the process of selecting national health objectives (Davis, 1998). As public health initiatives have grown too large to adequately monitor progress or impact improvement, the ownership of personal health has ultimately fallen back to the individual.

Theoretical Foundation

Pearce's (1976) Coordinated Management of Meaning (CMM) provides the theoretical and conceptual foundation for this study. Although multiple disciplines have researched gender motivated health messages, CMM provides the broadest framework to structure the major themes from the data. CMM allows us to look at conversational patterns that construct gender preferences and differences in health care procurement. We are also able to deconstruct conversational patterns from role models and determine the impact they have on the health care practices of others. In addition, Pearce (1989) introduces the frameworks of coordination, coherence and mystery, which further illuminate the relationship between health care and gender.

Originally introduced in the mid 1970's, CMM is grounded in a basic premise: communication is the process by which people "co-create, maintain, and alter social order, personal relationships, and individual identities" (Cronen, Pearce & Harris, 1982). Heath and Bryant (2002) contend that through CMM, people coordinate their lives by

managing the ways in which messages have meaning for, and through, larger patterns of meaning. Pearce and Cronen (1980) describe communication as “a process in which each person responds and interprets to the acts of another, monitors the sequence, and compares it to his or her desires and expectations.” As a result, CMM hinges on the rule of interaction between two parties, the structure of the interaction and the content of the message (Heath & Bryant, 2000). CMM was utilized to shed light on how men and women negotiated the procurement of health care, the content of these messages, the impact of role models and the rules that governed the communication. Participants in the study were asked a series of questions that probed their health care practices, the rules that governed those health care practices and the effectiveness of role models and their messages.

CMM states that people interpret and act on the basis of rules. Constitutive rules, or rules of meaning, are used to understand or interpret a message. Regulative rules, or rules of action, help us to determine appropriate behavioral responses. Rules help individuals know what behavior is appropriate and productive (regulative) and how to interpret other’s behavior (constitutive; Cronen et al., 1982). We learn, adapt and perpetuate rules from significant role models in our lives.

Another facet of CMM theory is that people learn behaviors that are appropriate for specific contexts (Pearce, 1976). Specifically, they rely on an interpretative process that incorporates six levels of understanding (Pearce & Cronen, 1980). These are: 1) context (the specific words used in a communication), 2) archetype (our understandings of speech acts, life scripts, episodes and contracts shared by a particular group such as men or women), 3) life scripts (communication that shapes an individual’s self

perception), 4) episodes (communication routines), 5) contracts (formal or informal rules that govern communication between two or more individuals), and 6) speech acts (an individual's performance of content). For the purposes of this study, archetypes and life scripts will be examined to illustrate the differences between men and women's health care communication.

In addition, coordination, coherence and mystery help us define and expand our communication patterns (Pearce, 1989). Coordination refers to the process by which persons collaborate in an attempt to bring into being their visions of what is necessary, noble and good and to preclude the enactment of what they fear, hate or despise. In a health care context, it centers on the values we may or may not place on procuring preventative health care and the degree to which we are successful in enacting those communication patterns.

Coherence, like coordination, is a human universal - something that human beings must do by virtue of their genetic composition as human beings (Pearce, 1989).

Coherence refers to all those processes by which persons invent, test and tell themselves and others stories that make intelligible the world around them (Pearce, 1989). We learn by observing and interacting with those around us. Regarding health care, behavior is often modeled by significant role models and helps us define and make sense of what is acceptable and our own personal norm. It also can be a powerful force in illustrating harmful or negative lifestyles, or those traits that we do not want to emulate as well.

Mystery is a framework that allows human beings to name those things that lie beyond human knowledge. Most traditional societies tell stories of gods, ghosts, and giants and name the mysterious as fate, god, karma, paradise, etcetera. (Pearce, 1989).

Individuals often rely on their faith and interpretation of mystery for support and understanding of health conditions. Most hospitals offer chapels or rooms for quiet mediation to contemplate the decisions and conditions that surround medical procedures. Like coordination and coherence, mystery provides an important part of creating and sustaining healthcare.

A New Direction

Imitation can be a powerful social learning vehicle. Role models provide a rich tapestry from which we weave key behavioral patterns over the life span. What we have yet to understand is the impact role models have on our ability to formulate healthy practices, which includes preventative health care. The role of gender is inextricably attached to the values men and women place on health care. This study sought to look at role models, both positive and negative, and how they communicated messages about health care. Further, the study was designed to determine what effect this had on health care practices in adulthood by males and females.

Perhaps there is no other time in history when we find individuals exercising their choice in the management of their health care needs (Crawford, 2002). With new and ever expanding sources of health care information, individuals can often experience information overload and confusion over lifestyle choices and the consequences of those choices. This study sought to explore the source of health care communicated messages relayed by role models and the impact this has on attitudes toward preventative health care. It also examines the role of gender in procuring regular health check-ups. With life expectancy rates reaching all-time highs for white males (75.4 years), black males (69.2 years) as well as for white females (80.5 years) and black females (76.1 years) living

healthier and better lives is an important pursuit of the population (Centers for Disease Control, 2005).