

LITERATURE REVIEW

Gender Construction

In Western societies, gender is a defining aspect of individual identity. It has a profound influence on our lives from the moment we are born, and we enact its social and cultural meanings at every level, from the intrapsychic to legal and political (Castaneda & Burns-Glover, 2004). The integrated self leans toward the behaviors others encourage and away from behaviors others discourage (Pearson & Davilla, 2001). From birth, people are treated differently because of genitalia. Male and female babies are dressed in different kinds and colors of clothing. Parents respond differently to male and female infants (Bell & Carver, 1980) and people describe identical behavior on the part of infants differently if they are told the infant is a boy or girl (Condry & Condry, 1976).

From a social constructionist's viewpoint, gender evolves as individuals interact within their social structures. This is consistent with CMM as we talk gender in to our discussions with others. As a society, we weave notions of gender based on the language we select and the opinions that are expressed on topics that are deemed either inherently masculine or feminine (Pearce, 1976). Further, gender may be seen as the product of psychological imprinting, social learning and language (Perry, 1992). In recent years, traditional theories of the psychology of women and men have been reconsidered and questions have been raised about the characteristics that are labeled masculine and feminine. Women have often been considered "deviant" or a variant of the norm (Gilligan, 1982). Only recently has women's development been seen from the perspective of a different developmental path resulting in "primary" or positive femininity (Gilligan, 1982). Horner (1972) discovered that until the 1970s, research on

women was usually discarded because they were so different and at variance with findings in men.

In a communication context, men and women exhibit different styles of conversation. Tannen (1990) asserts that women typically talk to build community and rapport whereas men use talk as a means of establishing status and independence. Similarly, the language of women tends to be perceived as having greater aesthetic qualities (for example, more pleasing to the listener) but less dynamic (for example, utilizing strong or active language) than does the discourse of men. Tannen (1990) also found that in non-verbal communication, women tend to be more expressive and more intuitive in perceiving the emotions of others than are men. Tannen (1993) asserts that “from the time they are little, girls approach conversation as a ritual. Conversation is a ritual that says life is going on as it should and girls want to play out those rituals. Men don’t understand it because it is something they haven’t done.” Tanner and Bly (1993) further assert that gender difference in conversation and verbal skills can be attributed to the size of the corpus colossum, or the bridge that binds the two hemispheres in the human brain. Bly (1993) illustrates that female brains possess a thicker corpus colossum even as fetuses and this provides a “superhighway” for greater intermingling of words and images between the two hemispheres of the brain. By comparison, he likens the male corpus colossum as a “meandering, crickly, country road.”

The differences between genders are further amplified by the ways in which men and women are socialized. Gilligan (1982) suggests that men and women experience relationships and issues of dependence very differently. Through socialization and subsequent moral development, males rely on separation and individuation to establish

their gender identity. Feminine identity does not depend on the achievement of separation from the mother or on the development of individuation. Because masculinity is defined by separation while femininity is defined through attachment, male gender identity is threatened by intimacy and female gender identity is threatened by separation (Gilligan, 1982).

Gender and Health Care

Women interact with the health care system differently than men do, with increased visits and different types of complaints (Watkins & Whaley, 2000). Excluding pregnancy-related visits, women are 33 percent more likely than men to visit a doctor, although this difference decreases with age (Centers for Disease Control and Prevention, 2001). The rate of doctor visits for such reasons as annual examinations and preventive service was 100 percent higher for women than for men and medication patterns differed significantly. Women were not only more likely to receive hormones, but also dramatically more likely to have antidepressants prescribed (Centers for Disease Control and Prevention, 2001).

Another reason why women utilize the health care system more than men is to fulfill their reproductive roles (Hausfeld, 1976). Specifically, doctors see women throughout pregnancy and throughout the life span to dispense and monitor birth control methods even though pregnancy and needing contraception are not ill conditions.

The female role itself contributes to doctor visits (Jenks, 2001). Specifically, the role of patient has traditionally been associated more with female attributes than with male characteristics (Gray and Meginnis, 1978). As Corea (1977) noted, from childhood, a female is encouraged to admit her pain, freely ask for help and to expect and accept

weakness in herself. Female patients are expected to be obedient (Entralgo, 1979) and to cooperate with doctors (Parsons, 1951). Overall, it has been deemed more acceptable for women to express suffering and accept assistance than it is for men (Nathanson, 1975).

In turn, the health care system responds to women and men in different fashions, often to the detriment of women's health (Watkins & Whaley, 2000). Studies have shown that medical practitioners treat cardiovascular disease less aggressively in women relative to men. In fact, across conditions, treatment protocols are based on a male model of medicine, with women's health problems viewed as deviations from a male-defined norm (Hoffman, 1995). Lee and Sasser-Cohen (1996) contend that the medical profession has, in fact, pathologized women's normal biological processes and body structure.

Central to the utilization of health care are constructions of masculinity and femininity, Courtenay (2000) suggests constructions of masculinity greatly influence men's well-being. Men in the United States exhibit higher death rates for all fifteen leading causes of death and die almost seven years younger than their women counterparts. Health related behaviors and beliefs are important contributions to these differences. Men in the United States are more likely than women to adopt beliefs and behaviors that increase risks and less likely to engage in behaviors that are linked to health and longevity (Courtenay, 2000). These social practices that undermine men's health such as smoking tobacco related products, avoidance of health maintenance checkups, excessive alcohol consumption and poor diet are often signifiers of masculinity and instruments that men use in the negotiation of social power and status (Courtenay, 2000).

Early research to investigate the psychological aspects of masculinity utilized the Bem Sex Role Inventory (BSRI; Bem, 1974) but it has been criticized for its inadequate operationalization of masculinity as a single gender related personality trait. Most researchers agree that masculinity as a construct is far more complex and multiple dimensions are necessary to describe a single conception of masculinity ideology (Fischer et al., 1998). One approach currently in favor to assess masculinity defines masculinity as sets of culturally defined standards to which men are expected to adhere and typically includes dimensions such as status, toughness, and conflict (Pleck, 1995). This plural term is desirable in that it reflects the notion that there are multiple standards of masculinity; various groups have different dimensions that are salient in their conception of masculinity (Brod & Kaufman, 1994).

Over the past twenty-five years, a growing body of research has explored the positive and negative impact of traditional constructs of masculinity on health. Men acknowledging greater masculinity-related stress associated with more traditional conceptions of masculinity have been found to be more anxious (Cournoyer & Mahalik, 1995), to be more depressed (Good & Wood, 1995), to be more globally distressed (Good et al., 1995), to have more trouble with interpersonal intimacy (Fischer & Good, 1997), to have greater coronary-prone behavior (Watkins et al., 1991) and to seek fewer mental health services (Good, Dell & Mintz, 1989). This is consistent with CMM in that men exercise the conversational logic “I’ve never been sick therefore I don’t need to go to the doctor,” as a means of achieving coherence.

Not all conceptions of masculinity yield negative outcomes. Men holding more traditional conceptions of masculinity have strengths in such areas as problem solving,

logical thinking, risk taking, anger expression and assertive behavior, which may be especially beneficial in times of crisis (Levant, 1995). Examples of how these positive aspects of traditional masculinity ideologies may manifest include remaining calm and problem focused in time of crisis and subsuming personal needs to the greater duty of providing for one's family. Thus, qualities embodied by more traditional masculinity ideologies can, at the same time, be both injurious and beneficial (Good, Sherrod & Dillon, 2000).

Similarly, new instruments have been created to assess the impact of the feminine gender role on health. While stress has traditionally been viewed as a health risk factor for men (Watkins & Whaley, 2000), health care providers now realize that stress is a cardiovascular disease risk factor for both genders. Women's stress-related health problems are not limited to cardiovascular disease; they include psychological disorders as well. The medical profession has historically accorded less importance to psychological distress than to physical illness (Watkins & Whaley, 2000).

Gillespie and Eisler (1992) identified categories of stressors integrally related to feminine gender-role socialization to create the Feminine Gender Role Stress Scale. The five areas of this instrument include 1) fear of relationships being devoid of emotional intimacy, 2) fear of being physically unattractive (mostly related to weight), 3) fear of victimization, 4) interpersonal conflict requiring assertiveness and 5) fear of failing to be nurturing. They observed that most stressors revolved around impaired interpersonal functioning, consistent with the idea that for U.S. women – past and present – success is defined in terms of interpersonal competence (Striegel-Moore & Marcus, 1995).

Since Durkheim's (1897) well-known work on suicide, social ties as well as social solidarity and support have been assumed to affect health. Recent research suggests that these factors play a key role in the development of disease and the maintenance and improvement of health. Thus, mortality rates as well as rates of chronic somatic illnesses tend to be lower among the married than among the unmarried, separated, or divorced (Fox & Goldblatt, 1982).

In addition, some research indicates that gender is a significant variable when accounting for gender differences in health care provider-patient communication. Women health care providers generally tend to conduct longer consultations, give more information, engage in more partnership building, are less directive, express more interest in psychological aspects of health and are more explicitly reassuring and encouraging than are male clinicians (Roter & Hall, 1998). Still other research has reported surprisingly contradictory findings. Roter et al. (1999) observed that female physicians actually spent less time with patients during prenatal visits, engaged in less facilitative communication, and made fewer expressions of concern than did the male doctors. Such contradictory findings are further complicated by inconsistencies in research on communication, satisfaction, and gender (Street, 2002).

Other research suggests that when the patient and health care provider are of the same gender, more productive provider-patient interactions may occur (Weisman & Teitelbaum, 1985). Some patients are more satisfied with women doctors (Bertakis et al. 1995), with male doctors (Ross, Mirowsky & Duff, 1982) while others prefer female doctors but by male patients only and male doctors but by female patients only (Schmittiel et al., 2000). The lack of concluding evidence with regard to productive

provider-patient interactions and gender provides an opportunity for future research, theory development and communication skill training.

Role Models

The earliest information available to children regarding what it means to be female or male comes from their parents (Perry, 1992). Parents influence their children's gender socialization both directly and indirectly via their interactions with their children, their gender attitudes, and the manner in which they model gendered behavior (Marmion & Lundberg-Love, 2004). Throughout childhood, children learn how to adopt gender roles, distinguish between the sexes and apply gender rules to the self and others. While this is primarily learned and reinforced through the influence of parents it is also affected by peers (Tanner & Bly, 1993).

Imitation plays an important role in the acquisition of deviant as well as conforming behavior, (Bandura 1986). New responses may be learned or the characteristics of existing response hierarchies may be changed as a function of observing the behavior of others. Bandura (1977) asserts through Social Cognitive Theory that social modeling is not simply response mimicry; rather, individuals generate new behavior patterns in a similar way by going beyond what they have seen or heard. In addition to cultivating new competencies, social modeling affects motivation by instilling behavioral outcome expectations or measures of self efficacy (Bandura, 1977).

According to Social Cognitive Theory, behavioral change is made possible by a personal sense of control. If people believe that they can take action to solve a problem instrumentally, they become more inclined to do so and feel more committed to the decision. People who believe that they can cause events may lead more active and

self determined lives (Luszczynska & Schwarzer, 2005). Self-efficacy has come to be widely regarded as a mediator of treatment for a variety of outcomes including phobic behavior (Hoffart, 1995), smoking cessation (Scholte, Breteler & Marinus, 1997), use of HIV prevention strategies (Jemmott et al., 1996), and improved health (O'Leary, 1992). According to Bandura (1997), treatment is successful when it creates expectations that a person's actions in a particular setting can be effective.

It is evident that much learning in North American society is still fostered through the presentation of real-life models, with advances in technology and written and audiovisual means of communication increasing reliance is placed on the use of symbolic models (Bandura, 1986). Pictorially presented models are provided in film, television and other audiovisual displays. Audiovisual mass media are extremely influential sources of social behavior patterns (Bandura, 1986). Because of the amount of time during which most young people are exposed to pictorially presented models, mainly through television, such models play a major part in shaping behavior and in modifying social norms and thus exert a strong influence on the behavior of children and adolescents (Himmelweit, Oppenheim & Vince, 1958). Consequently parents are in danger of becoming relatively less influential as role models.

Over the past twenty years, there have been numerous Canadian studies of health behaviors. The Health Promotion Directorate was established in 1978 as a response to the report "A New Perspective on the Health of Canadians." One study conducted by the Health Promotion Directorate focused on the development of a generation of nonsmokers programme (Goldfarb Consultants, 1981). The findings revealed that nearly half of smoking parents and smoking young people said they started smoking because they

wanted to be accepted, to be part of the crowd. That is, smoking parents and young people perceived smoking to be socially acceptable behaviour. The majority of smoking parents (63%) said they did not feel their smoking was a behavioral role model for children. That is, most parents who smoke tend to feel their behavior does not influence their children's behaviors (Goldfarb Consultants, 1981).

Parker et al. (2006) assert that the health of children and adolescents is directly impacted by the closeness of the relationship between a woman (not necessarily the child's mother) and child. Being in such close proximity, they often share similar patterns of healthy behavior or non-healthy behavior. For example, a woman who exercises frequently will positively influence her child to exercise. Women who engage in healthy behaviors and are physically healthy can often stress the importance of mental wellness and self-esteem to her children (Parker et al., 2006). This is consistent with Pearce's (1989) coordination and coherence frameworks. Families are a primary locus of institutionalized coherence. An adult's view of the world and the practices one is prepared to engage in are prefigured by one's parents' example. This is particularly true when the next generation comes along; new parents often surprise themselves by saying exactly what – and in the same manner – their parents said to them (Pearce, 1989). The framework of coordination also applies as children and parents negotiate among a variety of events and activities and the social contexts in which they occur. Over time, they negotiate their visions of what is necessary, right and good and attempt to eliminate what they fear or dislike (Pearce, 1989).

Conversely, researchers reveal that women who engage in unhealthy practices may not only be an unhealthy role model, but also may be a liability to the health of

children (Parker et al., 2006). Their inappropriate behaviours can adversely affect children and adolescents. During 2002, 11.4% of pregnant women smoked (Martin et al 2003). Cigarette smoking during pregnancy has been shown to contribute to behavioral problems and impaired intellectual development in children ((Palmer, 1995). The risk continues after the child is born. Women who smoke not only increase their own risk of heart disease and cancer but also expose their children to second-hand smoke, which has been shown to contribute to numerous health problems (Parker et al., 2006).

Based on the preceding review of the literature, the following research question is asked: Do positive and negative role model communication impact the procurement of regular health practices by men and women?