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## HEALTH AND GENDER MEDICINE FROM A PSYCHOSOCIAL PERSPECTIVE

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### ABSTRACT

The past three decades have witnessed numerous changes with respect to the treatment of gender in research on health and quality of life, leading to research in a more inclusive direction that focuses on the experiences of women as well as men. Gender is now considered a significant determinant of health and illness and health care has become more gender-sensitive. Incorporating sex- and gender dimensions in theoretical frameworks concerning various illnesses is not only important for reasons of gender equity. Because many health problems have unequal sex prevalences, the integration of a gender perspective in theory and research is also a necessary tool in obtaining comprehensive, valid knowledge about their relevant etiological factors.

The present chapter intends to: a) presenting the main perspectives that address the intrinsic interconnectedness between biological and social dimensions, which lies under gender differences in health and quality of life; and b) exploring how psychology can contribute to the emerging “gender medicine”. Some examples of how a gender perspective can be applied to investigate individuals’ quality of life will be presented.

The past three decades have witnessed numerous changes with respect to the treatment of gender in research on health inequalities, leading to research in a more inclusive direction that focuses on the experiences of women as well as men (Read & Gorman, 2010).

In broadest terms, women have longer life expectancies than men but experience poorer subjective health (Read & Gorman, 2010). Indeed, women have lower rates of mortality but report higher levels of depression, psychiatric disorders, distress, and a variety of chronic illnesses than men (Hansson, Hilleras, & Forsell, 2005; Prus, 2011; Tesch-Römer, Motel-Klingebiel, & Tomasik, 2008). In sum, there is an incongruity between epidemiological data, i.e. mortality and life expectancies, which is more positive for women, and the subjective perception, i.e. negative emotions and self-reported health, which is more encouraging for men.

If this datum may be largely known, the reasons of this discrepancy still deserve attention. Indeed, genetic and biological can only partially account for gender differences in health, as such differences display several facets in terms of morbidity and mortality, varying across countries. In this sense, the biological dimension is not sufficient to explain health inequalities.

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Such discrepancy might be explicated by many interrelated factors pertaining biological (sex) and socio-cultural (gender) dimensions, as well as life conditions (Denton, Prus, & Walters, 2004; Rollero, 2013 a; Rollero, Gattino, & De Piccoli, 2014). In this chapter we provide an overview of three theoretical perspectives that have consistently explained gender differences in health and quality of life addressing the intrinsic interconnectedness between biological and social dimensions: the feminist approach, the sociological perspective, and the psychological Multi-facet gender and health model (Bekker, 2003).

## **THE FEMINIST PERSPECTIVE**

One of the main point of criticism against traditional gender-biased medicine deals with the stereotypical and hierarchical approach to women's own health and illness experiences. Such stereotypical point of view does not correspond with women's subjective feelings. For example, defining menopause as an invariant neuro-endocrine event can easily distract from the high variability in symptom reporting as well as from the various psychosocial factors playing a role (Bekker, 2003). Feminist scholars argued that established medicine became an instrument of patriarchy, exerting a form of social control over the most intimate dimension of woman's personhood, her body. Many typical feminine bodily experiences, such as childbirth, post-natal depression, psychological disturbances and the menopause, were made subject to medical expertise in such a way as to place them outside of the control of women (Donnison, 1977; Moore, 2010). The process of medicalization, related to specific hierarchies of power, reinforces social control and the perception of women as weak and in need of others' care. Medical science, in this perspective, is simply one way of seeing the body, a discourse, an ideological gloss, one that set the dispassionate objectivity of the medical practitioner against the apparent whimsies of women's bodily awareness (Moore, 2010).

Another key point pertains to women as research subject. Although no one would doubt that female (as well as male) subjects should be included in health studies whenever relevant, women are still not always included in studies regarding phenomena that are highly relevant to the health of both sexes (Bekker, 2003). An example is pharmacological research where both human and animal studies have primarily been conducted on males. However, because of the existence of many biological, social, and pharmacologically relevant behavioural sex differences, obviously it is necessary to include female subjects in pharmacological studies.

## **THE SOCIOLOGICAL PERSPECTIVE**

The roots of gender inequality in health issues are numerous, interconnected and complex. In addition to genetic and biological differences, three categories of social variables have been identified as a source of health inequalities: behavioural, structural and social factors. It is well known that healthy lifestyle behaviours are significantly linked to health, as they help individuals preventing illness and disease (for a review see Denton et al., 2004).

Concerning social structures, sociological literature has documented a relationship between health inequalities and socio-economic inequalities in income, education, occupational status and employment status (e.g., Fernández-Ballesteros, 2011; Stafford, Cummins, Macintyre,

Ellaway, & Marmot, 2005; Denton et al., 2004). Studies also find that health and quality of life are a function of other social structural factors such as social support, marital status, place of residence, age and gender (De Piccoli, Gattino, & Rollero 2013; Fassio, Rollero, & De Piccoli, 2013; Gattino, De Piccoli, Fassio, & Rollero, 2013; Gattino, Rollero, & De Piccoli, in press; Rollero, 2013b; Trentini, Chacamovich, Peretti Wagner, Müller, Hirakata, & De Almeida Fleck, 2011).

Sociological literature on the influence of social factors pose two general hypotheses to account for gender-based inequalities in health: the differential exposure hypothesis and the differential vulnerability hypothesis. The differential exposure hypothesis suggests that women report higher levels of health problems because of their reduced access to positive material and social conditions (McDonough & Walters, 2001). This perspective underlines that, in respect to men, women are less likely to be employed, have lower incomes, more often are devoted to domestic labour and are likely to be a single parent. In sum, they are exposed to higher levels of demands in their social roles and experience more stressful life events (McDonough & Walters, 2001).

The differential vulnerability hypothesis instead poses that women react differently than men to social determinants of health (Denton et al., 2004). Indeed, multivariate analyses demonstrate that gender acts as moderator in the relationship between specific determinant of health and health itself. For instance, alcohol consumption is a more important predictor of health status for men than women, whereas having social support is a more significant determinant for women than men (Denton et al., 2004; Rollero et al., 2014).

## **THE PSYCHOLOGICAL MULTI-FACET GENDER AND HEALTH MODEL**

In order to conceptualize sex- and gender- health related phenomena from a psychological point of view, Bekker (2003) proposed the Multi-facet gender and health model. Her conceptualization first considers both the body, as biological sex, and gender, as cultural dimension of masculinity versus femininity. These two dimensions are related to three categories of variables: sex differences in social position, sex-specific individual functioning, and differential diagnostic and treatment. Indeed, men and women differ in professions they engage in, time spent on caring for other people, amount of leisure time, and number of hours in paid jobs: such daily life factors are relevant for sex differences in health (Bekker, 2003). Sex-specific individuals functioning, on the other hand, contributes to determine the development of sex differences in personal characteristics that are significant for health. As examples, Bekker (2003) considers somatic, psychological and cognitive processes that may affect body dissatisfaction – which in turn predicts eating disorders – and rumination – a coping strategy that contributes to depression. Finally, the author pays attention to the process of evaluating, maintaining and regaining health, when the role played by care workers is crucial. Indeed, research has shown that in talking with patients, deciding about diagnoses, and proposing treatments the biological sex of the patient triggers gendered expectations and communication.

In sum, the model comprises the numerous facets between sex, gender and health. Direct and indirect bodily factors leave their marks, in interaction with sex-specific daily life, gendered

person-related factors and gender bias in health care (Bekker, 2003). This conceptualization underlines that the differences between and among both sexes in health-related phenomena can not be explained by one single factors. Rather, multiple dimensions operative at different levels should be considered.

## **A GENDER PERSPECTIVE IN MEDICINE**

Gender differences do not pertain only to protective and risk factors, as above explained, but involve the whole welfare system and the illness treatment, from its genesis to diagnosis and evolution. Indeed gender biases have been shown in the relationships between health specialists and patients and they play a role even in patients' compliance. Nevertheless, medical science itself presents a subtle and covert form of sexism. As above anticipated, in pharmacological research both human and animal studies have primarily been conducted on males, assuming that males' symptoms, prognosis, and course are also females' and not gender-specific.

Fortunately, an opposite perspective is now developing. According to this perspective, different life conditions can account for gender inequalities in health, and gender differences have to be considered both in reference to health and to illness. It is necessary going beyond medicine based exclusively on the male body functioning (with the obvious exception for female typical bodily experiences). Born in the Eighties in line with the feminist movement, this perspective is receiving attention from many international organizations involved in prevention and health promotion. As significant example, here we refer to World Health Organization's (2008) argument. According to WHO (2008), medical research does not always deal correctly with gender issues. Indeed, "much research is gender biased – both in terms of what is studied, as well as in terms of how the research is done" (WHO, 2008, p. 187). For instance, some of women's health problem tend to be more slowly recognised, as well as the interaction between gender and other social factors. Even in ethical committees and research-funding bodies biases are present, leading to gender imbalance and to differential treatment of women scientists (WGEKN, 2007).

According to the WHO (2008), the following specific policies have to be implemented in order to correct such gender biases: collecting data disaggregated by sex in every kind of research; including women in clinical trials; analysing data using gender-sensitive methods; redressing gender imbalances in research. Moreover, health professionals need to be trained in gender issues, in order to tailor their communication to meet patients' needs. In sum, it is necessary "the integration of gender into the curriculum of health personnel as part of training on the social determinants of health" (WHO, 2008, p. 188).

### **Gender Medicine: A Possible Answer?**

Gender medicine aims to study how diseases differ between men and women in terms of prevention, clinical signs, therapeutic approach, prognosis, psychological and social impact. As already underlined (De Piccoli, 2015; Rollero, 2014), nowadays research on biological differences between men and women is constantly increasing. This is a positive phenomenon,

but should not represent an end point. Indeed, on the one hand it is imperative developing a specific knowledge on the influence of sex (as biological dimension) and gender (as psychosocial dimension) on health and illness, but on the other hand it is necessary addressing the role played by life conditions, social positioning, and social expectations, as they contribute to determine health and illness, as well as sex and gender do.

Gender differences in health are explained by genetics, but, as Lagro-Janssen (2007) claimed, the biological organism is an open system influenced by the environment and the evolutionary factors. The genes and sex hormones can not be the only explanation for the differences between sexes. The author argues that it would be necessary to review the two basic principles used in health treatments: neutrality (medicine is for persons and not for men and women) and universality (medication are universal, regardless individual specificities). Now medical science begins to demonstrate the weakness of these two principles.

Thus, it is important and required that research will develop reflection related to different areas, as follows:

1. Men and women show a different susceptibility to various diseases. This is attributable both to genetic factors and to a different exposure to environmental factors (e.g. dangers in the workplace, different eating habits, violence, poverty, lifestyle), as well as to a combination of both (Klinge & Bosch, 2005).

Empirical evidences show that gender has a significant influence on health behaviours, access to care and the consequent responses of the health system (Hawkes & Buse, 2013). Then, how does the interplay between gender-specific contextual changes and sex-specific biological changes yield to different health outcomes for men and women from birth to death (Short, Yang, & Jenkins, 2013)? It is necessary, therefore, to specify which protective and risk factors pertain to both genders and which are more specific, developing the study of the determinants of health and disease by integrating biological factors with life styles and conditions.

2. The knowledge of biological differences is not enough to prevent gender bias in medicine

(Risberg, Johansson, & Hamberg, 2009). Numerous studies have revealed the existence of gender biases among the medical staff: these inaccurate beliefs affect also the diagnostic and therapeutic choices prescribed to patients. Considerations on this aspect would be extended and diversified, because there are many aspects that could be considered (see Andersson, Verdonk, Johansson, Lagro-Janssen, & Hamberg, 2012; Verdonk, Benschop, de Haes, & Lagro-Janssen, 2009). Here we recall only that these biases typically produce a different access to cares for men and women, as they result in diagnostic errors damaging women in most cases, but also men (such as for osteoporosis or mental disorders, depression *in primis*) (see Andersson et al., 2012)

## **DIRECTIONS FOR RESEARCH**

On the grounds of the above described considerations, individuals' health and well-being can not be conceived without considering also contextual and social dimensions. Specifically, research should consider both sex-related biological and social factors, and the interplay

between them. In line with this perspective, a recent study provided insight into whether or not gender differences in the determinants of quality of life occur in a uniform (i.e., the same determinants operate in a similar fashion across all the domains of quality of life) or in a specific manner (Rollero et al., 2014). Results showed that sense of community and self-reported health operate in a similar fashion for both genders. On the contrary, social support is more predictive for women's quality of life, whereas the income level increases only men's quality of life.

Another research investigated the effect of gender as a moderator in the relationship between coping strategies and quality of life (Gattino et al., in press). Findings revealed that coping strategies could be an important consequence of gender linked socialization experiences, as social and instrumental support enhances relational quality of life for women, whereas self-blame is particularly maladaptive for men, as it decreases their global well-being.

Research should also focus on care professionals. It should be interesting first exploring gender biases among the medical staff and then using such result to improve professionals' gender sensitivity. Indeed, being medical science and professionals so incisive, a more appropriate attention to gender dimensions would advance the quality of the relationship between patients and welfare operators.

## CONCLUSION

Psychology – and particularly health psychology – can contribute to paying the accurate attention to these processes, developing a transdisciplinary research, where different expertises interact to better understand the human being (De Piccoli, 2014). The study of gender differences would allow a more in depth knowledge both for men and for women and would favour more appropriate treatments, more effective communication strategies, and trainings for care professionals on bio-psycho-social aspects involved in health and illness. This would have, in turn, positive outcomes not only for citizens' well-being but also for the welfare system, that would become more effective and efficient.

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