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The influence of coping strategies on quality of life from a gender perspective

Introduction

The World Health Organization (WHO) stated that the quality of life is not merely the absence of disease, but a state of complete physical, mental and social well-being. Specifically, quality of life (QoL) is defined as "the individual's perception of his/her position in life in the context of his culture and the value systems of the society in which he/she lives compared to his/her objectives, expectations, standards and concerns" (WHO Quality of Life Group, 1995, p. 1405). In other words, quality of life concerns a combination of physical, psychological, and social aspects, and emphasizes the proactive approach that individuals can take to their own well-being (WHOQoL Group, 1995).

This definition implies that quality of life involves both the individual and the social dimensions, on the one hand, and the subjective and objective aspects, on the other, since it is now clear that subjective factors interact with the objective ones and influence each other (Cummins, 2000; Cummins & Nistico, 2002). Indeed, as Hawthorne, Herrmann and Murphy underline (2006), even if social indicators (e.g. economic resources, gross domestic product) form the context where people live, quality of life is determined by the evaluation of their personal lives and social situation. Thus, QoL refers to a subjective evaluation that is rooted in a cultural, social and ecological context.

A very large amount of research has studied the determinants of quality of life (e.g. Cummins, 2005; Dzuka, 2012; Schalock, 2004; Sirgy, 2011; Stiglitz, Sen, & Fitoussi, 2011), considering the multi-dimensionality of the concept and the complexity of its determinants. Among these determinants coping plays a key role, being an important promoter of mental and physical health, as well as subjective well-being in the long run (Ben-Zur, 2009), even after controlling for demographic and medical variables (Kershaw, Northouse, Kritpracha, Schafenacker, & Mood, 2004). Coping represents cognitive and behavioural efforts to deal with stressful situations

(Lazarus, 1999; Lazarus & Folkman, 1984). Although the range of reactions to problematic situations is wide, dynamic and complex, researchers have identified broad conceptualizations of coping strategies. In their well-known model, Lazarus and Folkman (1984) dichotomised coping into emotion-focused and problem-focused coping strategies. Emotion-focused coping consists in attempting to reduce negative emotions related to the stressful situation and involves different strategies, such as self-blame, wishful thinking, and self-isolation. Problem-focused coping refers to the attempts aimed at actively changing the event and comprises strategies such as active problem solving, seeking emotional support, and planning. Another distinction between coping modes refers to the approach-avoidance classification, with approach coping aimed at eliminating, or managing the problem, versus avoidant coping, aimed at not facing the negative situation by cognitively (and even physically) distancing from the problem (Skinner, Edge, Altman & Sherwood, 2003). Avoidant coping strategies include denial, self-distraction, and substance use. The coping model developed by Carver, Scheier, and Weintraub (1989; Carver, 1997) goes beyond these dichotomies and incorporates both classifications, including emotion- and problem- focused coping strategies, as well as avoidant coping strategies.

In reference to the effects on quality of life, literature has shown that only problem-focused coping strategies are positively related to physical and psychological health outcomes (Glass, Flory, Hankin, & Turecki, 2009; Littleton, Horsley, John, & Nelson, 2007; Maan Diong, Bishop, Enkelmann, Tong, Why Ang, & Khader, 2005; Stanojević, Krstić, Jaredić, & Dimitrijević, in press), whereas emotion-focused strategies negatively affect psychological well-being (Penley, Tomaka, & Wiebe, 2002). In general, even avoidant coping strategies are negatively related to health and psychological well-being (Boals, vanDellen, & Banks, 2011; Littleton et al., 2007; Wilkinson, Walford, & Espnes, 2000), with the only exception of specific situations where there is a lack of control (Büssing, Fischer, Ostermann, & Matthiessen, 2009; Roth & Cohen, 1986).

A gender perspective on quality of life and its determinants

In respect to the treatment of gender in research on health and quality of life, recent literature has followed a more inclusive direction that focuses on the experiences of women as well as men (Read & Gorman, 2010; Rollero, Gattino, & De Piccoli, 2014). In general, there is a discrepancy between epidemiological data, i.e. mortality and life expectancies, which is more encouraging for women, and the subjective perception, i.e. negative emotions and self-reported health, which is more positive for men (Crimmins, Kim, & Solè-Aurò, 2010; Prus, 2011; Read & Gorman, 2010; Tesch-Römer, Motel-Klingebiel, & Tomasik, 2008).

However, studies on quality of life from a gender perspective have provided controversial results. Men tend to report higher QoL in the physical domain than women of the same age, despite higher mortality rates and lower life expectancy (Benyamini, Blumstein, Lusky, & Modan, 2003; Gallicchio, Hoffman, & Helzlsouer, 2007; Kirchengast & Haslinger, 2008). Gender differences for psychological and social domains have been reported in a survey of adults carried out in 23 countries (Skevington, Lofty, & O'Connell, 2004), showing women higher scores on the social domain, but lower scores on the psychological dimension, although subsequent cross-cultural data did reveal no gender difference (Skevington, 2010). Testing for gender differences with a sample of Kuwait University undergraduates, Abdel-Khalek (2010) found that men obtained higher mean scores than did their female counterparts on three dimensions of quality of life: physical, psychological and environmental. The same gender differences were obtained in a study carried out with a sample of Italian adults (Rollero et al., 2014).

Although these studies have largely investigated gender differences in respect to the dimensions of quality of life, inadequate attention has been deserved to the determinants of QoL for men and women. As MacKinnon and Luecken (2008) recommend, health psychology should focus not only on major relations between independent variables and an outcome variable, but also on how these relations occur and for whom. Indeed, beside biological differences, pathways through which contextual and psychosocial forces influence health and quality of life are different for men and women (Denton, Prus, & Walters, 2004). Following this suggestion, recent research (Rollero et al.,

2014) has demonstrated that gender is a moderator in the relationship between determinants of QoL and QoL. Specifically, among the predictors tested by Rollero and colleagues (2014) (i.e. age, educational level, income, social support, sense of community and self-reported health), social support was more predictive for women's QoL, whereas the income level was more significant for men's QoL.

Current study

In line with this perspective, present study addresses the question about the impact of coping strategies on quality of life, considering the potential moderator role played by gender. Although according to Lazarus (2000) there are no stable sex differences in coping styles, the coping literature gave evidence that men are more likely to use problem-focused coping, whereas women are more likely to apply emotion-focused coping (Matheson & Anisman, 2012). These results are seen as the consequence of beliefs and social norms that may influence appraisals and coping strategies. For example, emotional expression is more frequent among women than men, and to the extent that helpful social support exists, such a strategy lets the individual to confront his or her feelings and to move on (Stanton et al., 2000). In sum, gender related differences in coping could be an important consequence of gender linked socialization experiences (Matheson & Anisman, 2012).

The current research had two main purposes. The first one was to assess the predictive role of the coping strategies on QoL. We were interested in testing the impact of different coping styles on QoL rather than situation-specific coping (e.g., traumatic events, disease, bereavement in the family...), analyzing each domain of QoL. The second aim was to investigate the effect of gender as a moderator in the relationship between coping strategies and QoL's dimensions.

Following the multidimensional conceptualization of QoL (WHOQOL Group, 1998), the predictive role of independent variables was assessed separately for each domain, i.e. physical, psychological, relational and environmental. In line with literature, we hypothesized that problem-focused coping strategies (i.e. active coping, positive reframing, using support) should positively affect each

domain of QoL, whereas both emotion-focused (i.e. self-blame) and avoidance (i.e. denial, self-distraction, substance use) strategies should decrease QoL (Boals et al., 2011; Maan Diong et al., 2005; Glass et al., 2009; Littleton et al., 2007). Moreover, since women are socialized to express and share their emotions (Stanton et al., 2000), we supposed that the positive effect of using support should be stronger for women than for men. Since men are more likely to use problem-focused coping (Matheson & Anisman, 2012), the use of these strategies should be more positive for men than for women. If research has largely studied the relationship between coping strategies and different kinds of stress, e.g., health problems, difficult economic conditions, stressful works, etc.., or between coping strategies and personality, to our knowledge no study has tested the effect of gender as a moderator in the relationship between coping strategies and QoL's dimensions yet.

Method

Data were collected via a self-reported questionnaire, which took about 20 minutes to complete. Participants were contacted by the researchers themselves and by research assistants trained by the researchers and were asked to participate in a study about quality of life. Although the sampling technique does present limitations in that it was not purely random, every attempt was made to access a wide range of respondents in terms of the age range considered, gender, educational level and occupational status. Anonymity of the respondents was assured.

Participants

A total of 600 adults (56 % females) living in Italy participated in the research, aged from 25 to 70 (average age = 42.73; *SD* = 13.02). 58.6% of participants were married, 32.4% were unmarried, and 9% divorced or widowed. About the education, the majority was high school (41.5%) or college graduated (36.2%), whereas the others (20.3%) had a lower level of education. Most of the participants (73.8%) were still working, followed by retired people (10.5%), students (5.2%),

housewives (4.8%) and a small percentage of unemployed people (1.8%). In respect to women, men were more often single (Chi square = 9.92, p<.01) and childless (Chi square = 7.04, p<.01). Concerning the monthly income, 19.8% of participants declared a family income lower than 1200 Euros, 23.8% reported an income between 1200 and 2000 Euros, 30.7% between 2001 and 3000 Euros, and the remaining 25.7% more than 3000 Euros. In this last category, men were significantly more present than women (Chi square = 7.41, p<.01).

Measures

Participants rated items and answered questions on different topics. The following variables were investigated:

Quality of life. Participants responded to 24 items from the *Italian version of the WHOQoL-BREF* standardized questionnaire (De Girolamo, Becchi, Coppa, De Leo, Neri, Rucci, & Scocco, 2001). This 24 items scale includes four dimensions: Physical Health (WHOQoL_PH, 7 items, i.e. "To what extent do you feel that physical pain prevents you from doing what you need to do?"; α = .70), Psychological Status (WHOQoL_PS, 6 items, i.e. "Are you able to accept your bodily appearance?"; α =.79), Social Relationships (WHOQoL_SR, 3 items, i.e. "How satisfied are you with your personal relationships?"; α = .66), and Environment (WHOQoL_E, 8 items, i.e. "To what extent do you have the opportunity for leisure activities?"; α = .73). Items were scored on a five-point scale from (1) not at all, to (5) an extreme amount. Higher scores correspond to better quality of life.

Coping strategies. The coping strategies were assessed using the 28-item Brief COPE Inventory (Carver, 1997), measuring 14 coping strategies (Active coping, Planning, Positive Reframing, Acceptance, Humor, Religion, Using Emotional Support, Using Instrumental Support, Self-Distraction, Denial, Venting, Substance, Behavioral Disengagement, Self-Blame). Participants were asked to think about the more recent stressful events they experienced and to rate the frequency

with which they have used each coping option in dealing with these everyday stressors. Answers were provided on a 5-point scale from (1) never to (5) very often.

Socio-demographic items. We collected the following data items: age, gender, marital status, educational level, employment status and income.

Data analysis

Factor analysis (method Principal Axis Factoring, Quartimax rotation) was employed to evaluate the factorial structure of the items of the Brief-COPE. To test the differences in scores of the coping subscales and WHOQoL-BREF subscales according to participants' gender, a t-test analysis was conducted.

To test the hypotheses we performed four regression models (stepwise method) replicated on each of the four WHOQoL-BREF subscales. In each regression model the dimension of QoL was regressed onto demographic variables (gender, age, educational level, marital status, income) and coping strategies. Moreover, since gender was considered as a moderator in the relationship between coping strategies and QoL's dimensions, we included the interaction between gender and each factor of Brief-COPE. All statistical analyses were carried out using the SPSS 20.0 software.

Results

Preliminary item analyses lead to remove the items from the subscale Substance use (Kurtosis = 7.89) because of inadequate psychometric properties. Factor analysis conducted on the remaining 26 items showed eight factors. The explained variance was 49.6%. The first factor included six items from three subscales: Emotional support, Instrumental support and Venting ($\alpha = .78$). Items of the Active coping, Planning and Disengagement subscales loaded on the second factor, the two items of the latter subscale taken as reverse ($\alpha = .74$). The third factor coincided with Humor ($\alpha = .86$); the fourth factor corresponded to Religion ($\alpha = .85$); the fifth included Positive Reframing and

Acceptance (α = .66); the sixth factor corresponded to Self-Blame (α = .70); the seventh to Denial (α = .62) and the last one to Self-Distraction (α = .66).

Subscales scores were calculated by averaging across the means of the specific items included into the eight factors. Table 1 shows descriptive statistics and correlations between the coping strategies subscales. Almost all coping strategies subscales were significantly and positively correlated. Exceptions were correlations between: Humor and Denial, Humor and Self-blame, Humor and Active Coping, Support and venting and Denial, Self-blame and Religion, Self-blame and Positive reframing and acceptation, Active coping and Religion, Active coping and Self-distraction (not significant); Religion and Humor, Denial and Positive reframing and acceptation, Denial and active coping, Active coping and Self-blame (negative correlations). The most frequently used coping strategies (see Table 1) were Active coping (Mean 3.91) and Positive reframing and acceptation (Mean 3.42), followed by Self distraction (Mean 3.30).

Table 1. Descriptive Statistics and Intercorrelations between coping strategies subscales.

	1	2	3	4	5	6	7	8
Support and venting (1)		.033	.169**	.237**	.117**	.229**	.273**	.172**
Denial (2)			-.025	-.108**	.124**	.144**	-	-
Humor (3)					-	.075	.004	.226**
Positive reframing and acceptation (4)					.201**	.014	.303**	.277**
Religion (5)						.016	.071	.107**
Self-blame (6)							-	.103*
Active coping (7)								.103*
Self-distraction (8)								
Mean	3.05	2.17	2.76	3.42	2.67	2.66	3.91	3.30
SD	.741	.997	1.145	.686	1.266	.952	.610	.944
Kurtosis	-.232	-.222	-.808	.492	-.991	-.315	-.246	-.393

p<.05; ** p<.01.

Correlations between coping strategies subscales and WHOQoL subscales were positive in most of the cases (see Table 3). Not significant correlations were obtained between Self-distraction and all subscales of the WHOQoL, Denial and WHOQoL_SR, Religion and WHOQoL_PS, WHOQoL_SR

and WHOQoL_E. Correlations between Denial and the physical, psychological environmental dimensions of quality of life were negative, as well as the correlation between Religion and WHOQoL_PH.

Table 3. Descriptive statistics of the subscales of the WHOQOL and correlations with coping strategies subscales.

	WHOQoL_PH	WHOQoL_PS	WHOQoL_SR	WHOQoL_E
Support and venting	.133**	.119**	.135**	.156**
Denial	-.182**	-.136**	-.032	-.118**
Humor				
Positive Reframing and acceptation	.132**	.235**	.149**	.146**
Religion	-.123**	.034	.054	-.040
Self-blame	-.115**	-.245**	-.090*	-.095*
Active coping	.191**	.295**	.139**	.146**
Self-distraction	.004	-.022	-.025	-.007
Mean	3.79	3.44	3.78	3.22
SD	.579	.593	.733	.555
Kurtosis	.136	.318	1.053	.122

p<.05; ** p<.01.

Then, we tested gender differences on each coping strategy (see Table 4) and on each domain of quality of life (see Table 5).

Table 4. Gender differences on coping strategies.

Coping strategies	Men		Women				
	Mean	SD	Mean	SD	T	df	p
Support and venting	2.94	.71	3.14	.75	-3.22	598	**.001**
Denial	2.14	1.01	2.20	.99	-.73	598	.464
Humor	2.83	1.13	2.71	1.16	1.30	598	.193
Positive reframing and acceptance	3.33	.66	3.49	.70	-2.88	598	**.004**
Religion	2.41	1.21	2.88	1.27	-4.58	598	**.000**
Self-blame	2.68	.91	2.65	.99	.316	598	.752
Active coping	3.84	.69	3.91	.61	-.853	598	.394

Self-distraction	3.09	.98	3.47	.88	-4.87	598	**.000**

The results indicated that women, more than men, tend to use Positive reframing and acceptance, Self-distraction, Support and venting and Religion coping strategies.

As seen in Table 5, men outscored women on WHOQoL_PH, WHOQoL_PS and WHOQoL_E. Men and women were similar only concerning the perceived quality of their social relationships.

Table 5. Gender differences on each domain of QoL.

	Men: *M* (*SD*)	Women: *M* (*SD*)	*T* value	Sig.
WHOQoL_PH	3.89 (.55)	3.70 (.59)	4.15	<.001
WHOQoL_PS	3.53 (.59)	3.36 (.58)	3.42	<.001
WHOQoL_SR	3.83 (.73)	3.73 (.74)	1.71	n.s.
WHOQoL_E	3.28 (.57)	3.17 (.54)	2.37	<.005

In the first regression model[1] the dependent variable was the Physical dimension of QoL (Table 6). Active coping was the strongest predictor. Among the other coping strategies, a key role was played by Positive reframing and acceptation, that positively affected WHOQoL_PH, whereas Religion Self-blame negatively influenced this domain of QoL. The effects of the latter strategy were more relevant for men, being the interaction between gender and Self-blame significant. Among socio-demographic variables, educational level and income increased WHOQoL_PH.

Table 6. Multiple regression analyses (stepwise method) predicting WHOQoL_PH.

Predictor	β	t
Age	-.18***	-4.42
Educational level	.15***	3.72

[1] The categorical predictors used in the four models are: male, income between 1200-2000€, income between 2001-3000€ and income above 3000€ (income between less than 700 EUR to 1200€ as reference category), being single, being widow or divorced (being married as reference category).

Divorced/widowed	-.08*	-2.08
Income >3000 €	.09*	2.36
Active coping	.18***	4.89
Positive reframing and acceptation	.10*	2.56
Religion	-.09*	-2.11
Self-blame	-.08*	-2.03
Gender*Self-blame	-.15***	-3.72

*p<.05 **p<.01 ***p<.001 R^2 Adj. = .20 F (9, 543)= 16.61 p<.001.

About Psychological domain (Table 7), active coping was again the strongest predictor of QoL. Also Positive reframing and acceptation and Self-blame affected WHOQoL_PS: the first strategy increased it and the second decreased it. Even in this domain the effect of Self-blame strategy were more relevant for men. Also Humor and Support and venting significantly predicted WHOQoL_PS. Among socio-demographic variables, only high income contributed to WHOQoL_PS.

Table 7. Multiple regression analyses (stepwise method) predicting WHOQoL_PS.

Predictor	β	t
Income >3000 €	.14***	3.87
Active coping	.22***	5.74
Self-blame	-.21***	-5.17
Positive reframing and acceptation	.13*	3.14
Humor	.11**	2.91
Support and venting	.09*	2.16
Gender*Self-blame	-.17***	-4.23

*p<.05 **p<.01 ***p<.001 R^2 Adj. = .27 F (8, 548)= 26.55 p<.001.

When the Social Relationships domain was considered (Table 8), the interaction between gender and Self-blame was the strongest predictor, being this strategy more important for men. A significant difference between men and women was found also in relation to Support and venting

strategy and its effect was more important for women. Active coping and humor increased this domain of QoL, as well as income, while age and not being married decreased it.

Table 8. Multiple regression analyses (stepwise method) predicting WHOQoL_SR.

Predictor	β	t
Age	-.19***	-3.96
Unmarried	-.13**	-2.77
Income >3000 €	.26***	4.84
Income between 2000-3000 €	.17**	3.11
Income between 1200-2000 €	.10*	1.99
Active coping	.15***	3.60
Humor	.11**	2.63
Gender*Self-Blame	-.30***	-3.79
Gender*Support and venting	.25***	3.06

*p<.05 **p<.01 ***p<.001 R^2 Adj. = .13 F (9, 550)= 10.04 p<.001.

Finally, income was the strongest predictor of WHOQoL_E (Table 9) and the other socio-demographic variable that played a key role was educational level. Among coping strategies, Support and venting, Active coping, Positive reframing and acceptation enhanced WHOQoL_E. A difference between men and women was found, again, in relation to Self-blame coping strategy and, as for the other dimensions of QoL, in the case of men its effect was stronger.

Table 9. Multiple regression analyses (stepwise method) predicting WHOQoL_E

Predictor	β	t
Educational level	.10*	2.48
Income >3000 €	.24***	5.50
Income between 2000-3000 €	.16***	3.67
Support and venting	.13**	3.07

Active coping	.11**	2.56
Positive reframing and acceptation	.10*	2.26
Gender*Self-blame	-.15***	-3.59

*p<.05 **p<.01 ***p<.001 R^2 Adj. = .14 F (7, 545)= 14.29 p<.001.

Discussion

The current study aimed at assessing not only the major relation between coping strategies and each dimension of QoL, but also whether this relation differs for men and women. Descriptive statistics testing gender differences in QoL confirmed previous research carried out with a sample of Italian adults (Rollero et al., 2014): men outscore women in the physical, psychological and environmental domains. However, when considered as moderator, gender *per se* does not affect quality of life. This means that QoL does not change according to gender, but the effect of other predictors of QoL may be pronounced or diminished according to gender. In line with a growing literature (Denton et al., 2004; MacKinnon & Luecken, 2008; Rollero et al., 2014), these findings demonstrate that gender differences in health and quality of life go beyond biological differences and follow pathways including contextual and psychosocial elements.

Referring to coping strategies, our hypotheses were only partially confirmed. Problem-focused coping strategies, i.e. active coping, positive reframing, and using support, increase quality of life in all its dimensions, whereas emotion-focused coping, i.e. self-blame, diminishes both physical and psychological QoL. Both the use of religion and humor seems to only partially influence QoL, as the first decreasing the physical dimension and the latter slightly increasing psychological and relational QoL. Contrary to expectations, avoidance strategies, i.e. denial and self-distraction, do not play any significant role, although literature has largely shown that avoidant coping strategies are negatively related to health and psychological well-being. However, most studies have been carried out with subjects dealing with a specific stressful situation or a traumatic event (see the meta-analysis by Littleton et al., 2007). In the present study participants were not facing a real negative

event, but they were asked to think about the more recent stressful events they experienced. This might explain why avoidance strategies have no effect on QoL of our participants. As Lazarus (2000) underlines, one strategy is not necessary adaptive or maladaptive; rather it depends on the situation and the outcome that follows its particular use.

Probably the most noteworthy result concerning coping strategies pertains to the interaction between gender and support and between gender and self-blame. The first influences the domain of social relations: only for women social and instrumental support enhances relational QoL. This result is in accordance with traditional literature on gender differences, which has largely demonstrated that gender stereotypes define women as interdependent/communal and men as independent/agentic (Eagly & Karau, 2002). Women are socialized to maintain more emotional relationships and to be more embedded in their social networks (Gallicchio et al., 2007; Kawachi & Berkman, 2001). Emotional expression, as well as looking for social support, is more frequent among women than men, and such a strategy lets the individual to confront his or her feelings and to move on (Carver et al., 1989; Rollero et al., 2014; Stanton et al., 2000).

The opposite pattern has been shown for the interaction between gender and self-blame. In this case this strategy is particularly maladaptive for men, as it decreases their QoL in each of the four domains. To our knowledge, no previous study has examined this interaction directly. However, literature gave evidence that men are more likely to use problem-focused coping, whereas women are more likely to apply emotion-focused coping (Matheson & Anisman, 2012). Thus we can argue that for women emotion-focused coping represent a “normative” strategy, but for men it may be more harmful, as they are more familiar with problem-focused coping.

We are aware that our study shows some limitations. First, being the sample large but not representative, the generalization of present results needs caution. Second, since the study was conducted in Italy, it should be necessary replicating the same research in other countries, in order to investigate the external validity of results. Finally, as above specified, we recruited individuals facing no real traumatic event: this aspect represents an interesting development of research on

coping strategies, but at the same time further attention is required to investigate the same patterns in people coping with different and concrete stressful situations. In reference to gender differences, literature shows that each gender face specific stressful events, i.e. health and caregiving for women and economic troubles for men (Matud, 2004; Stefani, 2004), although some authors argue that gender differences in coping strategies are becoming shorter (Felsten, 1998; Matud, 2004).

In sum, our findings reveal that even coping strategies could be an important consequence of gender linked socialization experiences (Matheson & Anisman, 2012). As Ridgeway (2001) has pointed out, gender is not just a trait of individuals and a biological dimension, but is mainly an institutionalized system of social practices. Individuals are situated within that system and within social, cultural, and political contexts that condition their way of life and thus their health status (Dodoo & Frost, 2008; Gattino, De Piccoli, Fassio, & Rollero, 2013; Rollero, 2013).

We believe that understanding determinants of quality of life is critical for developing policies interested in health promotion. If we aim at improving individuals' quality of life, we have to consider the role played by gender, as men and women do not give importance to the same aspect in similar ways. More generally, for prevention and intervention programs, understanding crucial moderators has the potential to help direct limited resources to those who are most likely to benefit for them. In other words, specifying what distinguishes men from women could suggest specific actions which can increase people well-being, considering at the same time that different social categories give diverse meanings to their social and relational contexts. Institutions such as the WHO advocate gender-mainstreaming of health care, research, practices and politicise. Indeed, gender-mainstreaming in health, through the integration of gender concerns into policies, programmes and projects, pursues the aim of ensuring that both men and women achieve the highest health status and quality of life (WHO, 2001). Moreover, considering the most effective coping strategies contributes to interventions and health literacy programs aimed at promoting health and quality of life. Addressing this issue from a gender perspective may help in developing

specific strategies (in terms of services, communication, interventions) to sustain the best ways to cope with stressful situations for both men and women.

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