GENDER AND EMOTION

LESSON 23

Emotions are one of the basic ingredients of human existence, and the spice of life. Emotions are an integral component of a persons' personality man or woman. It is a common observation that men and women show different emotional response patterns; the way they express emotion is also different. Stereotypically it is thought that women are more emotional than men. Also their behaviors are guided by their emotions; they are led by their heart not head. Men, on the other hand, are thought to have control over their emotions; they can postpone their emotional reaction, and thus act rationally. But how much of these commonly held beliefs are true? Few questions need to be explored in this regard.

Do men and women have different types of emotions?
Are they born with different emotional packages?
Does the different genetic make up have ay thing to do with it?
Do different proportions of hormones play a part in gender differences in emotions?
BUT the most important questions still need to be posed i.e.:

Are there any real gender differences in emotion???
Do males and females have a different emotional make up, inherently, or is it only the expression of emotions in which they vary?

Research has shown that males and females both possess the same repertoire of emotions; it is their upbringing, societal attitudes towards gender roles, gender stereotypically, and observational learning that leads to different expressions of emotion. Off course biological variables do have a role to play; there is no denying the fact that hormonal imbalances, physiological conditions trigger different emotional experiences. Hence women experiencing certain emotions more than men do, and vice versa. But talking of average, normal, emotional experience, other variables being constant, the gender differences in emotions may be attributable more too psycho-social cultural factors, rather than biological influences.

The components of Emotions

Psychologists have posed a number of theories proposing various components of emotion. In the earliest of modern day explanations of emotion, their instinctual nature thus the physiological component, ea emphasized (Mc Dougall, 1923). Although psychologists agreed upon the physiological aspect of emotions, the later theories proposed the significance of the cognitive aspect of the emotional experience. Most theorists agreed upon the combined action of physiological/ physical arousal and cognitive experience in an emotional response. The issue for debate was thus the question as to whether the physical arousal was of prime importance or the cognitive labeling of experience. Today, most psychologists believe in the significance of the cognitive element, without denying the importance of the physiological accompaniments; off course many other psychologists do propose the edge of biological experience over the cognitive experience (Zajonc, 1984). Psychologists like Lazarus believe in the primacy of cognitions.

Schachter and Singer (1962) in their investigation had shown that both physiological arousal and cognitive labeling were significant components of emotional experience. Their experiment yielded that subjects could experience different emotions, even when similar levels of physical arousal were present; the experienced emotion depended upon the setting in which the emotion was experienced as well as the expectations of the participants.

Before moving forward to investigate and understand gender differences in emotion, one needs to comprehend the essence of the physiology cognition debate. If you were of a physiological opinion, then you will believe in the physiological changes in emotion that are the same no matter what the

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nature of emotion is. If someone sticks to the significance of cognition alone then the belief will be that emotional experience is caused by the cognitive experience alone, the physiological element being constant.

In order to identify their emotional experiences, men tend to use physical curs; women depend more on cognitive information (Pennebaker, & Roberts, 1992). Men's sensitivity to physical cues is supported by the fact that men notice and assess their internal physical states better than women; these states include blood pressure, heart rate, and blood glucose. But one must not take this to be the decisive evidence supporting men's edge over women in terms of the ability to gauge alterations in physiological states. Research has shown that in naturalistic settings, men and women are equally good at identifying changes in their own bodily states. Whereas women have in edge over men, in naturalistic settings, in terms of gauging the emotional responses of others. Women are capable, better than men, in identifying others' emotional experiences on the basis of using situational and contextual cues. Thus women have the ability, or sensitivity, to sense their own physical states, as well as others emotions.

As said earlier, men and women are endowed with similar emotions, but their expression, and the interpretation of the situation may be different. The socialization process has an important role to play in this regard. From very early childhood, boys are taught to control or restrain expression of certain emotions (e.g., grief), and allowed to express certain others (e.g., aggression). Same is the case with girls, but the emotions that they are taught to control, and allowed to express are different; they are discouraged form indulging into aggression, especially physical, and usually not discouraged from expressing grief or sadness; hence we see many women crying but hardly any man.

Many researchers have tried to identify similarities in emotional experiences of men and women, rather than differences. Universal features of emotions have been explored in such studies. Facial expression, or facial movements, accompanying emotional experience have been studied in different cultures. Research shows that some such movements are universal and are characteristic of emotions across cultures (Ekman, 1984; Ekman, Levenson, and Friesen, 1983).

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LESSON 24

GENDER, EMOTION AND MOTIVATION

Gender differences in different types of Emotion and Emotion-related Behavior

Gender and aggression

Empirical research has yielded that gender differences do exist in aggression, especially the expression of anger/ aggression. We have discussed this issue in detail in the section on "Gender differences in Personality". However few other findings will be discussed in this section too. Aggression is the behavioral manifestation of the emotion of anger. Aggression can be direct, physical; and it can also be indirect, social, or relational. Usually anger and aggression come together; however one may occur even the absence of the other. A person may be angry, but may not indulge into an aggressive act i.e., the person does not take any action; on the other hand the person may not be undergoing the emotion of anger, but may indulge into an aggressive act e.g., careful planning to harm others in order to attain personal gains (Anderson, & Bushman, 2002).

aggressive acts without anger

As previously discussed in detail, in some situations males and females differ in their expression of emotion; in many other they ore not much different. There are some gender differences in the type of aggression that people adopt. Men use more of physical aggression, women social or relational aggression. Research has revealed that there is a relationship between parenting styles and children's aggression scores. One study showed that children, whose parents are less nurturant and acceptant tend to behave more aggressively at school as compared to the children of nurturant and acceptant parents (Dubow, Huesmann, & Boxer, 2003; Eron, 1987; Huesmann, Eron, Lefkowitz, & Walder 1984; Lefkowitz, Eron, Walder, & Huesmann, 1977). Looking at child rearing practices in our culture, one can see that parents usually have a soften attitude towards daughters than sons; the girls usually do not get physical punishment the way boys do; parents, especially fathers avoid harsh, abusive, language with daughters, but not with sons. These practices may also be one contributing variable in the gender differences in the style of aggression used by people.

A review analysis of research literature pertaining to experimental studies in psychology revealed that in case of neutral and unprovoked situations, men tended to be more aggression than women. However, when women felt provoked or justified they were as aggressive as men (Eagly, & Steffen, 1986; Frodiet et.al., 1977). Meta analysis by Bettencourt & Miller (1996) yielded interesting findings on provocation. If a situation involved provocation like the frustration when someone blocked their path through an intersection, than both men and women showed similar responses. But in some form of provocation, gender differences were found. For example if someone insulted their intelligence, then men readily show an aggressive response; women do not respond aggressively as readily as men do (Bettencourt & Miller, 1996).

Affiliation, Love, Jealousy

People, both men and women do feel a need for affiliation do fall in love, and like to be loved. One aspect of love is jealousy. Researchers have found gender similarities and differences in all there facets of human emotion. Research shows that in love relationships, as well as marriages, trust is an element considered important for both men and women. Trust involves three separate ways in which a person views his or her partner (Rempel, Holmes, & Zanna, 1985). Trust implies:

- Predictability
- Dependability, and
- Faith

People want their partners to be predictable; one likes to be able to assess and estimate what the other person will behave like i.e., the partner should be predictable. People want their partner to be someone who can be depended upon; during a relationship people form ideas and assumptions about the personality attributes of their partner and from those assumption they develop a feeling of

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how dependable the other person is. Faith is another essential ingredient of a close relationship marked by attachment, love and happiness. When people have faith they are hopeful of the positive consequences.

Trust involves three ways:

1- Predictability
2- Dependability
3- Faith.

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GENDER AND EDUCATION

Looking at the issue of gender and education, two aspects need to be discussed;

a. Educational Deprivation
b. The School Experience

Education is one of the most basic rights of all children ……both male and female. Education brings enlightenment, and empowerment. For the children who are deprived of this right, all paths, leading to progress, prosperity, and a better life, are blocked. In case of the female child the impact is even more serious and long-term. Educated mother not only brings up their children in a better manner, but also actually contribute a lot to the survival of their children. Research data reveal that children of educated mothers are better than the children of uneducated mothers in terms of their health and education. Educated mothers are better aware of disease prevention, the significance of proper nutrition, importance of medical consultation, children's development/ growth pattern, and healthy lifestyles, as compared to uneducated mothers. In terms of personal well being, education leads to social and economic empowerment of women.

BUT how many females, all over the world, have this right? Large proportion of women are either denied this right, or do not have access to education. Women in some parts of the world are more privileged than those belonging to some other regions. Out of the 875 million illiterate adults in the world, two third are females. Majority of the 121 million children of the world, who are not in schools, are girls. In 2002, 24 million girls were not going to school in Sub Saharan Africa. Such Saharan Africa, South Asia, East Asia, and the Pacific are the regions where 83% of all girls out of school, belong to these regions (Verma, 2006).

Impact of Educational Deprivation

Denial of the right to education, or inaccessibility of educational facility has deep rooted personal and social consequences. For the person, the female, it implies that a number of doorways to social and economic empowerment will be blocked. The health status of educated women is better than that of the uneducated; educated women adopt more and better disease prevention strategies. They are better aware of and adopt precautions against, reproductive and childbirth complications. They can protect themselves against abuse and violence. Educated women are economically more empowered than uneducated women.

They are more aware of their legal and political rights.
Psychologically speaking, education enlightens women and gives a sense of self fulfillment and self-esteem. Therefore if the girl child and women are deprived of education, the chances of her utilizing her optimal potential are very bleak.

Barriers to Women Education

Cultural Practices

Many societies and cultures do not encourage their females to leave, home boundaries. The girls are involved in domestic chores from the very beginning. It is felt that education is only required when someone has to work out side home; and girls do not have to do that, since husbands will take care of their life.

Early Marriages

More girls remain uneducated in cultures where early marriages are practiced.

Lack of educational facilities

If schools and educational institutions are not available or accessible, then even the willing and interested parents cannot send their daughter to school.

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The School Experience and Gender

Most schools operate in a manner that promotes and strengthens gender stereotypes. This happen both in unisex as well as co-educational institutions. In 'girls only' school girls are taught traditional female roles and values; girls from such schools, when enter coeducational institutions for higher education, have some difficulties or psychological problems. They were always treated as an entity separate from men and were told to protect themselves against men; and now they have to mingle with them. Teachers, research shows, treat male and female children differently. Teachers promote stereotypical gender roles (Garrahy, 2001).

Even very young children indulge into gender segregation; the teacher generally permissive about it and in fact many encourage this practice (Thorne, 1993). One problem that may arise for many boys is that most junior school teachers are females, who may not be good or appropriate role models for growing boys.

Even when some male teachers teach in junior schools they are not the right role models; for most male teachers junior school teaching is not their main ambition, passion or the career path they would like to stick to. Usually the brighter male lot goes for higher education and professional qualification in order to join more paying careers. For girls usually better role models are available in school. Elementary school teachers, whether male or female, encourage compliance and reward children for being compliant (Cohen, 1992).When male teachers are teaching, there is less gender stereotyping. When students taught by male teachers are compared with those taught by female teachers, it is seen that the former make significantly less stereotypical explanations of the behaviors of men and women (Mancus, 1992).in initial years at school some, not many, gender differences are found in the achievement of children, in which girls have an edge (Bae, Choy, Geddes, Sable, and Snyder, 2008).Girls' grades are better and they score higher than boys in reading and writing. Besides gender factors like mothers' occupation and fathers' education have been found to be important in this regard. Regarding referral for special education services, the likelihood is higher for boys to receive such referrals; some studies suggest that this is a result of gender bias (Wehmeyer, 2001).
Some other differences emerge in middle school but this time more in favor of boys. In the earlier years difference in achievement were found on the basis of ability but now it is with reference to children's attitudes and interests. Girls usually do not opt for physical sciences as the major area of their interest. In middle school boys are more interested in taking part in science-related tasks and activities; they are more likely to use scientific equipment. Girls do show interest in participating in these activities, but are les likely than boys to actually do so. This is one of the reasons why girls have little interest and lower achievement in physical science (Lee and Burkam, 1996).Although girls still get comparable or better grades than boys in mathematics, they are less interested in math; considering their field of study, girls find math to be less interesting (Davis-Kean, Eccles, and Linver, 2002). Math is stereotypically perceived as a male domain, and that can be one of the reasons girls start losing interest in math. Boys, girls, parents, and teachers all hold to this belief about math (Nosek, Benaji, and Greenwald. 2002; Tiedenann, 2000).

However girls' interests in science and maths is lowered, but not there grades. During these years and then into higher classes, gender segregation begins, and activities, occupation and interests re seen to be separate for men and women. Sexual harassment, harassment otherwise, bullying and child abuse are problems faced by many children at school, both male and female; however the rate is higher for female students who go non-traditional vocational training institution.

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GENDER, WORK AND WOMEN'S EMPOWERMENT

LESSON 26

So far we have been primarily discussing gender differences, and to some extent similarities between genders. We talked about the biological basis of gender differences, the social variables and stereotypes that lead to gender disparity, and the differences as well as similarities in personality, cognitive ability and emotion. The role of medial in promoting and strengthening conventional gender roles was also discussed. We also looked into the nature and causes of educational deprivation and barriers to females' access to education. We saw that besides social pressures, and stereotypical beliefs, the very nature and process of the educational system also promote traditional gender roles. But from now on we will shift out focus a bit. We will see how the societal attitudes, beliefs about and women's status in the society in general affect different females' abilities aspects of women's life; the social, psychological, economic and health related aspects. Before beginning our discussion on Gender and Work, let us go through a few cases, or you may call them stories. The cases belong to our society, the characters commonly found around us, and the situations we are very well familiar with. The names are however fictitious and cases hypothetical.

Case 1

Shamin is a 12 year old bright girl, belonging to a middle class family. She went to school for five years, always topping the list of successful students. After class-5 her father decided that she will not be going to school any more. Shamin, being a child, protested by crying and begging but no one listened to her. Now she stays home and assists her mother in household chores and looks after her two younger siblings.

Case 2

Syma did her masters in physics. She was a scholarship holder throughout her career, never a burden on her parents. She wants to work in her university, where she has been offered a job, but the family doesn't agree. Although they are not against the idea. The family believes that if Syma starts working, their distant family and neighbors will think she is earning for them. Besides, she will not be able to get an appropriate match, with equal status, in their moderately educated class.

Case 3

Saira is specialist doctor, working in a hospital. She got married to a businessman. Soon after her marriage the husband and the in-laws prohibited her from joining duty. They had initially shown no such intentions. Saira protested, but her parents did not support her. Now she is at home all the time, looking after the household.

Case 4

Sajida is a teacher, who is the private sector, earning as much as her husband does. Both of them are back home from duty at 3:00 pm. Then Sajida starts her household responsibilities. he cooks, cleans washes, does ironing, and teaches her children all without any help. She goes to bed at 12:30 at night and wakes up at 5 in the morning to cook for the day and help her four children to get ready for school. The husband does not help her at all in all these chores; at every first of the new month, she hands over all her salary to her husband who decides how the money is to be spent.

Case 5

Shahida is a banker, a branch manager. After her experience and performance she is a candidate fit for promotion as an area manager. But every time a promotion is expected, some male manager is chosen. The bank offers foreign postings and training to efficient employees every year, but Shahida is never selected. Now she believes that she will never be able to rise to the highest ranks in her organization.

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All these cases present experiences that hundreds of thousands of females undergo not only in our society but all over the world. In our discussion on gender and work, we will see how different impediments block women's capacity building, and empowerment.
But first of all, let us understand some basic concepts and terminology; work, formal and informal work and empowerment.

Work
Work refers to an occupation; in the present context it refers to a formal occupation; or profession.

Formal Work versus Informal Work
Formal work is an occupation that is:

a) Learnt after formal training and learning a skill
b) A means of earning/income for the person
c) Performed at a specific work place and,
d) Performed during specific work hours

Informal Work
All work is not formal work. People work informally too. Most women indulge into informal work i.e., house work. Women's informal work is not paid for, it has no specific work hours or a work place. Women work for varying number of house, at various sites, and without an acknowledgment that they work; they are called "non working" members of the society. An average housewife may work for as many as 84 house week, 12 hours a day from 5 O' clock in the morning till midnight.

Formal and Informal Work combined
In case of most working women, they are involved in both types of work; they work in the workplace as well as at house.

Women Empowerment
Bringing power to women; making women powerful; facilitating autonomy and self-reliance of women.
Empowerment can be:

- Economic
- Social
- Legal
- Political

An empowered woman makes, or can make, her own life decisions, and is self reliant.
Going back to our cases we see that in case 1, Shamin who was not allowed to continue her studies, her very initial opening to empowerment was blocked; no education, no hope for empowerment. In case 2, Syma, is educated but not allowed to work; she is capable, equipped with knowledge and skill, but the family is not permissive of her attaining self reliance; she was dependent on her parents, therefore had t obey them. In case 3, the doctor, Saira, was already working and earning when she got married, but familial-social pressure put her empowerment to an end. Sajida's case, case 4, is an example of modern women's dual/multiple role. The family, and the significant others are permissive of her job, but no body bothers to share her additional load of housework. In spite of the fact that she is working and earning, she is not empowered since she does not have control over her own earnings, is not the decision maker even in case of her own life. In case 5, Sajida's case, the issue is not the familial or societal, attitudes, but the system within the organization that hinders her promotion and rising above her male colleagues. She is experiencing the Glass-ceiling effect.

The purpose of describing these cases is to sensitize you about the different barriers to women's empowerment and their very existence as human being. Human beings are born with a free will and

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basic goodness. All human beings have and should have, equal rights, equal treatment, equal opportunities to perform at their optimal level. Have you even come across a man who has experienced any of the treatments that females in the five cases described here? Definitely no!!

And one last work about the house wife (non working female). The very title suggests that she does not work. But comparing work hours, a housewife works, on average, more hours than an average man does. A man, in our culture, works around eight hours a day, and usually not on weekend; but the so called "non working woman works for around twelve hours a day, and on weekend too.

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LESSON 27

GENDER, WORK AND WOMEN'S EMPOWERMENT (2)

Recap:

- The concept of work and empowerment
- Five case studies
- Problems faced by women pertaining to economic empowerment

Gender, Work and Women's Empowerment

Women's empowerment, economic, requires a career or a formal occupation. A formal occupation requires education, training and skill. But considering women's empowerment or career development, one comes across a number of hurdles:

Number of hurdles in women empowerment.

No education;

In many parts of the world the girl child is denied the right to education, either due to societal attitudes, stereotypical beliefs, or inaccessibility of educational facility.

Faulty or non-career oriented education;

In many cases females do have a right and access to education, but the very nature of education imparted to them does not lead them to a career path.

1. Glass-Ceiling Effect;
2. Multiple/ Dual Roles;

Women, even when sharing all responsibilities of life with men, have to look after all the household affairs too.

3. Harassment
4. Violence against women

The first two issues have been discussed in detail in the section on gender and education. In this section the Glass-Ceiling effect and Dual/multiple roles will be discussed. The last two will be discussed later on.

Glass-Ceiling Effect

How will you feel in a situation like this?

'You are standing in the atrium of beautiful tall building; your favorite person whom you have not seen in the last years is standing on the roof of the floor above yours. You want to reach him at once in a jump, but you can't jump or even use a ladder to reach there because there is a glass ceiling between you two. All other ways ad passages to that destination are locked or blocked. You can see that person, you have the faith that if give a chance you can be there in a plunge; BUT you are unable to do so because the people in control have set up things in such a manner that it is impossible for you to reach where you wanted to reach'.

How will you feel?? Disheartted? Frustrated? Depressed? Angry? Helpless? or may be Trapped?? This is what most highly talented, capable, qualified and experienced female executives or professionals feel……. The glass-ceiling effect.

Glass-ceiling refers to "the invisible barriers arising from a complex set of structures in male-dominated organizations which prevents women from obtaining top positions in management and administration" (ILO, Geneva, 2003).

"This phenomenon prevails almost every where despite women's increased level of qualification and work performance. It has been demonstrated by research and statistics and is, at least partly, a result of persistent discrimination against women at work" (ILO, 2003).

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Glass-ceiling is different form the typical form of discrimination. It is not an open, concrete, stated barrier to women's access to higher status in an organization; it is an invisible, unsaid, and subtle barrier. The route to promotion, and pre-requisites for higher positions, one designed in such a manner that they favor men and proves to be hurdles for women. This state of affairs makes it difficult, if not impossible, for women to reach top positions in the management or administration.

Factors responsible for Glass Ceiling

Available research findings and statistics have shown that a number of socio economic variables cause the glass-ceiling (ILO, 2003).

Persistent discrimination against women at work

"The nature of women's typical career paths blocks their progress to top positions. Women are primarily placed in non-strategic sectors and personal and administrative positions rather than in posts leading to the top" (ILO, 2003).

"Women have less access to training and are cut off from formal and informal networks that are essential for advancement within enterprises" (ILO, 2003).

"Women workers still tend more than men, to bear the main burden of family responsibilities, as well as paid and unpaid work; this double burden hampers their upward movement" (ILO, 2003).

Consequences of Glass-Ceiling

1: Felt incapacity and inferiority
2: Frustration and helplessness
3: A sense of injustice
4: Job dissatisfaction
5: Strengthened gender stereotypical beliefs

Strategies for breaking through the Glass-ceiling

A number of practical steps can be adopted for facilitating women's access to top management positions.

ILO (2004; 2003) documents state strategies for promoting women to eliminate sex discrimination;

- "Improving legal frameworks to eliminate sex discrimination;
- Enhancing awareness of obligations and rights, including or gender equality;
- Affirmative action, mentoring and monitoring for women;
- More flexible and reduced working hours, as well as adequate childcare and elder-care facilities, to enable both parents to better combine family and career;
- Better access of women to a business skills training and entrepreneurship development to help them run their own business;
- Improving women's access to training, in particular in technical and management fields;
- Reviewing human resource development practice to recognize the potential value of non-conventional career paths and to facilitate women's access to managerial positions;

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LESSON 28

GENDER, WORK AND RELATED ISSUES

The purpose of our discussion of Gender and work is fourfold:

a) To develop an awareness of the hurdles in the way of women empowerment
b) To develop an understanding of how women feel and what they experience as a result of stereotypical attitudes towards women's work and their ability
c) To sensitize students to the significance, and the need for, gender equality and equity, and
d) To inculcate a supportive attitude, and a genuine desire to help women become economically viable units of the society

Issues in Gender and Work

The number of educated women is increasing all over the world, and so is the number of women in work and profession. In one society, more and more women are exhibiting excellent performance in their academic career; in many cases female high achievers are at par with male high achievers, if not out numbering them. Females are entering into a wide variety profession; the professions once considered men's professions are no longer exclusively for men. Females are entering the forces, flying aircrafts, and heading the police.

Yet very few women are the heads of organizations where both men and women compete for the highest position in the executive order. The same stands true for all other societies, whether from the East or West. ILO's yearbook of Labor Statistics (2003) presents data for the years 1996-1999, and 2000-2002 from 63 countries. The data reveals that in 45of these 63 countries, in 2000-2002, 30 to 60% of professional jobs were held by women. In 12 countries this rate was more than 60%. Eastern Europe and the Confederation of Independent States (CIS) had the highest overall share of women in professional jobs. The percentage of women's share ranged between 70 % and 61 % in many countries in Europe and Asia. However this share was quite low in countries like Pakistan (25.6%) and Bangladesh (25 %).

But while the overall share of females in professional jobs is pretty good, the case of women in managerial positions is not very promising. The number of women in managerial positions is increasing but the rate of increase is not very encouraging. The share of women in managerial positions is higher in Eastern Europe, North America, and South America as compared to East Asia, South Asia, and Middle East (ILO, 2004).The overall share of women in managerial jobs was 20-40 % in 48 out of 63 countries in 2000-2002. The ILO (2004, 2003) data reveal the share of women "administrative and managerial workers" to be:

U.S.A ____________ 45.9 %
Japan ____________ 8.9%
Pakistan ____________ 8.7 %
Bangladesh ____________ 8.5 %
Saudi Arabia ____________ 0.9 %

The share of women in top management positions, board positions, or corporate officer positions is even less encouraging.

Gender Differences in Career Development

Research data show that men and women pursue their careers in different patterns. Men choose a career path quite early as compared to women. Research shows that there is a higher likelihood that women will experience career interruptions, and will leave work temporarily for concentrating on child rearing or family crises (Phillips, and Imhoff, 1997). In most societies, in case of married women, the husbands' career is considered to be more important.

Many, if not all, women subjugate their own career goals and ambitions to those of their husbands' (Unger, and Crawford, 1992). Most women experience discrimination at all phases of their career, at

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selection, at posting, at promotion, and in salaries. Women are paid less than their counterparts, and experience harassment at workplace besides glass-ceiling. They are usually preferred for low status jobs. In the US, in comparison to every dollar that men earn, women earn 72 cents. The case is even worse in case of women belonging to minority groups (U.S. Bureau of Labor Statistics, 1999).

Sexual Harassment at Workplace

Sexual harassment is one of the major causes of concern for working women, or those aspiring to join the work force. If you are a man, how will you feel if:

"You are standing on the bus stop and every now and then someone touches you or pinches you. You get into the bus and someone starts passing ridiculing comments on your dress; makes fun of your body; laughs at you. Then you reach your office and you find people discussing your physique; the boss tries to hold your had when you hand him over a file;"

In all these situations you don't find the courage to respond back and to harshly snub the people bugging you. You probably be feeling embarrassed, helpless, or angry; and after some time you might decide to quit the job.

Sexual harassment may have the following consequences:

a) Shame and embarrassment
b) Interrupted career path in many cases
c) Hurt and low self-esteem
d) Fear, helplessness, inhibitions, and lack of self confidence
e) Negative attitudes of the society
f) Feeling of dependence; need for a male care taker
g) Limiting ones' self to a career in female-only environment

Sexual Harassment

According to ILO's (2003) "ABC of women workers' rights and gender equality:" Unwelcome sexual advances or verbal or physical conduct of a sexual nature which has the purpose or effect of unreasonably interfering with the individual's work performance or creating and intimidating, hostile, abusive or offensive working environment." The same document states examples of sexual harassment:

- "insults, remarks, jokes, and insinuations of a sexual nature and inappropriate comments on a persons' dress, physique, age or family situation;
- undesired and unnecessary physical contact such as touching, caresses, pinching or assault;
- embarrassing remarks and other verbal harassment;
- lascivious looks and gestures associated with sexuality;
- compromising invitations;
- requests for sexual favors" (ILO, 2003).

Sexual harassment is not just a gender issue; it is a human rights issue. It has deep rooted effects on the persons' psyche. Besides, it is discrimination as well as a health issue. Sexual harassment implies the extortion of sexual cooperation through subtle or explicit threats of job-related consequences and pervasive sex-related verbal or physical conduct that is unwelcome or offensive (U.S. Equal Employment Opportunity Commission, 1980). Although mostly women complain of being sexually harassed, it is not a women-only issue. Men, though less frequently, may also experience such treatment. One study showed that 20% of the surveyed women reported having been sexually harassed at the workplace; the males having experienced the same were 10% (Burgess, and Borgide, 1997; Matchen, and De Souza, 2000). However some researchers estimate that one in every two women working in an organization will experience sexual harassment at some stage of her career (Fitzgerald, 1993). Sexual harassment can be physical as well as psychological nature. Physical sexual harassment involves touching that is unwanted or unwelcomed. Psychological sexual harassment is

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intrusive, unwanted and coercive sexual attention from which there is frequently no viable escape (Fitzgerald, 1993). Research evidence suggests that most of sexual harassment is psychological in nature (Fitzgerald, 1993). Women may experience sexual harassment not just at the workplace alone, but at any place, any time of the day. Going to a crowded shopping mall, traveling by public transport or waiting on the bus stop; all are the highly probable sites of sexual harassment.

Sexual Harassment and Benevolent Sexism In many cases sexual harassment has its roots in benevolent sexism. The offender apparently expresses concern, sympathy or benevolence, whereas in fact the self esteem and self confidence of the target is being undermined.

Power, Status, and Harassment

The roots of sexual harassment can be traced into the power structure in a society. Power, more than sex in the precipitating cause of harassing behavior. Most societies are male dominated, men being in power; instead of sexual gains, it is the desire to display and exercise power that leads to an act of harassing others. Similar ideas have been proposed in the concept of "power asymmetries" (Depret, and Fiske, 1993).

How to Tackle Sexual Harassment

- **a)** State legislation and following international declaration of human rights, and implementation and enforcement of the same
- **b)** Organizational rules and regulations
- **c)** Children's (especially female children's) awareness campaigns, so that they learn form the very beginning as to how to handle such situations, also shedding inhibitions in expressing such experience.
- **d)** Complaint boxes in organizations
- **e)** Assertiveness training; the ability to say 'No' when you want to say "No".

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GENDER AND VIOLENCE

LESSON 29

Violence against women is an important gender issue for all concerned. It is a matter of concern for all those involved in the efforts for women empowerment and gender equality. Violence in all forms whether at workplace, or on the roadside, or domestic violence, is and indicator of one class of citizens being oppressed and exploited by another in a dominant positions. Before discussing this issue further, let us imagine these hypothetical situations:

Situation A:

"You are an educated, quite good looking, civilized, well groomed, capable, earning professional; you are living with a person, whom you have to be with for the rest of your life; that person criticize you all the time without any reason, ridicules you, makes fun of your looks, laughs at your ability, hurts you unnecessarily, and shouts at you, and abuses you all the time".

May be irritated, agitated, angry, aggressive and hostile; or may be helpless, heart-broken, and depressed; or may be all of these feelings are experienced by you.

Case B:

"You are a moderately educated, nice looking, sweet natured, shy, and quite person; you try your best to please others; you are married to an ill tempered person who slaps you, beats you and pushes you at even the slightest mistake that you make".

How will you feel?

Case C:

"You were married off by your parents, who gave a very lavish dowry on the wedding. After a few months there were problems in the marriage and you are sent back to you parents by the in-laws, who confiscated the entire dowry.".

How will you feel?

The purpose of stating these hypothetical situations are to make you imagine and visualize how women in such situations feel. All these situations represent only a few forms of violence practiced commonly against women. Women, from childhood, are trained and taught to accept and adopt what others decide for them. In the same manner they learn to accept minor forms of violence as a routine part of their life. Violence becomes an issue when it is practiced on an ongoing basis, persistently, and in a severe form. Although both men and women may be victims of some form of violence, the rate of female victims is higher. Besides domestic violence, many other forms of violence are experienced by females much more than males. Rape being the most common and severe form of violence experienced by women. Many other forms of violence are used in our part of the world as compared to others, e.g., acid burning, stove burning etc. Violence can be defined as an emotionally charged act marked by aggression, involving infliction of hurt or injury to the victim. Violence can be physical as well as psychological. Sexual harassment is one form of violence.

Domestic Violence

Domestic violence is one of the commonest forms of violence experienced by women. "Domestic violence or partner abuse is the physical, sexual or psychological maltreatment of a spouse, a former spouse,, or an intimate partner so as to gain or maintain power or control" (Papalia, Olds, and Feldman, 2001, p. 542). As compared to other forms of violence e.g. homicide, domestic violence is quite unreported or under reported. Domestic violence is exercised all over the world but no exact figures are available for any society, since most victims do not report its occurrence due to various reasons i.e.,

- Shame and embarrassment
- Fear of breaking a relationship
- Hope for an improvement in the relationship

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Whatever data is available is based upon the reported cases that are actually under reported. A survey of women showed that out of the severely physically assaulted women, only 46 % reported the happening to the police (Acierno, et. al., 1997).
There are two types of domestic violence (Johnson, 1995):

a) Common couple violence
b) Patriarchal terrorism

Common Couple Violence
This is the commonly exercised form of domestic violence. The conflict between the parties leads to an argument that turns into a fight. It does involve physical violence that can be minor or major and serious. In case of serious physical violence the likelihood of women being injured is higher form women than for men.

Patriarchal terrorism
This form is exercised by men alone. The man uses physical force along with other contrast strategies for dominating his family. This form of violence may end up into injury and even death to women and children.

The likelihood of women being homicide victims as consequence of domestic violence is higher than the likelihood of the same happening to men (Brannon, and Feist, 2000). Men are more likely to be physically hurt, injured, or killed by strangers, whereas women are more likely to experience the same by the husband. In our society and other group cohesive societies, it is not the husband alone who exercises domestic violence. Most of the times he is supported, aided, and assisted by other relatives as well e.g. the in laws. Usually very severe forms of domestic violence are reported; otherwise it does not come out of the boundaries of the household. The victims do not report it due to fear or shame (Bachman, 1994).

The analysis of reported cases in the U.S. has shown that:

- More than 9out of 10victims were women and as compared to men, they were more likely to be seriously harmed.
- Also, a woman abused once is more probable to be abused again

(Holtzworth-Munroe, and Stuart, 1994; U.S Bureau of Justice Statistics, 1994).

What Type of Women are Usually More Likely Victims of Domestic Violence?

- Those belonging to the lower socio-economic class
- Those financially dependent upon men
- Less educated or uneducated women
- Young women
- Women less exposed to life outside the household

What Type of Men Usually Exercise Domestic Violence?

- Less educated or uneducated men
- Those belonging to the lower socio-economic class
- Unemployed, or financially over burdened
- Drug or alcohol abusers
- Those who have experienced domestic violence being exercised in their home, as a child.
- Those who do not feel any familial or social pressure against their violent acts.

Wife beating is more common in some societies than others. These are societies:

- Where aggressive behavior is common otherwise too
- Where women have an inferior status

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- Where physical force is used to resolve disputes, among other factors (Broude, 1994).

Impact of Domestic Violence on Women

- Low self esteem, a shattered self-confidence, and heightened self-doubt
- Fear of being tortured again
- Helplessness
- Passive acceptance in many cases; they start believing that this is the way the life of a women is like, and they deserve it too

How to Tackle the Issue!!!

Creating awareness of basic human rights
Education of legal rights
Establishment, and accessibility of legal aid centers, and shelter homes
Individual counseling and therapy
Family therapy
Men need to be educated, at all levels, about gender equality, human rights and civilized conduct.
Media can play an important role

Other Forms of Violence against Women

Besides domestic violence, many other forms of violence are also experienced by women more commonly than men:

- Sexual violence
- Rape
- Physical assault by strangers

The Solution

Awareness and education about the likelihood of an incident, the probable sites, and places where help can be found
Self defense training in case of a probable attack
Sensitization to the significance of prompt reporting in case an incidence has taken place
BUT remember; women alone are not the victims of domestic violence. Many men also experience domestic violence from women.
In less serious violent incidents, many wives initiate the events and attack their husbands.

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LESSON 30

GENDER AND HEALTH

Health is the other name of well being. It is a state in which a person enjoys well-being not just in the physical sense but also psychologically and socially. "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946).Health is another major issue widely researched, debated, discussed and pondered upon by not just health researchers but also those striving for the attainment of gender equality. Health or a state of complete well-being is one of the basic human rights; in other words it is the right to enjoy a worthwhile existence. All humans deserve perfect health, access to health facilities, prevention of disease, and provision of healthcare when required. But do all human beings have these rights?
No!!

People belonging to different parts of the world have different amounts, levels and degrees of these rights and facilities. Some countries are highly privileged in terms of health care and health status, whereas some are extremely under privileged. The same applies to the case of women. The health-related needs, health status, health care facilities and access to these all reflect gender differences.

The Significance of Women's Health
Although the health and well-being of both gender is important, females' health needs to be given more attention because of various reasons:

The responsibility of reproduction:

- Females give birth to children
- An expecting mothers' needs to be taken good care of in order to ensure a problem-free pregnancy, good health status of the fetus, and a safe delivery.
- In case of young unmarried females, their body needs proper care and nourishment in order to be strong enough and ready for the reproductive responsibility that they have to carry in future.
- Besides childbirth, many other health conditions and problems are unique to women; menstruation, menopause, infertility, post partum depression, birth control, surgeries, abortions etc.

i. Risk of Disease
Research evidence shows that females are at a high risk of certain diseases that are preventable or treatable if diagnosed at an early stage e.g. certain cancers or HIV/AIDS. Proper health care and screening facilities can help preventing many health conditions.

ii. Females' Domestic Responsibilities
It is usually the female who takes care of the household and is responsible for the care and upbringing of the children. Only a woman with good health status can fulfill these responsibilities. Besides, women involved in dual responsibilities, i.e., household profession, are usually over burdened and more prone to stress-related disorders.

iii. Stereotypical Beliefs about women's health
In many cultures, females' health is not considered as important as men's health. This becomes an even serious problem when it concerns the dietary habits and poor nutrition provide to the girl child. In case of disease, women usually postpone consulting a doctor.

Gender and Health: Some facts
Life expectancy of women is generally higher than that of men. In most parts of the world, the expected life span of an average woman is a few years longer than that of a male (WHO, 2004).

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Throughout life, women have lower death rates (Hoyert et. al., 1999). But over the past few decades the gender gap in longevity has not been a broad as it use to be. One of the major reasons for this shrinking gap is the increase of women's indulgence in many health-compromising behaviors. Between 1979 and 1986, there was a significant increase in the rate of lung cancer in women. During this period the rate of death by lung cancer rose by 44 % in females, and only 7% in males. In U.S the leading cause of death resulting from cancer is lung cancer, and not breast cancer as generally believed (Rodin and Ickovics, 1990). The women who smoke as well as using contraceptive pills are at a higher risk of cardiovascular disease and stroke. The risk of acquiring HIV is also higher in women than in men (Rodin and Ickovics, 1990). The gender gap in longevity is present in most countries, though not of uniform size. The gap is wider in the developed countries than in the underdeveloped countries. The size of gender gap in longevity in some developed countries;

Poland 8 years
France 8 years
Spain 7 years
Finland 7 years
Austria 6 years
U.S.A 6 years

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GENDER, HEALTH, AND AGING

Why Women Live Longer?

There are various explanations of women's higher life expectancy. Different factors are considered to be responsible for their longevity.

Genetic Protection

Females are genetically protected becomes of two unique attributes that men do not have i.e., the extra X chromosome and the beneficial effects of estrogen, the female hormone. Women benefit from the protective effects of estrogen till before menopause (Rodin and Ickovics, 1990; USDHHS, 1992). This genetic protection is also considered to be a factor responsible for the higher rate of male infant mortality.

Behavioral Factors

There is a lot of research findings suggesting that on average man indulge, much more than women, into health compromising and risky behaviors. More men, than women, smoke and use alcohol and in higher quantities; these behaviors are linked to the development of diseases like some cancers, cardiovascular disease, respiratory problems, and liver cirrhosis.

The rate of deaths by motor vehicle accidents is also higher in men. The influence of alcohol is a contributory factor in this regard. Men, especially in adolescence and early adulthood fall victims to accidents resulting from behaviors not commonly practiced by females e.g. wheeling, jumping from high places, street fights, drowning or pedestrian accidents.

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LESSON 32

GENDER, HEALTH, AND AGING

If you analyze these cases, and compare them, you will realize that some problems are common to the four people we are talking about. Problems like reduced control over life, and some physical ailments are found in most people. In terms of psychological well being, the spouses in case 3 are better off than the first two cases. Companionship and social support are two significant variables in the well being and adjustment of an old person. The purpose of our discussion on 'gender and aging' is twofold i.e.,

a) To see the similarities, pertaining to aging, between the genders.
b) To see how genders differ in terms of age-related changes and their reactions to those.

"Aging" refers to the biological changes that take place with the passage of time. These changes are inevitable and irreversible. The pace at which these changes may take place many vary. Regular exercise and wise eating i.e., getting the required nutrients and avoiding damaging substances have been seen to slow down the process of aging.

There are individual differences in the pace of and extent to which people may age and feel aged. The concept of the age at which people may feel or look aged has changed over the past decades. In the early 1900's, in most parts of the world, the average life expectancy used to be somewhere 35-45. Today more and more people can expect to enter their 80s and 90s. On average people do live 70-75 years of age. The average life span of an American today is 75 years. With a prolonged life expectancy, scientists are also focusing upon improving the quality of life and preventing and as well as managing the effects of aging.

The Effects of Aging

The major characteristic of aging is a decreased efficiency of the function of the bodily organs. The speed at which one could walk or jog 15 years, or even 5-10, years ago is not the same at age 70. One can not carry the weight that one could carry some time back.

At age 85 the average human heart pumps 3.5 liters per minute; whereas it used to pump 6.9 liters per minute. At age 20, the average amount of blood flowing through the kidneys was 0.6 liters per minute, while it goes down to only 0.3 liters per minute at age 85. The amount and the type of food that one could eat and digest also changes with age.

However regular exercise can delay these changes. Considering individual differences, one can see that there are cases when people aged 70 are better than people aged 50 in terms of the functioning of their heart and other organs. Aging has two types of effects:

i. Physiological effects
ii. Psychological effects

Physiological /Biological Effects

a) Effects on the sensory process:
  - The efficiency of the sense organs is reduced, resulting into poor visual acuity, hearing impairment or loss, less effective kinesthetic sense, and less sensitive olfaction and gestation. Besides problems like cataract may also develop. The problems of vision and hearing are however correctable.

b) Manual dexterity and muscular movement is affected.

c) The immune system gets weaker and the body gets attacked by disease and infection easily; besides, it takes longer to recover.

d) The endocrine activity also solves down and the release of many hormones is either inhibited or stopped, or the hormones are released in insufficient amounts. In females, menopause is a major milestone.

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e) Many diseases like arthritis, Multi-infarct Dementia, Alzheimer's disease and Parkinson's disease are possible to develop in old age.
f) Hypertension and Cardiovascular disease are common in old person.
g) Some cancers are more prevalent in older persons e.g. cervical, breast or prostate cancer.
h) Bone fractures are also a common happening in old age, especially old women.

Changes in Appearance
Some prominent and some not so prominent changes take place in peoples appearance. The face of the person is the most affected region; however the whole body may show the age of the person. The hair line recedes, and the hair turns grey, and then white. Tooth decay and tooth loss happens; it not only affects the shape of the mouth but also affects the shape of the type of food one can eat. The skin is dry and wrinkled. A person's height may be shortened due to a decay of cushioning between the vertebrae.

Psychological effects of Aging

Learning:
Most old people can learn new things but not as readily and as fast as a young person. However there may be limitations in terms of what they can learn. A ___________ involving fine dexterity and eye hand coordination may take longer.

Attention and Concentration
Some research evidence shows that the old people can not concentrate on a task for as long as young person can do.

Memory
Old people may experience weakened memory especially short-term memory. In case of certain diseases like Alzheimer's the loss may be sever.

Intelligence
There is some evidence that old people can not perform as good as a young person on I.Q tests, suggesting that old people are less intelligent. However it is a debatable issue, because there is some other evidence too that suggests that younger people can perform better on these test because these tests involve skills that they are, or have been learning at school.

Self-esteem, Personality and self concept
There is a likelihood that as a consequence of inability to perform certain tasks that one could do earlier, and as a result of other people's negative attitude an old person may begin to feel worthless, feeling "not needed", and/or become cynical or cranky.

But there is research evidence available suggesting quite the opposite. In one study (Field, and Millsap, 1991) it was seen that older adults over a period of 14 years, had become more cheerful, open-minded, and frank. There was no change in the self esteem or satisfaction with life of more than 50 % of these as they entered late adulthood. Significant increases were found in nearly one third of the subjects. Some other studies have shown that older and younger people have equally high self-esteem; some studies even suggest that older people have higher self esteem than younger people (Bengston, Reedy and Gordon, 1985).

These findings appear to be in quite a contradiction with what people generally believe about older people. Research suggests that this attitude has to do with the person's perception of own age, and many old people perceive their age to be less than what it actually is. Also if they have lived fulfilling,

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satisfying, and successful lives, and are independent too, there is no reason why they should have a low self esteem.

Empty-nest Syndrome

Old people may experience the empty-nest syndrome. Empty nest feeling is what one feels when the children have left home forever, for their careers, marriage, or freedom. The old parents may feel lonely, bored, depressed, and emotionally robbed. But all parents do not feel the same. A number of variables determine their reaction to the empty nest; e.g. their own career and occupation, their financial position, social support, health and fitness, presence of the spouse, and proximity of children.

Losing the spouse

Loss of a spouse in old age is a trauma. Besides feeling lonely, it involves a variety of other practical problems too.

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LESSON 33

GENDER DIFFERENCES IN AGING

Before moving on to a discussion of gender differences in aging, let's have a look at some other psychological aspects of aging.

Old age is the period of "Ego integrity versus despair", as in Erikson's theory of psychosocial development. This is the last stage in Erikson's eight-stage model. People may be happy and satisfied with the way they spent their life. They are content with their achievements, and indulge into productive work. On the other hand they may be experiencing frustration and depression over the way their life was spent.

Work

Research shows that older people can perform as good as young people; they can even perform better than them. Older people work with better precision and care.

However they are slower than the youth. But then they make fewer mistakes too.

Gender differences in aging:

Since women have a higher longevity than men, more women than men experience problems associated with aging.

More women than men enter the category of the "oldest of the old".

More women than men have arthritis, and the subsequent restricted mobility, pain, and dependence.

Menopause and Osteoporosis cause problems to many women.

Also women are at a much higher risk of Osteoporosis i.e., brittle bones.

The presence of Osteoporosis causes bone fractures in many women which means prolonged bed rest and lack of physical activity.

The risk of Coronary Heart Disease (CHD) is about the same in older men and women, which used to be much less in pre-menopausal age.

However the rate of female CHD patients is less than male patients.

Marriage and Loneliness

Usually more women than men face loneliness in late adulthood; the primary reason being the gender difference in longevity i.e., men die before women do.

Also in societies like ours, wives are generally much younger than their husbands and they live in widowhood for many years.

Fewer men than women experience widowhood and its impact.

Marriage

Being married and the type of marriage one has is linked with health.

People who have had a happy marriage enjoy better health. There are gender differences in this regard. For men being married and having a companion may be sufficient even if the marriage had been turbulent.

In case of females the quality of marriage matters a lot. If the marriage is and has been turbulent, then it has serious effects on their health

Empty Nest Syndrome

Men and women may react differently to their empty nest i.e., life after the children have left home.

However a number of variables determine a person's reaction to this phase of life.

If all the children leave home within a span of one or two years, the impact is deeper; and if takes 5-10 years parents adjust better and less distress is felt.

Also, if they leave at the right time, then the parents are better prepared for it.

A number of studies have consistently revealed that midlife women whose children had left were more satisfied and happier than the midlife women shoes children were still with them (Neugarten, 1970; Turner, 1982).

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If the husband and wife have a caring attitude towards each other than the Empty nest does not cause any distress.

In fact they may get emotionally closer to each other.
The type of marriage also determines a couples' reaction to their Empty nest.
If it were a marriage that remained intact because of children, then there is a likelihood that it may break.
Although generally mothers seem to be affected more by a home without children, the situation may bring relief from the "chronic emergency of parenthood" (Cooper and Gutmann, 1987).
The Empty nest phase may be different for women who had not foreseen this.
Women who had not reorganized their lives in order to prepare for it find it hard (Targ, 1979).
Some men also find it hard to cope with the empty nest.
These are the fathers who regret not having spent more time with their children (Rubin, 1979).
If the mothers are working, especially full time, they feel little or no stress.
It has been reported that no effects of empty nest were found on the psychological health of employed mothers; their stress was increased on cutting back on employment and was decreased on going back to full time work (Wethington, and Kessler, 1989).
The case may be different in case of males.
When stress at various stages of men's lives was compared, it was found that they were most likely to report health-related stress at the empty nest stage (Chiriboga, 1997).
If the mother is an autonomous mother, the empty nest may be a pleasant experience for her.
Autonomous mothers are the ones who generally have a higher self esteem and who feel in control of their lives. Such mothers enjoy the maturity, growth, success, achievement and independent existence of their children as individuals in their own right.
They enjoy communicating with them at adult level and doing things with them.
In case of "coupled mothers" the case may be different.
These are the mothers who feel that they and their children are one and the same thing, the children being their extensions.
All their life's activities revolved around the children.
Their self esteem and feeling of control over their lives is lower than the autonomous mothers.
The empty nest experience may be quite difficult and painful for them.
The coupled mothers have a higher likelihood of experiencing anxiety and depression.

Personality
The way old men and women perceive or describe themselves may be different.
As compared to what they were like in youth, many older women perceive themselves to be more capable of solving problems, more assertive, less dependent, and more authoritative at home now.
In case of older men, many of them perceive themselves as more nurturant, cooperative and less dominant in old age (Bengston, Reedy and Gordon, 1985).
Older men experience a lack of control and power after retirement; women usually feel ______ in old age.
If the self concept and self esteem are hurt or lowered, different reaction patterns may be seen.
More women less than 80 years of age may feel depressed and more men may abuse alcohol (NIH Consensus Development Conference, 1991).

Financial Problems
Most retired people may experience financial problems.
Especially in a culture like ours, where the parents have to look after children's lives even when they have grown up the financial pressures may cause psychological as well as physical ailments.
In case of women, dependence is higher, because most women in out culture are house wives and they have to look up to the husband's pension or to their children.
The older people have some additional expenses if they are suffering from some chronic illness.

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If the pension is not enough and no additional resources are available, life becomes tough for both men and women.

In case of a single or widowed man, old age is tougher than a single or widowed woman. Since women are more industrious and equipped with household skills, they can manage life in limited resources better than men in similar circumstances.

In summary it can be seen that:

- Some physiological and psychological problems are common to both men and women.
- Some problems are found more in women.
- There are gender differences in the way people react to changing life situations.

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LESSON 34

GENDER AND HEALTH PROMOTING BEHAVIORS

As said earlier there are at least two aspects of the health issue:

a) Promotion of health, and
b) Prevention of illness

These are the two sides of the same coin, interrelated and complementing each other.

Health can be promoted in further two ways, by:

i) Adopting healthy lifestyles, and
ii) Proper utilization of available health services so that health problems, if any, may be diagnosed earlier and treated at the earliest stage.

Physical fitness is the other name of health. Regular exercise is the main way of attaining and managing physical fitness.

Fitness and Exercise

Health, as discussed earlier, is a state of complete well being: physical, psychological, and social. A person enjoys well-being when he/she feels fit and experiences fitness. Fitness is a condition that can be acquired and enhanced, and that can deteriorate too.

When we talk about fitness we are primarily referring to physical fitness; however it encompasses psychological and social aspects too. Physical fitness leads to shedding stress, and that may result into healthy, enjoyable, social relations. In other words complete well-being, i.e., health.

Fitness implies enjoying healthy existence as well as absence of disease. One direct correlate of fitness is exercise. Over the last 2-3 decades people in general have become more health conscious than ever before. They are more interested in fitness enhancing activities, and more conscious about wise eating. In short they are adopting healthier lifestyles.

Some of the major causes of this change in health-related attitudes and behaviors are that:

a) People today know that the leading causes of death today are not infections over which people had little or not control.

b) Life expectancy has significantly improved over the past 5-10 decades. That means that if people take good care of their health, they can stretch their life span considerably.

c) As a result of research findings, people are more aware of the fact that we can not only expand the life span, but we can also improve the quality of life a great deal by attaining and improving physical fitness.

Physical fitness does not mean a single function or process. It is a complex condition. A physically fit person experiences:

- A muscular strength
- Muscular flexibility
- Muscular endurance, and
- Cardio respiratory fitness

Fitness has tow aspects:

Organic Fitness

The ability for activity and mobility, that stems form the inbuilt qualities of a person's body e.g. the genetic make up of the person, age, gender, health status and problems, family history etc.

Dynamic Fitness

This type of fitness is learnt, and comes through experience and practice i.e., exercise. Dynamic fitness affects not only the physiology of a person, but the appearance too.

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There is no dearth of research evidence suggesting that exercise is directly related with the health and fitness of a person.

Exercise

How Much of Exercise is required for Good Health

People indulge into different types of exercise for different durations. Research reveals that one should exercise thrice a week; some do it more often. But there are certain standards for how much and what kind of exercise should be done.

The generally agreed upon standard is exercising for at least 15 minutes thrice weekly; in this time one is required to indulge into sustained activity at 70%- 85% of maximal heart rate. However different people are happier with different frequencies and intensity of exercise. Some people walk 5 miles at a stretch and are not tired. Some exercise for 20-25 minutes only and they find it to be enough for their fitness. Exercise gives the exerciser a feeling of well-being and elation. This is because of the release of endorphins as triggered by aerobic exercise.

Types of Exercise

Aerobic Exercise

In aerobic exercise the heart of the person beats at an elevated level for a considerably long duration (in minutes usually). It requires significantly increased consumption of oxygen for a long period. It is a high intensity, long-duration, and high-endurance exercise. The major elements are intensity and duration. How long and how intense the exercise should be, is calculated from a formula involving the age of the person as well as the maximum possible heart rate. Jogging, brisk-power walking, aerobic dancing, cycling, swimming, rope skipping are examples of aerobic exercise. An effective and true aerobic exercise requires that the heart rate is at an elevated level for 12-20 minutes. During this period, the heart and the respiratory system work at an elevated level; and the whole coronary system benefits from it. The ultimate benefit from this exercise is a rapid and intense consumption of oxygen, besides flexible and elastic blood vessels. Aerobic exercise is believed to be beneficial in terms of enhanced fitness; it results into cardio respiratory fitness and provides protection against coronary-heart disease.

Caution: Before moving on to an intense aerobic exercise regimen, one should have complete medical check ups and consultation with a physician in order to be sure that the body is fit enough to stand the rigor required by this exercise. This exercise can be dangerous for persons with coronary-heart problems.

Anaerobic Exercise

These exercises are similar to aerobic exercise, but do not require heightened oxygen consumption. Anaerobic exercises involve intensive bursts of energy for shorter durations. Short distance running or sprinting are anaerobics; some calisthenics are also anaerobic. Speed and endurance are the salient features of these exercises. These exercises are not suitable for people with coronary-heart problems.

Isometric Exercise

As compared to other age group, older people can benefit more from this exercise. The exercise involves muscle contraction against and immovable object e.g. a pillar, or a wall. Isometric exercises give the feeling of strength to the person exercising. The main benefit is in terms of muscle strength. However since it does not involve other movements, it has little contribution to physical fitness.

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Isotonic Exercise

Weight lifting is the best example of isotonic exercise. Muscles and joints are the main parts of body involved. Isotonic exercise primarily involves muscle contraction and joints' movements. The ultimate benefit is muscle tone, muscle strength and muscle endurance. These exercises can add to fitness if done for longer periods of time. The immediate benefits may be felt in terms of physical appearance and body shape.

Isokinetic Exercise

As compare to isotonic exercise, isokinetic exercise involves lifting weight and returning it too, to the starting point. Bringing the weight back requires additional exertion. This exercise requires special equipment and the person may have to go to the gym or purchase expensive machinery. However it is better than the isotonic or isometric exercise for attaining muscle strength and endurance.

Which Exercise should be chosen?

A person may choose an exercise regimen considering the following:

a) Physical condition, muscle strength and endurance level
b) Health Status
c) Physician's advice
d) Age

Types of Exercise

1- Aerobic Exercis
2- Anaerobic
3- Isometric
4- IsoTonic
5- IsoKinetic

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GENDER AND HEALTH PROMOTING BEHAVIOR

The Health Effects of Exercise

- Besides general physical fitness exercise has the following benefits:
- Regular exercise gives a feeling of well-being.
- The endorphin released in aerobic exercise gives a feeling of elation.
- Longer duration exercise helps in weight reduction.
- It helps in cholesterol control and reduction.
- Regular exercise, at least thrice weekly, adds to cardio-respiratory functioning and strength.
- Exercise improves physical appearance, and adds to self esteem of a person.
- Regular exercise has been found to be effective in improved immune functioning. Exercise or physical activities have been found to be effective in females' reproductive health problems and menopausal symptoms.
- Aerobic exercise helps alleviate and control depression and sleep disorders.
- Regular physical activity has been consistently found to be beneficial in cardiovascular conditions; both in not occurring in first place, as well as in management.

The Classic Alameda County Study

In this large scale study the researchers (Belloc, and Breslow, 1972) identified a set of health-related behaviors, or habits that could have a relationship with health. They took a sample of 2000 people from California and followed their mortality rates. Some indulged into the identified health habits and some did not. Five habits were found to have a significant relationship with lower mortality rates i.e.,

i. Sufficient sleep
ii. Moderate drinking
iii. No smoking
iv. Regular exercise
v. Weight control

Remember!!!
Exercise relaxes, and does not tire

Gender Differences in Exercise and Healthy Habits

Research supports the fact, that other things being equal, females have a longer life span than men. But research has also revealed that more males than females indulge into physical activity.

In one nationwide American study, 8-16 years olds were studied between 1988 and 1994 (Anderson et. al., 1998). They reported on vigorous play or exercise that led to working up a sweat or breathing hard. 80% of the subjects said that they did so at least thrice weekly outside of physical education classes. Those who did not meet the mark included 26% of girls and 15% of boys.

Another national survey conducted in the U.S revealed that although females indulge into most healthy behaviors more than men, they were lower than men in physical activity. The percentage of females was higher in wearing seat belts and trying to lose weight. They were lower in percentage in unhealthy behaviors like heavy drinking and smoking, drinking and driving, currently smoking, and being over weight. However exercising regularly and being very physically active, were two categories on which females were less in percentage than males (Health United States 199(, 1991, U.S. Department of Health and Human Services).

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Boys get more exercise than girls from an early age (Sallis et. al., 1993). In middle age and in later years, the likelihood of women exercising is even less. In fact they are unlikely to exercise. One possible reason for this is that there is little room for exercise in their lives. Besides, the absence of attitudes favoring exercise for middle aged women may be another cause of this trend (C. Lee, 1993; S. Willcox, and Storandt, 1996).

Factors affecting Women's Fitness Activity and Exercise

i. **Fatigue and Overwork**

In our society most women are house wives or formally non-working women. Those who work formally are expected to look after the house hold in the same way as a house wife. There is generally no trend of sharing house work. Many women therefore generally report fatigue and do not feel like exercising regularly. Also, taking out a slot from their daily time table exclusively for exercise, which is a purely personal activity, is usually found to be difficult. Usually the females who exercise on a regular basis are the ones who are not working full time in the office as well as at home.

ii. **Societal attitudes and Stereotypes**

Exercise is considered to be a men's thing and people do not look positively at women working out. Also other people, as well as women themselves, feel that house work is enough exercise. They are not aware of the fact that house work may be tiring but it does not give enough exertion to the body. Many people, including women, believe that once married and becoming a mother; women do not have to look after themselves.

iii. **Lack of Exercising Facilities**

Due to lack of parks, playgrounds, or gyms in neighborhood, most women keep postponing exercise even when they are keen.

Uptake of Medical Facilities

All states, all over the world, are interested in promoting health and preventing disease. The basic goal is to reduce the health care cost. Health care costs have been rapidly escalating for the past many decades.

With more advanced medical technology, and facilities for early diagnosis and screening, more and more people come to hospitals for treatment. Most of the hospital beds are occupied most of the time. In developing and under developed countries, the patients out number the hospital beds. Health care is a major burden on the national economy.

This becomes even more important because most of the complaints that most patients are admitted with, are preventable. Therefore it is in the interest of national economy that diseases be prevented and the health status of citizens improved, in order to cut down the health care costs.

When does uptake of medical facility become important?

In many situations, the health authorities want people to utilize health services. In many cases, especially involving women's health, even full fledged campaigns are designed to encourage women to contact the authorities and benefit from the available facilities. This becomes more important when the health authorities are offering screening services for diagnosing serious conditions like breast cancer, cervical cancer, HIV/AIDS, or Hepatitis.

The utilization of medical services is an area of concern for health professionals. Health psychologists have been exploring the poor utilization of various health services where the uptake considered vital for the health status of the society at large.

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A number of preventable health conditions can be controlled, managed and eradicated if available screening services are used by people.
Research shows that women are more likely than men to go for medical consultation, other than that required for pregnancy and child birth.
Women are more sensitive to bodily changes, and symptoms of illness.
Although no clear cut reason for this gender difference is known, it is believed that women are more focused upon and aware of their physical states. Because of this attitude they are more likely than men to notice any physical symptoms (Pennebaker, 1982).
Another explanation is that in case of women having children, they are trained in, and are more likely to notice any changes in the health and physical state of their children.
As a result they develop sensitivity to physical symptoms.
Some societal attitudes also account for this.
Men usually do not admit being unwell or weak, whereas women do not hesitate in admitting that they are in need have help.
Research evidence also suggests that although women have a higher longevity and men have higher mortality rate females tend to have a higher rate of acute illnesses like infectious and parasitic diseases, and digestive and respiratory conditions (National Centre for Health Statistics, 1996).
The rate of acute illnesses is very low in males, and only higher in case of injuries.
However, men are bedridden much less than women for recovery from injury.
Women's rate of acute conditions, other than pregnancy is eleven times higher than men.
This is probably one of the reasons why more women than men visit doctors.
Also it is seen that more women than men read about health matters, illness symptoms, and possible treatments.

Behaviors linked with the Diagnosis of Cancer
Some cancers, if diagnosed at an early stage can be treated with a prognosis up to 99 %.
Breast cancer is one such cancer that can be fully cured if identified at the very early stage.
Two behaviors can help in early identification:

- **a.** Breast Self Examination (BSE)
- **b.** Mammography

BSE if performed regularly, can help identify a lump or growth very early.
90% of all diagnosed breast cancer is located by BSE.
It is a regular examination of breasts by females themselves done every mouth.
However many women do not practice this regularly, or at all.
The primary reasons being lack of awareness of either the procedure it self, or the proper way of performing it.

Mammography
For women over 50, and even above 40, a regular yearly mammography is recommended for diagnosing breast cancer.
In many developed countries the service is provided free of cost.
However the rate of women turning up of it is not very promising.
Some estimates have shown that only 38 % of women 50 and 50 plus ever had a mammogram (Dawson, and Thompson, 1990).
The rate of Asian women settled in the west, who utilize the facility of mammography is even lower.
Women, whichever race they belong to have a tendency to avoid going for a mammogram due to various reasons:

- Fear of radiation
- Embarrassment over the procedure
- Anticipated pain

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- Anxiety
- Concern over costs, especially in case of poorer women (Fullerton et. Al., 1996; Lantz, Weigers, and House, 1997).

The economic factor is very important in women's uptake of medical care and facility.
Women, if not working have to look up to men for their health care.
In case of single women, or mothers in single parent families, women tend to postpone medical consultation due to limited economic resources.
The uptake of cervical cytology among women has also not been encouraging.
Research done in the past 20-25 years has shown that although a cervical smear can be very helpful in diagnosing cervical cancer, few women go for this examination.
The reasons may be the same as the ones for a low turn out for mammography.
It is estimated that around 10 % of Asian women eligible for this screening utilize it in Britain.
In this case finances are not a problem, because this service is provided free of cost.
In case of men many men keep postponing screening and tests for prostate cancer.
Very few men perform self examination for testicular cancer.
In both cases, most men either lack proper knowledge, or feel embarrassment over being examined by the doctor. Also in case of rectal or intestinal problems most men, avoid medical consultation in order to avoid endoscopy.

Factors affecting women's fitness activity and exercise.

1- Fatigue and overwork
2- Socetiel attitudes and stereotypes
3- Lack of exercising facilities

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GENDER AND HEART DISEASE

Recap:
In the last few lectures we have been talking about issues pertaining to Gender and Health. We have discussed the issue of longevity, social, cultural factors influencing health status, and uptake of available medical facilities. Besides, we have also looked into the relationship between exercise and health. We also talked about the very concept of "health" and being healthy.
Health, as defined and accepted internationally, is a state of complete physical, psychological/mental, and social well-being, rather than mere absences of disease. The emphasis of health psychology and other health related disciplines today is on health enhancement and disease prevention. The main objective behind this emphasis is at least twofold:

b) To improve quality of life, and in turn longevity, and
c) To reduce cost of healthcare

But interest and research in this area can not be restricted to these two areas alone. We know that many people, even when following perfectly healthy life styles, may develop serious illnesses. These illnesses or diseases develop as a result of variables, or risk factors, over which people have very little control. In the next few lectures we will be focusing upon health problems that can have serious consequences, and can be life threatening. We will be discussing some of the major killers of today. Although we will be talking about these diseases in general too, our main emphasis will be upon the risk factors for females, as well as how these diseases may affect a females' physical, mental, and social well-being.

In the forthcoming lectures, we will be discussing:

- Gender and Heart Disease
- Gender and Cancer
- Eating Disorders
- HIV/AIDS
- Problems of females' reproductive health
- Gender and mental illness

Some of these disorders are specific to women, or found more commonly in women. Whereas some occur in both men and women, but little attention is paid to the risk for women. In our discussion of these problems we will primarily focus upon data about females, and will discuss the general nature of the disease very little, assuming that this has been covered in health psychology.

Heart Disease
When we talk about heart disease in the present context, we are primarily referring to Coronary Heart Disease or CHD. CHD refers to problems, or diseases, affecting the circulatory system and hence the blood supply to various parts of our body including our heart. The main or root cause of CHD is atherosclerosis. Atherosclerosis refers to the thickening of the coronary arteries. Coronary arteries are the vessels, or the pipelines, that supply blood to the heart. Build up of plaques is the primary cause of this condition. When the blood vessels are thickened, they are less flexible, hardened narrowed and less capable of sustaining fluctuations in the pressure with which blood passes through these vessels. In common, everyday, vocabulary atherosclerosis may lead to a variety of problems:

- Difficulty in blood flow
- Blockade in blood flow
- Restricted blood flow and restricted blood supply to the heart and other organs, muscles and tissues

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- A lack or poor supply of oxygen to various organs and muscles
- A resulting pain especially in the chest region
- A resulting difficulty in breathing

What happens to the body when the blood vessels are not in a good shape???
In any living organism, if every thing goes wrong with even the tiniest part of the body, it affects the whole system. Similarly when the basic infra structure of the circulatory system is affected; it affects the whole system very seriously. The impact of problems in the circulatory system is serious because this system has a direct, continuous, non stop contact with the whole body. Arteries carry oxygen and nourishment to the heart. As a result of atherosclerosis the supply of these essential substances to the heart is restricted; it may be obstructed partially, and at times completely. This state of affairs may result into two different but related conditions:

- Angina Pectoris
- Myocardial Infarction (MI) or Heart attack

Angina Pectoris
It refers to the restricted blood supply to the myocardium, or the heart muscle. This temporary and usually short term, restriction or shortage of oxygen and nourishment results into the 'alarm' of heart disease, i.e., angina. This usually results into pain, mostly crushing pain. The pain is frequently experienced in the chest and arm region. However the pain may be experienced in other parts of the body as well. It is accompanied by breathing difficulty, and a feeling of suffocation. Symptoms of Angina are usually experienced after heightened stress or exercise, because the demand of the heart for oxygen and energy increases. These symptoms usually last for a few minutes and they are a warning that the heart needs to be taken care of.

Myocardial Infarction (MI)
MI is the serious form of CHD. When, as a result of obstructed blood supply, or blocked coronary arteries, oxygen supply to the myocardium is shut off, it damages the heart muscle. Like any other tissue or muscle, the heart muscle can not survive without oxygen. As a result the affected part or tissue of the myocardium dies in the absence of oxygen. The death of a part of myocardium is called an infarction; hence myocardial infarction or heart attacked. This damage to the heart muscle is permanent. The symptoms of an MI may include:

- Severe crushing or squeezing pain in the chest, arms, shoulders, back, abdomen or jaws.
- Weakness, dizziness, and/ or nausea.
- A feeling of severe suffocation, or difficulty in breathing.

The Risk factors in CHD

- Some risk factors in CHD that is inherent and fixed, over which one has no control e. family history, diabetes, congenital defects or gender; men being at a higher risk.
- The physiological conditions that may be associated with CHD including hypertensio obesity, and high serum cholesterol.
- A number of CHD risk factors are lifestyle related e.g., smoking, high cholesterol di sedentary lifestyle, and a stressful routine.
- Type A personality pattern has been known to have a positive correlation with CHD.

Gender and Coronary Heart Disease
Heart disease is the major killer in the modern world. Men, or women, both can develop CHD any stage of life. However men have been found to be at higher risk of developing CHD. Mos the research findings available on CHD focus primarily on men. Most of the data available on C

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in women has been yielded by studies involving mixed subjects. Very few studies are available that have investigated heart disease specifically in women.
Most of the broad based data available has been taken from American samples. Men and women of all age groups may develop CHD, but more men than women die of CHD. It has been found out that in the U.S., men at all age levels are at a higher risk of dying of cardiovascular disease (CVD). The difference between men and women for death by CVD is the greatest in the middle age years. In people aged 35-74 years, men have an almost double rate of death by CVD. Yet the rate of female deaths by CVD becomes pretty high in age groups 75-85 (Brannon, and Fiest, 2000).
Gender or sex of a person has been found to be one of the significant risk factors in heart disease. The famous, and widely quoted, Framingham, Massachusetts, research project identified a number of risk factors for CHD (Sytkowski, Kannel, and D'Agostino, 1990) . These risk factors include:

- Male sex
- Advancing age
- Cigarette smoking
- Hypertension
- Diabetes
- Obesity

Gender and Heart Disease: Some Facts

- Research shows that although the rate of death by heart disease in men is almost the double of women's rate, men have a significantly better prognosis than women.
- If men survive the first serious heart attack, then they are more likely to have a favorable diagnosis (Wenger, 1982).
- In case of diabetic people, the risk of CHD is almost the same in both men and women.

The Framingham Heart Study

The Framingham Study is one of the most authentic and broad spectrum investigations into heart disease. The study was initiated in 1948 (Brannon, and Fiest, 2000). Initially more than 5000 residents of Framingham, Massachusetts, USA were included as the sample, all free of heart disease at that time.
This prospective epidemiological study aimed to follow the sample for 20 years to study heart disease and related factors. Later on, considering the valuable information yielded by the study, the time period was extended and it continued for more than half a century. In 1971, 5000 children of the sampled subjects and their spouses were included in the sample. After about another 20 years a third generation was also included (Voelker, 1998). Therefore one can see that the risk factors, including sex, identified by the study are genuine risk factors.

Type a personality pattern is a significant risk factor in CHD, but there is no conclusive evidence available as to a lower rate of Type A behavior in females.

Coming back to the facts about CHD, we now know that:

a) Men are at a higher risk
b) Following an MI, the chances of survival of men are higher
c) The Framingham Study has revealed that women will be particularly prone to developing heart disease if they are: diabetic, overweight/obese and having a high level of LDL Cholesterol.

LDL refers to low density Lipoprotein i.e., the harmful or 'bad' cholesterol. Coronary heart disease is the major killer of women too; when the overall rates are considered, more women than men die of heart disease.

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What causes natural protection of women against heart disease?
There is significant evidence available, suggesting that young females are naturally protected against heart disease, and this causes a very low rate of females dying prematurely of heart problems. The same factors are one of the possible causes of lower life expectancy of men.
However, the protection of women against heart disease is restricted to young and middle aged women. These possible causes include the following;

1. Estrogen Levels:
The female hormone estrogen has the quality of diminishing the arousal of sympathetic nervous system, thus having a protective effect (Matthews, and Rodin, 1992).
2. Women tend to have higher levels of HDL or high-density lipoproteins. The high levels of estrogen in pre-menopausal women have been found to be related to high estrogen levels.
3. The HDL has a suppressing effect on the LDL, which is considered to have a harmful effect, and to be contributory factors in heart disease.
Therefore the higher HDL levels provide a protection against heart disease in women (Matthews, and Rodin, 1992). Pre-menopausal women, known to have high levels of HDL, as well as estrogen as compared to men, exhibit smaller increases in blood pressure, neuro-endocrine, and some metabolic reactions, in response to stress (K.A. Mathews, 1989; K.A. Mathews, Davis, Stoney, Owens, and Caggiula, 1991).
All these protective factors operate in pre-menopausal women, and the risk of developing heart disease in post menopausal women is about the same as in men. However the risk-age, for heart disease in women is around 15 years later than in men.

When are women at a higher risk of developing heart disease?
Women risk of developing heart disease rises in the post menopausal phase. In this period some direct and some indirect causes lead to heart disease, MI and/or death due to CHD:
Firstly, the estrogen levels decrease, or diminish removing the natural protection.
Women tend to gain weight during menopause that leads to various risk factors i.e., increased blood pressure, cholesterol and triglycerides (Wing, Matthews, Kuller, Meilahn, and Plantinga, 1991).

Which women have a lower risk of CHD?
Women with the following characteristics are at a lower risk of developing CHD:

i. Pre-menopausal women
ii. Women of normal/ideal weight
iii. Physically active women
iv. Women indulging into regular strenuous exercise
v. Women with lower cholesterol and triglyceride levels

Why are men at a higher risk?
Research has revealed a number of variables that cause a higher risk of heart disease in men:

i. **Testosterone:**

The male hormone testosterone, found in high amounts in men, has been found to be linked with competitiveness and aggression.
These behaviors are associated with stress, Type A behavior.
In turn testosterone has been found to be linked with CHD.

ii. **Unhealthy/Risky Lifestyles:**

More men than women indulge into risky behaviors e.g. smoking, alcohol use and eating high-fat foods.
These behaviors lead to conditions that may lead to developing CHD.
When men and woman indulge into similar risky behaviors, the likelihood of dying of CHD is higher for men than women (Fried et. al., 1998).

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iii. **High Stress occupations:**
More men than women are involved in high stress jobs and stress is a causal in CHD.

Preventing and Managing Heart Disease
Research shows that modifying life styles, altering or quitting unhealthy behaviors, and adopting healthy life styles can help prevent and manage CHD.
The following behaviors are therefore recommended for both men and women.

- Regular exercise
- Healthy eating; avoiding LDL, reducing cholesterol
- No smoking
- Weight maintenance
- Estrogen replacement therapy in females has been found to be practically Helpful

The Status of Research on Heart Disease in Women
There is a general dearth of investigations specifically aiming to explore heart disease in women. There are a number of probable reasons for this tendency on part of medical, or health-oriented, researchers:

a) It is mostly men who die early due to cardiovascular disease (CVD), and very few women die prematurely of CVD.
b) Heart disease is generally considered a men's disease; young or pre-menopausal women appear to have a natural protection against heart disease.

In older, menopausal, women, the risk is not hugely different from that for men. The data available on the prevalence of heart disease in women and risk factors involved have primarily been obtained from studies on general population.

'Sexism' and Male-dominance in Research on Heart Disease
Some health researchers are of the view that 'sexism' is the cause of the dearth of research into heart disease and related factors in women. Such researchers maintain that sexism, or positive bias towards men, operates in the allocation of funds, and research on men versus women (Altman, 1991). Besides, they believe, a concern over "male" problems is muchgreater than the concern over female problems; this is another factor causing dearth of research evidence available on women and heart disease.

As a result of this intentional or unintentional, positive bias towards men, heart disease in men gets greater attention.
Consequently heart disease gets diagnosed earlier in men, as more awareness and sensitization prevails in this direction. On the other hand there is very little evidence available on:

a) The risk factors for heart disease in females
b) Whether or not men and women have the same risk factors

The Changing Trends
In the recent past, especially after a growing interest in gender issues, a shift in the trend has been taking place. Although not yet significantly large in number, more research than before is being carried out for exploring heart disease in females. The increased rate of heart disease in females has also been a precipitating factor for the growing interest in research in this area.

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LESSON 37

GENDER AND CANCER

Cancer is another major killer of today. It is the second biggest cause of death. It is a disease, that frightens everyone, and that is considered to be a deadly condition. The very idea of developing cancer scares people because of the poor prognosis in most cases, the painful conditions in cancer, and the painful and complicated treatment.

In our discussion on cancer, we will not go into the extensive details of what cancer is and how it is caused and treated. We will go through the general nature and risk factors involved very briefly. Our major focus will be the cancers specific to either men or women. Some cancers may attack just any one, but some occur in men alone, or in women only.

What is Cancer??

Cancer is not one disease if one were to look into its development, symptoms or impact. It is a set of a number of diseases, more than 100 may be, that share a number of factors. No matter what type, all cancers are a result of a dysfunction in DNA.

In simplest terms cancer can be defined as an uncontrollable growth and spread of abnormal cells that turn into tumors (Brownson, Reif, Alavanja, and Bal, 1993). The presence of neoplastic cells characterizes cancer. These cells form colonies at various sites in the body.
These colonies or tumors may be of either of two types:

- Benign
- Malignant

Benign neoplasm's are not harmful, or cancerous. Malignant neoplasm or tumors are the cancer growths. Malignant cells damage and destroy the neighboring cells and may metastasize or travel to other locations in the body through blood or lymph.

Types of Cancer

The types of cancer are determined on the basis of the site where the neoplastic tissues develop:
The common types of cancer are:

Type	Site
Breast cancer	Breast
Cervical and uterine cancer	Cervix and uterus
Prostate cancer	The prostate gland
Skin cancer.	Skin
Lung cancer	Lungs
Colorectal cancer	Colon or rectum
Leukemia	Blood

The varieties of cancer can be many more than these. Research has shown that some cancers are specific to men and some to women alone. Besides, some cancers are found more commonly in men and some in women. The Center for Disease Control (2003), U.S.A, has given a list of most common cancers in men and women.

Cancers found most commonly in men:

i. Prostate
ii. Lung
iii. Colon
iv. Urinary and bladder

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v. Non-Hodgkin's Lymphoma
vi. Rectal
vii. Oral cavity
viii. Leukemia
ix. Pancreatic
x. Stomach

Cancers found most commonly in women:

i. Breast
ii. Lung
iii. Colon
iv. Uterine
v. Ovarian
vi. Non-Hodgkin's Lymphoma
vii. Skin Melanoma
viii. Rectal
ix. Cervical
x. Pancreatic

The Trend of Mortality Rates from Cancer

Brannon and Fiest (2000) have given a comprehensive account of the changing mortality rates from cancer.

For the major part of the 20th century, the overall mortality rates in the US were on the increase until 1993. These rates had risen almost three times from 1990 to 1993.

The rates began to decline after 1993. During 1993- 1996, the rate showed a downward trend.

Research evidence shows that the rate of lung cancer has been dropping for men and is on an increase for women.

The 5-year survival rate has improved for most cancers. This improvement is more prominent in case of breast cancer.

Smoking: a major risk factor

There is no dearth of evidence suggesting that cigarette smoking is on of the confirmed major risk factors in cancer, for both men and women.

Cigarette smoking has been found to be directly linked with lung cancer in both sexes. This habit has such a serious impact that researchers are now concentrating upon the risk to the well being of passive smokers.

Cigarette smoking is a significant risk factor in breast cancer too. it is not only hazardous to the female smoker but also those women who live with smokers.

The risk for breast cancer incidence and breast cancer mortality is dose- related.

Research has revealed that a 75% increase in breast cancer was noted in women who soked 40 or more cigarettes a day. The increase was only 20% for women who smoked 10-19 cigarettes a day (Calle, Miracle- Mc Mahill, Thun, & Heath, 1994).

Research also suggests that the age of initiating smoking, as well as the number of years smoked, is also significant contributory factors.

The Significance of Early Detection:

Modern medical research and practice have shown that in many cancers, an early detection is possible that ensures a very good prognosis and survival rate.

In case of at least two cancers i.e., breast and of testes, a self- examination can help in a very good, first stage, early detection.

Females all over the world are advised to perform breast Self examination (BSE) once every month so that any change or growth is promptly detected.

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Similarly men are advised to self-examine testes regularly, to detect any change or growth.
In most early –detected cancers, the patients have detected, noticed, or suspected the change themselves.
Effective screening facilities are also available for a number of cancers. These can identify any growth at a very initial stage.

- **Mammography or mammogram** is the x- ray performed for detecting breast cancer.
- Women, especially those above 40 years of age are recommended to have a yearly mammogram.
- For the detection of cervical cancer, a small, easy and painless i.e., **pap test or pap smear**, is highly effective. An early detection in this case can ensure total cure.
- Women, 35 or above are recommended to have a pap test yearly, and at times even six monthly.
- **Ultrasound** is also used for detecting any growth in the breasts.
- Screening facilities, some **diagnostic tests**, are also available in most well equipped pathological labs for detecting prostate cancer.
- Colo- rectal cancer can be detected early through various screening techniques, including **endoscopy.**
- In case of lung cancer it can be detected early if changes in voice, cough pattern, or breathing are noticed and reported to a physician in time.

The purpose of this description of screening approaches is to make you realize that an early detection of cancer can be made, and this is not something impossible that many people believe it to be. What is required is a regular practice of self- examination, an a prompt medical consultation in case of any lingering changes in the body.

What needs to be done???
Efforts at broad community level are required for sensitizing people about the nature of cancer, the risk factors involved, the symptoms, the significance of early detection and prompt medical advice. Awareness campaigns involving electronic media can prove to be helpful.

The female segment of the population deserves special attention because a majority of women in our culture are not educated and can not benefit from the available health education literature. Also, many women hesitate, and feel embarrassment, in disclosing any changes in their body to others, which is one of the causes of delayed diagnosis.

Men on the other hand tend to postpone doctor's consultation. Therefore involving TV and radio in health education campaigns may be a good approach for reaching the unrelated people at risk.

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LESSON 38

GENDER AND HIV/AIDS

In the last two lectures we talked about two major killers of today, namely Coronary Heart Disease, and Cancer.

The main emphasis was on three things:

a) The preventable nature of the two and the role of lifestyles
b) Gender differences found in CHD and Cancer
c) Preventive measures that can help to avoid the development of these diseases, that can be deadly if unattended i.e., examination and uptake of screening facilities along with a general awareness of the nature, symptoms and risk factors involved are important .

Research has shown that if the inherent risk factors are not present, then these health conditions are caused by our lifestyles to a great extent. In other words these diseases can be prevented if healthy lifestyles are adopted. And in case someone develops these conditions, lifestyle changes can improve the quality of life as well as longevity.

HIV/AIDS

HIV/AIDS is another major cause of death in many parts of the globe, affecting both men and women. It involves both genders in terms of its impact. HIV/AIDS is another health condition that is lifestyle related and in which gender differences are found. This is a health condition in which a very significant majority of the sufferers develop it due to the habits and behaviors that they indulge into. Off course in some cases the person becomes a victim without any fault of his/her own. In our discussion on HIV/AIDS, we will be focusing upon the gender differences in risk. However we will also be looking into the nature of the disease, and its mode of transmission.

What is HIV/AIDS?

Although most people are familiar with the two terms, in fact abbreviations, HIV and AIDS, most lack accurate knowledge of the two. HIV or Human Immunodeficiency Virus is the viral agent, a retrovirus. AIDS refers to Acquired Immune Deficiency Syndrome.

AIDS is a disease, infectious in nature that is caused by HIV. It is not necessary that everybody who is HIV positive (HIV^+) will develop AIDS. In other words, an HIV^+ person may die due to some other cause e.g., an accident, without having developed AIDS. The person may not even be aware of the fact that he/she is HIV^+. People do not develop AIDS at the time when they contract HIV. It may take an HIV^+ person five, or even ten years, to turn into a PWA or person with AIDS. AIDS is a syndrome i.e., a collection of symptoms. Therefore there is no 'single' symptom, or condition that characterizes AIDS. A PWA may develop any number of symptoms of a variety of conditions.

Till the early 1980s, AIDS was almost unknown. But in the following years the incidence and mortality rates have been on a rise. It is a disease that has become a matter of international concern. The major reason for this concern is its deadly, incurable nature. Besides, it is a condition that is preventable almost hundred percent.

What is HIV?

As said earlier, HIV is the virus that leads to AIDS. It is a retrovirus. "Retroviruses replicate by injecting themselves into host cells and literally taking over the genetic workings of these cells. They can then produce virus particles that infect new cells. After HIV enters the bloodstream it invades the T cells, incorporates its genetic material into the cells, and then starts destroying cells' ability to function" (Sanderson, 2004, P; 408). "T cells are responsible for recognizing harmful substances in the body and for attacking such cells, in part by releasing NK cells. Although HIV is able to stay in the body in a latent and dormant state, it gradually starts replicating itself, and in the process begins destroying the T cells" (Sanderson, 2004, P; 408-9).

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In simple terms, HIV damages and destroys the cells responsible for the body's immune system, robbing it off the defense against infections. As a consequence even the least serious infections can do a great harm to the victim.
And that is the stage when the person is said to have developed AIDS.

The course of HIV/AIDS
As already said, HIV may take quite long in turning into AIDS. How long it takes depends upon the condition of the body and its immune system. There are a number of stages that the body goes through from HIV to AIDS (Mc Cutchan, 1990).

Stage 1:
There are no clear cut symptoms. Within about a week after infection, symptoms like sore throat, fever, skin rash, and headache may be experienced. Usually mild symptoms are experienced. This stage may last for one to eight weeks.

Stage 2: Latent period
The latent period may last for as long as 10 years. During this stage the victim may remain asymptomatic, or may experience minimal symptoms.

Stage 3:
At this stage a cluster or group of specific symptoms is typically developed e.g. painful skin rash, fever, fatigue, swollen lymph nodes, night sweats, loss of appetite, persistent diarrhea, weight loss and white spots in the mouth.

Stage 4:
The immune system is unable to cope with or fight off these infections. The T cell (CD4 + T-lymphocyte cell) count drops down to 200 or less per cubic millimeter of blood, as opposed to the normal count of 1000 per cubic millimeter.
This is the stage of full blown AIDS.

Symptoms of AIDS
Full blown AIDS is marked by a variety of opportunistic infections that may attack the sufferer. These infections may involve the gastrointestinal tract, lungs, liver, bones, nervous system and brain. Symptoms may include general fatigue, greater weight loss, dry cough, shortness of breath, fever, purplish bumps on the skin (e.g. Kaposi's sarcoma) and AIDS related dementia.
The symptoms can be divided into three categories:

a) Opportunistic infections
b) Opportunistic tumors
c) HIV related Encephalopathy

There is no known case of AIDS that recovered from this stage.

Mode of Transmission

i) Homosexual or Heterosexual contact
ii) Blood transfusion
iii) IV (intravenous) drug use when infected syringes are used
iv) From HIV+ mother to baby during the birth process
v) In rare cases, through infected mother's mild to infant

The main careers
Bodily fluids primarily blood, and semen. The centers for Disease Control and Prevention (1996), in the U.S, data presented the cases of AIDS by mode of transmission in the world and the U.S:

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	World	U.S
Heterosexual	70-75 %	8 %
Homosexual	5-10 %	51 %
Homosexual & IV drug use	-	7 %
IV drug use	5-10 %	25 %
Blood Transfusion	3-5 %	1 %
Other	0-17 %	8 %

Gender and HIV/AIDS Risk

Although many segments of the population are at a higher risk than other, we will be discussing only gender differences in this regard. However research shows that three variables are important in the likelihood of HIV infection and developing AIDS: age, gender, and socioeconomic background. The Centers for Disease Control (2003) in the US describe common routes of transmission of HIV for men and women. Looking at their data one can see how modes of transmission vary for men and for women.

Modes of Transmission for men	**Cases %**
Homosexual Contact	57.3
Injecting drug use	21.2
Homosexual Contact & Injecting drug use	7.6
Heterosexual contact	4.3
Transfusion	0.8
Undetermined	8.0

The most prominent difference here is that only 4.3 % of men contract HIV/AIDS from women, whereas 39.4 women get infected by men. Male to female transmission is 8 times more likely than female to male transmission (Padian, Shiboski, Glass, and Vittinghoff, 1997). In the late 1990s it was observed that the number of HIV+, or AIDS infected women was on the increase. The rate is even higher in minority women in the U.S. According to the late 1990s figures, out of the adult and adolescent AIDS cases reported to Centers for Disease Control in the U.S, 20 % were women (Holmberg, 1996). Black and Hispanic women constituted 73 % of all AIDS cases in women, whereas in the entire population they comprise only 19 % (Holmberg, 1996).

Who is at a Higher Risk??

As compared to women, men are at a higher risk. In case of Pakistan too, most reported cases are males. The main reason for their high risk, as in case of HIV/AIDS in general, is indulgence into risky behaviors. In case of young adults, most of the infected persons are men (CDC, 1998). The rate is generally lower in people above 50 years of age, and they are less likely to be infected than young adults. But if the 50+ people get infected, they tend to develop AIDS more rapidly and to get more opportunistis infections (CDC, 1998).

The Case of HIV/AIDS, Some facts

There are 38 million people living with HIV/AIDS worldwide. 5 million people are newly infected every years; of these 800,000 are children (UNAIDS, 2004). The rate of HIV infection is the highest in the 20-45 years olds than any other age group. The HIV infection rate is three times higher in men than in women. Even sine the beginning of the epidemic, males constituted more than 80 % of all AIDS Cases (CDC, 2004).

What needs to be done???

Health education and awareness campaigns about the nature, risk factors, causes and symptoms of HIV/AIDS (e.g. use of syringes, blood transfusion).

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- Education for avoiding risky and harmful behaviors
- Encouraging people to adopt careful lifestyles and safer sexual practices
- Educating infected women about the significance of avoiding pregnancy
- Providing easily accessible screening facilities
- Health education programs for young adults

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LESSON 39

PROBLEMS ASSOCIATED WITH FEMALES' REPRODUCTIVE HEALTH

Problems Associated With Females' Reproductive Health
As said earlier, more females than males go for medical advice and help. Their frequent consultation with the physician is besides their visits for pregnancy related advice and care. One probable reason for this behavior is that women are endowed with a complex reproductive system. The structure and the functions of female reproductive system are complex and vulnerable to a variety of conditions. In our discussion of this subject we will focus upon a few of such problems that may affect a women's physical or psychological well-being.
We will be discussing the following problems:

a) Dysmenorrhea
b) Pre-menstrual syndrome
c) Menopause

The main objectives of our discussion of these problems are:

i. To create an awareness about the very existence of these problems
ii. Besides, we want to make the point that it is not necessary that all women experience these problems. Many women never experience any of these symptoms.
iii. Although there are certain stereotypes associated with females' reproductive health, one must realize that part of these problems are physical and part psychological.
iv. Most importantly, these problems are manageable.

Dysmenorrhoea
Dysmenorrhoea is pain along with cramping of the uterine musculature accompanying the menstrual period. In some females the pain can be very severe and debilitating. Whereas many women do not experience such a condition. There are two types of Dysmenorrhoea:

i. Primary
ii. Secondary

Primary Dysmenorrhoea
This type occurs without any causal disease. It usually begins in the teens and disappears after child birth.

Secondary Dysmenorrhoea
This type is caused by some primary disease process. The symptoms of Dysmenorrhoea are related to the primary condition e.g. endometriosis.

Etiology/Causes
Physical cause: Prostaglandins
Biologically active ad naturally occurring unsaturated fatty acids, prostaglandins, have been found to be related with Dysmenorrhoea. Prostaglandins have potent actions on blood cells, smooth muscles, fat cells and nerve tissues.
Psychological causes
Heightened stress level, especially negative stress has been found to be associated with Dysmenorrhoea.

Treatment
Physical treatment:
Prostaglandin Inhibitors e.g. ibuprofen, naproxen sodium and others. Regular exercise, especially aerobic exercise has been found to be very helpful in symptom relief as well as symptom control.

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Psychological interventions:
Relaxation exercises have been known to help. If positive imagery is added, the treatment becomes more effective.

Premenstrual Syndrome (PMS)
Commonly known as PMS, refers to the symptoms experienced by many females prior to the monthly period. The symptoms usually occur around 10 days prior to the beginning of the period. The common symptoms include depression, irritability, water retention, fatigue, and/or lethargy.

Etiology:
Physiological Explanation:
A number of physiological explanations are available about PMS. However most researchers, and medical professionals believe in the effect of insufficient progesterone, or insufficient progesterone relative to estrogen, or a high estrogen-progesterone ratio.

Psychological Explanation:
Psychological theories primarily focus upon a state of arousal along with an appraisal of one's inner state as negative or positive. Some theories extend the same approach even further.
These theories propose that the cultural stereotypes of the premenstrual women as being depressed and irritable, affect which environmental or physiological cues are attended to when attaching a label to increased arousal (Koeske, 1980).

The treatment of PMS
A number of treatments have been found to be effective in relieving the symptoms of PMS. The treatments include medical and psychological treatments as well as lifestyle changes.

Medical Treatment
Physicians, who strongly believe that PMS is caused by low levels of progesterone, recommend progesterone therapy (Dalton, 1964). Diuretics are also recommended in many cases (Appleby, 1960). Bromocriptine, that inhibits prolactin release, has also been found effective (Steiner et al., 1984). Medicines increasing the level of Serotonin have been recommended by some (Harrison et al., 1984). Some have found prostaglandin inhibitors to be effective (Jakubowicz et al., 1984). The use of evening primrose oil is also helpful (Horrobin, and Phil, 1983).

Psychological Treatment
The following interventions have been found to be effective:
- Relaxation exercises with imagery
- Cognitive therapy for changing appraisal of situation
- Role modeling through, video recordings of symptom free females

Lifestyle changes
- Regular Exercise, especially aerobic exercise, has been found to be effective.
- Healthy dietary habits are recommended e.g. reduced dairy intake.
- The PMS sufferers are advised to stop or restrict the use of refined sugar. They are recommended to acquire the sugar required by the body through complex carbohydrates, cereals etc.
- Multivitamins are also helpful.

Menopause
Menopause is a condition, or change that every women beyond the age of 45-55 years experiences. Menopause refers to the cessation of menstruation. In turn it means the end of fertility. At

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menopause ovulation stops permanently. The average age of menopause is about 51 years; in 4 out of 5 women menopause takes place between 45 and 55 years (Avis, 1999; Messill, and Verbrugge, 1999). Some women may have this experience as early as in their thirties, whereas some as late as in their sixties.

Symptoms of Menopause

Besides being a major life change with reference to fertility, menopause is considered a significant period because of the accompanying symptoms. Little or no physical discomfort is experienced by most women during perimenopausal phase (NIA, 1993).

Perimenopausal or climacteric, or "change in life", refers to the period during which the changes that lead to menopause are experienced. This period may be stretched over many years, beginning usually in the 30s. The commonly known symptoms include:

- Hot flashes or hot flushes
- Increased body weight
- Headaches
- Profuse sweating
- Sleep problems/insomnia
- Depression
- Dizziness
- Sensation of cold in hands and feet
- Irritability, and arthrosclerosis, among many others
- Osteoporosis (brittle bones)

The most common symptoms are hot flashes i.e., sudden sensations of heat that flash through the body due to expansion and contraction of blood vessels. Many women do not experience these at all, and many have these continually (Avis, 1999). There are many diverse views about these symptoms. Some viewpoints see these symptoms as purely psychological in nature, resulting from the menopausal women's perception of her changed physical ability.

Others regard these symptoms as clearly physical in nature, resulting from hormonal changes. A third view point considers these symptoms as resulting form both psychological and physical factors. However what needs to be kept in mind is the fact that not all women experience these symptoms, and not all women experience the same intensity and frequency of these symptoms if they experience any. The supporters of the psychological viewpoint use this fact as their main supporting argument. They propose that had the menopausal symptoms been purely physical in nature, then all women would have experienced the same symptoms.

The Sociopsychological approach

According to this approach, two factors determine the experience of menopause:

a) The woman's perception of a major life change, and the end to fertility

b) The societal stereotypes about menopause. This includes especially the attitudes, awareness, and behavior of the husband and near relatives.

If the research on menopause is scrutinized, it will show that "so-called menopausal syndrome may be related more to personal characteristics or past experiences than to menopause per se" (Avis, 1999, P. 129).

At the same time cultural and societal factors play a very important role. The typical menopausal symptoms are experienced more, and felt more seriously, in societies (e.g. western societies) where a women feels she is important primarily because of her body. Few problems are associated with menopause in societies and cultures where social, religious, or political power is acquired by older women after menopause (Avis, 1999;

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Treatment of Menopausal Symptoms

A number of treatments have been found effective in alleviating, controlling, and managing symptoms of menopause. Some of the more commonly used ones are mentioned here:

1. **Hormone Replacement Therapy:**
   Estrogen alone, or in combination with progesterone is used.
2. **Evening Primrose Oil:**
   Of the herbal remedies, evening primrose oil is claimed to have very positive effects.
3. **Exercise:**
   Regular aerobic exercise helps prevent, control and alleviate the symptoms.
4. **Cognitive Therapy:**
   Cognitive therapy for menopausal woman focuses upon the wrong perceptions about the end of fertility.

The menopausal women are made to realize that this is an age of more freedom when they are free of children's responsibilities, have more money, more leisure time, and more time for using their creative or intellectual potentials.

What Needs To Be Done???

- Health education for females
- Changes and additions in school curriculum pertaining to reproductive health.
- Encouraging girls to express their health concerns with mothers, teachers, or with health professionals.

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LESSON 40

OBESITY AND WEIGHT CONTROL

With a growing awareness about the risk factors in major killers, and the significance of health enhancement, people in general are becoming more weight conscious. The number of people indulging into regular exercise and opting for herbal medicinal remedies is on a constant increase. At the same time due to growing affluence and easy availability of junk food, the number of obese and over weight people is also increasing. Therefore, as the number of weight conscious people is increasing, the incidence of obesity is also rising. Obesity refers to too much of excess body weight, when the weight is due to excessive fat. In normal body weight, in case of women, fat should constitute around 20% to 27% of body tissue. In men, fat should constitute somewhere between 15% to 22% of body tissue. A proportion of fat more than this, account for excess fat in the body. Ideal weight ranges are available for men and women, all age groups, and all body frames. Body weight 20% more than the ideal weight is considered overweight. If the weight is more than even 20% excess weight, the person is considered to be obese.

The best and considered most reliable measure of obesity is Body Mass Index or BMI. BMI is calculated by dividing a person's weight in kilograms, by the person's height in metes. The sum is then squared. The BMI of a person tells if he/she is of normal body weight, over weight, or obese:

BMI	Body weight rating
19-24	Ideal
25-29	Moderately overweight
> 30	Obese

People with a BMI between 25 and 29 are 15%-30% above ideal weight. Those with a BMI more than 30, have about 40% excess body weights. Obesity is a matter of concern for health authorities, because many serious ailments e.g. CHD, cancer, or Diabetes are associated with obesity. In our culture the number of obese children and adults is also on the increase. Obesity is a significant health issue in U.S.A. In the US, 65% of adults are overweight, and 23% are obese (Center for Disease Control, 2003). 15% of the total school-age population is obese (Center for Disease Control, 2003). According to the 1995 reports, obesity increased by one-third over the last 20 years in the U.S (Williamson, 1995). A similar trend has been seen in other countries including Britain and Canada (Taubes, 1998).

Consequences of Obesity

- Negative self-perception and low self-esteem
- Self consciousness
- Negative altitude of peers
- General lethargy and fatigue
- Risk of CHD, hypertension, stroke, many cancers, diabetes, affected joints
- Reduced physical activity
- Stress and in many cases helplessness

Gender and obesity

Obesity is a matter of concern and a causal factor in poor self-concept for both men and women. However it is a matter of much greater concern for females. People usually tend to ignore the excess weight of a man as compared to that of a woman. Women are ideally and traditionally, supposed to be trim, slim and smart. It is seen that the risk of many ailments is higher in overweight women.

Therapeutic Interventions

1. Wise eating and curtailed eating/Dieting
2. Strenuous and regular exercise

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3. Behavior modification (e.g. contingency contracting)
4. Cognitive therapy for changing perceptions about eating and about the ability to reduce weight

Eating Disorders

While the number of overweight and obese people is on the increase, a number of people are adopting eve highly harmful ways of losing weight. This segment of the population who is almost obsessed with the idea of losing weight primarily consists of females. Most women, who want to lose weight, try and adopt varieties of diet plans; others develop eating disorders: Anorexia Nervosa, and Bulimia.

Anorexia Nervosa

Anorexia nervosa is marked by a drastically curtailed food intake with an intention to lose weight. The anorexic on average tries to maintain body weight 15% below what __________ should have been that persons' weight. They tend to have a BMI of 17.5.

Diagnostic Criteria for Anorexia Nervosa

American Psychiatric Association (1994) has given the following diagnostic criteria for Anorexia Nervosa:

1. Refusal to maintain body weight at or above a minimally normal weight for age and height.
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Disturbance in the way in which ones' body weight or shape is experienced, under influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
4. Amenorrhea (the absence of at least three consecutive menstrual cycles).

The incidence of anorexia world wide in not exactly known. In the US, about 0.5% of all women have this problem (Becker et al., 1994). In case of women attending professional schools for modeling and dance, 6-7% can be classified as having anorexia nervosa (Garver & Garfinkle, 1980). In one society, we can see that the number of underweight females is on the increase.

Bulimia Nervosa

This problem is an opposite of Anorexia Nervosa in terms of eating pattern. The bulimic binge eats, but then purges. The main intention is the same i.e., not letting body weight increase. The main characteristic of bulimia nervosa is binge eating followed by purging.

Diagnostic Criteria for Bulimia Nervosa

American Psychiatric Association (1994) has given the following criteria for diagnosing bulimia nervosa:

1. Recurrent episodes of binge eating, namely, eating in a discrete period of time (e.g., within any 2-hour period) and amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances, and feeling that one cannot stop eating or control what or how much one is eating.
2. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
3. The binge eating and inappropriate compensatory behaviors both occur on average, at least twice a week for 3 months.
4. Self-evaluation is unduly influenced by body shape and weight.

In the Pakistan society we rarely come across a bulimic person.

The exact prevalence of Anorexia and Bulimia Nervosa, in Pakistan, is not known. In North America the prevalence rate of bulimia is 1-3%, some surveys suggest that around 10% of women in college show symptoms of bulimia (Becker et al., 1999).

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Etiology of Eating Disorders
Although a concerns with body weight and shape in the major variable involved, there are other triggering factors too.

Genetic factors:
There is research evidence available suggesting that there are some genetic and physiological links involved (Rock and Raye, 2001). Twin studies showed the occurrence of eating disorders in both twins. The probability being higher for identical than fraternal twins.

Cultural factors:
Eating disorders are more common in societies where physical beauty is the most important characteristic of a woman.

The role of media:
Media portrays extremely their females in programs and advertisements. Teen age girls try to match the models and stars that they admire.

Stress and Anxiety:
As a result of extreme stress and anxiety some young females eat more, and if they are weight conscious they purge. For a stressed and under anxiety teenager nothing else seems to be under her control. Her body is the only entity that she can run the way she likes; so she uses it as a target. For some bulimics eating is a compensatory defense mechanism that gives them pleasures.

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GENDER AND PSYCHOPATHOLOGY

Gender and Psychopathology

Psychopathology refers to mental disorders, or mental illness.
Stereotypically speaking there are marked gender differences in psychopathology.
However empirical research does not support this view.
Men and women, both have an equal risk of developing any mental disorder.
Many mental health professional and researchers are of the view that it is the diagnostic criteria that are designed in such a manner that women are more likely to be diagnosed with certain mental health problems than men.

In our discussion this topic we will primarily focus on three things:

a) Gender, Stress and Coping
b) Gender bias in diagnostic criteria, and
c) Gender differences in mental disorders

In the section on gender and psychopathology, stress and mental disorders will be discussed.
The issue of gender and psychotherapy, and feminist psychotherapy will be tackled in the following lectures.

Gender, Stress and Coping

Stress refers to, "a state of challenge or threat that disrupts the normal rhythm and balance of a person's life" (Sanderson, 2004).
People feel stress when they are placed, by circumstances, in situations that tax or exceed their resources and endanger their well-being (Lazarus, and Folkman, 1984).
Therefore if one is caught in a problem situation and one feels out of resources and without skills for handling the situation, one feels trapped and threatened, hence stress.
On the other hand if another person is caught in the same situation but feels fully equipped with skills and resources for handling the situation, no stress may be experienced.
So one can understand that losing a job may be stressful for someone who has no savings and who is not hopeful of finding a new job.
Being out of job will not be much problematic for a person who is financially stable and has the qualification for another job.
Stress is accompanied by the physical component.
Stress is experienced in a fight or fight situation.
Stress is marked by an activated Sympathetic Nervous System.
As a result a person under stress may experience increased heart rate, hyperventilation, sweating, cold sweats dry mouth, shaky legs etc.
How stress will take its toll will depend upon how much does it prolong.
Different psychologists have explained the psychological and physical components of stress, but we will not go into the details of that since you must have acquired that knowledge in abnormal psychology or health psychology.
However we must keep it in mind that prolonged stress may have a serious effect on ones physical as well as psychological well-being.

Gender Differences in Reactions to Stress

For many years psychologists relied upon the findings of Walter Cannon that people respond to stress with heightened arousal i.e., the fight or flight response.
But recent research has proposed a divergent viewpoint.
This research suggests that the reaction proposed by Cannon may not apply to every one (Taylor et al., 2000).
Most of the previous research on stress has relied upon male samples.
Even when animals were used, they were mostly males, male rats mostly.

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Therefore there has been no clear cut evidence available on as to how females react to stress.
Recent research suggests that female's reactions to stress may be different from those of males.
It has been observed that men exhibit the traditional fight or flight response, whereas women may demonstrate the "tend-and-befriend response" (Taylor et al., 2000).
This research shows that in periods of stress, women prefer to affiliate with others, while men prefer less social interaction.

Experiments have shown that women refer to wait with other women when they expect that they will be given painful electric shocks.
Men in such situations prefer waiting alone.
The same scenario can be observed when men and women are waiting for their turn for a medical procedure in a hospital or dental surgery.

Gender Differences in Physiological Reactivity to Stress
Men and women may experience different types and levels, of physiological strain from stressors.
Men have been found to show more reactivity as compared to women when psychologically stressed (Collins and Frankenhaeuser, 1978; Kudielka et al., 1998; Ratliff-Crain, and Baum, 1990).
Gender differences have been reported in how people respond to stress and influence of stress on illness (Stoney, Davis and Mathews, 1987; Stoney, Mathews, Mc Donald, and Johnson, 1988).
Men in general have higher blood pressure than women and show greater B.P variations in stressful situations.
The higher physiological responsiveness of men under stress may be a contributory factor in the higher risk of CHD for men.

Religiosity: Does prayer help in Coping with stress?
Some researchers have tried to study a unique phenomenon, i.e., the effect of prayers on stress.
A study was conducted to investigate the impact of praying on physical health.
A group of 199 women was chosen in Korea and randomly assigned to two groups, prayer group and non-prayer group (Kwaug Cha et al., 2001).
These women were seeking treatment for becoming pregnant.
The photographs of the women in the prayer group were sent to church goes in the U.S, Australia, and Canada and they were requested to pray for the pregnancy of these women.
The study yielded amazing results.
50% of the prayers group females become pregnant, while only 26% of the non-prayer group became pregnant.
What was more striking was that the pregnancy rate at the clinic from where these women were chosen was 33% otherwise.
The prayer was found effective in case of women 30 years or above in age and not for these below 30.
Most importantly neither the women in prayer group, not their medical staff was aware of the fact that they were being prayed for.

Who feels how much stress and why??
As compared to men, women report greater number of stressors.
These stressors include major as well as minor stressors (Davis, Malthews, and Twamley, 1999).
There may be a number of reasons for this, including the self disclosure style of women.
Different events seem to cause stress to men and women.
When the strength of reactivity is compared with that of the opposite sex, it may be greater when the stressor is relevant to the persons' gender (Weidner, and Messina, 1998).
Greater reactivity is shown by men, in comparison to women, when their competence is challenged; In case of women, they show greater reactivity, as compared to men when their friendship or love is challenged (Smith et al., 1998).

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Men have been found to show greater reactivity, than women, when they are stressed psychologically (Collins, and Frankenhaeuser, 1978; Kudielka et al., 1998; Ratliff-Crain and Baum, 1990).

The sources of Stress:

Research shows that there are no gender differences in the biological/physiological reaction to stress (Taylor et al., 2000).

Stress triggers the same sympathetic nervous system activation in both men and women. However the sources of stress may vary.

The modern lifestyle and Stress

In the modern world, many women perform dual roles and responsibilities: working at home and at the workplace.

The additional burden may add to a hassled routine.

However being employed outside home has been found to have a positive effect on women's well-being.

Working women tend to exhibit less distress then the housewives; however they show more distress than employed men (Glass, and Fujimoto, 1994; Mirowrky, and Ross, 1989).

Both men and women, if employed generally have fewer health problems; but it seems that in case of working married women, they are under greater strain than their husbands (Nathanson, 1980; Northcott, 1980; Verbrugge, 1983).

In case of married women, especially these belonging to low-income families, psychological distress are increased by the strain of working and doing the majority of work associated with raising children (Cleary, and Mechanic, 1983; Gore, and Mangione, 1983; Lai, 1995; Simon, 1992, 1995).

In general employment has been found to have a positive impact upon women's well-being.

Employment outside home enhances the overall psychological well-being of women (Glass, and Funjimoto, 1994; Kessler, and Mc Rae, 1981; Rosenfield, 1992).

This positive effect is seen especially when women are able to exercise some control over what they do on their job (Lennon, 1994; Lennon, and Rosenfield, 1992; Roxburgh, 1996).

Among working women, the most positive levels of mental health are seen in women who like to combine a job with that of homemaker (Kessler, and Mc Rae, 1981).

Marriage of Experience of Stress

Marriage seems to have a positive effect; married people experiencing less stress as compared to the lonely unmarried people.

But some stressors are prevalent more in case of married people.

Women whether married or unmarried, show more psychological distress than men.

However, in case of married women the quality of relationship with the husband is an important variable in maintaining positive levels of mental health (Gove, Hughes, and Style, 1983; Vanfossen, 1981).

In some cases woman's employment may have a negative impact upon the husband's mental health if they are earning less than the wife, or if they have to do more housework due to it (Rosenfield, 1992).

But research also shows that both the husband and wife are less depressed when the women's employment outside the home is consistent with their preference.

If the husband helps with the housework, wives are less depressed; and helping the wife does not increase depression for the husband either (Ross, Mirowsky, and Huber, 1983).

Research done in the US and Australia has shown that in both countries, being married was a mental health advantage for both spouses.

When married and unmarried people were compared, lower levels of mental disorders were seen in married people.

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GENDER AND PSYCHOPATHOLOGY — LESSON 42

Gender and Psychopathology

Psychopathology refers to mental disorders, or mental illness. Stereotypically speaking, certain mental disorders are specific to, or more common in, women and certain others are found only in men. Some of such traditionally held beliefs are:

- Hysteria, dissociative disorders, is specific to women, especially young girls
- Mostly women are anxiety ridden and suffer from anxiety disorders, and very few men have anxiety
- Women are scared of insects, animals, or people and usually are phobic
- Men are brave, scared of nothing and do not develop phobias
- Depression in women is not something to be taken too seriously, since women have a natural disposition for feeling sad, and they recover with the passage of time
- Habit disorders, smoking, drug abuse, or alcoholism are men's problems

These and many other wrong perceptions are not only held by the members of most societies, but are also promoted, strengthened, and passed on to the younger generation. Most modern research suggests that there are no significant differences in mental illness, except a few. There are only two or three categories of mental illness where women are in higher proportions, and vice versa. The differences that have been found in clinically diagnosed cases are not consistent. The rates of only two illnesses have been found higher in women:

a) Mood disorders
b) Anxiety disorders (Cockerham, 1996; Kessler et al., 1994).

Men have higher rates of personality disorders (Cockerham, 1996; Kessler et al., 1994). Research has further shown that females are also higher in case of tendencies toward such depression and anxiety that, although not clinically diagnosable, make people feel psychologically distressed; This fact stands true for the U.S as well as other countries of the globe (Cockerham, 1996; Desjarlais et al., 1993; Lai, 1995).

In our discussion on the present topic, we will be focusing upon two things:

1. The gender bias in the diagnostic criteria, and
2. The facts about existing gender differences in psychological disorders

The Diagnostic Criteria

Diagnostic criteria refer to the standards laid down and used by psychiatrists and psychologists for categorizing and labeling people as mental patients, or as suffering from a mental illness. These criteria not only decide whether or not a person is mentally ill, but also specify the type of disorder. A number of psychologists are of the opinion that there are inherent biases in the diagnosing and identifying procedures. These have been designed in a manner that the likelihood of women being diagnosed as mentally ill is higher. The most commonly used criteria, worldwide, is the Diagnostic and Statistical Manual of Mental Disorders or DSM. The DSM, developed by the American Psychiatric Association, is the most widely used criteria. The first version came in 1952, the second edition in 1968, followed by the third edition in 1980, and the slightly revised edition of the same in 1987. In 1994, DSM-IV was developed, that was not much different from the previous version. A text revision of the DSM-IV appeared in year 2000. In the 2000 revision, the diagnostic categories remained unchanged; however the text descriptions were enlarged. The DSM covers more than 240 different diagnoses. It also includes descriptions of symptoms characteristics of the disorders. It has a multi-axial system, and contains five axes or dimensions for diagnosis. The first three axes cover the diagnosis, whereas the remaining two provide criteria for the evaluation of stressors and overall

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functioning. Information regarding the age of onset, the course of disorders, and the gender ratio of the disorder

The Issue of Gender Bias in Diagnosis of Clinical Disorders
A number of researchers and mental health professionals have criticized the multiaxial system of the DSM for an inherent gender bias (Kaplan, 1983a, 1983b; Lerman, 1996; Marecek, 2001). The main criticism posed against the prevalent diagnostic system of the DSM is that women are more likely to be diagnosed with problem behavior, whereas actually the problem may be due to some other cause than pathology. In the diagnosis of mental illness, man are used as the norm, and this increases that likelihood of females being diagnosed as disorder-positive when the behavior under consideration is occurring more frequently in women and not in men. "Professionals have used male-based norms to define healthy versus pathological behavior"(Cook, Warnke, and Dupuy, 1993, Pp. 312-313). As a consequence of this tendency, behavior and personality characteristics of men are treated as normal, and behaviors typical of women are considered abnormal or pathological. Therefore, characteristic male behaviors like competitiveness, assertiveness, independence and an aggressive attitude are thought to be a part of a healthy mental functioning. On the other hand characteristic female behaviors like emotional experiences are taken to be indicative of underlying psychopathology.
Some critics have raised the criticism that the cultural background and life circumstances of the person under consideration for diagnosis are ignored in the DSM criteria (Lerman, 1996; Marecek, 2001). Some critics believe that although the DSM-IV and DSM-IV-TR have given consideration to the significance of cultural factors, it does not give due importance to these factors (Dana, 2001). The assumption that the DSM follows is that although a person's circumstances may be relevant, the problem primarily resides within the person. Therefore, the source of the problem is the person, and not the circumstances.

Consequently, if a raped or acid burnt women is depressed, isolated, phobic or severely anxiety-ridden, she will be labeled as having one of the relevant disorders. Hence 'what' she is will be important and not 'why' she is like that.

In some cases even the American Psychiatric Association itself has also warned against over diagnosis or under diagnosis. Referring to the diagnosis of Personality Disorders, it has been said that the clinicians "must be cautious not to over-diagnose or under-diagnose certain Personality Disorders in females or in males because of social stereotypes about typical gender roles and behaviors" (American Psychiatric Association, 2000, P. 688).

Typical Gender behaviors likely to be Diagnosed as Disorders:
In case of Personality Disorders, certain behaviors or symptoms that may be put into a category of these disorders are actually exaggerated forms and extensions of typical male behavior. These male behaviors are the prevailing gender stereotypes. For example: "a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as cognitive or perceptual distortions and eccentricities of behavior" is the way in which the Schizotypical Personality disorder is characterized (American Psychiatric Association, 2000, P. 697). The Antisocial Personality Disorder is described as: "pervasive pattern of disregard for, and violation of the rights of others" (American Psychiatric Association, 2000, P. 701). This includes physical cruelty, telling lies, stealing or fighting.

An exaggerated picture of the traditional male gender role can be seen in the description of the above mentioned Personality Disorders (Brannon, 1976).

On the other hand, some descriptions are exaggerations of the stereotypical female gender role. "A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fear of separation" (American Psychiatric Association, 2000, P. 701).

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This is how Dependent Personality Disorder is described. This is a blow-up of the conventional, stereotypical feminine role.

Culturally Promoted Behaviors that can be labeled as Mental Disorders

There are a number of behaviors and tendencies that are promoted by our culture in men and women. Many of these genders specific behaviors, if adopted intensely and expressed frequently, may appear to be symptoms of certain disorders included in the diagnostic criteria. In this section we will discuss some of those, with reference to the labels that they may acquire.

Anxiety in Women

Most women are trained to be dependent upon men. They are taught, directly or indirectly, that men are their protectors and saviors, and they can not face the world outside home without a man. Major decisions are usually taken by men, about the house hold, girls' education, occupation, mobility and marriage. As a result women find it hard to take independent decisions. Therefore, whenever they are caught in a problem situation, they feel anxiety. Consequently one finds more women expressing anxiety and helplessness. Besides, in a male dominated society, girls are brought up with a belief that they have to always please others, especially men. A consistent attempt for perfection and a fear of failure also nurture anxiety generated attitudes, and tendencies including obsessive tendencies.

Women and Phobias

From very early childhood, girls learn to be scared of insects, animals, strangers, and strange situations. Besides, a feeling of dependence on the 'perceived protectors', mothers as role models are possible contributory factor. Young boys do not have fathers as role models for phobias and fears. Since girls are kept protected, much more than boys, they turn into over-cautious mothers with phobic tendencies.

Women and Depression

Men are discouraged from expressing pain, hurt, and grief. Women and young girls are not discouraged, if not encouraged, from an open expression of such feelings. For women, crying, weeping, sighing, and lamenting are socially acceptable behavior. At the same time anger and aggression are discouraged in woman, and considered acceptable for men. Consequently women may cry, and lament uninhibitedly, but may not be expected and allowed to express anger over matters involving their relationship with men, no matter who they are; fathers, brothers, or husbands. Such circumstances and situations may promote behaviors similar to clinically diagnosable depression.

Some facts about Gender Differences in Psychopathology

Although, as said earlier, no significant gender differences exist in the incidence of specific categories of mental disorders, some gender differences in some disorders have been found.
We present here some facts pertaining to specific disorders in males and females. Gender differences are found in the onset of schizophrenia; males tend to have an earlier onset than women, more hospitalization, and higher relapse rates (Szymanski et al., 1995). Major depression is more common in women with a 2:1 ratio. There are no known differences in bipolar disorder (American Psychiatric Association, 2000). Dysthymia is more prevalent in women with a ratio of 2-3:1. The prevalence of depression in women is almost double as compared to the prevalence in men (Culbertson, 1997). This gap widens during mid to late adolescence (Hankin et al., 1998). The rate of personality disorders is higher among men.

In case of Substance Related Disorders, men are higher in Alcohol dependence (ratio 5:1), Amphetamine dependence (ratio 3:1-4:1), Cannabis, cocaine (ratio 1.5-2:1), Hallucinogens (ratio 3:1), and Opiates (ratio 1.5-3:1).

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Women are at a higher risk in sedatives, hypnotics, or anxiolytics (American Psychiatric Association, 2000). Women are at a higher risk of panic attacks with and without agoraphobia (ratio 2-3:1), and social phobias in women in general population (men higher in clinical settings).
There are no gender differences in Obsessive Compulsive Disorder or Posttraumatic Stress Disorder (American Psychiatric Association, 2000).

Conversion Disorder is substantially more common in women than in men (ratio 2-10:1) (American Psychiatric Association, 2000).
Women account for 95% of somatization disorder patients (Tomasson, Kent, and Coryell, 1991). In the U.S, this diagnosis is rare in men, but not so in other cultures (American Psychiatric Association, 2000).
There are no gender differences in Body Dysmorphic Disorder. Dissociative Identity Disorder is more common in women with a ration of 3-9:1. Sexual dysfunction, Paraphilias is rarely diagnosed in women, and the men to women ratio are 20:1.

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GENDER AND PSYCHOTHERAPY

Most students doing an under graduate or graduate course in psychology are familiar with the various perspectives or prevalent models in psychology. All of these models have their specific approach towards the understanding and explanation of mental illness, as well as the therapeutic interventions for treating these disorders. In our discussion on gender and psychotherapy we will not go into the details of the commonly known psychotherapeutic approaches that may be around 400 in number. It is assumed that you are already fully aware of these approaches. Our emphasis, in this segment of this course, will be upon the feminist approach toward psychotherapy. As discussed earlier, the feminist approach emphasizes women's issues, the impact of socialization, gender stereotypes, issues specific to women's well being, and similar topics. Before starting our discussion on gender and psychotherapy, let us try to find the answer to a question!

What is common between psychoanalysis, Behavioral Therapy, Client-Centered Therapy, Existential Therapy and Rational Emotive Behavior Therapy?
If the question puzzles and confuses you, then think about another question!
What is common between Freud, Jung, Adler, Watson, Skinner, Rogers Maslow and Ellis??
We are sure that you have found the answer. In the former question, all the therapeutic approaches mentioned were given by male psychologists. And in the latter, all the psychologist mentioned are males. Not only that all these are male psychologists but, more than that they are all male psychologists, from the west, all white.

In our discussion on gender and psychopathology, we mentioned that men are used as norms; stereotypically masculine gender roles are considered as a standard. As a result, a behavior deviating significantly from this norm, i.e., feminine behavior, is likely to be identified as pathological. A similar trend has been observed, and can always be expected, in the therapeutic intervention if the therapeutic process is male-dominated, male-centered, and male-controlled.

As a result of the feminist movement of the 1960s, psychological approaches, and therapeutic interventions also saw a shift in focus. Psychotherapists with a feminist approach do not deal with, and understand, pathology in the same manner as a conventional therapist would usually do. We find two key elements at the core of the feminist therapeutic process:

a) Gender
b) Power

"It is built on the premise that it is essential to consider the social and cultural context that contributes to a person's problems in order to understand that person" (Herlihy, and Corey, 2001, P. 343). Herlihy and Corey have given a very good account of the historical evolution, nature, and process of feminist therapy. "A central concept in feminist therapy is the psychological oppression of women and the constraints imposed by the sociopolitical status to which women have been relegated" (Herlihy, and Corey, 2001).

Traditional Versus Feminist Theory

While some psychologists on one hand were trying to give feminist theory a shape and polish it, many others were looking into the faulty perceptions of genders held by conventional approaches in psychology.

In a similar attempt, Worell and Remer (1992) highlighted six features/characteristics of the prevalent traditional theories. These characteristic show the outdated assumptions about the role of a person's gender in behavior. These characteristics determine the nature and process of psychotherapy.

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Worell and Remer (1992) described the following characteristics:

Androcentric Theory
Such theories draw conclusions about human nature form male-oriented constructs.

Gendercentric Theory
These theories rest on the assumption that men and women follow separate developmental paths. This assumption appears to have the underlying belief that men and women are separate entities, and therefore the course and nature of their development is different.

Ethnocentric Theories
These theories propose that all cultures, nations, and races have the same factual evidence related to human development and interaction.

Heterosexism
This approach views heterosexual orientation to be normative; therefore this orientation is the socially acceptable norm and desirable behavior.

Intrapsychic Orientation
It is a tendency towards finding
The origin of behavior in intrapsychic causes. As a consequence instead of finding fault with the circumstances and other external variables, it is usually the victim who is to be blamed.

Determinism
This a pessimistic approach in the sense that it assumes that behavior, and personality are pre-determined, and fixed at an early stage of development.
All these characteristics make the nature of conventional therapies quite fixed, inflexible, and single tracked. Feminist therapy, on the other hand, involves more flexibility, human element, and an interactionist approach .

The Characteristics of the Feminist Theory
Worell and Remer (1992) have shown how the main features of feminist theory can be used as criteria for evaluating whether a theory for counseling women is suitable or not. Besides describing the characteristics of conventional psychotherapy, Worell and Remer (1992) have also described the essential elements of feminist therapy.

i. Gender-free Theories
Feminist theory considers socialization processes to be very important. As opposed to conventional theories feminist theories explain gender differences considering the experiences of the socialization process to be of prime importance. The conventional theories take these differences to be stemming for the 'true' nature of people.

ii. Flexible Theories
Feminist theory involves constructs and strategies that are equally applicable to individuals as well as groups, all ages, races, cultures, genders, or sexual orientations. One can take this feature to imply that feminist therapy gives due importance to the lifestyle, gender, cultural origin etc. when viewing the problems of the client.

iii. Interactionist Theories
As the very name implies, different aspects of human experience are covered; cognition, affect, and behavior. Besides, the contextual and environmental variables are also taken into account.

iv. Life-span Perspective
As compared to the conventional perspectives, the feminist perspective does not limit its understanding of behavior or pathology to socialization in early years alone. The whole life-span is considered important and all stages of development treated as significant contributors.

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Human development is not restricted to the so-called "formative years" alone, but it is a life long process. Changes, growth, and addition of new facets in personality may take place at any stage.

Principles of Feminist Psychology

Feminist theory is based upon the following principles (Herlihy, and Corey, 2001):

The personal is political

Social transformation should be a goal. We should go for social change, not just individual change.

The counseling relationship is egalitarian:

Feminist theory, counseling, or therapy is not skewed towards the therapists. It gives an important and active place to the client. The client is perceived as someone who has the potential to not only change (within herself), but also who can produce change. Instead of being the only, and the final authority, the therapist is just another source of information.

Clients have an active role in defining themselves.

i. ***Feminist theory honors women's experiences:***

Unlike other theories and therapies, men's behavior is not considered as a norm. These theories place women's experiences at the very core of the therapeutic process in understanding their distress. A goal of feminist therapy is to replace patriarchal "objective truth" with feminist consciousness, which acknowledges a diversity of ways of knowing. Women are encouraged to express their emotions and their intuition and to use their personal experience as a touchstone for determining what "reality" is." "Theories of feminist therapy evolve from and reflect lived experiences that emerge from the relationships among the participants" (Herlihy, and Corey, 2001, P. 352).

ii. **Feminist therapy reformulates the definitions of mental illness and distress:**

Deviating from the conventional approach, feminist therapies define and do not see distress, pain, or psychological problems as a disease. Only a part of clients' distress, pain, and agony consists of the intrapsychic and interpersonal factors. These factors only partially explain the problem. The rest can be explained after an understanding of the external factors.

Therefore, feminist therapy reframes distress as a communication about unjust systems, rather than a disease. Similarly pain is understood as an evidence of resistance and the skill and will to survive (Worell, and Johnson, 1997). Whereas the conventional approaches may define pain as indicative of some deficit or defect.

iii. **The use of an integrated analysis of oppression:**

In the understanding of oppression, the feminist therapists use an integrated, all involving approach. In understanding and explaining human behavior, or distress, the feminist therapies give importance to the culturally shaped gender roles; the effect of stereotypical upbringing and differential treatment of genders. Cultural practices, primarily those of raising children, affect the personalities, perceptions, and attitudes of both men and women.

When men go for therapy or counseling, they find it difficult to express their emotions as they have learnt that vulnerability is a weakness; they have this problem even in their daily, routine life. Women; on the other hand, experience another problem. Since they have not been independent, and have learned to give prime importance to the family's well-being, rather than their own wishes, they find it hard to identify and honor what they want out of therapy.

LESSON 44

FEMINIST THERAPY

Feminist therapy is guided by the principles of feminist psychology. The problem is not looked at as merely intrapsychic or interpersonal. The cultural factors operating, the socialization process, the social context and the political perspective, all are taken into consideration.

The definition of distress, pain, and "mental illness" plays an important role. The therapeutic process, in any type of psychotherapy, depends upon how the therapist understands "mental illness", or distress for which the client seeks help. For a therapist with a feminist approach, only a part of distress can be understood in terms of intrapsychic or interpersonal factors. In simpler terms, unlike many other approaches, the feminist therapist does not treat the client as solely responsible for own distress. Psychological distress is understood as a communication about the systems that are not just; similarly pain is an expression and proof of resistance, and the skill and will to survive (Worell and Johnson, 1997). And when a person is resisting, it indicates the person's ability to remain alive and powerful n the presence of oppression (Brown, 1994). Considering the basic premises of feminist psychology, one can understand what will be the goals of feminist therapy.

What does feminist therapy aim to achieve?

Feminist therapy is not restricted to females alone, whether clients or therapists. Feminist therapists can be males as well as females. Similarly the clients are not restricted to the female gender alone. Clients may be women, men, children, families or couples.

"The primary goal of feminist therapy is transformation, for both the individual client, and society as a whole".

"The major goal of feminist therapy is empowerment, which involves acquiring a sense of self acceptance, self-confidence, joy, and self-actualization" (Herlihy and Corey, 2001).

Changes targeted at individual level:

The main goal is transcendence, not adjustment. At individual level personal empowerment is the goal. Personal power is what is worked upon. The clients are helped in three things pertaining to personal power:

a) Recognizing personal power
b) Claiming personal power
c) Embracing personal power

When the clients recognize, claim and embrace personal power, they can realize the impact of the constraints they had been subjected to as a result of gender role socialization. Personal power not only promises freedom from these constraints, but also helps the person to think about and consider and opt for other alternatives, and other options of leading their lives. The person should learn to live as an "individual" and not as a 'men' or a 'women'. Societies have fixed, unrealistic, and too demanding gender- related expectations from people. Clients are helped in attaining self confidence, interdependence, resilience, and trust for self and others. Clients are also assisted in identifying their true potential, in getting rid of over-concern with body and appearance, and developing new and healthy perceptions of self.

Changes targeted at societal level:

Feminist therapy gives importance to the person-society relationship. All societies are patriarchal and sexist. When persons attain personal power, a change in the society also takes place. Feminist therapy has the goal of replacing current patriarchy with a feminist consciousness (Herlihy and Corey, 2001).

Rather than being sexist, patriarchal, or gender imbalanced, the society should be encouraging relationships that depend on each other (interdependent), that involve cooperation rather than one

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gender in the helping and the other in the "helped" position. The relationships should be mutually supportive.

It can be said that feminist therapy aims to develop and maintain gender equality at individual-societal, as well as client-therapist level.

The task of the therapist:

The feminist therapist helps and assists the clients in adopting new ways of thinking and perceiving. It is similar in approach to cognitive therapies, in the sense that it focuses upon the manner in which one perceives one's self. However, the target areas/cognitions in case of feminist therapy are related to: gender roles; the thinking, affect and behavior patterns, resulting from socialization, and; one's self concept and perception of self-appearance resulting form societal expectations, learning and the gender images promoted by media.

The feminist therapists, according to Worell and Remer (1992) help the clients in the following:

- "Become aware of their own gender role socialization process
- Identify their internalized gender role messages and replace them with their own constructive beliefs
- Understand how sexist and oppressive societal beliefs and practices influence them in negative ways
- Acquire skills to bring about change in the environment
- Develop a wide range of behaviors that are freely chosen" (Herlihy and Corey, 2001).

Specific counseling goals pertaining to women:

Worell and Remer (1992) have also described specific counseling goals that the therapist attempts to attain in efforts to:

- "Help women and men to trust their own experience an their intuition
- Enable clients to appreciate female-related values
- Assist women in taking care of themselves
- Help women accept and like their own bodies
- Define and act in accordance with their own sexual needs rather than another's sexual needs" (Henlihy and Corey, 2001).

The clients' experience in the Therapeutic Process:

The feminist therapist may have the background and belief in any of the theoretical perspectives. This may affect the way the therapeutic process is carried out. However the main goals and targets remain the same. What the client undergoes and experiences during therapy may vary from client to client, and from problem to problem. There is a likelihood that the clients may be dealing with the following themes:

- "Exploring anxiety and defenses
- Understanding power and control issues
- Examining external forces that influence behavior
- Identifying messages received in growing up
- Learning to accept appropriate responsibility
- Critically examining social dictates and expectations
- Exploring one' values
- Reflecting on the meaning of life (Herlihy and Corey, 2001).

Therapeutic Techniques

Although the feminist therapists may use, like any other psychotherapist, a variety of traditional and non-traditional intervention, certain techniques are more likely to be used (Sharf, 2000; Worell and Remer 1992; Enns, 1993).

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Gender Role Analysis:
The client is helped in understanding the impact of gender-role expectations in her/his life.

Gender Role Intervention:
Placing the client's problem in the context of society's role expectations for women; helping the client see how social issues affect her problem.

Power Analysis and power Intervention
Helping the client recognize the power difference between men and women. Empowering the client to take charge of herself and her life; getting prepared for taking responsibility for making decisions for one's life.

1. Bibliotnerapy
Encouraging the client and providing her reading materials, to read about various aspects of her problem. The reading material may include fiction as well as non-fiction. For example a client may be recommended to read about how the media in particular, and the society in general, promote over-concern with women's growing age or thinness.

2. Self Disclosure
The therapist relates her/his personal experiences and makes the client realize that the therapist is also someone like the client, and has undergone similar experiences.

3. Assertiveness Training
The ability to take charge of life, feeling of self confidence, and the courage to say 'No' when one wants to say 'No' is developed and encouraged.
Besides these interventions, reframing and re-labeling, group work, and social action are also used.

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