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SOCIALIZATION OF WOMEN AND ITS IMPLICATION ON THEIR HEALTH STATUS

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Abstract

Gender socialization championed primarily by the family impacts differently on the health status of women and men. Based on the perspective of the social role theory, a case has been made in this conceptual paper that women experience poor health status as a result of multiple social roles and responsibilities placed on their shoulders. The Feminist theorists concurred with the social role theorists that macro and micro sociological structures marginalize women on many fronts, which adversely affect their health status. This is perpetuated through role orientation acquired, reproduced, and sustained through the conduit and process of socialization, which takes place primarily within the family. This study recommends that social policies that hold promise for women to increase control over their lives and particularly to reduce any type of discrimination confronting them have to be institutionalized to improve their overall wellbeing. Women should also be proactively involved in social decision-making, principally in those affecting them directly. This should not be limited to just health treatments but also in all other aspects of their lives. Since men play a significant role in the gender socialization process because of their status as family heads in most cultures, they should be more encouraged to champion women's causes through education and formulation and implementation of feasible social policies. This is a critical step geared towards addressing gender inequalities in contemporary society with its promise of improved health status for all.

Keywords: Gender Socialization, Family, Women, Health Status, Social Roles

Introduction

Gender socialization championed primarily by the family impacts differently on the health status of women and men (Anselmi & Law, 1998). It is therefore no coincidence that men and women embrace the sick role differently with women overly at a disadvantaged position. The literature thus draws a host of lines between health status of men and women. Such disparity dwells on areas such as mortality where men's death rates are higher at all ages than women. In other words, men have a lower life expectancy than women in almost all societies. This revelation, however, does not necessarily imply that women have better health status than men because they render the sick role more in every society.

The classical sick role theory propounded by Talcott Parsons in the 1950s was the first theoretical concept to explain illness and health from a medical sociological perspective. In contrast to the biomedical model, which pictures illness as a mechanical malfunction or a microbiological invasion, Parsons in his classical work on the sick role described it as a temporary, medically sanctioned form of deviant behaviour (Segall, 1997). Parsons used ideas from Sigmund Freud's psychoanalytic theories as well as from Functionalism and from Max Weber's work on authority to create an 'ideal type' that could be used to shed light on the social forces involved in episodes of sickness.

Freud's concepts of transference and counter-transference led Parsons to see the doctor/patient relationship as analogous to that of the parent and child (Kaba & Sooriakumaran, 2007; Boateng, 2010). The idea that a sick person has conflicting drives both to recover from the illness and to continue to enjoy the 'secondary gains' of attention and exemption from normal duties also stems from a Freudian model of the structure of the personality. The functionalist perspective was used by Parsons to explain the social role of sickness by examining the use of the sick role mechanism. In order to be excused from their usual duties and to be considered not to be responsible for their condition, the sick person is expected to seek professional advice and to adhere to treatments in order to get well. Medical practitioners are empowered to sanction their temporary absence from the workforce and family duties as well as to absolve them of blame.

Weber identified three types of authority namely charismatic, using the force of personality; traditional, how it has always been; and rational/legal, which relies on a framework of rules and specialist knowledge. While individual doctors may have any or all of these types of authority in some situations, it is assumed that their credibility as a profession is based on their patients accepting their rational/legal authority in making diagnoses, prescribing treatment and writing sick-notes. From Parsons' perspective, doctors are the sole determinants of health and illness. Rendering or playing the sick role in the context of this conceptual paper is to seek medical attention when indisposed or unwell.

As indicated previously, women render the sick role more and this has many connotations. One of such obvious connotations is that women's health status is poorer than men. The higher life expectancy for women could also be attributed to the fact that they render the sick role more than men and are therefore more likely to admit illness and readily seek medical help and interventions than men. Rendering the sick role more may also be one of the reasons why doctors are more likely to diagnose women as ill as compared to men. It is even evident that women are given prescriptions more often than men even when they have the same complaints or medical diagnosis. It is therefore unsurprising that some feminist theorists believe that women's bodies and their illnesses have long been the target of medical consumerism and medicalization (Segall & Fries, 2011). Indeed, women are the overwhelming favourite target of medical consumerism because they submit more to higher medical screening in the form of laboratory tests, blood pressure monitoring and other consultations (Kazanjian, Morettin, & Cho, 2004). They are thus more submissive when it comes to their engagements with health care providers as compared to men who are even less likely to have regular family physicians (Segall & Fries, 2011).

Women may also have a higher life expectancy because they engage less in alcohol abuse which has negative health repercussions on its patrons' health. Men are thus three or more times likely to be diagnosed with antisocial personality disorder than women (WHO, 2001). The good news though is that men are more ready to disclose problems of alcohol abuse to their health care providers than women. In a related area of mental health for instance, women are more likely than men to suffer from eating disorders (Gucciardi & Stewart, 2002). Further, they are more likely to receive diagnosis of panic disorder and generalized anxiety disorder than men (WHO, 2005). They are therefore more susceptible to depression, being affected by it at twice the rate of men (Kornstein & Wojcik, 2002; WHO, 2004). The fact that women are exposed more to depression makes them more likely than men to attempt or contemplate suicide (Kornstein & Clayton, 2002).

Many attempts aimed at accounting for the health status differential between men and women have been premised upon the Biology-Sociology debate. The

biological debate premised upon the argument that women are innately more superior to men and are therefore, biologically well created to live longer and also overcome ailments better despite being exposed to more illnesses than men. This idea is based on the mechanistic-individualistic paradigm or biological perspective of health. This revelation which is based on biological reductionism is widely questioned in Sociology. Sociologists do not endorse it and believe strongly that the differential in gender health status has more to do with social disposition than Biology. WHO (2008) for instance identified differences in power, privilege, and opportunity as determinants of people's health and that men and women possess different access to health resources influencing who becomes ill and the kind of resources available to cope with the illness once it occurs (Clow, Pederson, Haworth-Brockman, & Bernier, 2009). Inferring from the social role theory which assigns differing roles and expectations for men and women, it could be said that the role accumulation, role overload and role conflict, gendered patterns of socialization and social acceptability, the nurturing and caregiver responsibilities of women, and the gender role differences in risky behaviour are the possible determinants for the differences in the health status of men and women (Segall & Fries, 2011).

The role accumulation hypothesis suggests that more roles rendered by women result in better health. This is very theoretical since many of the roles rendered by women do not intrinsically or extrinsically add to their health status. Rather, engaging in multiple roles poses a physical, emotional, and mental toll on women thus impacting negatively on their health. The situation is even worse in contemporary times where women are now playing a more active role in the mainstream of society, which in itself is positive, but has saddled women with more responsibilities since domestic roles are still being carried out mainly by women. The role accumulation by women therefore has the tendency to impact negatively on their health. The role overload and conflict hypothesis presuppose that undefined and multiple implicit roles by women bring about role strain with its repercussion of stressing out women with adverse impact on their health. This situation is particularly worse with regards to single-parent mothers who are evidently most vulnerable to the adverse health outcomes associated with role strain and stress (Maclean, Glynn, & Ansara, 2004). It is therefore no coincidence that most women identify stress as their major health concern (Thoits, 2010).

The social acceptability hypothesis suggests that due to socialization into gender roles, women are more willing to render the sick role more than men. Contrary to this conventional explanation, however, women rather socially accept their multiple roles they are socialized to render which invariably predispose them towards marginalization and poor health. The sick role is therefore not just a mere social role but emanates out of the physical, emotional and mental stress associated with the many roles socially assigned to women. Society thus positioned and socialized women to play the sick role or become more susceptible to illness. Further, the nurturant hypothesis points out that women sacrifice their health needs to ensure that members they care for in the family such as children, spouses, parents, and the sick within the family are well in order to fulfil their social role as caregivers. Further the stress associated with the care giving role translates most often to poor health outcomes for women. It is even evident that many women play the sick role so as to be guaranteed the marginal strength to care for their dependents. Lorber (2000) confirmed the above explanation when he concluded that social roles and marriage improves men's health and worsens that of women.

Obviously, the social role theorists generally see the poor health status of women as emanating primarily from socialization especially within the family. The higher morbidity and health care utilization of women

can therefore be said to be as a result of interaction between social and biological factors associated with womanhood. What is not definite, however, is the role of the forces of medicalization within patriarchal cultures in accounting for the poor health status of women (Segall & Fries, 2011). It is evident so far that socialization within the family plays a key role in determining the health status of people and their reactions to health conditions. This conceptual paper therefore aims at helping to fill the knowledge gap on how socialization predetermines the health status of women.

The Family as Primary Gender Socialization Agency

The fact that gender socialization contributes significantly to people's health status implies that the family - which is the primary agent of gender socialization – has a critical role in influencing people's health status. The family is an economic unit collectively producing and consuming wealth and resources. It therefore plays a major role in the health of the family, for instance caring for dependents (sick, elderly, children etc.). It further shapes the values and attitudes of its members in a process of socialization and also provides foundations for critical lifestyle choices (values) for individuals.

Families are an important site for health. It provides the location for surveillance and monitoring of people's health through overt means and through the development of self-surveillance. Families play an important role in people's decisions to render or not to render the sick role. Families can seriously affect the amount and style of adherence to treatment regimes. The family, from the functionalist perspective, is to ensure good health of its members. This becomes an important functional requisite for the family to render. Generally, the family plays a role as mediating between the informal and formal arenas of health care patronage and consumption.

A critical look at all the explanations of gender disparity in health discussed previously points to the family as the primary habitation for such disparity. Largely the combined social roles of women, which predisposes them to ill health takes place within the family. Female children are socialized into accepting multi-tasking social roles, which eventually impacts negatively on their health as they practiced these roles during adulthood. Since the theoretical and practical components of gender socialization process occurs in the family, it becomes an important conduit in addressing the dismal health status of women.

Gender socialization in the family needs to change so that women are not socially brainwashed into believing that they are the primary group responsible for rendering almost all social tasks within the family. Gender socialization needs a recast to spread out fairly the social roles and expectations for women and men, so that no particular group will be at an advantage position over the other. This calls for a reformation of the family which is the primary source of gender socialization. This is in spite of the contemporary competition confronting the family by the other social institutions in the gender socialization process. This competition notwithstanding, the family still remains the primary habitation where gender socialization finds reality and meaning.

Feminist Theorists' on Gender Health Disparities in the Family

Feminist theorists believe that macro and micro sociological structures marginalize women on many fronts, which adversely affect their health status. This is perpetuated through role orientation acquired, reproduced, and sustained through the conduit and process of socialization, which takes place primarily within the family. The primary focus of feminist theorists' is therefore premised upon how sexism pervades our social institutions and social life. As a matter of fact, due to feminists' advocacy, there is

presently a minimal shift in the traditional social roles for women for the better in almost all cultures. Although some of the traditional barriers and differentiation in gender roles within the family and the larger society, sex-typing of work, and parenthood are undergoing changes, the gender gap still persists in many societies with its adverse impact on women's health.

Feminists' theorists firmly hold on to the belief that gender role differential through socialization serves as a precursor to unbalanced differential risk accumulation and its associated stressors which ultimately manifests itself in poor health status of women. The social position of women in many cultures does not augur well for their health. The differential access to life opportunities – education, work etc. - even makes matters worse for women and their health. Many feminists' see the peripheral position of women as systematically constructed. They believe this plays out in the public sphere in the form of poor involvement or participation of women in social institutional affairs and systemic decision-making affecting their lives and that of their children.

The feminists' perspective on women's health status as discussed previously has been met with some criticisms. The critics of the perspective believe that holding men directly responsible for women's poor health status is absurd since men alone do not define gender roles in societies (Mikkola, 2017). In other words, women are equally culpable in defining their social position. Further, women's higher life expectancy in many societies is indicative of their health status superiority. In spite of these criticisms, however, the fact still remains that blatant violence of all forms - physical, sexual, mental, emotional, and psychological – against women adversely complicates issues for their health (Boateng, 2017). The philosophy of the feminist school of thought is thus clear that social alienation of women in many societies with its manifestations in increasing feminization of poverty, unemployment, underemployment, over representation as victims of domestic violence among others combine to impact negatively on the health status of women in many societies, especially societies embedded with patriarchy.

Conclusion

So far it has been established that the health of women in general is in jeopardy because of the excessive social roles and responsibilities placed on their heads. Excessive social roles for women are perpetuated through socialization, primarily taking place within the familial fold. Gender socialization therefore features significantly in defining and perpetuating social roles with its roots in the family. The family being the primary host for gender socialization indirectly links men and patriarchy to the excessive social roles assigned to women because they are deemed as the heads of families particularly in patriarchal cultures. This is in spite of the fact that they might not be involved directly in gender socialization process because of their social status and roles, yet they are largely the architects of the gender socialization process per their status as men. Gender resocialization, therefore, becomes critical as a way of ensuring that a particular group of people, in this case women, are not overly burdened with social roles with its potential adverse impact on their health status. Gender resocialization should be directed at attaining egalitarianism of social roles for all the sexes within the family without the strict jacket or sex-typing of social roles presently informing socialization particularly within the family as a social institution.

Recommendations and Policy Implications

In order to address the negative health status of women emanating from negatively skewed social roles placed on their heads demands some social policy interventions. There is the urgent need for social policies that hold promise for women to increase

control over their lives and particularly to reduce any type of discrimination confronting them to be institutionalized. Such social policies can aid in the decrease of women's exposure to risk factors through education and legislation. This will assist in improving their material wellbeing, status and available life choices that can impact positively on their health status.

Women should also be proactively involved in social decision-making, predominantly in those affecting them directly. This should not be limited to just health treatments but also in all other aspects of their lives. This is a drive towards empowering women to strive further in reaching their full potentials as a dependable group in ensuring a functional society. Further, women need to be encouraged more in appreciating the need to strengthen social networks and communities to enable them provide practical and emotional support to each other in times of need. Through preservation and strengthening of social networks, women can maximize the benefits associated with social capital which can be translated into general wellbeing and improved health status. As established previously since men play a significant role in the gender socialization process because of their status as family heads in most cultures, they should be more encouraged to champion women's causes. This is without a doubt a critical step geared towards addressing gender inequalities in contemporary society with its promise of improved health status for all.

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