## CHAPTER-2
### REVIEW OF RELATED LITERATURE

<table>
<thead>
<tr>
<th>Sr.No.</th>
<th>Details</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Introduction</td>
<td>71</td>
</tr>
<tr>
<td>2.2</td>
<td>Research periodicals and journals</td>
<td>72</td>
</tr>
<tr>
<td>2.3</td>
<td>Pre-Psychological Studies about Social Support</td>
<td>73</td>
</tr>
<tr>
<td>2.4</td>
<td>Pre-Psychological Studies about Mental Hygiene</td>
<td>77</td>
</tr>
<tr>
<td>2.5</td>
<td>Pre-Psychological Studies about Illness Behaviour</td>
<td>80</td>
</tr>
</tbody>
</table>
CHAPTER 2
REVIEW OF RELEVANT LITERATURE

2.1 INTRODUCTION:

Psychology is the study of human behavior. It is both a basic science as well as an applied science. As a basic science, it tries to discover through research the basic principles about human behavior. As an applied science it tries to apply these principles to solve the various practical problems connected with its basic aspect.

Research is based mainly on review of relevant literature. Once a topic has been decided upon it is essential to review all relevant material connected with the topic. In fact review of literature continues throughout the research work. Since a research report, either a dissertation of thesis, is supposed to be study in depth aiming contribution to knowledge, a careful check should be made that the proposed study has not previously been carried out completely new and original problems are rare however a previous study should not be exactly replicated unless the techniques used had been facility or the findings and conclusions doubtful or unless some new sources of information had been discovered to shed new light on the problem. If is necessary related to previous research studies. In some subject areas it is important to locate the problem within a theoretical frame work and in such cases the underlying theory needs to be reviewed as well.

Clinical Psychology includes both these facts. Its scientific aspect is rooted in research that provides the knowledge that is pre-requisite for any practical application.

The three topics which are universally held adequate for clinical Psychology (1) Social support (2) Mental hygiene (3) illness behavior for the clinical field and satisfaction for its persons.

May be it is relatively difficult to ascertain productivity within these factors. May be the domain has been left to economist who seem to deal with hard kind information for Indian culture because it is not yet work-oriented.

In clinical field, very few studies have been reported on this subject in the population of the Gujarat state. Thus, this kind of research is a pioneer study in the clinical field.
2.2 RESEARCH PERIODICALS AND JOURNALS:

Research periodicals, journals contain information about new ideas and developments. There are many periodicals in clinical field, which are the best sources for the reports in present researches. These periodicals provide more up-to-date treatment to the current issues in clinical field than books. These are the important sources for determining the contemporary opinion. Some association and institutions publish many periodicals. They provide dissemination of clinical field research and exchange of experiences among various clinical field personnel in the field of clinical.

Abstracts contain a brief summary of the contents of the research article. It is a kind of most useful reference guide to the researcher. In some countries, clinical persons have their special "Clinical Abstract". Some of the abstracts are given below:

Locating the sources of information:

In order to locate the sources of information, the researcher first needs the study in the library and use of Internet in his area of research. When he is motivated, then he is able to search the sources for setting the information. Library is an important and valuable source that provides valuable information. The following are the locations of sources of the information.

Library:

The researcher should be acquainted with the techniques of skillful use of the library. A suitable and computerized library provides useful information within a short period. Library is the storehouse of wisdom. Library possesses a printed guide, which indicates the location of the stacks, the periodicals, reference division, reading room, books for different subjects, microfilm equipment, pamphlet, journals, government documents, monograms, computer generated reference materials, newspapers, clippings, special indexes, abstracts, and catalogue. There is some regulation for using the stacks. The librarian should possess work. The catalogue helps a lot to the researcher for easy location of any material required for the study; The Xerox facility in the library helps the researcher in providing Xerox copy of any material desired by the researcher.

The researcher has to collect the information about heart attack and heart diseases from direct sources and indirect sources as stated above. Here, the researcher
has to collect the material about the dependent three variables which are related in the present study. These variables are as under and their pre-studies are also shown here.

2.3 PRE-PSYCHOLOGICAL STUDIES ABOUT SOCIAL SUPPORT:

(1) "A study of social support received by the working male and female with reference to different age-groups"

By: Prof. Arefa Mansuri.

The present study is an attempt to investigate the differences in the social support received by the working males and females of different age-groups. The sample consisted individuals of Ahmedabad city of which 20 were male and 20 were female. The social support was measured by the social support scale devised by Ritu Mehra and P. Kalhara. The personal data sheet consisted of age, gender, income, marital-status; conflict with co-workers etc. was obtained. The collected data was analysed on the basis of age-groups and gender using 'r' test. Results revealed that there is no significant difference in social support received by the working male and female of different age-groups.

(2) "AIDS/HIV patients and level of social support, an empirical study of patients of Rajkot district in Western India."

By: Mr. Uttamkumar B. Lunagariya, Lecturer, Shri D.H. Kabariya Arts Mahila College, Amreli.

AIDS/HIV a silent killer draculla. Spreading like forest fire cutting across age, sex caste, class geographic boundaries of the world, is considered a biological disease having no remedial measures found till today. (Patel & others)

It has also its social cultural and psychological conserve. The root cause of the disease is mostly researched out as unsafe multi-partner sexual behavior groups (HRB groups). Among HRB groups, sex workers well known red-lishi area of Delhi is reported as AIDS/HIV production factory. (India Today)

It is well known fact that sexual behavior though apparently a biological act, is social, cultural, psychological behavior because nouns, values, customs, attitudes,
perceptions motivation etc. factors play great role in the sex-behavior. It is also true that AIDS/HIV disease has social, psychological, ethical economic concerns.

(3) "A psychological study of mental hygiene, social support and life satisfaction of L.I.C. holder service class people."

By: Bhini M. Karavadara, M.A. Psychology, Rajkot.

Year: Ph.D. Thesis 2007

Sample: 600

Tools: Social support test (Ritu Mehra & P. Kalhara)

Statistical Methods: t-test, r-test and F-test.

Result: Age, sex, residence are effected on the social support.

(4) A comparative study of job involvement and social support of married and unmarried employee women.

Researcher: Malek Altak F.


Sample: 120 employee women

Tools: Social support test (developed by Dr. Ritu Mehara & P. Kalhara)

Statistical Methods: F, (Anova), r-test

Result: Experience of the service and marital status effect on social support of the employee women.
(5) **Psychosomatic problem and social support among working women.**

Researcher: kaliya H. L.

Year: 1998

Sample: 30 women

Tools: Social support scale

**Result:** (1) Social support significantly effect on psychological diseases (2) The number of the children, the kind of the work, educational level and other factors of the family do not affect on social support.

(6) **"A prospective two-wave panel study of social support, psychological distress and well being among married people contextual perspective"**

Researcher Frenford Jamel Alen

Year: 2001

Sample: 215 married male-female

Tools: Social support test...

Result: (1) The cooperation of the life partner among the people effect on psychological well being. (2) The cooperation of the life partner get more than support of the friends among the people effect less anxiety.

(7) **A study of the social support in the reference of the family construction among the employee men and women.**

**Researcher:** Prof. Aarif Mansuri

**Year:** 2009, 13th international & 44th national conference (IAAP)

**Sample:** 78 (38 male, 40 female)

**Tools:** Social support test (developed by Dr. Ritu Mehara & P.Kalhara)

**Statistical Methods:** t-test

**Result:** There is no significant effect of social support of the joint family and separate family among the employee men and women.
(8) A study of social support among the difference age of the employee women and men.

Researchers: Prof. Aarefa Mansuri

Year: 2009, 13th international & 44th national conference (IAAP)

Sample: 20

Tools: Social support test (developed by Dr. Ritu Mehara & P. Kalhara)

Statistical Methods: t-test

Result: There is no significant difference of social support of the age difference among the employee women and men.

(9) A comparative study of the mental hygiene, psychological well being and life satisfaction effective variables in the form of social support among the difference income of women and men.

Researchers: Giti J. One Dalen Carin Senders & Tiny K. M. Williams

Year: Inflibhet

Sample: 459 married

Result: (1) There is no significant effect of the sex difference in the social support. (2) More social support effect of the relatives in mental hygiene and life satisfaction.

(10) Determinants of Social Support among Gay Men the Context of AIDS.

Researchers: Turmar Hays

Year: 1983

Sample: 440

Tool: Social Support Scale, Cross Verification.

Result: The research shows that family members do not do sex disorder to the HIV negative persons. And it also shows the characteristics of HIV negative patients.
2.4 PRE-PSYCHOLOGICAL STUDIES ABOUT MENTAL HYGIENE :

(1) Kochguway Vinitha :

Examined the hypothesis that greater the anxiety, the greater the maladjustment among 10 grade 200 girls students of Patana, School Students folk mohsin-shamsual adoption of bell adjustment inventory and academic anxiety scale for children, and were categorized into high-anxiety (HA) group and low-anxiety (LA) groups using a medium split procedure. Findings indicate greater adjustment problems in the case of the HA group in areas pertaining to home health, social and emotional aspects. Academic anxiety was also found to be significantly related to over all adjustment. Findings support the hypothesis.

THE SOCIO-PERSONA VARIABLES & MENTAL HYGIENE :

SEX : Social values, norms, roles have always distinguished between males and females. Right from childhood, females are conditioned to be shy, co-oriented towards home & children etc. When women go for career it is viewed differently than males.

Dr. Balder Sharma, "A study of organizational climate and employer employee relation in India. Not by Bread Alone, Shri Ram Centre for industrial relation and human resources."

Several studies gathered data on Psycho-socio variables of married working women:

(2) Terman and Marril (1937) :

He has studied about mental hygiene and other matters. He wanted to find out whether there is any effect of the sex on the mental hygiene.

He got all information by the questionnaire from different schools of the students who were studying in the std. 8th to 12th. He used analysis of variance the statistical method for his research.

The result showed that the mental health of the boys and girls differ.*14
(3) **Archana and Vandana:**

In a study conducted by them it was found that mother who had children between 6 to 12 years were most troubled. These women were overburdened with manifold responsibilities of the house, children and job. It had an impact on their mental health also, while man did not feel so. So sex has definite influence on mental hygiene.

(4) **Rai V. K. and Yadav V. C. (1993):**

Rai and Yadav have studied on the students of the secondary school about Mental Hygiene along with the effect of their social and economical position. They have studied about the following their aims if there is any effect of the sex of the student on his mental hygiene.

These students were studying upto 9 and 12 standard and their age was about 13 to 20 years. They were from rural and urban area. Their sample was that of 501 students from the higher secondary school. Among them boys were 251 and girls were 250. They had used the mental hygiene scale.

The result showed that the position of mental hygiene differed about boys and girls. More over the mental hygiene of boys was higher than mental hygiene of the girls.*16

(5) **Parul Vadodaria (1993):**

Her aim was to study the anxiety neurosis of the students of the colleges of Rajkot city.

It was specially found the effect of mental hygiene and sex on anxiety neurosis. The result proved that there was significant difference between the anxiety neurosis of boys and girls.*17

(6) **Prof. Alka Makad (1995):**

The comparative study of the mental hygiene of the boys and girls who were studying in the colleges of the Morbi city.
The result showed that the mental hygiene of the boys and girls significantly differed.*18

(7) Aghara (1995):

The study about mental hygiene on the base of socio-economic status of the students of the higher secondary school. It was found that there was no significant effect of the sex on the mental hygiene of the students.*19

(8) Punam Pomal (1996):

Among all her research objectives one was to find out what is the effect of the different personal social variables of the teachers on their mental hygiene.

She concluded from her result that there was no significant difference of mental hygiene between female teachers and male teachers.*20

(9) Nilam Nakum (1995):

The mental hygiene of the patients of the cancer hospital of Rajkot city. A significant difference was found between the M.H. of male patients and female patients.*21

AGE : We have just seen in a study conducted by Arnold that new comers are more satisfied with their jobs and the ones with 13 years experience were unsatisfied. Young employees who have just joined are more enthusiastic, energetic, ambitious, willing to change so they experience more satisfaction than middle aged people. They have lost their enthusiasm with age and they are bored with routine work. Middle aged people also have lot of social responsibilities. So they are not very happy in their jobs. The older people get more matured and have achieved most of the things at the end of their career and have finished their social obligations which make them mentally free. State of mind is different at different age, so it is seen that age affects mental health.
(10) Prabhakaran (1986):

He has chosen in his study a sample of three groups, first range group was with the age of 15 to 20 years, second range group was from 21 to 25 years and third group was from 25 to 30 years. He has found from the comparative study of these three groups that when age increases, the mental hygiene also increases. It was found there was vast difference between 1st and 3rd group.*22

(11) Minaskhi D. Desai, Prof. Department of Psychology, Sau. University, Rajkot. :

Self-Perception and Mental Health:

Our mental health is closely tied to our self-perception. Aspects of our self-concept strongly affect how we handle stress and how stress affects our well-being. Self-perception process plays an important role in producing depression, anxiety and feeling of helplessness. At the same time, these self-perception processes can be used to alleviate such problems.

There are several aspects of self-perception such as, self-efficacy, perception of control, self-complexity, self-discrepancies etc. People make many self-attributions, including those explaining why they succeeded or failed. People's experience regarding their action or the outcomes of these actions lead them to develop generalized expectancies that outcome are internally or externally controlled and accordingly they are called internals or externals.

2.5 PRE-PSYCHOLOGICAL STUDIES ABOUT ILLNESS BEHAVIOR

(1) "Is illness behavior related to chronicity in patients with intractable pain?"

By: I.Pilowsky and N.D.Spence, Department of psychiatry, University of Adelaide, Adelaide 5000 Australia. (2003)

One hundred patients, referred for the management of intractable pain, completed a 52-item illness behavior questionnaire (IBQ). Responses were scored on 7 scales: General Hypochondrias is, disease conviction, psychological versus somatic
perception of illness, affective inhibition, affective disturbance, denial and irritability. IBQ scale profiles were used to study the relationship between chronicity of pain and pattern of illness behaviour reported. Except in the case of one scale, no significant correlation emerged. This overall lack of association between chronicity and illness behaviour remained even when the patient sample was restricted to those 20 patients having substantial organic pathology associated with their pain. These findings suggest that degree of chronicity is unlikely to play a major role in determining the illness behaviour manifested by patients with intractable pain.

(2) Illness behaviour questionnaire (IBQ) : Translation and adaptation in India.

By: Vijoy K. Varma, Anil K. Malhotra and S.K. Chaturvedi

The illness behavior questionnaire (IBQ) of Pilowsky and Spence (1981), which was developed as a self report instrument to record aspects of illness behaviour particularly those attitudes that suggest inappropriate or maladaptive modes of responding to one's state of health (Pilowsky 1971) was translated into Hindi and adapted. Factor analysis of the data revealed four meaningful factors which correspond with the four out of seven factor reported by original authors.

(3) Cross-cultural Medicine: cultural aspects of health and illness behavior in Hospitals.

By: Joseph Hartog, MD, and Elizabeth Ann Hartog, Rn,MA, San Francisco.

Obviously the complexities of many cultures are such that one cannot master any but one's own. But an approach can be developed. Like the psychotherapist, we can all ask, "What do you mean by that?" A genuine interest, a willingness to give a little extra and a respect for customs can go a long way toward improved communication and compliance, and thus a better outcome. We should ask about customs and practices, listen, explain and correct for our own cultural biases me diaries and interpreters, colleagues and other hospital staff and be aware of the possible distortions in transmission. But, as stated above, a good caring relationship is still the greatest insurance against, and antidote for, the inevitable cultural mistakes.
Illness behaviour of tuberculosis patients undergoing dots therapy: a case-control study.


Illness behavior questionnaire (IBQ), a self-report instrument was administered to 103 tuberculosis cases and a similar number of age, sex matched controls to find out the difference in illness behavior profile of the two groups. The tuberculosis patients were receiving treatment from two DOTS centers in East Delhi and the controls were from the same locality. The tuberculosis patients exhibited features pertaining to general hypochondnasis (GH), affective inhibition (AI) and affective disturbance (AD) more than the controls and the differences between the two groups were statistically significant. However, denial of problem (D) was seen more in controls compared to tuberculosis patients.

Does the illness behavior questionnaire measure abnormal illness behavior?

By: Zonderman AB, Heft MW, Costa PT Jr.

Abnormal illness behavior (AIB) has been proposed as a construct measuring the inappropriate or maladaptive modes of responding to one's state of health, and the illness behavior questionnaire (BQ; Pilowsky, 1975) was designed to measure this construct. Previous studies using small samples have failed to agree on the factor structure of this questionnaire. The present paper examines the factor structure of the illness behavior questionnaire and critically evaluates the interpretation of its dimensions as well as the construct of AIB. A factor analysis of responses from 1,061 health care and non-health care seeking subjects yielded six interpretable factors which substantially replicated Pilowsky's previous results. Six scales were calculated and correlated with several personality measures. The results indicated that the illness behavior questionnaire is saturated with neuroticism, a dimension known to be related to excessive medical complaints. But excessive medical complaints cannot be equated with hypochondrias is or AIB in the absence of objective medical information. In the absence of evidence for the discriminate validity of the IBQ, its use as a diagnostic device is unwarranted. Treating elevated IBQ scores as indicators of abnormal illness
behavior without corroborating medical information may be more misleading than accepting patients' symptom reports at face value.

The investigator wants to compare the results of the present study as per hypothesis with these above studies in the fourth chapter.

Research cannot be done in vacant field. With the help of pre-information and studies, new research is made in progress. If there is any doubt about results of pre-research, so for that solution new research is made. So, the dependent variables of this research and in the clinical fields some pre-studies are taken as a sample with kind effort as under.

Research is based mainly on review of relevant literature. Once a topic has been decided upon it is essential to review all relevant material connected with the topic. In fact, review of literature continues throughout the duration of research project work. It is necessary to be related to previous research studies. In some subject areas it is important to locate the problem within a theoretical framework and in such cases the underlying theory needs to be reviewed as well.

So, here the researcher has explored some previous studies as per dependent variables of the problem.

**PRE-RESEARCHES OF ILLNESS BEHAVIOUR :**

There are some pre-studies about illness behaviour by some researchers.

**MORE PRE-STUDIES ABOUT ILLNESS BEHAVIOUR :**

(6) **Researcher :** Adlar  
**Title :** The study of psychosomatic patient of working people.  
**Year :** ---  
**Sample :** 100  
**Tools :** Vocational Maladjustment Test
Conclusion: There are three reasons for the Illness Behaviour (Psychosomatic behaviour). (1) Inadequate personalities (2) Paranoid personalities (3) Emotional personalities.

(7) Researcher: Jagruti Vyas

Title: The study of Mental Hygiene, Adjustment and Anxiety of High Blood pressure patients of Rajkot city.

Year: 2005

Sample: 480

Tools: Mental hygiene inventory, Adjustment scale, Anxiety scale

Conclusion: The study shows the effect of sex, area and kinds of family upon the anxiety also.

In the first decade of the twentieth century, several notable psychologists established their own schools of thought, one immediately following the other. First, Freud established the discipline of psychoanalysis. Following Freud, John Watson created behavioral psychology, then Carl Jung founded the school of analytic psychology and Alfred Adler established the school of individual psychology. Alfred Adler was the first psychoanalyst to challenge Freud, the father of modern psychology.

Cameron, James M. (1909) one important landmark marking the progressivism of the early 20th century was the creation of the National Committee for Mental Hygiene in 1909. It was brought forth after Clifford Beer published his memoir, A Mind That Found Itself, which detailed his experience in psychiatric hospitals. Mental hygiene promoted new trends in mental health care, notably the employment of psychologists and social workers, development of community outpatient clinics and aftercare programs, and the need for psychopathic hospitals and wards. The asylum began to be seen as an “inferior facility” which “quartered the failures of society”, strengthening that institution’s custodial role.

Despite the growth of psychology and the creation of mental hygiene, only a small number of patients were affected by the spirit of progressivism. Mental hospitals continued to grow (and to become more overcrowded and understaffed).
From 1880 to 1940, the number of people within asylums increased five times as fast as the general population, to 445,000 persons.

A host of new therapeutic techniques came to play in the 1930’s. Electroconvulsive therapy was introduced by Ugo Cerletti in 1938. Its primary aim was to render patients meek and manageable, and continues to be used in the present day on depressed patients who have not responded to other forms of treatment. Insulin-coma therapy and metrazol-shock treatment were both invented in the 1930’s. Both treatments were experimental and failed to improve the lives and minds of patients, but stayed in use for at least twenty years, until the creation of antipsychotic drugs in the 1950’s. Prefrontal lobotomy was introduced by Antonio Egas Moniz, but was developed by Walter Freeman and James Watts, also in the 1930’s. Between 1936 and 1960, an estimated 50,000 lobotomies were performed in the United States.

Psychiatry’s opinion of the asylum changed rapidly in the postwar era. Brought about by the aforementioned growth in Neo-Freudian psychoanalytic thought and frustration with the asylum, after 1945 psychiatrists left mental hospitals in preference of private and community practice—80% of psychiatrists registered with the American Psychiatric Association (APA) made the shift by 1955.

The mentally ill have long been misunderstood and mistreated, neglected and abused. In earliest history there existed no division between medicine, magic, and religion. Across most cultures in the ancient world, mental illness was considered an affliction brought on by the supernatural—God, or demons. The earliest known treatment for mental illness was trepanning, the opening of the skull, which was performed to release evil spirits.

Thus far, mental health and mental hygiene was of specific interest of psychologists, psychiatrists, social workers, and those who took a personal interest. It took World War Two (WWII) (1939-1945) to bring mental illness into societal focus and cause a social paradigm shift, which in turn brought great political changes. WWII provided frightening evidence of the extent of mental illness in American society.

12 percent of men screened for induction into the military were rejected on neurological or psychiatric grounds, comprising 40 percent of all rejections.
Furthermore, 37 percent of Army men were discharged due to neuropsychiatric problems.

Psychiatry’s opinion of the asylum changed rapidly in the postwar era. Brought about by the aforementioned growth in Neo-Freudian psychoanalytic thought and frustration with the asylum, after 1945 psychiatrists left mental hospitals in preference of private and community practice—80% of psychiatrists registered with the American Psychiatric Association (APA) made the shift by 1955.

Following the return of WWII veterans, society became curious about mental illness. Movies such as *The Snake Pit* and books such as *One Flew over the Cuckoo’s Nest* were produced and written, popularizing the plight of the mentally ill. In *The Snake Pit*, the mentally ill protagonist was displayed as sympathetic enough for people to relate to. There was also a boom in popular exposé articles published about mental illness and the state of asylum. It is evident that public display of mental illness had an effect on the population—an enormous growth in voluntary mental health organizations moved underway, from 50 existing organizations in the 1930’s to over 200 in the 1940’s. Sociologists Franklin Chu and Sharland Trotter supported Richard Rumer when he asserted that the 1950’s and 1960’s had “heightened public consciousness of mental health care.

However, epidemiological studies began to develop a greater social consciousness towards understanding the mentally ill. August Hollinshead and Fredrick Redlich established an empirical relationship between social status and psychiatric problems, which led to a belief that mental illness was to some extent relative, based on a social dimension and connected to groups and communities. In turn, a focus on preventative

Psychiatry in communities arose, assisted by popular literature such as articles in Life and Reader’s Digest on mental illness, as well as published social-scientific critique. As a result of the publications about the deplorable conditions in mental hospitals and the rising environmental considerations, the mental hospital itself was newly considered to be a cause of disability itself.

President John F. Kennedy, a staunch supporter of the mentally ill and mentally retarded, asserted in 1963 that “the mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities.

JFK signed the act into law less than one month before his death, issuing with the act a special message emphasizing three things: the large numbers of mentally ill
persons and great costs incurred in caring for them; the horrific conditions in state hospitals; and the hope offered by new therapeutic techniques and psychotropic drugs.

These decentralizing, deinstitutionalizing policies, though effective on paper, did not work as planned. The distinction between “care” and “treatment” became distorted. While community policies paid rhetorical homage to the need for care, their primary focus was on providing therapeutic treatment. The social and human needs of patients were often ignored, or overlooked. This raised a host of concerns over the deinstitutionalizing legislation of the 1960’s, as many chronically mentally ill persons no longer had state hospitals in which to reside and became deinstitutionalized from state hospitals to nursing homes, jails and prisons, or into homelessness. Though sometimes offered therapeutic services, their placement (if not with caring family and friends) left them vulnerable to social ostracism, without necessary social services.

Sociologist David Mechanic blames the unfortunate initial results of deinstitutionalization on a lack of empirical evidence. He maintains that “the operation of mental health programs has preceded more on an ideological thrust than on any empirically supported ideas concerning the feasibility and the effectiveness of particular alternatives.

Social factors that shape gender roles also influence the gender difference in reporting symptoms (Waldron, 1997). Given the same level of symptoms, the female gender role allows women to seek many sorts of assistance whereas the male gender role teachers’ men to Act string and to deny pain and discomfort. In addition, men’s social role permits them to take more risk. Men are more likely to need health care because of such risks as alcohol consumption and job hazards, but women are at greater risk through physical inactivity, unemployment, and stress. When all risk factors are controlled, the illness gap between men and women may be quite narrow, although men generally have worse chronic health than women (Verbugge, 1989).

David Mechanic (1978) reviewed several studies that reported ethnic groups. Jewish Americans, for example, were more likely to seek professional medical behavior; Mexican Americans felt were serious and to inflate others that doctors regarded as minor; Irish Americans tended to deny pain stoically. These differences demonstrator the powerful effects of culture and context on the experience of illness and sick role behavior.
Age is yet another factor that influences people’s willingness to seek medical care, with young and middle-aged adults showing the greatest reluctance. Children are more willing to seek help than adolescents, especially male adolescent (Garland & Zigler, 1994).

Ironically, people under stress are less credible when they claim that they are ill. Patients who reported physical and psychological distress compromised their credibility (Skelton, 1991).

One of the first studies to include women was the Framingham Heart Study (Dawber, 1980). Even though both men and women participated nearly all participants reported relatively similar levels of activity. As a result, when the investigators looked at the coronary benefits of activity for all participants, they found very few. However, when they compared extremely inactive participants with the maximally active, they found that inactive men and women were about three times more likely to develop coronary heart disease. The Almedsa County Study also found that both men and women can decrease cardiovascular disease and increase life span through leisure-time physical activity (Kaplan, Strawbridge, Cohen, & Hungerford, 1996). In addition a study of post-menopausal women in Iowa (Kushi, et al., 1997) found that older women who exercised moderately at least four times week had much lower rates of all cause mortality than women who were sedentary. Even moderate physical activity once a week significantly reduced the chances of death from CVD. In this study, vigorous activity also reduced death rates but was not superior to moderate physical activity.

Can women reduce their risk of CVD by doing ordinary housework? Unfortunately, one study that addressed this question (Pols, Peeters, Twisk, Kemper, & Grobbee, 1997) found that neither housework nor job-related activity lowered women’s cardiovascular risk factors. Although this study of middle-aged and older Dutch women found that such leisure-time activities as sports, cycling, and gardening tended to lower blood pressure, reduce body mass index, improve waist-to-hip ratio, and decrease waist circumference, work activity and housework did not contribute to a favorable cardiovascular profile. Because some women performed heavy work on the job and others spent a lot of time doing housework, the authors
were somewhat perplexed by this finding and suggested additional research on the benefits of all types of physical activity for women’s cardiovascular health.

The United is only one of many industrialized Western countries that have seen lifestyle changes and dramatic reductions in cardiovascular deaths among its population. One study from Finland (Jousilahti, Vartiainen, Toumillehto, Pekkanen, & Puska, 1995), for example, showed nearly a 50% reduction just the decade from 1972 to 1982. For this group, about one-half of the reduction in deaths was due to a healthier lifestyle, including reductions in total cholesterol, better control of blood pressure, and reductions in cigarette smoking.

What factors explain this gender gap? Hormones (Williams, 1989) and lifestyle (Matthews, 1989) have both been hypothesized as factors, but lifestyle alone does not account for the gender gap. Statistically adjusting for lifestyle factors such as smoking, education, physical activity, cholesterol levels, and blood pressure did not change the risk for elderly men (Fried et al., 1998). Even with the same risk factors as women, men were still more than twice as likely to have died from coronary heart disease.

If gender is truly an inherent risk factor for CVD, then the differences between men and women should be similar throughout history, but the gender gap in heart disease was small until the 1920s (Nilkifirov & Mamaev, 1998). Until that time, CVD deaths for men ages 25 to 74 years were only about 20% higher than women. From that time until the 1960s, the gap between men and women began to expand during middle age, as men’s rates increased while women’s rates declined. As a consequence, men now have twice the cardiovascular mortality as women during middle age. This historical perspective suggests that factors other than biology are at work in creating the gender gap, but it leaves the discrepancy unexplained.

Although the Framingham Heart Study was not the first to suggest that people with high blood pressure have more cardiovascular problems than those with normal blood pressure, it provided solid evidence of the importance of hypertension. The Framingham study (Dawber, 1980) divided blood pressure into three categories: normotensive (normal blood pressure), borderline, and hypertensive. Regardless of people’s age or gender, their risk of cardiovascular disease increased with increase in blood pressure, clearly indicating that high blood pressure is a risk factor. Since tht
time, many other studies (e.g., Fried et al., 1998; Reed, MacLean, & Hayash, 1987) have confirmed the dose-response association between blood pressure and rate of cardiovascular disease.

Now in the third chapter methodology will be discussed.