Social Science & Medicine 200 (2018) 44–51

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Gender matters in cardiac rehabilitation and diabetes: Using Bourdieu's concepts

Jan E. Angus[a,*], Craig M. Dale[a], Lisa Seto Nielsen[b], Marnie Kramer-Kile[c], Jennifer Lapum[d], Cheryl Pritlove[e], Beth Abramson[e], Jennifer A. Price[f], Susan Marzolini[g], Paul Oh[g], Alex Clark[h]

[a] *University of Toronto, Toronto, Ontario, Canada*
[b] *York University, Toronto, Ontario, Canada*
[c] *College of the Rockies, British Columbia, Canada*
[d] *Ryerson University, Toronto, Ontario, Canada*
[e] *St. Michael's Hospital, Toronto, Ontario, Canada*
[f] *Women's College Hospital, Toronto, Ontario, Canada*
[g] *University Health Network, Toronto, Canada*
[h] *University of Alberta, Edmonton, Alberta, Canada*

ARTICLE INFO

Keywords:
Gender
Cardiac rehabilitation
Diabetes
Cardiovascular disease
Health related practices
Bourdieu
Qualitative research

ABSTRACT

Background: Habitual practices are challenged by chronic illness. Cardiac rehabilitation (CR) involves changes to habits of diet, activity and tobacco use, and although it is effective for people with diabetes and cardiovascular disease (CVD), some participants are reportedly less likely to complete programs and adopt new health related practices. Within the first three months of enrolling in CR, attrition rates are highest for women and for people with diabetes. Previous studies and reviews indicate that altering habits is very difficult, and the social significance of such change requires further study.

Purpose: The purpose of the study was to use Bourdieu's concepts of habitus, capital and field to analyse the complexities of adopting new health practices within the first three months after enrolling in a CR program. We were particularly interested in gender issues.

Methods: Thirty-two men and women with diabetes and CVD were each interviewed twice within the first three months of their enrolment in one of three CR programs in Toronto, Canada.

Results: Attention to CR goals was not always the primary consideration for study participants. Instead, a central concern was to restore social dignity within other fields of activity, including family, friendships, and employment. Thus, study participants evolved improvised tactical approaches that combined both physical and social rehabilitation. These improvised tactics were socially embedded and blended new cultural capital with existing (often gendered) cultural capital and included: *concealment*, *mobilizing cooperation*, *re-positioning*, and *push-back*.

Conclusions: Our findings suggest that success in CR requires certain baseline levels of capital – including embodied, often gendered, cultural capital – and that efforts to follow CR recommendations may alter social positioning.

1. Introduction

In sociological literature, the co-constitution of habitual practices and social contexts is widely acknowledged (Bourdieu, 1996; Shilling, 2008), and this phenomenon is often theorized and studied in sociological studies of people with chronic illness (Charmaz, 2002). Yet, in health sciences research, there is little uptake of these sociological perspectives, particularly in studies of cardiac rehabilitation (CR), which encourages changes to habitual practices in order to achieve risk modification. CR is a complex evidence-based intervention that is shown to reduce or prevent CVD-related morbidity and mortality as well as improve functional status and quality of life (Anderson and Taylor, 2014; Anderson et al., 2016). However, there are reports that not everyone benefits equally; for example, women are less likely than

* Corresponding author. Lawrence S. Bloomberg Faculty of Nursing, Suite 130, 155 College Street, Toronto M5T 1P8, ON, Canada.
E-mail addresses: jan.angus@utoronto.ca (J.E. Angus), craig.dale@utoronto.ca (C.M. Dale), lisaseto@yorku.ca (L.S. Nielsen), MKramer-Kile@cotr.bc.ca (M. Kramer-Kile), jlapum@ryerson.ca (J. Lapum), PritloveC@smh.ca (C. Pritlove), ABRAMSONB@smh.ca (B. Abramson), Jennifer.Price@wchospital.ca (J.A. Price), Susan.Marzolini@uhn.ca (S. Marzolini), Paul.Oh@uhn.ca (P. Oh), alex.clark@ualberta.ca (A. Clark).

https://doi.org/10.1016/j.socscimed.2018.01.003
Received 14 June 2016; Received in revised form 30 December 2017; Accepted 3 January 2018
Available online 06 January 2018
0277-9536/ © 2018 Elsevier Ltd. All rights reserved.

men to access and complete CR (Samayoa et al., 2014). Such gender based comparisons are informative, but can only gesture towards the complex and differing social, economic, and geographic circumstances that contextualize efforts to alter deeply embodied habits in response to chronic illness (Hankivsky et al., 2010). Gender is a practice, a social phenomenon that maps on to the physicality of individual, sexed bodies. It may differently shape struggles to overcome habits and activate new health knowledge in everyday practices (Lorber, 2011; Robinson and Robertson, 2014). We argue that a gender analysis of encounters with CR should draw on social theory to illuminate the contextual conditions that contribute to health and illness experiences for men and women. The qualitative study reported in this paper is the first to draw on Bourdieu's (2001; 1998) social theory of practice in a gender analysis of challenges encountered the early months of CR attendance.

1.1. Background

Globally, 63% of deaths in 2010 were attributed to non-communicable diseases, with CVD and diabetes among those most responsible for global mortality (World Health Organization, 2011). The rise in these diseases is attributed to a corresponding increase in four embodied habits – also known as risk factors – that are considered modifiable: tobacco use, physical inactivity, use of alcohol, and unhealthy diets (World Health Organization, 2011). Risk modification programs such as CR are recommended for people with CVD and diabetes, but women are less likely than men complete CR (Samayoa et al., 2014) and participants with diabetes have significantly higher rates of attrition than non-diabetic participants, thus undermining health benefits (Armstrong et al., 2015; Yohannes et al., 2007). There are many challenges involved in acting on the recommendations of health education programs for those with CVD and diabetes, as Shaw's et al. (2016) qualitative synthesis indicates. Other qualitative syntheses of experiences with CR programs indicate that program attendance and resultant changes to habitual practices are embedded within social context; men and women report numerous and differing social and economic barriers to CR (Angus et al., 2015; Clark et al., 2012). Also, attrition is highest within the first three months of enrolment to a CR program, attesting to the difficulty of integrating new patterns into habitual practices (Dorn et al., 2001).

The impositions of chronic illness on everyday life have received considerable attention in social science. Bury argued that chronic illness affects much more than bodily function; it disrupts biographical expectations and requires subsequent "… mobilization of resources in facing an altered situation" (Bury, 1982, p. 169). Bodily challenges and resultant changes to daily activities contribute to this altered situation. Corbin and Strauss (1987) considered the disruptions of illness, both biographical and physical, as well as the struggle to maintain a coherent sense of self. Charmaz (2002) also noted that illness threatens the loss of valued facets of identity and raises the prospect of a loss of self. In her view, "… the boundaries and the content of self-concept are rooted in habits constructed over time", habits which include patterns of "thinking, feeling, and acting" (p. 315). Thus, changes to habitual practices, even changes that potentially improve health, may threaten identity and social position. Shilling (2008) agreed that illness poses a threat to the comfortable coexistence of habit and identity, but further examined the relationship between habitual activity and relationships within social and physical contexts, arguing that habits are much more than simple repetition of action. He emphasized the co-constitution of habits and the social world. For example, socially patterned habits of tobacco use, physical inactivity and diet contribute to the incidence of CVD and diabetes at the population level, which in turn prompts development of health care programming such as CR.

Shilling (2008) reminds us that some may creatively meet the crisis of illness by re-establishing identities and routines, effectively changing elements of the world and repositioning themselves within it. Radley (1988) studied men's styles of adjustment to CVD, with attention to the regulation of action and experience. Marital relationships contributed to adjustment styles in his analysis, wherein divisions of domestic responsibility either foreclosed or offered opportunities for change – and informed whether the men opposed change or adapted their routines to illness. More recently, Wheatley (2006) drew attention to the "reskilling" efforts of CR participants as they engaged in risk-reduction at multiple levels of consumption, production, leisure and bodily maintenance. In her study, most participants ultimately concluded that complete eradication of risk was unrealistic, arriving instead at individually-defined patterns of "acceptable risk".

In the sociological literature, it is clear that adopting new health-related practices is a complex matter that requires resources, threatens identity, and is contextually embedded. In the health sciences, observed gender differences in CR attendance and has stimulated numerous qualitative studies describing challenges for men and women in adopting the prescribed regimens of CR, particularly in contexts where activities, social expectations and resources are differently organized according to gender. Our systematic review of these studies (Angus et al., 2015) found that many studies focused exclusively on men (see for example, Robertson et al., 2010) or women (see for example, Traywick and Schoenberg, 2008); yet only a few defined or theorized gender and its social context. Routines of diabetes self-care as well as CR-inspired changes to habitual practices, which emphasize embodied practices such as dietary patterns, exercise, and stress management, have potential to disrupt the organization of gendered domesticity (Dale et al., 2015; Mroz et al., 2011; Mroz and Robertson, 2015). While attending CR, men may prioritize efforts to rehabilitate a positive masculine identity lost through illness (Dale et al., 2015; Galdas et al., 2012; Robertson et al., 2010). Immigrant men and women sometimes create hybrid approaches by blending CR recommendations with traditional, alternative and cultural knowledge in their uptake of new health practices (Galdas and Kang, 2010; Seto Nielsen et al., 2012). In our study, we wanted to enhance gender analysis by recruiting both men and women, and drawing on a theoretical position that would support study of the social, gendered nature of CR-related change in habitual practices. With this in mind, we focused on Boudieu's (1996) social theory.

1.2. Theoretical foundations

Boudieu's (1996) analysis of the contextual antecedents of people's habitual practices is sensitive to the contingencies of social spaces. *Practices* are produced in complex relationship with three other concepts: *habitus, field,* and *capital* (Bourdieu, 1998). *Habitus* involves the embodiment of social position (or positions); it is the basis of a deeply socialized and pre-reflexive repertoire of activities, responses, manners, and tastes (Bourdieu, 1998, p8). Social positions (for example, gender, income, nationality) are interpreted according to distinctions in appearance and patterns of activity. People habitually act and expect others to act in ways that reproduce the assumptions underpinning group identity, thus habitual practices are resistant to change because they are not simply an individual property but a reciprocal social production.

Habitus is embedded within *fields*, or local non-monetary social economies wherein exchanges and reciprocities are fundamental to group cohesion and continuity (Bourdieu, 1998). A field is a site of struggle, a structured system of social positions wherein certain types of capital legitimize social positioning (Bourdieu, 1998). In Bourdieu's (1986) formulation, *capital* extends beyond economic resources; people also accumulate, embody, and are positioned according to cultural (education, skill or knowledge), social (networks, supportive contacts), and symbolic (distinction or prestige) capital. Cultural capital, in particular, can manifest in embodied forms (practical skills, linguistic abilities, tastes) that contribute to habitus and are central to our inquiry. Thus, the acquisition of cultural capital "is work on oneself (self-

Download English Version:

https://daneshyari.com/en/article/7328350

Download Persian Version:

https://daneshyari.com/article/7328350

Daneshyari.com