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THE IMPACT OF SOCIAL MARKETING ON BREAST CANCER COMMUNICATION: A THEMATIC ANALYSIS OF HEALTH CARE COMMUNICATION IN THE MEDIA

by

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B.S., University of North Dakota, 1993

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This thesis submitted by Maribeth S. Overland in partial fulfillment of the requirements for the Degree of Master of Science at St. Cloud State University is hereby approved by the final evaluation committee.

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THE IMPACT OF SOCIAL MARKETING ON BREAST CANCER COMMUNICATION: A THEMATIC ANALYSIS OF HEALTH CARE COMMUNICATION IN THE MEDIA

Maribeth S. Overland

Breast cancer is the second major cause of death in women, yet little research exists that examines the content of the messages that women readers of magazines receive about the disease.

The advent of the women's health movement in the late 1960s and early 1970s initiated radical social change in which women demanded greater access to health care information. Historically, women's health messages, specifically those about breast cancer, were communicated from a mechanistic-structural approach. The women's health movement implemented a more holistic-social approach to breast cancer and women's health in general.

This research examined selected samples of three highly circulated popular women's magazines and the New York Times pre- and post- the women's movement during 1964 to 1994.

A textual analysis of breast cancer articles was conducted to examine thematic units characteristic of mechanistic-structural and holistic-social communication. Thematic units are recurring assertions made by communicators such as repeat patterns of ideas.

Significant results were identified in two areas of analysis: 1) an increase in the number of articles addressing the topic of breast cancer during the time period studied, and 2) an increase in the percent of thematic units characteristics of holistic-social marketing communication.

Data indicate there has been both an increase in the quantity and a shift in the quality or type of information on breast cancer as presented in the data. The increase in the quantity is substantiated by more than a 250% increase in both the number of articles and thematic units about breast cancer from 1964 to 1994. The data show a less dramatic, though significant, shift away from mechanistic-structural and toward holistic-social marketing in mass media breast cancer messages during the period studied.

Factors contributing to the increase in quantity of breast cancer messages could be: 1) the activism of the women's health movement; 2) a call for more valid research on the topic of breast cancer; 3) a campaign to create a public perception of breast cancer as a political, versus a women's, issue; and 4) the aging of the feminist leadership of the women's movement resulting in increased awareness of and personal experience with breast cancer.

Data reveal that while there has been an increase in the percent of thematic units characteristic of holistic-social marketing, the increase is not nearly as dramatic as the quantitative increase. In light of this discouraging finding, this researcher offers the following contributing factors to this significant, though minimal, qualitative shift: 1) the approaches to breast cancer messages continue to focus on the most common methods of addressing the disease; and 2) the research and practice of medicine, historically and currently, denigrate women's health issues which may, in fact, be caused by institutional medicine maintaining a male-dominated status-quo which exists within a paternalistic hierarchy.

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Chapter 1

INTRODUCTION

With the advent of the women's health movement in the late 1960s and early 1970s, a radical decade of challenge began for society. The ramifications of the women's movement would be felt in the media and in what Ferguson (1983) in Feminine Forever referred to as the cult of femininity in general. The women's movement pushed the leaders in all areas, including health care, to make new choices.

The Women's Liberation movement had opened up the previously taboo subject of not only the technical competency of doctors but of modern medicine altogether. Doctor's practice, it appeared, was grounded and governed as much by myth as it was by science. Doctors exhibited ignorance on such subjects as menstruation, birth control, menopause, breast-feeding, the proper management of childbirth, vaginal infections, the dangers of hormones, and the dangers of x-rays such as those used in mammography (Ehrenreich, 1978; Lenz & Myherhoff, 1985; Ruzek, 1978, The Boston Women's Health Collective, publishers of Our Bodies Ourselves, 1971 and The New Our Bodies, Ourselves, 1984).

Authors Pincus and Ditzion (1984), in the preface to The New Our Bodies, Ourselves, stated that in 1969 there was practically no women's health information easily available. The first publication by the Collective, Our Bodies, Ourselves (1973) (thought by most historians and sociologists, as well as women throughout the world to be the ultimate women's health resource), helped spark many women to explore the health issues

most important to them. The Collective was first organized by a group of women who gathered to talk and think about women's lives and what could be done to improve them. The women had all experienced similar feelings of frustration and anger toward specific doctors and the medical maze in general. The women of the Collective initially wanted to do something about the doctors who were condescending, paternalistic, judgmental, and non-informative.

The information gathered by women throughout the early years of the women's health movement included comparing notes about their personal experiences with doctors. What was revealed were countless ways in which doctors acted, in the guise of a medical relationship, to reinforce male domination. Female patients were put down, made to feel badly about their bodies, misinformed about proper female anatomy, sexuality, personality, child-rearing practices, denied control of their own reproductive functions, and more (Ehrenreich, 1978). What they discovered confirmed their need for greater education and more accurate information about their bodies in order to make responsible decisions regarding their health care. In response to a demand for better information, a shift needed to occur in health education and communication to women.

One response to the increase in women's awareness about their own health concerns by mass communication media was a shift to a new holistic-social marketing approach when presenting women's health care coverage. Specifically breast cancer. Health education is an approach which attempts to change a set of behaviors in a large-scale target audience regarding a specific problem in a predefined period of time (Clift & Freimuth, 1995). Holistic teaching-learning takes into account the entire interactive system of environmental factors, individual developmental needs and tasks, as well as being sensitive to equal rights issues to promote healthy life choices by participants (Tice, 1993). Social marketing is defined as the design, implementation, and control of programs aimed at increasing the acceptability of a social idea or practice in one or more

groups of target adopters (Smith, 1991). In the specific case of educating women about breast cancer, social marketing addresses: women's knowledge of their own bodies, attitudes toward life style, diet, the health care provider's practices in health care with respect to breast cancer; awareness of early detection and prevention methods; practical considerations (e.g., location, cost, confidentiality of the health care facility); and the role of the patient in the management of the cancer (Clift, 1989; Downie, Fyfe, & Tannahill, 1990; Freimuth, 1995; Kotler, 1980).

The role of education in public health programs is somewhat akin to that of marketing in the commercial world. For some, health communication is closely aligned with marketing and is seen as a process through which individuals and groups change health behavior as a result of their analysis of the cost of adopting the new behavior and the benefits they will obtain from engaging in these behaviors (Clift & Freimuth, 1995).

Until recent decades, public health was concerned primarily with the mechanistic-structural elements of disease (Manoff, 1985). The emphasis in the communication of breast cancer issues has traditionally adhered to the preferences of western medical institutions, i.e., technical diagnostic procedures (i.e., biopsies) surgical treatments (e.g., radical and modified mastectomy), radiation, and chemotherapy.

The shift to social marketing in the communication design of messages about breast cancer is reflected in copy that emphasizes the whole person within her environment rather than reducing the focus to an isolated breast. Messages addressing breast cancer from a social-marketing orientation would include topics such as prevention, life style, the role of the patient, alternative medicine, (i.e., macrobiotic diet), and cancer support groups' benefits. Popular women's magazines today include more personal narratives of women who have been diagnosed and are surviving and sharing their stories with others. Research findings that cover the positive and the negative results of traditional western medicine's fight against cancer are being reported in order

that readers can make informed choices in the management of their health care. These developments reflect a paradigm shift from a mechanistic to a holistic approach to health care communication.

The women's health movement mobilized the consumers of women's health information to demand messages that provided women patients with knowledge that would empower them to make informed choices about their health care. The new communication approach is compatible with the goals of holistic health communication in that it brings together all the components of effective rhetorical communication: meaning and context, action, motivation, value commitments, trust, equity and fairness, ethics and integrity, and accountability (Eyo, 1993).

Statement of Purpose

Based on the above, it would appear that a claim could be made that there has been a shift in the approach to breast cancer communication over the period of the past two decades. However, a review of the literature did not yield evidence of this hypothesis having yet been tested. Therefore, it was the purpose of this study to answer the following question:

Has there been a significant shift in the communication about breast cancer issues in the popular press toward a holistic-social approach and away from a mechanistic-structural approach? Textual analysis was used as a method of testing this question. Health care articles pertaining to breast cancer were taken from selected print media between 1964 and 1994.

This research explored health care related messages delivered by three popular women's magazines (Better Homes & Gardens, Ladies Home Journal, and Good Housekeeping) and the highly influential New York Times concerning health care communication. Messages were evaluated to determine if there had been a shift in the communication approach during the years 1964-1994.

REVIEW OF LITERATURE

History of Women's Health Movement

The radical women's liberation movement of the late 1960s and 1970s gave impetus to the birth of the women's health movement. The health movement began in a small discussion group about women and their bodies that was part of a women's conference held in Boston in the spring of 1969, one of the first gatherings of women meeting specifically to talk about their own health related issues with other women (Pincus & Ditzion, 1984). For many it was the very first time they had joined together with other women to talk and think about their health and what they could do about it. Calling themselves the doctors group, they shared the similar feelings of frustration and anger many had shared toward doctors who rarely deviated from their training and socialization. They attributed one reason for their frustration with doctors to the ways of traditional western mechanistic medicine.

These women told story after story of their doctors' condescending, paternalistic, judgmental and non-informative behavior toward them. As they talked and shared mutual horror stories, they realized just how much they needed to learn about their bodies in order to take control of their own health. Through their research and subsequent discussion, it became apparent that the lessons to be learned from women about their bodies and health needs would change the course of their lives. To their surprise, the lives of hundreds of thousands of women around the world would be altered because of their pioneering efforts. The result of this collaboration of women came to be known as the Boston Women's Health Book Collective. The emphasis of the Collective has always been on what women can do for themselves and for each other in staying healthy, healing themselves, and working for change (Sanford, 1984).

This significant social movement came about as revolutionary response to a system that had become unbalanced; western medicine was losing the compassion and the personalism that makes the practice of medicine a health art as well as a hard scientific practice. As medicine became more specific, practitioners began to lose touch with human's health needs for a sensitivity that does not lend itself to scientific rational-mechanistic approaches. A health system had developed that was lacking in the feminine ethic of care and concern for the whole person as a complex unity of mind and spirit (Lenz & Myerhoff, 1985). The women's health movement was born out of the frustration of women who challenged the scientific, male-dominated medical professional's authority in order to give women control over their own bodies. This period represented a time when women recipients of many professional services were no longer accepting whatever they were given with gratitude, especially when those services were judged to be inadequate and often times offensive. "It was this growing sense of exclusion from decisions affecting even their own bodies that fed women's discontent with the male-dominated health care system" (Lenz & Myerhoff, 1985, pp. 115-116). Women loudly demanded a greater say in what medical services they got and how they were treated by health care institutions. "Disinclined to obey professionals simply on faith, clients openly challenge professionals, arguing that they can evaluate advice and make crucial decisions about their own lives" (Ruzek, 1978, p. 1).

Politicizing Women's Health Care

The women's health movement raised the issue of health care from that of a woman's health issue to a political issue. By the late 1960s, feminists began to insist that women had the right to information about their bodies and the drugs, devices, and medical procedures that doctors recommended (National Women's Health Network, 1994). As it became more apparent that the traditional male-dominated health care system was skewed more toward advanced medical technology, gargantuan hospital

centers, a high degree of specialization, and miracle drugs than it was toward healing the whole person, the women's health movement became a social force to be reckoned with by the medical establishment. Feminist health activists such as Downer in an address to the American Psychological Association in Hawaii in September, 1972, explained why the health care system was deplored by so many:

> In what has been described as 'rape of the pelvis,' our uteri and ovaries are removed often needlessly. Our breasts and all supporting muscular tissue are carved out brutally in radical mastectomy. Abortion and preventive birth control methods are denied us unless we are a certain age, or married or perhaps they are denied us completely. Hospital committees decide whether or not we can have our tubes tied. Unless our uterus has 'done its duty,' we're often denied. We give birth in hospitals run for the convenience of the staff. We're drugged, strapped, cut, ignored, examined, probed, shaved--all in the name of superior care. How can we rescue ourselves from this dilemma that male supremacy has landed us in? The solution is simple. We women must take women's medicine back into our own capable hands. (Ruzek, 1978, p. 1)

It was often times consumer groups, led by activists such as Downer, who would boldly challenge the professionals through creative methods. The women of this movement knew that in order to reclaim their hold on their own bodies, they needed as much information as possible. In order to be as informed as possible, an aspect of the women's health movement was its encouragement and empowerment of women to talk to each other about their actual experiences of what went on in the doctor's office. Breaking this social taboo breached the usual veil of privacy that surrounded the doctor-patient relationship by removing the mysteries of medicine and replacing them with common experiences.

The National Women's Health Network was incorporated in 1976. This network utilized women's common experiences and complaints with the health care system to drive the creation of a fledgling women's health movement (Scherzer, 1995). The network recognized that women's health issues needed to be addressed in the context of race, ethnicity, economic and social standing or, in other words within their daily environment. As feminist centers opened around the country, feminist health care centers

were developing as well. These facilities promoted the concept of self-health, which referred to a reconquest by women of their own bodies and a feminist approach to health care.

The self-health concept was consecrated by the First National Women's Health Conference, organized at Harvard in 1975 (Castro, 1990). Slowly at first, but with increasing speed, women no longer accepted the fact that they were expected to turn responsibility for their bodies over to the traditional male-dominated, depersonalized health care system--a system, for example, that continued to encourage women to sign away their right to be consulted before a breast biopsy would result in the loss of a breast. The women's movement emphasized women's health and body issues and was committed to guiding women toward self-acceptance and greater participation in health care management through understanding how their bodies worked in a healthy state, rather than isolating the diseased or dysfunctioning body part (i.e., breast) as the primary focus.

Health care became a matter of national concern for all women. The National Women's Health Network (NWHN) was founded on the belief that every woman has the right to the best health information available. Organizations such as NWHN and grass roots women's advocacy groups put increasing pressure on the institutions that created health policies (e.g., Congress, Federal Drug Administration, Department of Health and Human Services) and media and governmental offices that disseminated information to the public. Women demanded that they be better educated and informed about their bodies and health issues relevant to their situation in life in order to take a more active role in their own health care decisions.

Friedan's (1963) The Feminine Mystique was one of the early signposts of the politicizing of the women's health movement. The book was a basic existential analysis of women's health issues that needed to be addressed and were not. The thalidomide

scandal, which struck in full force in 1962, had opened the discussions of the appropriate use of abortion and had generated an attitude of extreme skepticism in regard to administering potentially dangerous drugs to women such as DES and birth control pills which were made available without pretesting. Master's and Johnson's (1966) Human Sexual Response challenged the traditional sexual scenario by offering scientific evidence that women are multi-orgasmic and that their sexual pleasure derives from active partnership rather than passive receivership.

In the late 1980s and early 1990s a health scandal served as a further catalyst for politicizing women's health issues. It was widely reported by the media that Dr. Roger Poisson, a breast cancer surgeon and researcher at St. Luc hospital in Montreal had submitted false data to a series of major research trials over a period of 13 years. These were not just any trials, but the large clinical trials that had set the standard for breast cancer treatments around the world: B-06, published in 1985 which ushered in the lumpectomy era; B-13, published in 1989, which underpinned the practice of giving chemotherapy to women with Stage I disease; B-14, which demonstrated that tamoxifen was of benefit to women with estrogen positive tumors; B-16, which showed that tamoxifen plus chemotherapy gave longer disease-free survival for women over 50 (Batt, 1994). This story documented the shocking breaches of trust that were occurring between doctor and patient, researcher and funder, government watchdogs and taxpayers. Media coverage made the news widespread that there had been cover-ups and deception by the very agencies that were established to protect those participating in and making decisions based upon this medical research. The Poisson affair catapulted the women's health movement to dramatically reconsider and review their approach to fighting the injustices inflicted upon women by the health care industry.

For women to become informed and involved in their own health care, they needed to assume a pro-active role in the fight against breast cancer and for women's

health issues in general. But even the major women's organizations, such as the National Organization for Women (NOW) in the United States and the National Action Committee on the Status of Women (NAC) in Canada, did not address the disease that was killing so many of their own sisters, mothers, and aunts. Rebick, as cited in Hoy (1995), a former NAC president and someone who has a family connection to breast cancer death, stated:

> We were all caught up in other issues and we just didn't realize how political the treatment and handling of breast cancer was. We saw it strictly as a medical problem, not a feminist issue. It was a mistake clearly. That's all I can say. And until the AIDS thing happened and we saw how a disease can be dealt with in a politicized way, we just didn't get involved in breast cancer. It was the breast cancer victim who started the movement. Now we're getting involved, but we should have begun a lot earlier. (p. 29)

Advocacy and political pressure are mandatory to force more funding for breast cancer research, according to Dr. Susan Love, surgeon, author, and one of the founders of the National Breast Cancer Coalition (Hoy, 1995). Love stated,

> We have a blood test for prostate cancer. For breast cancer, we don't have a clue. I think the reason more is not known about this disease is because, in part, it's a woman's disease, and women have been well socialized to be good little girls and not to demand more attention. (p. 28)

There were an estimated 184,300 American women who could have potentially been diagnosed with breast cancer in 1996, according to American Cancer Society figures. Sadly the number of deaths in 1996 due to this horrific disease reached almost 45,000. The fact that this figure had finally leveled off after years of escalation is no real consolation to those facing breast cancer today. The fight against breast cancer has not produced any remarkable breakthroughs as far as cause or cure in the past 50 years (National Cancer News, 1996). What has changed, though due mostly to increased political advocacy efforts by women for more education and awareness, is the role of the health care consumer in the management and treatment of her disease and her increasing savvy as a consumer to expect pro-active, unbiased communication of women's health issues.

Holistic Health Care

According to the authors of The New Our Bodies, Ourselves (1984), a common myth held by most people is that medical care keeps us healthy. Although deep down many of us believe that medicine has created and sustained our health through the technological advances of the past 50 years, public health studies show that our health is primarily the result of the food we eat, the water we drink, the air we breathe, the environment we live in, the work we do and the habits we form (Sanford, 1984). These factors in turn result primarily from the education we receive and our earning potential. Still other factors contributing to good health are the control over one's personal life and the influence we have over the larger forces that affect all our lives (Salk, Sanford, Swenson, & Luce, 1985).

By focusing on more profitable crisis-care after people get sick rather than using the tremendous resources available to help us prevent illness before it happens, the medical establishment shows itself unwilling to consider what really can and must be done to keep people healthy. Science and technology editors of The Economist (1994) in an article entitled Why doctors argued that doctors are taught to minister to the sick. In fact, most would say that the doctor's job is to sift through symptoms, decide what is wrong, prescribe a treatment, and determine the medical prospects of the patient. But this mechanistic view reduces patients to their component parts. This is an approach that lends itself to automation. If you take an inhumanly mechanistic view of doctoring, the job becomes much easier to standardize. Dr. Thomas Inui, a professor of medicine at the Harvard Medical School, is an academic proponent of what he called social healing and what ordinary folk have long called tender loving care. Dr. Inui's thesis is that patients are more than the sum of their symptoms and systems. This fast growing field of revolutionary medicine, known as holistic, sees the body and its responses as a set of compromises that have evolved over time.

Reformers of health care such as Dr. Inui and others, conceptualize health and illness in a completely different way than that advocated by the mechanistic view. According to many feminist health movement activists, a more holistic approach is better suited to the treatment of cancer-related disease. Health is regarded as a state of being, a heightened sense of self-realization, self-liberation, and self-actualization, whereas illness reflects a breakdown in the individual's normally harmonious balance of mind and body in relation to the social world in which she lives (Ruzek, 1978).

The concepts and strategies that emerged from the women's health movement constituted a comprehensive system which has become identified as holistic health care.

> Holism embodied the feminist challenge to the mechanistic-structural model of traditional western medicine which, especially since of the advances of modern medicine, had come to expect that every disease including mental illness could be traced to specific pathogenic or biochemical abnormalities. The holistic approach instead considers health and healing from the perspective of whole persons in relationship to their total environment. (Lenz & Myerhoff, 1985, pp. 124-125)

Holism maintains that biological organisms have a tendency toward wholeness, toward righting imbalances, and that these self-healing properties are evidence of a holistic tendency in nature. According to Lenz and Myerhoff (1985), this approach to medicine expresses the core values of feminine culture, with its faithfulness to mind-body unity and to the body's natural propensities for health and balance.

The holistic approach contrasts with the mechanistic-structural approach of traditional western medicine which addresses: treatments (e.g., surgical procedures including radical mastectomy, modified mastectomy, and lumpectomy), radiation and chemotherapy, and technical aspects of diagnosis (i.e., biopsies). Mechanistic approaches represent the motivation of the practitioner to perform only those medical services which are based upon scientific knowledge, experience, and expertise. Conversely, the holistic model supports health policy analysis and procedures which are broad, comprehensive, and inclusive of all matters affecting health. Four primary divisions identified as central to holistic health are the: (1) system of medical care, (2) life style (self-created risks),

(3) environment, and (4) human biology. This alternative epidemiological model is said to provide a more balanced approach to the development of health policy when compared with the limiting, traditional divisions of prevention, diagnosis, therapy, and rehabilitation (Dever, 1980).

Mechanistic-Structural Health Care

Prior to 1970, when the women's movement began addressing health issues, the breadth and depth of information available to women concerning their health care, specifically breast cancer was limited at best. Generally the information presented was from the physician's point of view and, thus, most supportive of his area of interest and expertise (e.g., surgery or research). Most would agree, as stated before, that this science-aggrandizing approach supports the theory that the doctor's job is to sift through symptoms, decide what is wrong, prescribe a treatment, and determine the medical prospects of the patient based upon the physicians' specialty. But this mechanistic view reduces patients to their component parts. Although few physicians would admit that this is all there was to medical practice, the mechanistic approach lends itself to automation. If you take an inhumane mechanistic view of doctoring, the job becomes much easier to standardize (Economist, 1994).

Little, if any, participation in the decision-making process was afforded the patient who was left to deal with whatever consequences resulted from the physician's decision. Meanwhile, women who hoped for recovery were suffering from the horrific consequences of radiation, chemotherapy and mutilating surgery, while the death rate continued to climb with no real prognosis for a reversal of the trend.

Incidence Statistics

According to current statistics (American Cancer Society, 1996; National Cancer Institute, 1996) the incidence rate for breast cancer increased dramatically through much

of the 1980s, rising from 85.2 cases per 100,000 women in 1980 to 112.4 in 1987. From 1973-1991, incidence rates increased 8.5% for white women under 50 years old, 31.8% for white women 50 and older, 26.1% for black women under 50, and 32.0% for black women 50 and older. Since 1987, however, incidence appears to have leveled off. During that same period (1973-1991), breast cancer mortality rates decreased 14.0% for white women under age 50, while increasing for white women 50 and older (4.0%), black women under 50 (2.0%), and black women 50 and older (26.3%). For women of all races and all ages combined, the mortality rate increased 1.8% from 1973-1991. The marked increase in breast cancer incidence that began in the early 1980s is evidence of the nationwide increase in mammography screening, particularly in women ages 50 and older. Because mammography can detect tumors earlier than they would be discovered symptomatically or through clinical exams, increased mammography use results in increased case reporting. Stabilized incidence rates in the past three years are consistent with the expectations based on the assumptions that excess cases detected earlier by mammography would reach a peak, then begin to decline.

According to the American Cancer Society (1996), breast cancer is the second major cause of death in women after lung cancer with an estimated 184,300 new invasive cases among women in the United States during 1996 and a death rate of approximately 44,300 deaths in the same year.

Contributing Factors

Evidence is mounting that lifestyle (e.g., tobacco, diet) and socioeconomic and cultural factors influence a person's general health and chances of developing cancer, as well as the mental and emotional ability to cope with cancer if it occurs. The American Cancer Society (1996) proposes that perhaps as many as 50% of patients who develop fatal cancer could have been saved had they been able to use existing knowledge about smoking, diet, exercise, and means of early detection. Therefore, based on 1996 statistics

provided by the Society, 131,220 women's lives could have been saved had they been aware of cancer risks and early detection and changed their behavior accordingly. In addition, research on behavioral modification is having a significant impact on symptoms of cancer and its treatment, such as pain, nausea, and vomiting. Other research deals with stress during treatment and during recovery after surgery or radiation treatment. The response of both patient and family members to the disease, the patient's sexual concerns, rehabilitation, employment, insurance needs, and ways to provide psychosocial support have emerged as important areas for research and intervention in clinical care. These issues need to be considered by media managers and health care communicators in providing socially responsible reporting of breast cancer issues.

The Silent Epidemic

Breast cancer is not a woman's issue. Rather, it is a universal disease of epidemic proportions. It is estimated that, as of February, 1995, 2.6 million American women may have breast cancer and not even know it (Hoy, 1995). Hoy reported that in the April 10, 1993, issue of The Globe and Mail; Columnist Stephen Strauss pointed out that during the previous two years his newspaper had published 600 stories, letters, editorials, and announcements specifically relating to AIDS. The New York Times had published 1,182 AIDS-related stories during that time. Still there was an outcry in the media industry that the press was ignoring the issue of AIDS. Strauss, as cited in Hoy (1995), wrote:

> In February, the National Research Council in the United States issued a report suggesting that the disease 'will disappear' not because it is cured but because those who are afflicted are 'socially invisible'. . . At the same time, around 10,000 women died of breast cancer, an issue we wrote about 39 times. Just 11 stories about breast cancer appeared in the New York Times during a similar period. (p. 26)

AIDS activists have rallied their strengths and pushed the people in power to put more money into research, treatment, and providing better information about risk factors. Michael Fumento, as cited in Hoy (1995), pointed out that in the U.S., AIDS funding

continues to skyrocket, despite the fact that federal health agencies all dramatically lowered their original estimates of AIDS cases. In fact, concentration on AIDS has in general prompted a de-emphasis on funding for other medical diseases. Because AIDS is routinely called an epidemic, but breast cancer rarely is, media stories highlighting the danger of AIDS appear in stark contrast to stories playing down the seriousness of breast cancer. The media frequently presents with stories arguing that women are being unnecessarily frightened by breast cancer statistics. Hoy (1995), in citing from a U. S. News & World Report story, argued that:

> It is true that the widely quoted one-in-eight statistic for U.S. women is often not presented as a lifetime risk of one in 19,608. But as in a lottery, where everybody has a ticket but only one will hit the jackpot, women have no way of knowing precisely when, or if, their number will come up. After all, some eighty percent of breast cancer victims have none of the known risk factors, apart from being a woman. (p. 29)

This casual and almost negligent attitude toward a disease that has reached epidemic proportions, and continues to be the second highest cause of death for women next to lung cancer, needs to be responsibly addressed in order to affect a positive change in our present medical situation.

Media and Feminist Politics

Ferguson (1983) pointed out that, with the advent of the women's movement in the early 1970s, a radical decade of challenge began for women, the media and, in general, the cult of femininity. This decade found media management having to make new choices about the form and content of the messages carried to the female readership. This challenge would include those in communication leadership presenting health issues to a growing audience of consumers who had, for the first time, a coalition of supporters advocating for a more pro-active approach to educating women on health care issues. The challenge to those in a leadership role in women's health care communication during this period would be to enlighten women with information regarding breast cancer in a

manner that would empower them to take control of the management of their own health care. Drawing attention to the grim statistics and personal tragedy of breast cancer through the popular media was unthinkable for women diagnosed before the mid-seventies. But as more and more personal cancer memoirs were published, the conspiracy of silence about this epidemic began to fall apart. By speaking out, women proved that they could not only survive the treatment ordeal but rebel against the silence that expected them to disappear into the shame-ridden world of the disfigured. Outspoken women instead began to tell their untold tales, animated by a sense of purpose. Even more shocking, they demanded that all women involve themselves in decisions about their own course of treatment (Leopold, 1996).

As women became convinced that the practice of medicine could be hazardous to their health, they began to realize the price they were paying for turning over the responsibility for their bodies to a depersonalized, male-dominated health-care system. The late 1960s and 1970s gave impetus to the burgeoning feminist movement which brought the development of a new feminine body consciousness into American women's living rooms through the media. Women's changing attitude toward their bodies redefined illness. As more information about women's normal biological functioning became available, this altered the perception of both feminine body consciousness, and the practice of medicine. This specific social movement emphasized women's health and body issues and was committed to guiding women toward self-acceptance through understanding how their bodies work. More recently, the movement has expanded to include preventive medicine among its aims. Lenz and Myerhoff (1985) stated that:

> Specifically, their critique of a system cited its emphasis on technology, the depersonalization of the individual, the dominant-subordinate relationship of doctor and patient, the performing of unnecessary surgery (particularly mastectomies, cesareans, and hysterectomies), and the use of intrusive techniques in examination. (p. 16)

Critics of traditional medicine, including women, men and various organizations, have been presenting a challenge from within as well as outside of the medical professions. But it was women who truly mobilized the discontent into a moving force addressing alternatives. James S. Gordon, a physician and advocate of self-help, as cited in Lenz and Myerhoff (1985), wrote that: "although a variety of individuals of all ages have been active in the movement for self-care, patient's rights, and institutional reform, women have consistently led efforts for change" (p. 124).

What would happen if, instead of promoting only those medical procedures which dramatize technological advances and the intervention of science to cure all ills, society looked at whole systems that create the pressures that cause disease? Instead of simply encouraging individuals to eat right or exercise, what if our market-driven society asked whether or not the corporate world has a responsibility to reduce stress by changing the current high-pressure style of operations in this competitive world? Perhaps society should be asking what it means to have the media encourage harmful behavior such as smoking and a fast-food-frenzied life style without providing the corrective messages about the relationship such behaviors have to an unhealthy lifestyle. Should women, in their effort to gain greater control over their health care, ask more questions related to the environmental factors potentially related to breast cancer?

If women's health care is to continue to improve into the 21st century, these questions and many more like them must be asked by women who want to take an active role in the management of their health care. Currently, women's key allies in the struggle to put women's issues on the national agenda are growing. A new trend has emerged in medicine, as 50% of the United State's new primary-care physicians, medicine's front-line for diagnosis and treatment decisions, are women (Aburdene & Naisbitt, 1992). The push to drive women's health issues into the spotlight has been fueled by the growing number of women in medicine, the aging of the baby-boom women and the revelations

from health-care activists that research into breast cancer has been grossly mishandled and underfunded.

The leadership of health care information is changing, with women taking a more active role in the policy-making and communication of women's health issues. With this cultural shift in leadership there may come a greater, more holistic emphasis on a social approach to health care communication.

Communication About Health Care

"Health communication, like health education, is an approach which attempts to change a set of behaviors in a large-scale target audience regarding a specific problem, i.e. breast cancer, in a predefined period of time" (p. 68), according to authors Clift and Freimuth (1995). They reported further that the focus of public health shifted in the decade of the 1980s from treating infectious diseases to preventing chronic ones, such as AIDS, heart disease, and cancer. Health communication now includes a focus on behavioral and psychological variables that might enhance prevention and adoption of healthier behaviors, as well as on family and social systems which could strengthen or weaken these changes.

What communicators who discuss the importance of this holistic approach to health care want to bring to people's attention is healthful behavior and positive role models. However, by current media standards, the holistic approach is not viewed as being particularly newsworthy.

Public health communicators need to convey information so that it becomes personally relevant. Why don't people do what's good for them? Why don't they stop smoking, eat right, practice safe sex, get their kids immunized, and why do teenagers keep trying dangerous drugs and ruining their lives? Why can't we sell good health the way we sell toothpaste? These have been often-heard questions throughout the country as medical statistics in America continue to tell a story of increasing disease rates.

Although 20 years of marketing has not truly answered the questions, the principles of social marketing have lead to improved programs of public health.

Writers such as Kushner (Breast Cancer: A Personal History and Investigative Report, 1975); Rollin (First, You Cry, 1976); Campion (The Invisible Worm, 1972); and Lorde (The Cancer Journals, 1980) brought the subject of breast cancer and all its evils to the attention of thousands of women. These writers charted the passage from one mode of treatment to the next, documenting the complexities of their emotional journey with as much detail as they gave to their account of physical therapies. They addressed the long standing medical practices that had gone unchallenged, and unproven, for more than half a century. In a world where informed consent did not exist and surgical high priests could still lay down the law these pioneers dared to challenge the status quo (Leopold, 1996). Thanks to the women's health movement gradual widening of media coverage, first by such authors as those mentioned, then in women's magazines, and then by national newspapers such as The New York Times, breast cancer has become domesticated, incorporated openly into daily routines and conversations. It has gone public (Leopold, 1996). The challenge to the women's movement poses to mass media is to increase coverage that enlightens and educates women on the extent and scope of breast cancer in their lives today. In order to accomplish such a task, this thesis argues that a more personal and holistic reporting approach is necessary to reach women empowered to adopt behaviors that would permit them to become aware and responsible for their own health care choices.

Social Marketing

Social marketing was first introduced by Kotler and Zaltman in 1971 to define a process in which marketing communication techniques and concepts are applied to social issues and causes instead of products and services. Social marketing has evolved from business practices in which a product and sales orientation have been supplanted by a

consumer one. Businesses (e.g., health care organizations) are now more likely to focus on meeting consumers' wants and needs than on producing new products and then trying to convince consumers to buy them. In health promotion a parallel process has been a shift from a more traditional top-down approach in which authorities prescribe health and social behaviors (and perhaps launch information campaigns to support the programs), to bottom-up efforts where the needs and wants of the people are actively solicited, attended to, and acted upon in program planning, delivery, management, and evaluation (Bunton & MacDonald, 1992). Social marketing takes a holistic approach to health promotion where programs are developed to satisfy consumers' needs, strategies are developed to reach the audiences in need of the program, and information campaigns are managed to meet organizational objectives. Social marketing is a practical way to integrate service delivery with consumer demand. People must want to use new services. They must know how to use those services easily and then must be able to seek them out effectively. Social marketing gives health-care communicators a way to increase consumer demand and improve service delivery by using a single and systematic framework.

Marketing, in general, relies on designing the organization's offering in terms of the target market's needs and desires rather than in terms of the seller's personal tastes. Marketing is a democratic rather than elitist approach. Social marketing of health care brings together in a holistic approach all the components of a persuasive communication strategy with cultural sensitivity to the target population. This holistic-social approach focuses as much on the process, for the sake of all concerned, as it does on product. The elements of process and product could themselves be defined as interactive and mutually reinforcing. Social marketing encompasses several important points that differentiate it from commercial mass marketing. Social marketing is a program design and implementation process. Social marketing is a theory and a practice that suggests a process for attitude and organizing interventions. Social marketing promotes behavior

change in communications campaigns designed to achieve results such as: stop smoking, don't use drugs, stick to one faithful sexual partner; it promotes safe practices and product use like condoms, immunizations, and regular breast examination for cancer screening. Finally, social marketing focuses not on everybody, but on target adopters--a specific subset of a population chosen because it is at particular risk and because its members share important values that make it possible to address appeals to them that work for the entire subgroup (Smith, 1991).

Suppose the product being offered is mammography. Clift and Freimuth (1995) offered this example of the promotion aspect of social marketing:

> What has the market research told planners about women's knowledge, attitudes, and practices with respect to breast cancer and screening/prevention techniques? Specifically, what do they know, think, and believe about mammography? What are their fears and misconceptions? Then, even if the screening is free, what are the psychological costs to a woman who goes in for a mammogram? (e.g., fear, anxiety). What are the practical considerations? For example, will she have to take leave without pay to be screened? Will she be embarrassed to have co-workers know where she's been? In terms of place, where will she have to go to be screened? Is it too public a place, or too intimidating? And finally, how will mammography be promoted? What are appropriate message channels, and what are the most salient messages? Who are credible sources of information and should all levels of fear arousal be avoided? (p. 69)

In considering these questions, it is necessary to approach social marketing from the active, rather than passive, consumer perspective. Social marketing assumes that consumer input into the proposed program (i.e., health service) is a continuing process and not one that occurs at a single point in time. The emphasis of this approach to consumers is to seek to build relationships with them over time and to continually offer them opportunities to interact with program staff.

The National Cancer Prevention Awareness Program is an example of a social marketing campaign designed to use positive affect to change people's feelings about a negative issue such as cancer. There is little a campaign can do to change the negative attitudes associated with cancer. If these feelings become overwhelming, however, individuals may stop contributing to cancer research and may avoid messages designed to

reduce their likelihood of contracting cancer. The National Cancer Prevention Awareness Program was designed to promote a more positive view of issues related to cancer prevention. For example, the campaign reinforced a positive, good-news theme, described risk factors that individuals could control, and recommended positive steps or actions to take to prevent cancer (Cancer Net News, 1995).

Health care communication from a social marketing perspective addresses the increasing demand by women for information which will empower them in the decision-making process in the management of their own health care. The media's responsibility in this area would be to create a credible source of information through which consumers of health care could be educated and informed about relevant findings and recommendations regarding quality health care. The media, while not solely sufficient to bring about widespread behavioral change, nevertheless provides an entry point to any health promotion campaign. How media choose to carry out this responsibility lies in the hands of the leadership and its commitment to society.

Health Care Leadership

Effective leadership in health care is crucial to facilitating the shift in messages about breast cancer from a traditional structural-mechanistic marketing approach, representative of historical western institutionalized medicine, to a social marketing approach that represents the feminine perspective of holism.

Holistic leadership, as cited in Tice (1993), takes into account the entire interactive system of environmental factors, individual developmental needs and tasks, and organizational aims and potentials that do and/or should impinge on a given organization. The leadership would serve the welfare of all concerned, be sensitive to equal rights issues, and undergird the well-functioning activity of every part working hard to form the material, formal, and spiritual conditions necessary for healthy growth among participants and in the organization as a whole. Holistic leadership focuses as much on

process, for the sake of all concerned, as on product. The elements of process and product would themselves be defined as interactive and mutually reinforcing.

This holistic social marketing approach is evident in the new leadership of women's health, and in women's reports about breast cancer in particular. Since the formative years of the women's health movement, and in particular, following the publication of Our Bodies, Ourselves (1973), there has been a growing number of women's health activist groups, women's health organizations, clinics, and support groups. The philosophy held by these organizations and their leaders, whose foundations of women's health care are rooted in the women's health movement, is illustrative of the holistic paradigm of leadership defined by Eyo (1993). Eyo stated that leadership is 50% followership. Leaders and followers (e.g., health care experts and health care consumers) are in complementary and reciprocal roles, and together they constitute an organic unity that represents power and empowerment, vision, service to humanity, justice, equity and fairness, women's issues, change, accountability, value commitments, multiculturalism, motivation, ethics and integrity, authenticity, meaning and context and action (Appendix). All of these elements are intertwined as the rhetorical communication of this relationship impacts individuals, organizations, and communities. The relationship between leader and follower is one that is interactive and simultaneous. These are the same qualities found in the holism of women's health initiatives. Early leadership efforts by those who served as catalysts of the women's health movement (e.g., the women of the Boston Women's Health Collective, charter members of The National Breast Cancer Coalition, Dr. Frances Kelsey, Sharon Batt, Susan Love, Byllye Avery and countless women who shared their personal experiences), have provided the foundation for present holistic leadership in health care. "The women's movement helped propel women into the upper ranks of health communication and social marketing and I think they have certainly played a significant role in designing and implementing social marketing efforts

concerning breast cancer" (Long, personal communication, February 23, 1997). These women, who are now in the upper ranks of health communication, include people such as: Bernadine Healy of the National Institute of Health, Beverly Schwartz with the National AIDS Information and Education Program and Terry Bellicha Long, Chief of Communications at the National Heart, Lung and Blood Institute. According to Long (personal communication, February 23, 1997):

> Social marketing techniques have been applied to breast cancer issues largely due to the leadership of the National Cancer Institute. This includes efforts to reach minority populations, especially with messages about mammography. The messages on detection are undergoing quite a bit of change right now, but whatever the new messages turn out to be, I don't think the social marketing perspective will be lost.

These present day leaders are promoting holistic-social marketing from within their leadership positions in agencies that set policy, secure funding and disseminate information. The majority of these organizations specifically address the significance of effective and wide-ranging communication to women of all ages, races, and socioeconomic levels.

Present organizations addressing breast cancer nationally include: The National Women's Health Network, whose mission is to work for a health care system more appropriate for all women, as consumers and providers, and to improve access to health care services for poor women, older women, women of color, lesbians, rural women and disabled women. The NWHC's specific mission regarding breast cancer is: to promote good breast care, to lessen the number of women who are diagnosed with breast cancer, and to advocate for the best detection methods and treatment services (1993).

The Public Health Service Office on Women's Health has implemented and coordinated the National Action Plan on Breast Cancer (NAPBC), a major public-private partnership to eradicate the disease as a threat from the lives of American women. A principal activity for NAPBC is the coordination of a women's health communication strategy and the establishment of a National Women's Health Information Center with an

800 toll-free number and Internet capacity to disseminate a broad range of women's health information.

The message that is conveyed by organizations such as these and the leadership of the women's health movement as a whole is that, although strides have been made in improving the status of women's health in recent decades, particularly in the last few years, sustained efforts by policy makers, activists, health care providers, the media and all feminists are necessary to continue making progress toward extinguishing the silent epidemic of breast cancer.

The study that follows attempts to gauge the effectiveness of this effort in contributing to change by the mainstream mass media from a mechanistic emphasis in reporting to a holistic one.

Chapter 2

METHODOLOGY

Publications

Two sources of print media were chosen as representative samples of sources for articles addressing the topic of breast cancer. The New York Times was selected from the daily news category because of its reputation as one of the nation's most widely read newspapers. Better Homes and Gardens, Ladies Home Journal, and Good Housekeeping were chosen as representative of popular women's magazines based upon their consistently highly ranked circulation (World Almanac and Book of Facts, 1964, 1974, 1984, 1994) within that group of print media sources. The sample publications were selected based on the cluster method as described by Budd, Thorp, and Donohew (Reinard, 1994). The multistage cluster sampling method, according to Reinard (1994), is that in which groups of messages appear in a sequential pattern. The segmented samples of health articles focusing on breast cancer in the fourth year of each decade representing pre- and post- women's health movement (as referred to in this study) in selected popular women's magazines and the highly circulated New York Times is the representative cluster for this study.

Procedures

Articles addressing the topic of breast cancer contained in the sample print media references were identified. A textual analysis focusing on thematic content as presented by Krippendorf (Reinard, 1994) of these articles was conducted.

Coding units are categories used to count the communication forms in the examples chosen. According to Reinard (1994), there are many different types of units that can be coded for textual analysis. This particular study identified thematic units which are recurring assertions made by communicators such as repeated patterns of ideas or treatments.

This researcher and a colleague conducted the textual analysis of thematic units following a training session to establish the criteria for coding. The second coder was given a brief paragraph to read in order to familiarize herself with the concepts of holistic-social and mechanistic-structural marketing approaches. After a general discussion of the different approaches, a list of thematic units and their definitions was provided and discussed. A set of 16 articles, one each from 1965, 1975, 1985, and 1995 of the selected popular women's magazines and the New York Times were jointly coded by the research and the second coder to ensure consistency in coding. The specific articles chosen for the coder training were selected based upon their representation of the eight thematic units in the study.

Thematic units contained in these articles were coded under the global categories of mechanistic-structural and holistic-social marketing communication characteristics. The specific thematic units identified as characteristic of mechanistic-structural communication were:

1. treatment
2. diagnosis

Treatment thematic units were defined as including surgery (e.g., radical and modified mastectomy, lumpectomy), radiation, chemotherapy, and alternate procedures. An example of an article coded as treatment would be a New York Times (1974) report that described symptoms of breast cancer treatments and types of surgery in light of First Lady Betty Ford's radical mastectomy surgery. The article stated that: "about 95% of

women with breast cancer undergo radical mastectomy--removal of breast, underlying chest muscle and lymph glands extending back under armpit; less radical form is a simple mastectomy in which only the breast is removed" (p. 23). The thematic unit of diagnosis was defined as biopsy procedures. A Good Housekeeping (1974) special report, "An Up-To-Date Medical Guide to Every Woman's Basic Health Needs," included an article that discussed breast cancer diagnosis. The article stated: "When a breast tumor is diagnosed, the primary treatment is surgery. The physician first performs a biopsy by taking a sample of the suspect tissue and examining it under a microscope to determine absolutely whether or not cancer is present. Fortunately, 65-80% of these biopsies are benign" (p. 57) The specific thematic units identified as characteristics of holistic-social communication were (Clift & Freimuth, 1995):

1. knowledge;
2. attitudes;
3. early detection;
4. prevention;
5. practical considerations;
6. role of patient.

The thematic unit of knowledge was defined as those units that referenced incidence, risk factors, genetic studies, case studies, and research findings. An example of an article coded for knowledge was a November 1974 New York Times (1974) article that stated: "The incidence of discovering a second cancerous breast has risen in recent years through aid of more refined tools and technology" (p. 23). Attitudes was defined as those units that addressed women's beliefs, values, myths, and fears. An example of an article coded for attitudes was the Good Housekeeping article entitled "Women's Attitudes About Breast Cancer" which stated: A recent Gallup survey reveals that the disease women

feared most is cancer--especially breast cancer, the most common malignancy in women" (Yuncker, 1984, p. 28). Early detection was defined as those units referencing self-examination, mammography, and regular medical evaluations. The article in Ladies Home Journal entitled "Today's Health Challenges for Women" stated: "The most important protection for a woman is a breast self-examination each month and a regular physical examination by a trained physician each year. Recognizing the danger signals of breast cancer is crucial: a lump in a breast, a change in shape or a discharge from the nipple" (Heckler, 1984, p. 31). Prevention was defined as those units which focused on diet, exercise, stress-reduction, and environmental factors. An April, 1994, New York Times article coded for prevention reported on a New York State Health Department report suggesting an association between the high rate of breast cancer on Long Island with those living near chemical plants. This prompted citizen groups that fight breast cancer in the Northeast to scrutinize potential environmental hazards close to them. Practical considerations was defined as those units which addressed cost factors, location, and availability of services. An example of an article coded for practical considerations was the "Medicine Today" article in Ladies Home Journal which stated, "The American Cancer Society together with the National Cancer Institute now underwrites 20 special breast cancer detection centers across the nation, where the annual exam (which may cost $50 to $100 when done by a private doctor) can be obtained free" (Zimmerman, 1974, p. 26). Role of patient was defined as those units promoting active versus passive participation in health care management by the patient. An example of an article coded role of patient would be the May, 1974, New York Times article reporting on the New Jersey Legislature and State Board of Medical Examiners taking steps to ensure that women with breast cancer are fully informed about their treatment before they enter the operating room. This action followed the concern voiced by many women that patients

have not been made aware of alternatives to the one-step procedure in which mastectomy immediately follows a biopsy.

An article could have multiple codings based upon the spectrum of topics concerning breast cancer that were addressed. An example of a multi-coded article would be the following excerpt from a 1974 Ladies Home Journal "Medicine Today: Breast Cancer" article:

> The cancer women undoubtedly fear most is breast cancer--and with good reason (attitude). It is the most common cancer, and is fatal to more women than any other (knowledge). This grim disease is made grimmer still by the fact that the standard surgical operation used against it, radical mastectomy, is known as the operation women fear most (knowledge/treatment/attitude). . . . He insists that, in skilled hands, the more conservative procedures may be just as effective as radical surgery but far less disfiguring and painful. Moreover, he passionately believes that in some--but not all--cases, there is a choice, and that women patients, not their doctors, should make it (role of patient). (Zimmerman, 1974, p. 22)

Analysis

A content analysis of the coded data was conducted to determine whether there has been a significant increase in the communication of breast cancer issues from a social marketing perspective as measured by selected samples from the print media. Codings were assigned by this researcher and a colleague trained in the categories, each coding independently. Coding agreements were initially obtained for 314 of the 346 units, resulting in inter-rater reliability of 91%. Final coding assignment for the 44 units initially in question were resolved through discussion by the coders, resulting in 100% agreement for the codings.

Chapter 3

RESULTS

Descriptive statistics were used to present and analyze the data. Examination of the selected publications resulted in a total of three articles in 1964, 36 articles in 1974, 24 articles in 1984 and 87 articles in 1994. The corresponding number of thematic units found for each year was nine in 1964, 80 in 1974, 64 in 1984 and 193 in 1994. A global presentation of the data is found in Table 1.

Table 1

Summary of Articles/Thematic Units

Year	Total Number of Articles	Total Number of Thematic Units	M-S/H-S[a] Thematic Units	M-S/H-S Unit Percentages
1964	3	9		NS
1974	36	80	31%/69%	31%/69%
1984	24	64	36%/64%	36%/64%
1994	87	193	24%/76%	24%/76%

[a]M/S = mechanistic/structural
H/S = holistic/social

Significant results are found in a comparison of the data between years. Results in Table 1 do indicate a significant increase in the quantity of communication on the topic of breast cancer in the thirty years examined. As noted in Table 1, 1964 revealed only

nine thematic units represented in three articles on breast cancer. This is an insignificant number upon which to base any comparative analysis. It does indicate that, in and of itself, pre- the women's movement, the amount of media attention given to breast cancer was minimal. This might be explained by the fact that, even though breast cancer was a leading cause of death for women, it was not the primary health concern, nor the leading cause of death for women in their twenties. It was young women in their twenties who were the most radical activists of the women's movement, focusing their energies toward an agenda that addressed the issues of health care most relevant in their lives: contraception and access to affordable health care.

There were 12 times as many articles dealing with breast cancer in 1974 as in 1964. This decade reflects the time period when the women's movement and, in particular, the women's health movement, was first gaining recognition and a place in mainstream media. Analysis of thirty-six 1974 articles revealed a total of 80 thematic units devoted to the topic of breast cancer. Twenty-four 1984 articles yielded 64 thematic units. Eighty-seven 1994 articles yielded 193 thematic units. The number of articles and corresponding thematic units devoted to the topic of breast cancer had more than doubled from 1974 to 1994. However the data would indicate that this has not been a steady progression of increase since analysis of 1984 articles and thematic units revealed a decrease. The decrease in the number of 1984 articles devoted to breast cancer may be explained by the focus on three other issues in the area of cancer incidence during that year. These issues were environmental causal agents (e.g., tobacco, pesticides, industrial chemicals, toxic waste), DES during pregnancy, and colon cancer due to diagnosis of President Reagan.

The most significant increase in the shift to a holistic-social approach is noted in 1994, with 147 thematic units compared to 41 in 1984 and 55 in 1974. There are two possible explanations for this phenomenon. As earlier mentioned, breast cancer was not

the primary health concern of the women who were active in the movement in the 1960s. Three decades later, the leadership of the women's movement had aged and their priorities had shifted as breast cancer became their number one health concern. Another explanation for the significant increase is that this period followed a paradigm shift in the women's movement from a philosophical perspective of breast cancer as a women's issue to one of it being a political issue that demanded a place on the national health care agenda. This came as a result of the leadership observing the success of those involved with the AIDS movement.

Significant results are also found in a comparison of the percentage of thematic unit types (i.e., mechanistic-structural and holistic-social) between years. The proportion of holistic-social thematic units totals 76% for 1994. This content trend demonstrates a greater shift toward holistic social marketing when compared to the proportions in 1984 of 64% and in 1974 of 69%. The proportional difference noted between 1984 and 1974 data does not appear to be significant.

Holistic-Social Thematic Units

A more detailed comparison of mechanistic-structural communication messages (as defined by the coding categories treatment and diagnosis) with the holistic-social communication messages (as defined by the coding categories knowledge, attitudes, early detection, prevention, practical considerations and role of patient) is presented in Table 2.

Table 2

Individual Thematic Unit Codings Holistic--Social (% of Contribution)

Year	Knowledge	Attitudes	Early Detection	Prevention	Practical Consideration	Role of Parent
1964 (n=7)	3	2	2			
1974 (n=55)	21 (38%)	15 (27%)	11 (20%)	4 (7%)	2 (4%)	2 (4%)
1984 (n=41)	14 (34%)	5 (12%)	10 (25%)	4 (10%)	3 (7%)	5 (12%)
1994 (n=147)	71 (48%)	19 (13%)	14 (10%)	12 (8%)	15 (10%)	16 (11%)

Examination of the data contained in Table 2 further supports confirmation of the hypothesis and allows further examination of the contribution(s) of each thematic unit to the overall holistic analysis. Although no clear pattern emerges, there are contribution fluctuations noted. The only category that appears to have remained relatively stable in its contribution is that of prevention with a 7% contribution in 1974, 10% in 1984, and 8% in 1994. The thematic unit of knowledge remained relatively stable from 1974 (38%) to 1984 (34%) and then significantly rose in 1994 where it contributed 48% of the items coded in the holistic-social category. The thematic unit of attitudes was characterized by a significant decrease in its contribution from 27% in 1974 to 12% and 13% in 1984 and 1994 respectively. The thematic unit of early detection remained relatively stable from 1974 (20%) to 1984 (25%), but was significantly less of a contributor in 1994 (10%). The thematic unit of practical considerations demonstrated a small but steady increase in its contribution from 4% to 7% to 10% throughout the cluster years examined. The thematic unit of role of patient demonstrates only a 4% contribution in 1974. A significant increase was noted in the contribution of this category in 1984 (12%) and it

stable in 1994 (11%). The varying fluctuations across thematic units over the various years are congruent with the concept of holism which constantly readjusts elements within a system to achieve balance.

Chapter 4

CONCLUSION AND DISCUSSION

Statement of Findings

The researcher has learned from the results of this study that there has not been as much change as had been hoped for in the focus on the issues of breast cancer in mainstream media. The data reveal limited change in the communication approach by mass media to effectively address this health issue in a true holistic manner to millions of consumers. When one considers that each year this silent epidemic kills more women than any disease other than lung cancer, it is little comfort to learn of such limited effort to stem the tide of this killer disease by the multi-million dollar mass media organizations during the past three decades.

There has been both an increase in the quantity and a shift in the quality or type of information on breast cancer as presented in these selected media resources in the past three decades. The increase in quantity is substantiated by more than a 250% increase in both the number of articles and thematic units about breast cancer from 1964 to 1994. A less dramatic, though significant shift away from mechanistic-social and toward holistic-social marketing is found in a comparison of 1974 and 1994 data, during which time there was a 7% increase in the proportion of thematic units characteristics of holistic-social marketing. It is readily apparent, based on the prolific explosion in the sheer quantity of articles devoted to the topic of breast cancer in the past three decades, that breast cancer has become a national concern. In this researcher's opinion, the major factors that resulted in this communication change were:

1. the activism of the women's health movement following publication of <u>Our Bodies, Ourselves</u> (1973) by the Boston Women's Health Book Collective;
2. the heightened awareness and attitudes of women toward their bodies and their health as a result of a growing consciousness raising movement within the female population;
3. women's collective anger and resulting mistrust and call for valid research on the topic of breast cancer as a result of the Poission/Fisher Scandal of the mid-1980s;
4. the shift in the women's health movement to create a public perception of breast cancer as a political, versus women's issue as a result of the success of the AIDS activists' national campaign;
5. the aging of the feminist leadership in the women's health care movement which resulted in their increased awareness of, and personal experience with breast cancer.

Like the increase in the quantity of articles and thematic units in the past three decades, there has been an increase in the percent of thematic units characteristic of holistic-social marketing. It must be noted, however, that this qualitative shift has not been nearly as dramatic as the quantitative increase. Though the shift to holistic-social marketing is positive in and of itself, the fact that the magnitude does not parallel the analysis in quantity is discouraging. This significant, though minimal, shift could be explained from two diametrically opposing viewpoints:

1. that the approaches characteristic of the mechanistic-structural focus on breast cancer continue, in fact, to be the most common methods of addressing the issues of breast cancer;
2. that the research and practice of medicine in its existing structure has in the past and continues to denigrate women's health issues. This may be caused by

medicine traditionally being a male-dominated profession existing within a larger social, political, economic, and communication system grounded in paternalistic hierarchy.

Additional Considerations

One critical factor that may help to explain the slow rate of increase in holistic-social marketing messages is the absence of media attention to what have been identified as important areas of emerging research in clinical care. These areas include the response of patient and family members to cancer, sexual concerns of the cancer patient, ongoing rehabilitation, employment, and insurance coverage. This represents social irresponsibility by the media and may account for the continuing predominance of mechanistic-structural messages.

An emerging social/health care phenomenon that has the potential for setting women's health care back 100 years is that of the proliferation of Health Maintenance Organizations (HMOs). Contrary to popular political rhetoric that advances health care for all, medicine is big business in this country. HMOs and the American Medical Association pour millions of dollars into setting the agenda for this country's health care system through lobbyists and public relations/advertising. Billable units cannot be generated in a profit-driven system through the fostering of such practices as those promoted by holistic-social marketing. As long as the bottom line in health care remains profit-centered, the media will continue to exploit women's health care through the advancement and glorification of those practices characterized in mechanistic-structural messages--surgery equals significant billable units. Therefore, it is reasonable to project that as HMOs flourish both the marketing and practice of holistic-social medicine will decrease correspondingly.

Recommendations to Readers

Based upon the results of this study, readers should be aware of the deficiencies in the communication of women's health issues, specifically breast cancer, in the mainstream mass media.

A recommendation to health communicators would be that, after learning of the results of the data presented in this study, communicators should enlighten themselves to adopt a more holistic approach to breast cancer and, in fact, women's health issues in general. Mass media should realize that if the product they produce is to serve as a credible and effective change agent in the quality of women's lives, a more significant shift to a holistic-social marketing approach must be implemented. In order to better serve their audience, leadership within mass media should implement an active recruitment of women for advisory boards and focus groups to more accurately assess women's health care communication needs and interests.

More importantly to this researcher, it is hoped that women in general who read this study are made aware of the limits of mainstream media in effectively communicating women's health, specifically breast cancer issues. It would be the recommendation of this researcher that women do not rely on popular mass media to address their health concerns. Rather, women should seek out and consult publications and programs that target women's health issues through a holistic approach. Examples of these health care resources would be magazines such as Prevention; online resources such as the CancerNet News; local support groups for those living with cancer; and community and campus libraries offering a variety of current health periodicals and journals.

This researcher sincerely hopes that readers of this study realize the urgency for change in breast cancer communication. It is hoped that future researchers will address this topic and provide additional data that will motivate health care communicators and

women in general to become effective change agents in creating a significant shift to a holistic attitude toward women's health.

Implications for Future Research

Suggested areas of future research would include:

1. a replication study examining publications that a re primarily health focused in content (e.g., Prevention Health);
2. the role of holistic-social marketing in communication regarding other types of cancer;
3. examination of the impact of the shift to holistic-social marketing documented in this research on women diagnosed with breast cancer post 1994;
4. examination of the impact of the AIDS movement on the women's health movement;
5. the current role of feminist leadership in health care today as compared to the roles they played in the earlier women's health movement;
6. examination of the impact of HMOs on the women's health movement.

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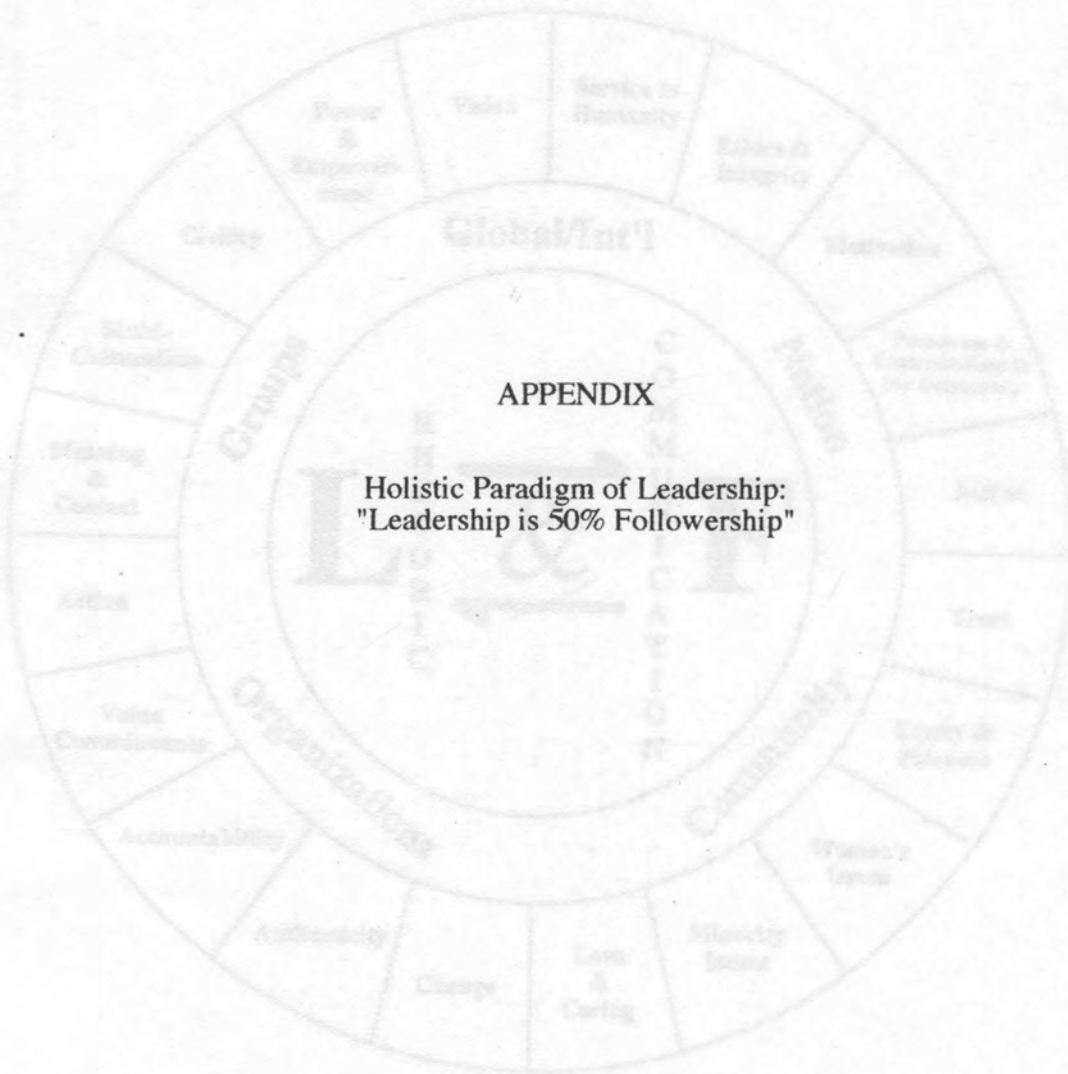
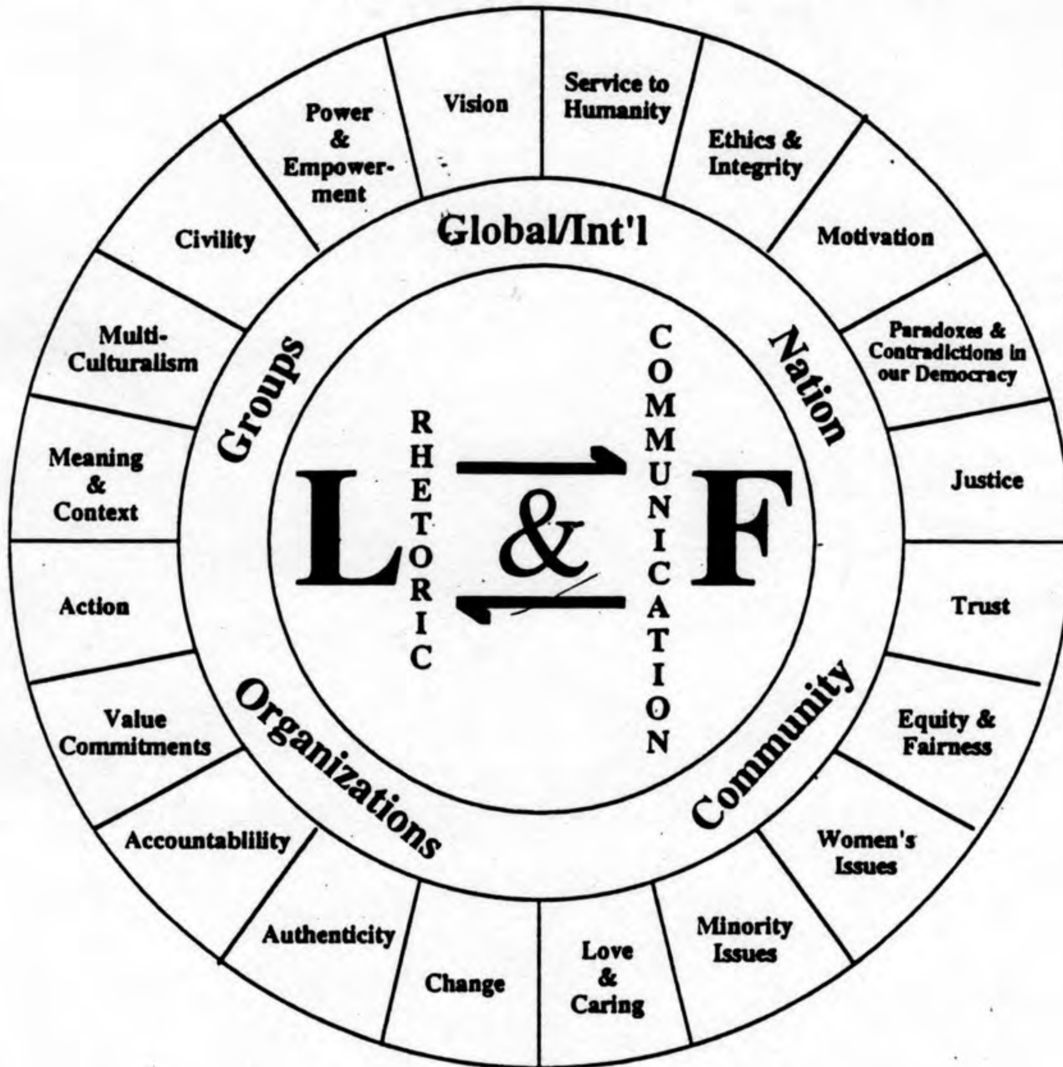
APPENDIX

Holistic Paradigm of Leadership: "Leadership is 50% Followership"



Holistic Paradigm of Leadership:
"Leadership is 50% followership"



(Leadership & Followership are "Complementary & Reciprocal Roles.")
They constitute organic unity.
There is "interactive & simultaneous" relationship.

strategic intent

Bassey Eyo
1993