Original Article

A feminist perspective on stroke rehabilitation: the relevance of de Beauvoir's theory

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Abstract

The dominant view of women has changed radically during the last century. These changes have had an important impact on the way of life of women in general and, undoubtedly, on women as patients. So far, gender differences have received little attention when developing healthcare services. Stroke hits a great number of elderly women. Wyller *et al*. found that women seemed to be harder hit by stroke than men; they achieved lower scores in tests of motor, cognitive and ADL functions, both in the acute phase and 1 year after stroke. It is reasonable to expect that differences in outcome among male and female sufferers may in part be explained by the fact that rehabilitation services are designed primarily to meet the needs of men. de Beauvoir's feminist theory maintains that one's body is fundamental in creating the person, which is a lifelong process. Traditionally, the female body has been exposed to alienation and oppression through life. This has led women to develop a life in immanence. This we feel can be of significance in connection with rehabilitation after a stroke, particularly for elderly women. In this article we will discuss how de Beauvoir's theory can throw new light on the experiences and rehabilitation of elderly women and point to ways of improving the process of rehabilitation.

Keywords: stroke, women, rehabilitation, feminist theory.

Introduction

This paper discusses stroke rehabilitation from a feminist perspective, focusing on the situation of elderly women. The theory of de Beauvoir (1974) is explored as a potentially fruitful theoretical perspective that may supplement existing perspectives on rehabilitation, which generally fail to focus on the implications of gender differences in terms of health and illness.

The dominant view of women has changed radically during the last century. These changes have had

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an important impact on the way of life of women in general and, undoubtedly, on women as patients. Nevertheless, gender differences have received little attention in the development of healthcare services. The 'normal patient' is considered to be gender-neutral, although the general understanding of such a patient is heavily influenced by the illnesses and needs of men (Clancy & Massion, 1992; Fleury & Cameron-Og, 1997; Malterud, 1997; Kearney, 1999; Nou, 1999; Hoffman 2000).

Stroke hits a great number of elderly women (Jentorp & Berglund, 1992; Ellekjær *et al.*, 1997; Norwegian Council of Research, 1995). Wyller *et al.* (1997) found that women seemed to be harder hit by a stroke than men; they achieved lower scores in tests of motor, cognitive and ADL functions, both in the acute phase and 1 year after the stroke. They suggest possible biological and pathophysiological causes for these findings.

Disease, and the experience and behaviour associated with it, are not only biological realities, however. They are at least in part social constructs formed by cultural ideas and perceptions and by personal experience. Disease must therefore be understood from the triple perspective of disease, illness and sickness (Kleinman, 1988). The way people cope with disease is closely associated with the life they have lived prior to the disease. Women and men live quite different lives in many respects. They tend to have different roles at home and in the work place; consequently their life experiences, values and life goals may differ (Skjønsberg *et al.*, 1993; Thorsen, 1993; Beutel & Marini, 1995; Wærness, 2000). This may have wide implications in terms of rehabilitation.

Most current female stroke patients are between 50 and 85 years old (Norwegian Council of Research, 1995; Ellekjær *et al.*, 1997). They were born in the period 1910–50. Women born before 1935 are called the *housewife generation*, indicating that the great majority of them married and started a family early in their lives (Skrede, 1996). Their place was in the home, and only there. Women born in the period 1936–50 are called the *mixed generation*. They grew up with ambivalent signals about the relative importance of education and work. At the same time, they had primary responsibility for home and family. Most female stroke patients will be from the housewife or mixed generations.

Women born in the period 1951–65 are called the *generation of equality*. Their gender roles and life cycle expectations have changed radically, compared with older women, in that men and women live in comparative equality (Skrede, 1996). Most health professionals of today, including nurses, physical therapists, occupational therapists and physicians, will represent the equality generation. Their roles, values and life expectations will differ radically from their old female patients. It is reasonable to assume that these differences may generate quite different perspectives and expectations in terms of rehabilitation goals and treatment approaches following a stroke. This issue will be explored in this paper.

de Beauvoir's feminist theory maintains that the body is fundamental to understanding the life of a person. The world is conquered and subjectivity developed through one's body. The biological body represents both possibilities and limitations (Merleau-Ponty, 1962; de Beauvoir, 1974; Moi, 1999). A stroke may dramatically alter the body. In order to understand the implications of such changes for rehabilitation and for life following a stroke, a theoretical understanding of these changes is essential. According to a feminist perspective, bodily changes must be understood from a gender perspective. The body is both a biological reality, and a socially and historically constituted entity (Merleau-Ponty, 1962; de Beauvoir, 1974; Moi, 1999).

Although some of de Beauvoir's descriptions and conclusions about the lives of women may be exaggerated or partly dated, we feel that her ideas point to significant insights for understanding health, illness and rehabilitation after a stroke, particularly for elderly women. Moi (1999), a noted de Beauvoir scholar, claims that feminist theory has much to learn by returning to her ideas, as 'no feminist has created a better theory of the bodily sexually differentiated person than has Simone de Beauvoir' (Moi, 1999, p. 23).

One may question the current relevance of a feminist theory developed in the 1940s in France, when women's rights and influence in society were very limited. The lives of women, at least in the western

world, have in many ways been radically changed. Sexual freedom, improved access to contraception, education and work, and improved child care facilities underscore this. The world of women is no longer a closed home. All the same, men still have more power than women in important aspects of society, such as politics, economy and culture. Men earn and own more than women, whose role in the arena of paid work is still defined by their having primary responsibility for children and home (Blom, 1992; Skjønsberg *et al*., 1993; Skrede, 1996; Buvinic, 1999; King, 2000; Wærness, 2000). In this sense, de Beauvoir's theory is still relevant. In this paper, however, we focus on the relevance of her ideas for elderly women, who grew up and lived the major parts of their lives in a context dominated by traditional male and female roles. We assume that de Beauvoir's ideas are particularly helpful in understanding their situation.

In the following sections we review her ideas and present important critique directed towards the theory. Following a discussion, in which we propose a modified understanding of some of de Beauvoir's ideas, we move on to illustrate how a feminist perspective on the altered body following a stroke may have several important implications for stroke rehabilitation.

Central concepts in Simone de Beauvoir's feminist theory

From the perspective of rehabilitation, it is particularly de Beauvoir's ideas of the gendered body as fundamental in understanding the lived experience of women that are of interest. These ideas are primarily formulated in *The Second Sex* (1974). de Beauvoir stresses that the female body places women in a particular situation that has traditionally led to oppression and lack of freedom. Although in principle free and independent, women have traditionally been subjected to social structures that have restricted and oppressed them and forced upon them the role of *the Other* in society. This position of lack of freedom has generated a certain kind of experience that fundamentally influences the way women act and master their situations. This may also be of particular significance in situations that require the overcoming of illness.

A feminist perspective on the body

de Beauvoir's ideas about the female body are grounded in the phenomenology of Merleau-Ponty (1962), with whom Simone de Beauvoir worked closely. Phenomenology maintains that lived experience is fundamental in all human understanding and provides the basis for all meaningful human action and interaction in the world. Although accepting the importance of gender, Merleau-Ponty (1962) never developed this idea in his work. de Beauvoir, on the other hand, made this her major focal point. In this sense, she contributes to a further development of phenomenology, an increasingly influential philosophy within nursing.

de Beauvoir maintains that biological gender is basic. The female body, with its particular biological characteristics and reproductive functions, places women in the world in a particular way. It creates distinct situations, challenges and demands that women must relate to one way or another. Within feminist discourse, there has been disagreement on the centrality of female biology. Most feminists have emphasized that the inferior position of women in society is not the result of biology, but of social constructions that can be changed to achieve equal opportunities for women and men. Questions of biology have been controversial among feminists, because biological differences have been related to determinism (Jaggar, 1983; Offen, 1988; Hageman, 1990; Evans, 1995; Halsa, 1996; Moi, 1999).

However, to de Beauvoir it is not primarily the biological female body that makes one a woman, but the experiences and possibilities that women meet and create throughout life (de Beauvoir, 1974; Moi, 1999). A woman develops in a constant interaction between demands put on her from society and her own projects within the situations she finds herself (de Beauvoir, 1974). According to de Beauvoir (1974), freedom, oppression and alienation are phenomena that a body is 'exposed' to in the world. Traditionally, the female body has been exposed to alienation and oppression throughout life (de Beauvoir, 1974).

Instead of regarding the body as an object, Beauvoir claims that the body is a *situation.* The body perceived as a situation is deeply related to the individual woman's (or man's) subjectivity. The body is a fundamental kind of situation in that it creates the foundation for the experience of oneself and the world. It provides us with our perspective on the world. At the same time, the body is engaged in a dialectical interaction with its surroundings. As the *gendered* body is a situation, a female body is in a different situation than a male body. The body is one of several situations, which include class, race and nationality. The body as a situation is fundamental, because it is the basis for a person's experiences of her/himself and the world. It is always part of lived experience (Moi, 1999).

The body of a female stroke survivor is quite different from the body of a healthy woman. Stroke is characterized by brain damage, which can lead to physical and cognitive malfunctions, reduced abilities and changed appearance. Following de Beauvoir, these changes will place the female stroke survivor in a fundamentally different situation, requiring new ways of being in the world. Recent research supports this (Seymour, 1998; Overboe, 1999).

de Beauvoir also describes the body as a *background,* referring to the general understanding of what it means to be a woman at any given time. The background understanding of the body is expressed in myths, ideology and traditions and cannot be separated from its cultural context. Knowledge about their background is important to understand the women. Skrede's (1996) work suggests that women's ways of life have changed radically during the last century. From being primarily housewives bound to the tasks of home and children, women have moved towards relative equality in terms of possibilities, rights and the freedom to pursue an independent career. These changes have significantly impacted on the values, expectations and roles of women as patients and professional helpers. Miles (1998) demonstrates how cultural understandings of the body impact on women's experienced health and illness in fundamental ways.

Transcendence and immanence: fundamental processes in the formation of the self

Transcendence and *immanence* are complementary terms that recur throughout *The Second Sex* (de Beauvoir 1974). These two terms, which give expression to challenge and conservation, represent polarities that match those of 'subject-object' and 'the one – the other'. de Beauvoir considers freedom a universal and fundamental individual and social value, and a presupposition for transcendence. She makes a distinction between freedom on this existential level and concrete freedom in the life of individual women and men. She argues that it is a cause for outrage that some people have far greater freedom and far more opportunities for transcendence than others (Moi, 1999). Women are, in most countries, given less freedom than men (de Beauvoir, 1974). Freedom is expressed through projects initiated by the individual. It is through projects that the individual masters the world and makes it hers/his. Thus the actual state of affairs is changeable (de Beauvoir, 1974).

Transcendence captures the idea that people are directed beyond themselves towards something else, something more, by their intentional consciousness. They have an urge to go beyond what is given, i.e. the circumstances that they find themselves in. Transcendence finds expression in actions and projects with a clear content and target. Transcendence is not the same as developmental changes related to growth. It requires conscious and purposeful action performed by a conscious, creative human subject (de Beauvoir, 1974). Human transcendence must be challenged or extended by other people, and this happens when the projects which transcendence is engaged in, mean something for other people.

de Beauvoir uses the term immanence to refer to stagnation. Immanence is associated with tedious, repetitive work without mental challenges. Immanence implies 'a degradation of existence into the "en soi" – the brutish life of subjection to given conditions – and of liberty into constraint and contingence' (de Beauvoir, 1974, p. xxxiii). de Beauvoir relates immanence to the world of women. She describes home as the centre of the world for a married woman. House-

work and the bringing up and nurturing of children, characteristically repetitive work, are her responsibilities. The same tasks are performed many times a day, daily, weekly, monthly and yearly. Rather than looking purposively to the future, life goes continuously in circles. The purpose of her work is to conserve, to maintain the status quo (de Beauvoir, 1974).

de Beauvoir argues that people tend towards both transcendence and immanence. What distinguishes human existence from other life forms is that conservation is integrated with challenge and that the subject does not have prescribed limits for her/his challenges. Skrede's (1996) analysis suggests that the ideas of de Beauvoir have influenced women's lives greatly during the last century. Through the women's liberation process, within which de Beauvoir played a central role, women have sought freedom and transcendence primarily through independent careers outside home. Only lately have women started to question the assumption that transcendence and freedom may only be captured through paid work outside home, realizing that the new ways of women have impacted greatly on their traditional roles as mothers and carers (Chodorow, 1978; Lundgren-Gothlin, 1992; Halsa, 1996; Brembeck *et al*., 1999). Nevertheless, in contrast to earlier generations of women, very few modern women opt for a housewife career as their major occupation. Consequently, double workload (paid work and major responsibility for home and children) continues to be common among women (Blom, 1992; Skrede, 1996; Wærness, 2000).

The process of alienation

Where oppression exists, the world is divided up so that some people can meet unlimited challenges and others conservation. Some are given responsibility for the community. Their lives become a mechanical repetition. They are not given the possibility to develop themselves and the oppressor does not recognize their need for transcendence. A woman's situation in a patriarchy is characterized by her being forced to live in immanence. This is not a reflection of women's biology or of any preference on the part of women, claims Beauvoir, but is the result of social structures (de Beauvoir, 1974).

From early childhood, girls are 'taught' to be immanent, boys to be transcendent. In most societies they grow up with a clear gender hierarchy where man is central, the one who is continually challenged to be transcendent (de Beauvoir, 1974). While boys' games typically involve the active use of their bodies, fighting, trying to be best, be heroes, girls frequently receive signals that stimulate adoption of traditional female roles (including dolls, feminine dresses, etc.). This largely unconscious and hidden process frames the consciousness of both men and women.

According to de Beauvoir, the female body is marked out for the propagation of the race: 'It is in the grip of the race from puberty to the menopause' (de Beauvoir, 1974, p. 55). The menstrual cycle, pregnancy and birth do not serve the individual or the subject. They serve the egg and the race. These changes frequently give a woman's body a series of unpleasant experiences and may endanger her health, both in the short term and in the long term. In a sense, she experiences that her body is both a part of herself and at the same time something apart from her self, an object. This creates a paradoxical situation, which may have consequences for her identity and the experience of alienation. This experience of *alienation* from her own body is reinforced in pregnancy (de Beauvoir, 1974).

A woman must live in the conflict between the race and herself for a large part of her life. Compared with a woman, a man would seem to be far better off. His sexual life does not counter his personal existence (de Beauvoir, 1974). According to Beauvoir, a woman's biology and her responsibility for procreation represent a basic set of differences that objectify and alienate her in relation to men. It makes the situation of the female body different and more restricted (de Beauvoir, 1974).

The menopause represents a new drastic change in a woman's body. Some women may experience this as a state with many discomforts and a lack of vitality, while others experience greater health, balance and strength because of the physiological independence that the menopause represents. Traditionally, the position and status of women in society is further

diminished after the menopause, as they are no longer central in terms of reproduction and their cherished beauty and youth are waning (de Beauvoir, 1974).

Narcissism: a particular form of alienation of women

With the onset of puberty the future is not only something that a woman faces. It inhabits her body and literally becomes her reality. Whilst an adolescent boy makes plans for his future, adolescence is a period of transition and waiting for a girl. Observing women of her day, Beauvoir maintains that the girl is waiting for Mr Right, the fairy-tale prince who will seal her fate. She sees men, not herself, as a tool to make her whole, to emancipate her. Her task is to win a husband, and in this context her body is a woman's most important asset. Her body is capital she must exploit, make attractive for men. Her body must be seen. That is why women spend so much time, energy and money preening and slimming, to enhance their facial and bodily beauty. de Beauvoir calls this preening and admiring of one's own body *narcissism*. It is a specific form of alienation process where the ego is an absolute goal, which the subject merges with. de Beauvoir emphasizes that narcissism is not a basic trait of a woman, but that society forces her to reject her true self, and at the same time direct her affection towards her self. Narcissism necessarily implies bad faith, i.e. dishonesty and self-deception. It is women's dilemma in a patriarchal system.

Recent research indicates that the idea of narcissism may still be relevant. Waaler (1990) carried out a study of 400 women aged 16–30. A large number of these women had negative feelings about their own bodies. It is often claimed that we live in an age where body and appearance are strongly focused, and huge sums are invested in making the body successful and attractive (Thesander, 1994). Seymour (1998) found in her qualitative study of young people with varying degrees of bodily paralysis that many of the informants seemed to be reproducing, rather than challenging or transcending, conventional forms of masculine or feminine bodily expressions. While masculinity is associated with promise of power, strong muscles, sports, hunting and occupying the space, femininity is associated with notions of beauty, attractiveness, fashion and slimness. This can be understood as an expression of narcissism, and suggests that our consumer society contributes to maintaining and deepening female narcissism. On the other hand, the increasing adoration of the masculine body may be interpreted as a form of male narcissism.

The question is whether this vanity is primarily a feature of younger people or whether it lasts throughout life. A stroke often changes one's appearance. There are reasons to believe that negative changes in appearance may strike women hard. They may experience their bodies as being less attractive and attractiveness is strongly linked to women's social status, identity and self-image.

Critique of de Beauvoir's theory

Feminists have criticized de Beauvoir for essentialism in the way she outlines the biology of women, particularly her description of women's experiences with hormonal and bodily changes around puberty, pregnancy, birth and the menopause. She has also been criticized for describing childbearing as a source for vulnerability, alienation and oppression, in short for considering *biology as destiny*. Shaanning (1992) and Moi (1999) reject this critique of essentialism, arguing that de Beauvoir develops a critique of sexism by stressing the fact that being born with a female body starts a process that will have specific, yet unforeseeable, consequences. If we want to understand what a women is, generalizations about sexual differences will never be enough, whether this is understood in terms of sex, gender and both. Instead, de Beauvoir invites us to study the variety of women's lived experiences and the complexity of women.

Others (Knizek, 1993) have stressed that although bodily experiences may be a source of vulnerability, they can also be a source of strength, because they give women practice in paying attention to bodily changes, interpersonal relations and emotions. In relation to health, illness and rehabilitation, that could be of great importance, as these experiences may provide women with a kind of bodily competence that may assist them in dealing effectively with disease.

de Beauvoir has also been criticized for not contributing to improving women's situation and self-respect, but idealizing men's lives as free and autonomous, by portraying women's lives as unfree and oppressed. This is related to Beauvoir's argument that economical independence and participation in life outside home, e.g. in politics and employment, are basic for women's liberation, as they provide women with possibilities for transcendence.

In line with this, Beauvoir's theory may be criticized for portraying the caring work of women in terms of immanence rather than in terms of transcendence. She does not acknowledge the possibilities in motherhood, the unique relationship between mother and children as a privilege and source of transcendence in women's lives. In our view, this is the most controversial point in de Beauvoir feministic theory. Moi (1999) writes that de Beauvoir herself was highly ambivalent about mothers, motherhood and pregnancy and that all her texts, including *The Second Sex,* are haunted by a destructive 'mother image'.

In our view, although caring work is primarily directed towards the needs of others, and in that sense puts the carer in the role of *the Other*, caring work also opens for transcendence. Taking care of the ill and elderly and raising children poses opportunities for stretching beyond oneself and one's immanent situation. Providing the conditions and *milieu* necessary for security, growth and personal and social development is a highly complex task, for which women are still primarily responsible. Moreover, history is replete with examples of women mobilizing for social change in order to improve the circumstances of children, the sick, the poor and the old. (Wyller, 1969; Blom, 1992). In our view, transcendence and immanence seem to have more to do with individual control and choice and social valuation of the particular activities and projects than inherent characteristics of tasks themselves.

Another important criticism against de Beauvoir is that of *the imperialism of consciousness* (Schaanning, 1992), which refers to the struggle for ideological power and dominance. It seems that de Beauvoir has taken over men's view of reality, which is a problematic standpoint for many feminists (Schaaning, 1992). In our view, the important point is de Beauvoir's argument that women need to gain power over their own lives and that this requires gaining consciousness of differences and diversities among woman and between women and men. Understanding of 'the normal patient', developed by research on men, may be considered as 'imperialism of consciousness', which needs to be questioned in relation to illness and rehabilitation of women. The task of feminist research is to illuminate ways that the healthcare services have been influenced by patriarchal consciousness, and the consequences that this may have for female patients.

To summarize, the critique of de Beauvoir's theory has been directed towards her view of the biological body as essential in understanding gender differences. She has also been criticized for portraying the life of men singularly in positive terms and the life of women in negative terms and for failing to recognize positive aspects in the traditional life and experiences of women. The critique of essentialism has been challenged. The other critical points, while relevant, do not, in our view, threaten the integrity of the theoretical insights of de Beauvoir. On the other hand, they may contribute to reviving the insights of de Beauvoir.

Rehabilitation: a challenge to transcendence?

The professional goal of rehabilitation for most stroke patients is to regain as much as possible of the functional level they had before their stroke. The primary focus of rehabilitation is on muscular and functional recovery. Physical training, similar to that experienced in sport activities, has been a central part of traditional rehabilitation programmes. This gives men a distinct advantage in terms of the outcomes of rehabilitation, as bodily strength, physical training, playing and competition are more strongly connected to masculinity and men than to women and femininity (Fleury & Cameron, 1997; Seymour, 1998; McSweeny & Crane, 2001). Following de Beauvoir's emphasis on the centrality of the body, facilitating bodily recovery is fundamental. The challenge for healthcare professionals is to foster bodily recovery,

taking the lived experience of the patients into account. This implies the need to exploit women's experiences of their bodies (Knizek, 1993; Seymour, 1998), as well as to tailor training programmes for women that are more in accordance with women's ways of using their bodies. Dancing, movements to music, swimming, walking and housework activities are associated more with a female way of using their body (Limacher, 1998; Daley & Buchanan, 1999; Binde & McCallister, 1999; Abel *et al.*, 2001). For elderly women, activities related to their roles as housewives and mothers will probably support their lifelong inclination and earlier experiences, thereby providing a link to their pre-illness skilled body. In addition, exploring the meaning of changes in bodily appearance for the individual woman is essential. Some elderly women continue to stress feminine appearance, while others feel that menopause and maturity have provided them with the freedom to reject these traditional pressures. It is important to individualize the rehabilitation efforts, taking each woman's values into account, in order not to enforce oppressive conceptions on her.

Closely associated with the lived experience of a woman is the functionality of the body. When a body is ascribed functionality, it is seen as a tool to obtain various goals, such as material wealth, recognition and fame, to satisfy the basic need for food, to keep a home together and to take care of other people (Waaler, 1990). The identity and self-image of some women, particularly working class women, are strongly linked to their body's functionality. For men, the need or demand that the body should provide recognition and that it be a tool for production (paid work) generally ends when they become pensioners. This is a normal progression and may indicate that the demands of functionality for a man's body lessen over the years. The demands to maintain a home and to care for the well-being of others – the classic arena of women – in principle last throughout life. To experience that one's body is less useful or prevents a satisfactory functioning in earlier roles may therefore give women a strong sense of loss. From a rehabilitation perspective, evaluating how the woman perceives her situation and functioning following a stroke is essential in order to design a relevant rehabilitation programme that gives the woman a sense of relevant help.

Doolittle (1994) found that stroke patients' most important focus and goal for rehabilitation was to master 'activities of concern', i.e. activities that were important to them before their stroke. These activities gave the person identity, continuity and the vision of a life that would be worth living (Doolittle, 1994). This corresponds with de Beauvoir's statement of the body as a situation involved in meaningful projects as a way of grasping the world. In order to foster the energy and motivation necessary to participate in training activities, the link between these activities and the personal goals of the patients must be made apparent for them. This is frequently not the case, as traditional rehabilitation programmes are formed around muscular and neurological functioning.

Many of those women who today and in the immediate future will be afflicted by a stroke belong either to the housewife generation or to the mixed generation. If de Beauvoir is right in her assertion, one may assume that a considerable proportion of these women have lived a life in immanence and lack of freedom. Some research provides support for this assumption. Album (1991) found that health workers experienced that women and men reacted differently to being patients. Women took on a passive role and gave the professional health workers responsibility for making them well again. They kept to their rooms, where they lay down or sat in bed. They read, did a little handiwork, rested and talked together about their health problems, children, grandchildren and domestic topics. The men, on the other hand, played an active role. They put on training suits and walked about in the corridors. They too spoke about health problems. Otherwise, hunting trips and sports activities dominated the men's conversations. They often told tales of strenuous hunting excursions. The male patients were attracted to fitness and bodily activity (Album, 1991). Similarly, Ahlgren & Hammarstöm (2000) found that men participated more actively in selecting treatment options than women, who tended to hope for specific help rather than asking for it. These differences in how the role of patient was tackled may be an expression of female immanence and male transcendence.

The communication between the stroke survivor and the helpers is of great importance for patients' improvement. In a qualitative study of vocational rehabilitation, Ahlgren and Hammarström (2000) found that women more often than men experienced that doctors distrusted them and that the social insurance officers made decisions for them. The outcome of rehabilitation was better for men, whether they adopted the offered measures or not. They also found that men in contact with the healthcare system could demand more specific investigations in order to find an adequate treatment. The women were more inclined to ask and to hope for non-specified help. They continued to follow the prescribed treatment even if no improvement was apparent. While men's suggestions were listened to and supported, women's non-specific requests for help failed to elicit support. On the contrary, the women's own plans were considered unrealistic. Consequently, the officers made decisions for them. The authors concluded that several factors strongly influenced the outcome of the rehabilitation process in favour of men. This included gendered structures in the rehabilitation system, the meeting between the client and the doctor/social security officer, and the division of domestic duties within marriage. Malterud (1993, 1994) suggests that health professionals adopt an approach to communication that explicitly asks female patients to verbalize their hopes, expectations and needs for help in order to secure that women express their particular experiences and needs. Incorporating women's needs requires conscious effort on the part of healthcare professionals.

Apart from physicians, almost all the professional helpers that a woman meets following a stroke are women. One would imagine that female helpers would more readily understand the situation of a woman who has had a stroke, and that this community of women would be a source of strength in the process of rehabilitation. The results of the study by Ahlgren and Hammarström (2000) challenge this assumption. This may be explained by the fact that many of the female helpers are younger and belong to the generation of equality. Their lives have presumably been characterized by transcendence. They may not have sufficient understanding and insight into the situation and problems facing older women, because their lives have been and are different, and because they have been trained in a gender-neutral tradition, which in practice is often a male tradition.

In addition, younger helpers may unconsciously operate from a different set of values. The results of Waaler (1990) and Seymour (1998) suggest that young women are strongly influenced by values related to bodily fitness and beauty. Such perceptions may put elderly, disabled female patients at a great disadvantage, as their chances of meeting such criteria are slim. If they also have more problems participating in traditional rehabilitation programmes than men and are less explicit about their needs and personal goals, or express goals that differ greatly from those valued by their younger helpers, the helpers may have problems offering adequate help. In order to contribute to a more gender-sensitive rehabilitation approach, health professionals need to learn more about similarities and differences between the experiences, perspectives and needs of men and women and between young and old women. The ideas of Simone de Beauvoir may significantly contribute to challenging traditional rehabilitation practice, thereby opening up for new ways of understanding the needs of patients following a stroke. This may point to new ways of designing rehabilitation programmes that better meet the needs of the patients.

Conclusion

We believe that a feminist perspective on ill-health, including disease, illness and sickness, will introduce new ways of looking at problems, and new answers for the rehabilitation of woman after illnesses such as stroke. A greater consciousness of gender is necessary, both in the various health sciences and amongst practising health workers.

de Beauvoir's feminist theory maintains that one's body is fundamental for becoming the person one is, but it is not destiny. It is the body within all other situations – the interaction between the body and the surroundings – that makes one the woman or man one becomes. Traditionally, the female body has been exposed to alienation and oppression throughout life. This has led women to develop a life in immanence.

This we feel can be of significance in connection with rehabilitation after a stroke, particularly for elderly women. Women who have suffered a stroke must re-create their own existence and this requires transcendence. They must be challenged with projects that promote transcendence, using their damaged bodies to re-conquer the world so that they experience quality of life despite the restrictions of the stroke.

We agree with Moi (1999) that de Beauvoir has formulated an insightful theory about the bodily, sexually differentiated person. Her thesis that the body is a situation that encompasses both limits and freedom is applicable to both healthy and sick women. It may be difficult to realize the freedom and possibilities for stroke survivors with serious disabilities, who may experience their body as a destiny of losses. Healthcare professionals face a great challenge in helping stroke survivors to create new possibilities. As most helpers are from the equality generation, they may have difficulties understanding the consequences of a life in immanence and the particular needs of elderly women in helping them create a new, meaningful life. de Beauvoir's feminist theory provides a useful perspective when trying to understand the situation of elderly female stroke survivors.

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References

Abel T., Graf N. & Niemann S. (2001) Gender bias in the assessment of physical activity in population studies. *Sozial und Präventive Medizin*, **46**(4), 268–272.

Ahlgren C. & Hammarström A. (2000) Back to work? Gendered experiences of rehabilitation. *Scandinavian Journal of Public Health*, **28**, 88–94.

Album D. (1991) Det kjønnsdelte pasientfellesskapet. (The sex-separated patient fellowship). In: *Mellom idealer og realiteter. Studier i medisinsk sosiologi* (*Between Ideals and Realities. Studies in Medical Sociology*) (eds D. Album & G. Mindrè), pp. 27–55. ad Notam, Oslo.

Beutel A.M. & Marini M.M. (1995) Gender and values. *American Sociological Review*, **60**(3), 436–448.

Binde E.M. & McCallister S.G. (1999) Women, disability, and sport and fitness activity: The intersection of gender disability dynamics. *Research Quarterly for Exercise and Sport*, **70**(3), 303–312.

Blom I. (1992) *Kvinnenes Verdenshistorie (The World History of Women)*. Cappelen, Oslo.

Brembeck H. (1999) Det (post) moderne moderskapet. In: *Familj och kön. Etnologiska perspektiv* (eds B. Meurling, B. Lunggren & I. Lövkrina), pp. 171–189. Studentlitteratur, Lund.

Buvinic M. (1999) *Promoting Gender Equality. UNESCO International Social Science Journal*, **51**(4), 567–579.

Chodorow N. (1978) *The Reproduction of Motherhood.* California Press, Berkeley.

Clancy C.M. & Massion C.T. (1992) American Women's health care – a patchwork quilt . . . . *Journal of the American Medical Association*, **268**(14), 1918–1920.

Daley A.J. & Buchanan J. (1999) Aerobic dance and physical self-perception in female adolescents: some implications for physical education. *Research Quarterly for Exercise and Sport*, **70**(2), 196–200.

de Beauvoir S. (1974) *The Second Sex.* Vintage Books, New York.

Doolittle N.A. (1994) Clinical ethnography of stroke recovery. In: *Interpretive Phenomenology. Embodiment, Caring, and Ethics in Health and Illness* (ed. P. Benner), pp. 211–224. Sage, Thousand Oaks, California.

Ellekjær H., Holmen J., Indredavik B. & Terent A. (1997) Epidemiology of Stroke in Innherred, Norway, 1994 to 1996. *Stroke*, **28**(21), 80–2184.

Evans J. (1995) *Feminist Theory Today. An Introduction to Second-Wave Feminism.* Sage, London.

Fleury J. & Cameron-Og K. (1997) Women's rehabilitation and recovery. *Critical Care Nursing Clinics of North America*, **9**(4), 577–587.

Hageman G. (1990) Forskjellighetens dilemma (The dilemma of the difference). *Historisk tidsskrift*, **2**, 162–177.

Halsa B. (1996) Variasjoner over et tema. Feminisme Som Teori (Variations over a theme: feminism as theory). In: *Hun og Han. Kjønn i forskning og politikk (She and He. Sex and Gender in Research and Politics)* (ed. H. Holter), pp. 141–194. Pax, Oslo.

Hoffman E. (2000) Women's health and complexity science. *Academic Medicine*, **75**(11), 1102–1106.

Jaggar A. (1983) *Feminist Politics and Human Nature.* Rowman and Allanheld, Totawa, New Jersey.

Jentorp P. & Berglund G. (1992) Stroke registry in Malmø, Sweden. *Stroke*, **23**, 357–361.

Kearney M.H. (1999). *Understanding Women's Recovery from Illness and Trauma*. Sage, London.

King A.E.V. (2000) *Progress for Women in the New Millennium: the Way Forward.* UN Conference Report 'Beijing

+5 Women 2000. Gender equality. Development and Peace for the 21st Century'. Special Session of the General Assembly, 5–7 June 2000. www.un.org/womenwatch/confer/documents/04Dec2000

Kleinman A.M.D. (1988) *The Illness Narratives*. Basic Books, New York.

Knizek B.L. (1993) *Den psykiske krop. Om sundhed, sygdom og køn (The Psychological Body. About Health, Illness and Gender)* Gyldendalske Bokhandel, Nordisk Forlag A.S., København.

Limacher M.C. (1998) Exercise and rehabilitation in women. *Cardiology Clinics*, **1**(16), 27–37.

Lundgren-Gothlin E. (1992) *Kön och existens: Studier i Simone de Beauvoir's Le Deuxieme Sex (Sex and Existence: Studies in Simone de Beauvoir's Le Deuxieme Sex)*. Daidalos, Göteborg.

Malterud K. (1993) Strategies for empowering women's voices in the medical culture. *Health Care for Women International*, **14**, 365–374.

Malterud K. (1994) Key questions – a strategy for modifying clinical communication. Transforming tacit skills into a clinical method. *Scandinavian Journal of Primary Health Care*, **12**, 121–127.

Malterud K. (1997) Medisinsk kvinneforskning (Medical feminist research.). *Kvinneforskning*, Norges forskningsråd. Sekretariatet for kvinneforskning **21**(3–4), 81–87.

McSweeny J.C. & Crane P.B. (2001) An act of courage: women's decision-making process regarding outpatient cardiac rehabilitation attendance. *Rehabilitation Nursing*, **26**(4), 132–139.

Merleau-Ponty M. (1962) *Phenomenology of Perception*. Routledge, London.

Miles A. (1998) Women's bodies, women's selves: illness narratives and the 'Andean Body'. *Body & Society*, **4**(3), 1–19.

Moi T. (1999) *What is a Woman? And Other Essays.* Oxford University Press, Oxford.

Norwegian Council of Research (1995) *Konsensuskonferanse. Behandling av slagpasienter (Concensus Conference. Treatment of Stroke Patients).* Rapport nr 8. Komiteen for Medisinsk teknologivurdering. Norges Forskningsråd, Oslo.

Nou (1999) *Kvinners helse i Norge (Norwegian Public Report on Women's Health).* Statens forvaltningstjeneste, Statens trykking, Oslo.

Offen K. (1988) Defining feminism: a comparative historical approach. *SIGNs: Journal of Women, Culture Society*, **14**(1), 119–157.

Overboe J. (1999) Difference in itself: validating disabled people's lived experience. *Body & Society*, **4**(5), 17–29.

Schaaning E. (1992) *Modernitetens Oppløsning (The Dissolution of Modernity).* Spartacus forlag, Oslo.

Seymour W. (1998) *Remarking the Body Rehabilitation and Change.* Routledge, London.

Skjønsberg E., Gulli B.M. & Munk-Madsen E. (1993) *Kvinner og EF (Women and the European Communion).* Cappelen Forlag A/S, Oslo.

Skrede K. (1996) *Levekår i tre kvinnegenerasjoner (Living Conditions in Three Generations of Women).* Rapport no. 8/96. Senter for kvinneforskning, Universitetet i Oslo, Oslo.

Thesander M. (1994) *Det Kvindelige ideal (The Ideal of Women*). Tiderne Skifter, København.

Thorsen L.M. (1993) *Det Fleksible Kjønn (The Flexible Sex).* Universitetsforlaget AS Det Blå Bibliotek, Oslo.

Wyller I. (1969) *Sykepleiens verdenshistorie (The World History of Nurses)*. Forlaget Land og Kirke, Oslo.

Wyller T.B., Sødring K. M., Sveen U., Ljungren A.E. & Bautz-Holter B. (1997) Are there gender differences in functional outcome after stroke? *Clinical Rehabilitation*, **11**, 171–179.

Waaler N. (1990) *Forfengelighetens pris. Kvinnekropp – fysisk aktivitet – reklame. (The Price of Vanity. Female Body – Physical Activity – Advertisement)*. Norges Idrettshøgskole, Oslo.

Wærness K. (2000) *Hvem Er Hjemme? (Who is at Home?)* Fagbokforlaget, Bergen.