Chapter 11

Women's Physical Health and Well-Being

Understudied, Mythologized, but Changing

The line between physical and mental health has become increasingly blurred as more and more evidence accumulates linking the two. The purpose of this chapter is to take a holistic look at women's physical health and well-being from the perspective of health psychologists who have studied women's sexuality and reproductive health, chronic diseases, and the impact of health care practice and policy on women. We turn out attention here from women's bodies as objects of appearance (Chapter 10) to women's bodies as agents of physical health and subjective well-being. Before you read any farther, please complete the checklist in Box 11.1. We'll refer back to your answers later in this chapter.

HEALTH PSYCHOLOGY

More and more evidence suggests that conditions typically believed to be largely medical—such as heart disease, cancer, AIDS, and menstruation—are social as well as biological (Travis, 1988a). For example, consider the debate about when to limit medical intervention; that is, when to pull the proverbial "plug" on medical technology. Few people focus exclusively on biological signs of being alive without also considering the "quality of life" a patient is likely to face. At a less dramatic level, whenever dietary and lifestyle changes are indicated for treatment or prevention, the prescription calls for behavioral changes by individuals. Evidence is accumulating that psychological well-being, such as being optimistic, predicts health (Jones et al., 2004). Both the definition of health itself and the activities indicated for health maintenance or recovery benefit from the knowledge base amassed by health psychologists. A strong example of such a holistic approach to health is

Box 11.1
Stress Inventory

Put a check next to each of the following signs of stress that you have experienced in the past 4 to 5 weeks.

Weight gain _____
Crying _____
Muscle stiffness _____
Confusion _____
Headache _____
Loneliness _____
Orderliness ____
Irritability _____
Accidents _____
High spirits _____
Vibrant activity _____
Intense concentration ____
Self-confidence _____
Creativity _____
Insomnia _____
Lowered performance _____
Forgetfulness _____
Taking naps _____
Feeling out of control _____
Feelings of suffocation _____
Restlessness _____
Dizziness, faintness _____
Decreased efficiency _____
Increased sexual desire _____
Revolutionary zeal _____
Feelings of affection _____
Sense of euphoria _____
Feelings of power _____

the Women's Health Initiative (WHI), a 15-year project sponsored by the National Institutes of Health targeting 164,500 postmenopausal women (Matthews et al., 1997).[1]

Gender as a Marker

Why do we need a special focus on women's health (Chrisler, 2001)? Some health issues disproportionately affect women as compared to men (e.g., osteoporosis and eating disorders) as well as different segments of the population of women (e.g., breast cancer and lupus). Some illnesses (e.g., coronary heart disease and AIDS) function differently for women and men. Other health concerns are unique to women (e.g., hysterectomy and menstruation). Although interest in women's reproductive health is important, all too often women's health is framed almost exclusively by a myopic focus on these unique capacities of women (Stanton, 1995). Being a healthy woman involves a lot more than being reproductively fit, and as we saw in Chapter 5, life doesn't end when reproductive capacities cease.

The **androcentric** assumption that men's bodies are normative still appears in the field; for example, gender bias in how information is presented in medical textbooks persists (Dijkstra et al., 2008). Additionally, women were routinely excluded from clinical trials (the gold standard of medical research) into the 1990s because men are at greater risk of dying younger, because women's variable hormonal levels may confound findings, and because of concerns about pregnancy during data collection. Ironically, these same differences may be some of the reasons why findings from men might not readily generalize to women (see Hamilton, 1996, for an overview).

However, there have though been praiseworthy improvements into the 21st century; for example, the overall participation by women and men in clinical trials for new drugs approved by the USA's Food and Drug Administration equalized (Yang et al., 2009), and the number of studies looking separately at data from women and men has risen across 1990 to 2005 (Aulakh & Anand, 2007). Still, there is room for continued improvements—specifically targeting better representation of women in early phase trials and in critical areas (such as the development of heart drugs; Yang et al., 2009), more and better done gender-segregated analyses (Aulakh & Anand, 2007), and within-gender analyses focused on race and ethnicity (Mak et al., 2007).

Mortality and Morbidity

There's an intriguing paradox about women's health: women generally live longer than men (lower **mortality**) but are sicker (higher **morbidity**). On one end of the life course, about 125 male embryos are conceived for every 100 female embryos, and 27% more boys than girls die during their first year of life (Strickland, 1988). On the other end of the spectrum, for those who reach 100 years old, only one man is alive for every five women (Rodin & Ickovics, 1990). Overall, an American baby born in 2007 is expected to live until *she's* 80.4 years old (76.8 for Black women: 80.8 for White women) or *he's* 75.4 years old

[1]For more information about the Women's Health Initiative visit *http://www.nhlbi.nih.gov/whi/* (Retrieved September 2011).

(70.0 for Black men; 75.9 for White men) (CDC, 2011a).[2] The life expectancy advantage for women has shrunk from 7 years in 1990 to 5 years in 2007.

Life expectancy and infant mortality are often used to gauge the overall health of a population, and there has been a generally steady drop in infant mortality in the United States (from 26 infant deaths per 1,000 live births in 1960 to 6.75 in 2007; CDC, 2011a). However, wide disparities in infant mortality remain across racial and ethnic groups: highest among non-Hispanic Black (13.31), Indigenous Native American (9.22), and Puerto Rican (7.71) mothers. Compared to 58 countries globally, the United States ranks 42nd in health and well-being; Canada, 14th (Lopez-Claros & Zahidi, 2005).

Table 11.2 compares mortality trends for American women and men on diseases that rank among women's top ten killers, as well as a handful of select other causes of death that will come up later in our discussions (CDC, 2011a). The death rate for the total population has declined 42% since 1950, driven largely by fewer deaths from heart disease, stroke, and accidents (although deaths from accidents have been rising since 1992). For both women and men, note that heart disease and cancers top the list.

TABLE 11.2
Top Causes of Americans' Deaths in 2007 from the
U.S. Centers for Disease Control and Prevention (CDC, 2011)

Multiply numbers by 1000; ranked for women	*Women*	*Men*
Overall	**1,219.7**	**1,203.9**
1. Heart diseases	306.2	309.8
2. Cancers (malignant neoplasms)	270.0	292.9
(Breast / Prostate)	(40.6)	(29.1)
3. Cerebrovascular (brain)diseases	81.8	54.1
4. Chronic lower respiratory (breathing) diseases	66.7	61.2
5. Alzheimer's disease	52.8	21.8
6. Unintentional injuries (accidents)	43.9	79.8
(Motor vehicle-related injuries)	(8.2)	(20.9)
7. Diabetes mellitus	35.9	35.5
8. Influenza and pneumonia	28.6	24.1
9. Nephritis, etc. (Kidney diseases)	23.8	22.6
10. Septicemia (Infections)	19.0	15.8
Others of Special Interest:		
Suicide	4.7	18.4
Homicide	2.5	9.6
HIV	2.1	5.4
Black	11.3	24.5
Latina/o	1.8	6.3
White	0.7	3.1

[2]The at-birth life expectancy for women in the United States in 2007 (80.4) is lower than in 22 of 28 other developed countries sampled by the CDC, with Japanese women topping the list at 86.0 years (CDC, 2011a). Canada, at 82.6 for women, is topped by 13 other countries.

The second half of our medical paradox has to do with being sicker (**morbidity**). Women are more likely to report illness and to seek medical attention through telephone calls and office visits than are men, although hospitalization rates are similar when childbirth is excluded (Leventhal, 1994; Woods, 1995). In a general health survey, 36% of women and 42% of men rated their health as excellent (Woods, 1995). Does this mean that women are more biologically predisposed to illness than men? Not necessarily; there are a host of other possibilities to explain this **intergroup difference**, including differential socialization about help-seeking and admission of weakness, gender stereotyping that fits better with being sick for women than for men, and the stresses of women's roles.

The flip side of this disparity between the health of women and men has to do with behaviors, attitudes, and expectations for men. Men are less likely to seek health care for illness, injuries, and prevention and to practice everyday health-protective behaviors from wearing sunscreen to seatbelts (reviewed in Courtenay, 2000, and Good & Sherrod, 2001). Men also are bigger risk-takers than women (Byrnes et al., 1999), likely contributing to men's much higher mortality from unintentional injuries. Physicians average less time with male patients and are less likely to issue health-risk warnings to men. Indeed, men's health knowledge is worse than women's (Beier & Ackerman, 2003). Images of masculinity involving independence, invulnerability, and powerfulness mediate against help-seeking, especially in areas directly tied to manhood (e.g., prostate exams). Thus, both images of femininity and masculinity serve to widen the health gap between women and men.

The femininization of health care does not extend to all women. For example, stereotyping of African American women as strong and long-suffering, combined with a common distrust of the medical system, works against their use of the medical system and encourages delays in seeking medical treatment (Collins, 1996). Latinas are less likely than other women to seek out regular pelvic and breast exams (Ramirez de Arellano, 1996), and lesbians may restrict medical contact to maintain privacy and to avoid anticipated homophobia. Even when treatment is sought by women, the tendency to regard a woman's complaints of physical maladies as "all in her mind," when there is little or no evidence to justify a psychological over a medical diagnosis (referred to as **psychologization**), may interfere with effective treatment of women by the medical system (Grace, 2001).

Consistent with what we have seen in previous chapters, Elaine Leventhal (1994) proposed that *gender be considered a marker for further analysis of health patterns rather than a cause in and of itself.* In this chapter, we take Leventhal's suggestion and think of gender as a *lens* through which we can view women's health. The answers won't rest in biology alone, but rather in how being female interacts with other aspects of women's lives. As we have seen in earlier chapters, contextual factors play a significant role in affecting women's attitudes and behaviors. With this in mind, we'll explore what we know about the psychology of women's sexuality and then turn to psychologists' roles in reproductive health, chronic diseases, and health care practice and policy.

WOMEN'S SEXUALITY

To put sexuality in context, a large-scale survey of American's sexual behavior identified 17.7 years as the average age of first intercourse, with first vaginal intercourse being premarital for 82.9% of the sample (Else-Quest et al., 2005). As for the frequency of sexual intercourse reported by women, as we might expect, there are large variations across ages,

study designs, and countries (Schneidewind-Skibbe, et al., 2008). Higher rates are reported by women from the United States and Europe, with declining rates after age 50. Interestingly, changes across age were not found in African and South American studies, highlighting the role of culture in affecting sexual norms. But getting accurate data is difficult. In a study with an American sample, retrospective reports collected at the end of the study *under*-reported participants' sexual activities relative to the daily dairies they kept during the preceding 3 months (McAuliffe et al., 2007).

We might consider it reasonable to think about sexual behaviors as natural acts that are normal and instinctive, should be uninhibited, and can be expressed in diverse ways across humans and animals. Leonore Tiefer (1994) argues that such thinking can reduce sexuality to **biological essentialism**—a biological imperative that *drives* people to act. By overemphasizing the biological, this view can discount how sexual attitudes and behaviors are shaped within a **social context**. When that social context changes over time, attitudes and behaviors also change—an evolution that sexologists have charted across historical periods. Furthermore, viewing sexuality as a natural drive absolves us of working at being sexual—of teaching it to our children and of making it work as only one aspect of our more-than-biological relationships. Sexuality, like women's health in general, is more than biology; it is filled with social meanings and feelings.

"Machines without Motors"?

William Masters and Virginia Johnson (1966) conducted pathbreaking and detailed observations of the stages of sexual responsiveness experienced by heterosexual women and men during intercourse. Despite their attempts to provide a gender-neutral model of sexuality, critics have pointed to fundamental assumptions that suggest instead a model of male dominance and female passivity (Tiefer, 2000; White et al., 2000). Although Masters and Johnson do describe detailed physiological reactions to sexual stimulation, they tell us little about the totality of sexuality by ignoring what the person is thinking and feeling (like "machines without motors"). Sexuality is implicitly, exclusively, and narrowly defined by heterosexual genital contact (Christina, 1997; Rothblum, 1994).[3] Furthermore, all women and all men are lumped together, ignoring their individual differences (Townsend, 2002), gender stereotyping about female and male sexuality, and stereotyping for different subgroups of women. For example, consider the diverse expectations we have about Asian women as presumably passive, Indigenous Native American women as property, mothers as asexual, Jewish women as uninterested, and so on (Reid & Bing, 2000).

This tendency to medicalize women's sexuality to the exclusion of psychological and social components spills over into treatment for women's sexual problems. The *Diagnostic Statistical Manual of the American Psychiatric Association* (DSM–IV, 1994) identifies four categories of female and male sexual "dysfunction": sexual desire disorders, sexual arousal disorders, orgasmic disorders, and sexual pain disorders. Each reflects a disturbance in the assumed universal sexual response cycle described by Masters and Johnson. A working group of noteworthy sexologists charge that such a mechanical view of women's sexuality fails to acknowledge differences between women's and men's views of sexuality

[3]Even female-female sexuality can be co-opted into male-defined models of sexuality by playing to male voyeuristic fantasies (Diamond, 2005).

and sociopolitical conditions, to distinguish psychological "desire" (for intimacy, to please one's partner, etc.) from physiological "arousal," and to recognize differences among individual women's sexual needs and satisfactions (New View, 2011). The result is the pharmaceutical search for the female version of Viagra (a widely publicized drug to treat male erection problems) as a simple (and likely profitable) way to treat women's problems. Reducing remedies for women's (and men's) problems to a pill fails to acknowledge the full meaning of sexuality in women's and men's lives.

A complete picture asks what women and men want from sexuality. Folk wisdom holds that men seek pure pleasure from sexuality, in contrast to women who seek emotional connection (Hatfield et al., 1988), but this really is too simple an overgeneralization. A well-done survey of 445 women and 477 men in San Francisco did find that women attached less importance to pure pleasure, conquest, and relief of tension than did men (Leigh, 1989). In contrast to men, who ranked pleasure first, women cited emotional closeness as their top reason for engaging in sexual behaviors, regardless of their sexual orientation. Digging deeper into the data, men ranked attachment as a close second to pleasure and even considered pleasing their partner more important than did women. Indeed, other research concludes that how one thinks about one's own sexuality (our sexual self-**schema**) (Andersen et al., 1999) as well as sexuality related terms (Noland et al., 2004) are remarkably similar for women and men.

Attitudes and Behaviors: A Double Standard?

The traditional **double standard** of heterosexual sexuality suggests that sexuality is more socially acceptable for men than for women. Indeed, young women report receiving more restrictive messages from their parents about sexuality than do young men (Morgan et al., 2010). This logic would further predict that men would be more sexually experienced than women, men would hold more permissive attitudes about sexuality than women, and women would be more openly sexualized by men than men by women. Although a meta analysis of 30 sexual behaviors and attitudes found mainly similarities between women and men, there was some support for these predictions (Petersen & Hyde, 2010). Men reported slightly more sexual experience than women, as well as moderately more pornography use, masturbation, and casual sex. Men generally held slightly more permissive attitudes than women overall, with a medium difference in men's more accepting attitudes about casual sexuality. Looking across the 1960s to 1980s, gender differences in sexual attitudes and behaviors narrowed (Oliver & Hyde, 1993) and then stabilized across the 1990s and into the 21st century (Petersen & Hyde, 2010).

Notice that the gender differences identified by this meta analysis largely have to do with casual sex encounters—exactly the focus of the double standard. Indeed, when women's and men's beliefs about sexuality are examined within the context of intimate relationships, they are more mutual and more alike than different (Seal et al., 2008; Tiegs et al., 2007). When it comes to casual sex, though, a long-standing finding that garnered lots of public attention came from an experiment in which women and men were propositioned by an other-sex **confederate**; some men took her up on her offer, but all women declined his (Clark & Hatfield, 1989). More recently, Terri Conley (2011) conducted a series of four studies to explore this finding more fully. She found that both women and men agreed that the woman proposer was a better prospect than the man, and that the gap in interest closed

when the proposer was made more appealing (a famous person, sexually skilled). Thus Conley concluded that decision making about casual sex has less to do with the gender of the decider and more to do with the attractiveness of the opportunity (also see Epstein et al., 2007).

As for the greater sexualization of women by men (as opposed to of men by women), there is continuing evidence that men over-sexualize unacquainted women (Levesque et al., 2006) and even show stronger associations between women and sexuality on an **Implicit Associations Test** (Lindgren et al., 2007). As we might expect, there are individual differences in men's sexualization of women. College men most likely to sexualize women exhibit more risk factors (hostile masculinity, desire for impersonal sex, and drinking on dates and in sexual situations; Jacques-Tiura et al., 2007) and are generally more interested in casual sex (the same goes for women; Lenton et al., 2007). Furthermore, the media (*Cosmopolitan* magazine, television dating programs) promote this sociocultural message about men's hyper-sexuality (Farvid & Braun, 2006; Zurbriggen & Morgan, 2006). Not so surprising to us, power comes into play here. When college women and men had power over another student, they expected and perceived greater sexual interest from their subordinate (Kunstman & Maner, 2011).

Consistent with patterns we have seen with other stereotyping, evidence of a double standard of sexuality is not always clear-cut (Fugre et al., 2008); instead, its existence appears in more subtle forms. For example, students reading others' "journals" recalled more information consistent with the double standard than countering it (Marks & Fraley, 2006); alcohol consumption by women (but not by men) was linked with sexual disinhibition (Young et al., 2007). Intoxication is more strongly linked with sexual behaviors among sexual minority than other youth (Herrick et al., 2011).

Margaret Gentry (1998) asked undergraduates to evaluate a hypothetical woman or man described as either monogamous or engaged in multiple heterosexual relationships and enacting low, moderate, or high levels of sexual activity. On direct, obvious measures, women targets were treated similarly to men, such that all promiscuous and highly active targets were downgraded (also see Marks & Fraley, 2005). Opposing the double standard, an aura of being liberal and assertive surrounded the more active woman target, who also was most appealing to men. In contrast, women preferred the woman target described as below average in sexual activity, consistent with the double standard's dictate that "good" women should be sexually reticent. Thus, newly evolving images of sexuality include a complex mixture of similarly permissive expressed attitudes for women's and men's sexuality, some overt acceptance of the sexually assertive woman, and some subtle signs of clinging to the old stereotyping of men as sexually dominant and women as not virginal but selective.

Additional signs about the subtlety of what remains of the double standard appear in people's reactions to sexual transgressions by women and men. Undergraduate students concocted a stronger justification of love for an extramarital partner when marital cheating was done by a woman than by a man (Sprecher et al., 1998) and evaluated female pornography actors more negatively than male (Evans-DeCicco & Cowan, 2001). Unobtrusive observations of Wisconsin's procedures to establish paternity and child support revealed that non-married women were questioned far more extensively about their sexual practices and partners than were men (Monson, 1997). In prime-time television, depictions of sexually negative consequences were more common when women, rather than men, initiated sexual activities (Aubrey, 2004). Although students reacted negatively to both male and

female targets described as having a sexually transmitted infection (STI) compared to a non-sexual infection control, they did express more social rejection toward the STI woman than the STI man (Smith et al., 2008).

Consequences of the Remaining Double Standard

Residuals of the double standard continue to impact women's knowledge and communication, decision making, token resistance, risk taking, and what research is and isn't done. Both possessing adequate sexual knowledge and being able to communicate about sexuality are inhibited by double-standard expectations that women who are informed and assertive are sexually promiscuous ("sluts" as opposed to "studs") (Wyatt & Riederle, 1994). Furthermore, lack of knowledge is part of a complex mix that predicts risky sexual behaviors (Ayoola et al., 2007; Marston & King, 2006).

Exploring decision making, Charlene Muehlenhard and Marcia McCoy (1991) surveyed 403 mostly White college women about being in situations where they wanted to engage in first-time intercourse with a man and either overtly declined or openly acknowledged their desire. The former women gave in to a double-standard **script** that asserts that women, irrespective of their desires, refuse. The researchers included individual difference measures of the woman's traditionalism, acceptance of the double standard, and attitudes about sexuality. None of these measures predicted how each woman reacted—nor did her sense of her partner's actual belief in the double standard. Women who pursued their desires were more likely to *think* their partner disavowed the double standard than did women who went along with the double-standard script, despite their desire to do otherwise. This speaks volumes about how women's immediate interpersonal context influences their decision making above and beyond even their own personalities, attitudes, and desires.

One of the most dangerous offshoots of a sexual double standard has to do with "**token resistance**." Token resistance reflects the notion, fueled by a double standard stressing women's purity, that women will say "no" to sexual activity when they really mean "yes." Most seriously, token resistance is a risk factor for sexual victimization (Krahe et al., 2000).

When respondents thought about token resistance in the abstract, women and men reported similar rates of token resistance (Muehlenhard & Rodgers, 1998). However, when asked to give real-life examples of token resistance, both women and men wrote stories that didn't fit the scenario of saying "no" when meaning "yes." Rather, they wrote true stories about saying "no," possibly waffling a bit in their mind, but ultimately meaning "no" with certainty and without regrets. Although belief in women's reliance on token resistance may be a way for sexual predators to justify sexual assault (and even rape), research evidence suggests that women and men most often say what they mean: *"no" means "no."*

Remnants of the double standard continue to influence women's sexual risk-taking behaviors, involving exposure to pregnancy, sexually transmitted diseases, and even HIV infection (Wyatt & Riederle, 1994). For example, insisting on condom usage may conflict with some women's beliefs that sexuality is natural and spontaneous, that condoms are uncomfortable for men and that women should be passive and let men control heterosexual encounters (Gavey & McPhillips, 1999). Being "swept away" is a common theme in romance novels, and women who read lots of these books are more likely to hold negative attitudes about condoms (Diekman et al., 2000). Most distressingly, young people continue to regard a woman who is carrying a condom negatively (Frankel & Curtis, 2008), as well

as more sexually willing and less justified in claiming sexual assault (Hynie et al., 2003; Kelly & Bazzini, 2001).

College women report that they failed to plan contraceptive precautions prior to a date because to do so would admit that sexual pursuits are expected (Wright, 1992). Indeed when women read a hypothetical diary entry by a woman who provided the condom in a casual relationship, they rated the writer less positively than when she introduced a condom in a committed relationship (Hynie et al., 1997). Undergraduate women also overrely on questioning their partner as a way to reduce HIV risk (Mays & Cochran, 1993). These patterns converge to suggest that accurate knowledge of adequate prevention alone, without sufficient understanding of the potent role still played by the double standard of sexuality, is not sufficient to reduce sexual risk-taking behaviors (Cochran & Mays, 1993).

Finally, the double standard portrays women as passive and without sexual desire, making sexual desire a topic largely ignored by researchers (Jackson, 2005). In a controversial paper, Roy Baumeister (2000) concluded that women are more "erotically plastic" than men by engaging in a wider array of sexual behaviors over time, by being more responsive to sociocultural variables, and by showing less consistency across attitudes and behaviors. Although subsequent commentary about these conclusions didn't question their validity (Baumeister et al., 2000), questions were raised about what these differences mean. Most consistent with the approach we have taken in this book, Janet Hyde and Amanda Durik (2000) argue that gender roles that privilege men allow men to be more sexually open, consistent, and focused on themselves than women, making men less "plastic" (contextually variable) than women.

Women's Sexual Well-Being

Not surprisingly, a woman's sexual well-being depends on her body satisfaction and sense of agency and personal control. As we saw in Chapter 10, self-objectification can affect sexual functioning. Interestingly, it is not a woman's overall body dissatisfaction—but rather her context-specific negative body image during sex—that predicts ambivalence in sexual decision making, lower sexual self-efficacy, and less engagement with her partner (Yamamiya et al., 2006). Sexually satisfied women initiate sexual contact more often, express their sexual needs clearly in their primary relationships, and exhibit high levels of **agency** (Mosher & Danoff-Burg, 2005). Furthermore, personal control and self-efficacy are associated with safer sexual behavior (Pearson, 2006). Conversely, women who implicitly associate sexuality with submission report less sexual satisfaction (Kiefer et al., 2006), and this relationship is mediated by women's compromised feelings of sexual autonomy (Sanchez et al., 2006). Consistent with this reasoning, women who hold feminist beliefs report higher sexual satisfaction and condom-use self-efficacy (Schick et al., 2008). Interestingly, only women who both held feminist beliefs and adopted the label of being feminist rejected the **double standard** of sexuality (Bay-Cheng & Zucker, 2007).

REPRODUCTIVE HEALTH

Make a list of the medical personnel with whom you interact on a routine basis. You might see a dentist, a general practitioner, an optometrist, and so on. If you are a woman, you

might visit a gynecologist.[4] What's the comparable physician for a man? Only women's health care is so routinely divided.

The Case of Breast Cancer

Cancer presents an ideal opportunity to address this division of women's health care because it can develop in any body part, including women's and men's reproductive structures. Beth Meyerowitz and Stacey Hart (1995) analyzed the contents of medical and psychological publications reporting cancer research in 1983 and 1992. In the leading medical journal, *Cancer*, more studies focused on breast and reproductive cancers in women than their incidence would warrant. In contrast for men, studies of reproductive cancers were under-represented. Paralleling this pattern in the psychology literature, breast cancer survivors dominated samples of research participants, even beyond what we would expect, given their optimistic survival rates. Not surprisingly, middle-aged and older women overestimate their risk of dying from breast cancer (Wilcox & Stefanick, 1999). Although breasts indeed are the leading site for cancer in women (with a 2007 rate of 120.4 in 100,00 women), occurring more than twice as often in women's breasts than lungs (54.5), the *top cancer killer is lung cancer*. In 2007, lung cancer (with a death rate of 40.0 in 100,000 women) claimed about as many women's lives as breast (22.8, ranked #2) and colon (14.1, #3) cancers combined (CDC, 2011a).

My point is not to diminish the importance of research on breast cancer, the seriousness of being diagnosed with breast cancer (Fischer, 2001; Petersen & Benishek, 2001), the body image threats raised by breast cancer (Helms et al., 2008; Rubin & Tannenbaum, 2011), or the importance of monthly self-examination and routine mammograms. Rather, we might ask: Why this obsession with breasts? The question itself suggests an answer, but let's go beyond the obvious sexual possibility (see Wilkinson & Kitzinger, 1994). The incidence of breast cancer in the United States is highest among White women (121.0 in 100,000 in 2007), followed by Black (117.0), Latina (88.2), Asian (83.4), and Indigenous Native American (67.3) women (CDC, 2011a). However, Black women are most likely to die from breast cancer (31.4 per 100,000 women), followed by White (22.2) and then Latina (14.6), Indigenous Native American (12.8), and Asian (11.2) women.

Breast cancer is detected most frequently in a select subset of privileged women whose survival surpasses others', raising questions about the amount of attention afforded breast cancer detection and treatment. Are the women most susceptible to breast cancer as influential as Latina women, for example, who are at highest risk for cervical cancer, a disease that disproportionately strikes Indigenous Native American (Tom-Orme, 1995) and African American women as well (Leigh, 1995)? Or, what about African American women, of whom almost one of every 250 will struggle with lupus, a blood disorder in which the immune system becomes overactive (Sullivan, 1996)? Issues of power and privilege are raised here, not between women and men, but among women (**intragroup differences**).[5]

[4]A thought-provoking feminist critique of gynecology as a specialty practiced on women by and for men is offered by Diana Scully and Pauline Bart (2003).

[5]The point that we are tackling here has to do with broad racial disparities in health in the United States. For a look at how culture, gender, and power all play into this problem, as well as a look at some examples of community-based interventions, see Airhihenbuwa and Liburd (2006).

A questionable belief that may underlie psychologists' apparent obsession with breast cancer assumes that breast vulnerability is especially devastating for women. However, research evidence indicates that even complete breast loss, although certainly traumatic, is no more psychologically debilitating than other amputations or serious cancers (Wilkinson & Kitzinger, 1994). The three most common concerns reported by mastectomy patients focus on difficulty in engaging in strenuous activity, fear of reoccurrence of the cancer, and obtaining high quality medical care—none of which focus on breast loss itself.

As you read this chapter and other texts in the field, you will encounter this division of women's health into reproductive and nonreproductive concerns. Still, some recent developments are starting to strain this artificial separation. For example, is HIV a sexually transmitted disease for women and thus a sexual/reproductive threat? Or is it a general threat to women's health and well-being? We'll discuss it along with other chronic diseases later. For now, let's explore the psychology of a sampling of reproductive concerns including menstruation, pregnancy and miscarriage, and abortion.

Menstruation

Elissa Koff and her colleagues (1990) asked 80 college women, recruited from introductory and intermediate psychology classes, to simply describe the causes of menstruation. To be graded as correct, an answer must include information that the uterine lining is shed if fertilization has not taken place. Only 41% of the answers met this criterion, and fully 24% provided incorrect or irrelevant information.

The menstrual cycle. Menstruation is the shedding of the lining of the uterus, approximately 2 to 3 ounces of menstrual blood and uterine tissue, typically over 3 to 5 days on a 28-day cycle (Klebanov & Ruble, 1994). The menstrual cycle is characterized by changing hormone levels, the development and release of an ovum by the ovaries, and preparation of the uterus for possible implantation of an ovum, if it is fertilized. If fertilization does not occur, declines in estrogen and progesterone levels signal the shedding of the endometrial lining, or the start of the menstrual flow.

The *menstrual cycle* begins on the first day of menstruation when one of the many immature ova begins to mature in one of the two ovaries. Over the next 2 weeks (the **fol-**

Box 11.3

Sexual scripts are cognitive frameworks we each construct that guide our sexual behaviors, help us plan for sexual encounters, and organize our memories. We all have our own script, which is affected by our gender, our individual characteristics, and our culture (Schneider & Gould, 1987), including the magazines we read (Kim & Ward, 2004). There are five components to our sexual script, so you might want to think about your own views about each of the following before you read on.

- Who is and isn't an appropriate sexual partner for you?
- What acts are on and off limits?
- When is sexuality appropriate: time of day, across your life course?
- Where is sexuality appropriate: in what setting and under what circumstances?
- Why do people have sex (e.g., pleasure, reproduction, form bonds)?

licular phase), the follicle grows and matures as a new lining replaces the one just shed. By about the 16th day, estrogen reaches its peak and the ovary releases the fully developed ovum (**ovulation**), which survives about 2 days during which it can be fertilized. Over the remaining 2 weeks (the **luteal phase**), progesterone levels rise and stimulate the ovaries to release a mucus-like substance to prepare the uterus for a fertilized egg. If fertilization has not occurred on or around the 24th day, estrogen and progesterone *decline* rapidly, marking the **late luteal** or premenstrual phase, as the uterus again prepares to shed its lining and thus initiate a new menstrual cycle.

Although many college women may be misinformed about menstruation, Koff and her colleagues found considerable agreement about physical and emotional stereotyping associated with menstruation. These women attributed four categories of *physical* changes to menstruating—all of them unpleasant: general discomfort (cramps, aches, and pains); water retention and weight gain; tender or swollen breasts; and a variety of autonomic signs (nausea and temperature changes). This negativity extended to *emotional* changes focusing on depression, emotional lability (mood swings), and irritability. Finally, women agreed that there were few, if any, changes in their cognitive or *intellectual* abilities (e.g., reduced concentration) related to menstruation. Interestingly, much of what these women described about the physical and emotional changes associated with menstruation are not really about menstruation itself, but rather about the late luteal or premenstrual phase.

Students' emphasis on the late luteal phase, which typically lasts about 4 days, is shared by both the popular media and the scientific community.[6] The assumption underlying much of this attention is that the marked hormonal changes that accompany this normal phase of the menstrual cycle account for physical, emotional, and cognitive changes in women—an assumption captured in popular references to "raging hormones" (Davis, 1996)—although in reality hormone levels are falling. The common discourse for this phase uses the term "premenstrual syndrome" (PMS) or the more benign term, "premenstrual *symptoms*." The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association (which, in essence, defines abnormality) described Late Luteal Phase Dysphoric Disorder (LLPDD) as a bona fide disorder in its 1987 third edition, but renamed and relegated Premenstrual Dysphoric Disorder (PDD) to the appendix as a syndrome in need of further testing and to a subsection under depression in its 1994 fourth edition (Caplan, 1995).

"Premenstrual syndrome." In the popular media, both medical experts and women's testimony are used to establish PMS as a medical malady (Kissling, 2002). Sometimes these messages are mixed, following negative, sensationalized headlines with text that works to dispel myths (Merskin, 1999). Still, stereotyping of maladjusted women comes through loud and clear, with PMS suffering estimated to affect from 5% to 95% of women according to these articles, with most converging on estimates between 30% and 60%. When college students read just the basic fundamentals of PMDD as a psychiatric disorder, their perceptions of how problematic menstrual changes are for women in general increased (Nash & Chrisler, 1997).

[6]Carol Tavris (1992, p. 140) reports that researchers' interest in PMS, Premenstrual Syndrome, or Premenstrual Tension grew from one article in a medical journal in 1964 to 305 articles in medical journals and 120 in psychological journals in 1988–89. How might this attention fit with the emerging women's movement across this same time period?

Box 11.4

Stereotyping about "PMS" can be seen in the story about Sarafem, a drug approved by the U.S. Federal Drug Administration (FDA) and marketed by Eli Lilly, generating $2.6 billion in sales in 2000. Now marketed by Warner Chilcot (2005), their website claims that it "relieves both the mood and physical symptoms of PMDD (Premenstrual Dysphoric Disorder). Many physicians believe that Sarafem helps to correct the imbalance of serotonin that could contribute to PMDD."

Sarafem actually is a lower dose of the antidepressant, Prozac, re-packaged in a pink capsule and costing 13 cents more per daily dose (Rebensdorf, 2001). In November of 2000, the FDA released a letter sent to the Lilly Corporation regarding an advertisement that the company was airing on television. The ad featured a frustrated woman irritably pulling at a shopping cart that was interlocked with other carts (FDA Warning Letters, 2000). The ad diagnosed her with PMDD and offered Sarafem for relief. The FDA charged that this message confused the serious DSM diagnosis of PMDD with general stereotyping about PMS. The FDA warned that this confusion both broadened the scope of pathologizing women's normal behavior and trivialized the seriousness of genuine PMDD, urging the company to withdraw this and other similar promotions. It seems interesting to me that since the FDA effectively limited the market for Sarafem, it has moved to a smaller, specialty pharmaceutical company focused on women's health care and dermatology.

The story of Sarafem speaks about our readiness to biologize women's problems and treat them simply with a pill, raising questions about who profits from such an approach (Gurevich, 1995). Furthermore, some feminists argue that this pattern serves to deflect women's efforts for social change away from political activities inward and toward individualized clinical treatment (Nicholson, 1995; also see Gannon, 1998).

To be clinically diagnosed with **Premenstrual Dysphoric Disorder**, a woman must present at least five symptoms from a list of 11 during the week before and a few days after the onset of menses (DSM-IV, 1994, p. 717). At least one of these must include markedly depressed mood, anxiety, affective lability (sadness), and anger or irritability. Furthermore, "the disturbance seriously interferes with work or with usual social activities or relations with others," is not "merely an exacerbation of the symptoms of another disorder… ," and is "confirmed by daily self-ratings during at least two symptomatic cycles" (DSM-IV, 1994, p. 718). Researchers estimate that about 5% of American women do suffer with such intense perimenstrual symptoms (Klebanov & Ruble, 1994).

For a less clinical diagnosis of PMS, over 150 popular indicators have been identified (Gurevich, 1995). Many of these are negative (Moos, 1968) but some are positive (Delaney et al., 1988). You checked off some of them in Box 11.1 at the start of this chapter. My experience with this checklist is that men, like women, check many items, raising questions about how moods are related to menstruation if men have them. These checklists also raise important questions about what truly does define PMS (Parlee, 1993) and how broad its scope legitimately is. Some definitions are so broad that almost all women (and likely some men) would be diagnosed with PMS (Caplan, 1995).

Separating physical fact from stereotyping fiction is challenging. Pamela Kato Klebanov and Diane Ruble (1994) conclude that *physical* changes involving pain, water retention, and weight gain have enjoyed consistent support, at least when based on women's

self-reports. In a few cases where more objective measures (actual weight checks) have been employed, the validity of even these effects becomes questionable. On the other hand, in studies where women are given **placebos**, reports of physical symptoms persist. Moving from physical to cognitive and *intellectual* consequences, there is no consistent evidence to conclude that women's abilities change across the menstrual cycle.[7]

Conclusions become fuzzier when we focus on *emotional* changes. Hypotheses involving hormones have received, at best, modest support, and linkages with other physiological mechanisms (e.g., neurotransmitters) have not been established convincingly (Klebanov & Ruble, 1994). Sociodemographic characteristics, social environments, and individual differences among women may each play a role in constructing PMS. In sum, PMS is experienced differently by different women, if at all.

Looking at sociodemographic subgroup variations, race and ethnicity seem to play a role in PMS reports. For example, none of the African American women nurses studied by Kathryn Lee and Amanda Rittenhouse (1991) reported mood swings, and fewer Asian American women indicated experiencing cramps or weight gain. Controlling for socioeconomic levels, Anglo-Saxon women appear to be at greatest risk for premenstrual symptomatology (Maluf & Ruble, 1993, cited in Klebanov & Ruble, 1994). In a large-scale study of women in 10 countries, patterns and beliefs about menstruation varied widely according to country of residence, religion, literacy, age, work environment, and social status (Severy et al., 1993). For a long time, the impact of gender was not even considered, yet there is evidence that men's general moods cycle too in weekly patterns that may synchronize with women's (Gallant et al., 1991; McFarlane et al., 1988). Although menstruation is unique to women, mood cycles are not (which is why our opening checklist may apply similarly to women and men).

Turning to women's **social context**, stress and social support may affect reports of premenstrual symptomatology. For example, women nurses who acknowledged less satisfaction with their social lives and low levels of social support also reported more perimenstrual symptoms (Lee & Rittenhouse, 1992). Heightened exposure to work, familial, and financial stress was related to reports of negative moods during the late luteal phase (Gallant & Derry, 1995). Similarly, more symptomatic women reported lower marital quality and less perceived support from their spouses. Interestingly, the relationship between symptomatology and employment was moderated by choice, such that homemakers who chose their role reported the lowest symptom ratings in contrast to the highest ratings from women for whom employment was unwanted (Coughlin, 1990).

Personality, attitudes, and expectancies (**individual differences**) may influence women's perceptions of premenstrual moods. Although only a few studies have focused on personality correlates with PMS, emotionally symptomatic women may be higher in external locus of control, lower in self-esteem (Gallant & Derry, 1995) and optimism (Chrisler et al., 2006), and higher in fear of anxiety symptoms (Sigmon et al., 2000). Premenarcheal girls, who picked up their attitudes toward menstruation from sources stressing negative aspects, expected more distressed symptomatology (Brooks-Gunn & Ruble, 1982), and daughters continue to describe communications with their mothers about menstruation as negative in tone (Costos et al., 2002). Women who held more sexually objectified views of their body exhibited more disgust and shame about their menstruation (Roberts, 2004).

[7]Because physical indicators are the only "symptoms" of PMS confirmed by research, I elected to discuss this topic here under physical health rather than in the next chapter on mental health.

Finally, whether or not an individual woman's expectancies become self-fulfilling remains unclear (Gallant & Derry, 1995). For example, Pamela Kato Klebanov and John Jemmott (1992) used a fictitious saliva test, presumably measuring hormonal levels, to convincingly persuade actually premenstrual White women to *believe* they were premenstrual or in the middle of their cycle. As predicted, those who believed this reported more pain, but the finding did not extend to negative affect. Similarly, although fully 40% of 101 employed women said they experienced PMS, none exhibited actual premenstrual affective change across the two cycles studied (Hardie, 1997). What is clear is that what women report can be **primed**. If we labeled the items in Box 11.1 as responses to menstruation and put "distressful" items first and then "joyful" ones later, women's reports would be more negative than if we flipped them and put the positive items first (Aubeeluck & Maguire, 2002). Expectations surely affect reporting, but it's unclear if they influence actual experiences.

Although the existence of PMS may be more medical fiction than fact, societal beliefs about menstruation still may impact women's lives. Tanith Oxley (1998) asked British undergraduate and professional working women to describe how they manage their own menstruation. Although women reported mastery at managing their pain and discomfort, dominant themes involved being highly self-conscious of their bodies and avoiding situations that might expose their menstruation. These themes of disruption and fear of exposure appear in another study in which 18 to 22 year-old menstruating and non-menstruating women interacted with a male interviewer (Kowalski & Chapple, 2000). Menstruating women who believed the interviewer knew of their condition felt less liked by the interviewer and made less of an attempt to positively impress him than did menstruating women who believed the interviewer to be unaware. Furthermore, menstruating women, regardless of interviewer's perceived knowledge, were less motivated to be impressive and felt less liked than non-menstruating women. These findings suggest that menstruation has a psychological impact on women that probably has linkages to societal taboos about menstruation.

Women's fears about societal taboos are not unfounded. Both women and men, especially those scoring high in **hostile sexism**, rated a menstruating, compared to the "average," woman more negatively (Forbes et al., 2003). In a clever laboratory study, participants interacted with a **confederate** who appeared to accidentally drop a hair clip or a tampon from her purse (Roberts et al., 2002). When the woman dropped a tampon, she was rated as less likeable and competent, and participants even tended to avoid sitting close to her. Among participants holding more traditional gender stereotypes, the reminder of menstruation was associated with increased body **objectification** of women in general. The social meaning of menstruation comes through loud and clear in Box 11.5.

Childbirth

Health psychologists have contributed to our understanding of the medicalization of childbirth and the postpartum period. The use of technology in childbirth, such as electronic fetal monitoring and an epidural shot for pain reduction, has become expected and routine, but it affects mothers and fathers differently. Kristi Williams and Debra Umberson (1999) interviewed 15 married couples with a firstborn 2 to 4 months after childbirth. For women, medical technology transferred some of their ownership of control not only onto medical personnel but onto fathers as well. For fathers, medical intervention enhanced their per-

Box 11.5
If Men Could Menstruate--
(Steinem, 1978)

What would happen, for instance, if suddenly, magically, men could menstruate and women could not?
The answer is clear—menstruation would become an enviable, boast-worthy, masculine event:

- Men would brag about how long and how much.
- Boys would mark the onset of menses, that longed-for proof of manhood, with religious ritual and stag parties.
- Congress would fund a National Institute of Dysmenorrhea to help stamp out monthly discomforts.
- Sanitary supplies would be federally funded and free. (Of course, men would still pay for the prestige of commercial brands such as John Wayne Tampons, Muhammad Ali's Rope-a-dope Pads…)
- Street guys would brag ("I'm a three pad man")…
- Lesbians would be said to fear blood and therefore life itself—though probably only because they needed a good menstruating man…

In fact, if men could menstruate, the power justifications could probably go on forever.

If we let them.

ceived involvement and importance in the birthing process, mainly by providing access to the baby. In sum, medicalization seems to level the playing field by involving men more, sometimes providing fathers with medical information not readily disclosed to the mother.

Debate surrounding the medicalization of childbirth has often crystallized around the alleged overuse of Cesarean sections (Stanton & Danoff-Burg, 1995). C-section rates for U.S. women have spiraled upward from 23% of births in 1991 to 32% in 2007 (Menacker & Hamilton, 2010). Although lower infant mortality rates have been attributed, in part, to C-sections, maternal mortality is 4 times higher for Cesarean than vaginal deliveries. In addition, at least one-third of these women suffer postoperative infections, and almost all experience abdominal pain. The medical justification for many C-sections has been undermined by provocative patterns in their incidence: C-section rates are inflated among women of higher socioeconomic status, among those who are privately insured, and in hospitals with high malpractice claims and employing physicians fearful of legal entanglements. Women having C-sections show no differences in depression, anxiety, or confidence in mothering, but they do tend to be less satisfied with their delivery experiences (DiMetteo & Kahn, 1997). Thus, there appear to be no atypical psychological consequences for mothers delivering by C-section; however, there are medical and pragmatic bases from which to suggest their overuse.

We hear a lot in the popular press about postpartum blues and depression, and unlike their use as synonyms in the media, they refer to different syndromes (Stanton & Danoff-Burg, 1995). **Postpartum blues** may occur in the 10-day period after childbirth during which time the new mother may experience depressed mood, tearfulness, mood swings, anxiety, and other symptoms. Estimates of incidence vary widely, from 26% to 85% of new

mothers. Comparing these women to other women, there is evidence that mood fluctuations are more pronounced for postpartum women. However, compared to other women who are recovering from elective gynecological surgery, new mothers' symptoms may be milder. Furthermore, an expanded look at women's affect during this period shows heightened positive feelings as well, suggesting that the "blues" exist within a context of enhanced happiness. No definitive link has been established between these so-called "blues" and hormonal markers.

Postpartum depression refers to a period of at least 2 weeks in duration during the first year after giving birth when symptoms of clinical depression appear (Stanton & Danoff-Burg, 1995). Incidence rates of 8% to 26% have been offered, at least for mild depression. Evidence does suggest that rates of mild depression are higher in new mothers than in other women; however, these postpartum levels are no higher, and possibly even lower, than depression levels during pregnancy and appear lower in women with strong partner support (Thorp et al., 2004). No biological markers have been linked to postpartum depression. The predictors for postpartum depression appear no different than those for depression during other periods of women's lives, hence calling into question the usefulness of this concept.

Another perspective on postnatal depression regards it as a relatively safe way to express concerns about motherhood, especially feelings of inadequacy and a disjunction between what the new mother expected and is actually experiencing (Mauthner, 1998). Additionally, other emotions may come into play postpartum, such as anger, which also may depend on childcare stress (Graham et al., 2002).

Miscarriage

About 10 to 25% of clinically recognized pregnancies in the United States end in miscarriage (American Pregnancy Association, 2011). Reviewing the psychological literature on women's reactions to miscarriage and drawing on interviews with 65 women 4 months after their miscarriages, Margaret Madden (1994) concluded that reactions are individualized. At the time of their miscarriage, most women reported feeling sad, with frustration, disappointment, anger at one's self, fright, and feeling troubled being expressed by more than one of every five women. Only 10% recalled feeling relieved, and much of this came from an end to uncertainties initiated by physical troubles rather than relief to see the pregnancy terminated. As one might expect, immediate emotional distress was more intense when the woman had become attached to the fetus (regardless of the length of the pregnancy), held herself responsible for her loss, and was unable to talk to anyone. Distress was reduced by sensitive health care providers who provided information and involved a woman in her own treatment decisions as much as possible (Geller et al., 2010).

Women's reports at the time of Madden's interviews 4 months after their miscarriages are a tribute to their resilience, coping, and acceptance. Still, most expressed concerns about a recurrence, and many described feeling blue on occasion when something triggered their memory, when they were upset about something else, and when they were fatigued. However, these feelings lessened with time and did not dominate their lives. The most frequent emotion expressed by these women was hope, and as many women expressed sadness as happiness. In sum, there are **individual differences** in women's reactions to miscarriage. Because a woman is not devastated with depression and grief, as folk wisdom

and the popular media might suggest, does not mean that she is uncaring or even deviant from what most women typically report.

Abortion[8]

Globally, an estimated 42 million women induced abortion in 2003, ending one of every five pregnancies (World Health Organization, 2011). The World Health Organization (2011) concluded that legal restrictions on abortion do not affect its incidence, but they do limit its safety. Unsafe abortions conducted by insufficiently skilled persons or in unsafe conditions accounted for 48% of all abortions worldwide. In the United States, about 1.2 million legal abortions were reported in 2007 (compared to 4.3 million live births). The rate of abortion is 19.5 for every 1,000 American women ages 15 to 44 (48.2 for Black and 13.8 for White women; *Statistical Abstracts of the United States*, 2011, Table 101).

In the United States, abortion is a hotly debated moral and political issue that extends into the arena of public health policy (Russo & Denious, 1998). It is clear that the legalization of abortion has reduced abortion-related deaths of women in the United States: between 1975 and 1982, mortality from induced abortions declined 89%, compared to a decline in mortality of 35% associated with pregnancy and contraception (Rosenberg & Rosenthal, 1987). The risk of a woman's death from abortion during the first 9 weeks of gestation is estimated at one death per half million abortions (National Center for Health Statistics, 1988, cited in Travis, 1993). Based on data such as these, Surgeon General Koop concluded in 1989 that abortion can be a medically safe procedure with no greater health risks than carrying a pregnancy to term (Wilmoth, 1992). His declaration of medical safety shifted interest toward psychology and the possibility of a "postabortion syndrome." Since then, psychologists have addressed questions about who seeks abortions, what the immediate consequences are for women, and the effects of denied abortion on women and children.

Brenda Major and her colleagues (2009) critically reviewed this vast and oftentimes flawed body of research and came to the following conclusions. "First, the relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy for nontherapeutic [not health-threatening] reasons is no greater than the risk among women who deliver an unwanted pregnancy" (p. 885). Second, abortion because of a fetal abnormality is no more traumatic for women than miscarriage, having a stillborn, or losing a newborn. Because it is virtually impossible to control for all pre-existing and co-existing threats to a woman's mental health beyond having experienced one or more abortions, the link between abortion per se and mental health risks cannot be convincingly substantiated. Not surprisingly, the strongest predictor of a woman's post-abortion mental health is her pre-abortion mental health.

Although "the majority of adult women who terminate a pregnancy do not experience mental health problems" (p. 885), this does not mean that all women avoid these outcomes. There are wide **individual differences** among women who experience a range of positive, negative, and ambivalent emotions and outcomes. These variable reactions suggest that **social contexts** make a difference—including the degree to which a woman wanted and felt committed to her pregnancy, secrecy and perceptions about the stigma of abortion, low

[8]For a fuller discussion of psychological and health issues related to abortion, see Beckman and Harvey (1998). For ideas about how to teach the topic of abortion, see Greene (1995).

self-efficacy for coping with abortion, low actual or expected social support, and use of avoidance or denial coping strategies (Major et al., 2009).

Section Conclusion

In each of the areas we explored so far, including women's sexuality, menstruation, and reproduction, the tendency to biologize each function has detracted from our ability to see each as a normal process that is part of women's broader lives, including their psychological well-being and social and interpersonal contexts. "Raging hormones," alleged to accompany routine menstruation and the postpartum period, lose their force when we consider men's mood cycles and the trauma of any medical procedure, respectively. Presumably universally devastating miscarriages and "post-abortion syndrome" also dissolve when held up to scientific scrutiny. Across each area, there are diverse **individual differences** in women's experiences and outcomes, as well as influences from their **social contexts** (also see Hinchliff et al., 2010, on menopause). Why then is there so much misinformation about women's sexuality and reproductive health? Just asking this question itself is an important insight to take away.

CHRONIC DISEASES

Chronic diseases are defined as irreversible, accumulative, or latent illnesses or impairments that require continued medical and personal care to avoid further disability (Lubkin, 1995). As we saw, the two leading causes of women's (and men's) death are cardiovascular diseases (#1) and cancer (#2). A wide range of chronic diseases in women has been studied by psychologists including diabetes (Butler & Wing, 1995), autoimmune disorders (Chrisler & Parrett, 1995), and chronic pain (Reading, 1994). Here, we look at the leading killer of women, cardiovascular diseases, and a recent addition to women's list of significant health threats, HIV. Both are important examples because they typically play out differently for women and men, making what we know about men's developments of questionable utility for women.

Cardiovascular Diseases

Cardiovascular diseases, encompassing coronary heart disease, stroke, hypertension, and congestive heart failure, are the leading cause of women's death in the United States, accounting for about 25% of all women's deaths (26% of men's; see Table 11.2). Over the past 35 years, death from coronary heart disease has *decreased* for men at the same time that it has *increased* for women (reviewed by Chrisler, 2001). Surprisingly, fully 36% of women surveyed in 2005 did not think women were at major risk for heart disease , and almost two-thirds of women who die suddenly from coronary heart disease reported no previous symptoms (CDC, 2010a). In 2006, about 8.8% of African American women, 6.6% of Mexican American women, and 6.9% of U.S. White women were living with coronary heart disease.

Sally Shumaker and Teresa Smith (1995) reviewed research on cardiovascular diseases in women from the perspective of health psychologists. There were differences in

who, when, and how women and men present themselves to medical personnel for heart disease. Women tended to be of lower socioeconomic status and possessed less formal education than presenting men. African American women are especially prone to hypertension, which afflicts about 39% of Black women (compared to 25% of White women) between the ages of 18 and 74 (Crawford-Green, 1996). Related to both hypertension and cardiovascular heart disease for a disproportionate number of African American women is obesity, a common outcome of diets high in fat and low in fruits and vegetables—in other words, "diets of poverty" (Leigh, 1995).

The recognized onset of women's heart disease appears to lag 7 to 10 years behind that of men, but this could be confounded by differences in presenting symptoms. More men are likely to seek treatment because they suffered a heart attack (myocardial infarction) as compared to the majority of women, who initially present with complaints of chest pains (angina pectoris). Follow-ups of women with chest pain are less likely to show narrowing of their arteries, suggesting that this may not be as accurate a marker for heart disease in women as it is for men. Similarly, noninvasive procedures like stress tests may more accurately identify male sufferers than female. When women do present with myocardial infarction, these attacks are more likely to be misdiagnosed and to prove fatal.

The combination of different presenting symptoms, different markers for the disease, and expectations that heart disease is restricted to men (among women themselves, family and friends, as well as physicians) all may lead to misdiagnosis. Even more disturbing, when an African American woman and a White man presented identical symptoms, heart-trained medical students were more likely to misdiagnose the woman and treat her symptoms as less severe (Rathore et al., 2000). Once diagnosed, referral and aggressive treatments are more common for men, even controlling for women's older age of diagnosis, their disease severity, and their preoperative status. One study found that men were twice as likely to have bypass surgery as women with similar medical profiles (Travis, 2005). Looking at prognosis, heart attacks are more deadly for women; 38% of women (and 25% of men) die within one year after a heart attack (American Heart Association, 2005). Women are more likely to experience stroke and less likely to recover than men, with poorer functional outcomes and lower quality of life (Reeves et al., 2008). There is also limited evidence suggesting that women experience less health-related quality of life and more depression following bypass surgery than men, although this procedure generally is physically beneficial for both.

Although risk factors for women have been understudied, research has identified coronary-prone behavior characterized by: a sense of time-urgency, hostility, and impatience (Weidner, 1994), being overweight, and cigarette smoking[9] as risk factors. Recent comparisons suggest that anxiety may be more of a risk factor for women; hostility, for men (Consedine et al., 2004). Greater exposure to chronic stressors (including PTSD; Kubzansky et al., 2009), higher sensitivity to interpersonal stress, and internalizing coping styles are associated with heightened risk for cardiovascular diseases in women (Möller-Leimkhler, 2010).

After diagnosis, cardiac rehabilitation programs are equally effective for women and men when they are used, but some researchers suggest that these typically are designed to better accommodate men so that women's participation may be structurally discouraged

[9]Although ceasing to smoke may contribute to weight gain, on average this amounts to 4 to 8 pounds, which generally does not enhance the risk associated with being overweight.

(Shumaker & Smith, 1995). Although social supports have proved protective for men, initial research with women suggests that women derive both strain and support from their social networks, possibly making them less beneficial. Finally, lack of exercise, depression, and anxiety have been associated with heightened risk in men, but their relationship for women is yet to be fully researched.

HIV/AIDS[10]

Across 2006 to 2009, the overall incidence of new HIV infections in the United States has been stable at about 50,000 cases annually, with over half these cases accounted for by men who have sex with men. Heterosexuals made up 27% of new cases in 2009, with 8,800 women accounting for 68% of these cases. The remaining general group is injection drug users who represented 9% of new infections and with similar numbers of men (2,400) and women (1,960). By far, *the most common form of transmission of HIV to women is through heterosexual contact*, and race/ethnicity matters: Black women (39.7 per 100,000) were infected at a rate 15 times higher than that for White women (2.6); Latinas (11.8), over 4 times higher than White women. The U.S. Centers for Disease Control and Prevention (2011b) estimates that about one million Americans (25% women) are living with HIV, with 21% unaware of their infection, and reports that more than 18,000 people with AIDS (28% women) die each year.

The most common paths of transmission in the United States are anal or vaginal sex (although oral sex is also a possible route) or sharing needles with an infected person (CDC, 2011b). For transmission to occur, blood, semen, vaginal secretions, or breast milk must come in contact with a mucous membrane or damaged tissue or be directly injected into the blood stream. Female-to-female transmission is rare, although possible. A good resource for information about the transmission of HIV in the United States can be found on the CDC's (2011a) website.

Globally, the prevalence of HIV infection appears to have stabilized between 2001 and 2007, estimated at 33 million adults (half women) and children living with HIV (United, Nations, 2010). About 2 million people worldwide die each year due to AIDS. The hardest hit region continues to be Sub-Saharan Africa, where two-thirds of people living with HIV reside, where women account for almost 60% of all HIV-positive adults, and where the most common mode of transmission is heterosexual sex. HIV also disproportionately affects women and girls, who most frequently are the caregivers to stricken family members and who assume parenting responsibilities for orphaned children.

Psychologists have played two major roles in dealing with HIV: devising and implementing models of prevention and helping infected people live with HIV infection and its stigma. The image of who has HIV has changed away from thinking about at-risk groups to at-risk *behaviors* (Batchelor, 1988). For example, a monogamous gay man practicing safe sexual behavior is at lower risk than a lesbian injected-drug user who shares needles.

Reducing women's risk. Effective risk-reduction interventions to cut down on high-risk behaviors typically involve risk education, risk sensitization, self-efficacy building, and skills training as core components (Kalichman et al., 1996). Although education is a start,

[10]For more information about psychology and HIV, check out the Office of AIDS at the American Psychological Association (*http://www.apa.org/pi/aids/index.aspx*).

understanding HIV transmission is not enough to ensure protective behavior (Morokoff et al., 1995). For poor ethnic-minority women, risks associated with daily living—including exposure to the elements among the homeless, care of dependent children, hunger, drug withdrawal or acquisition, acute illness or trauma resulting from physical or sexual assault, threat of withdrawal of emotional and financial support from sexual partners, and loss of loved ones—often outweigh the risks believed to be associated with HIV-risky behaviors (Mays & Cochran, 1988; Thomas, 1994). Physically abused women also are more likely to engage in risk-enhancing behaviors (Beadnell et al., 2000). To undercut transmission through shared needles, needle exchange programs must be responsive to the special needs of women (Brown & Weissman, 1993), and researchers must be sensitive to gender differences in injection behavior—starting with women's greater likelihood of sharing drug paraphernalia (Morokoff et al., 1995).

As for heterosexual transmission, the proper use of *latex* condoms reduces the risk of exposure, and college students are most favorably inclined to condom introducers who express a care and responsibility theme (Castaneda & Collins, 1998). However, unflagging condom use is rare, even among women engaged in high-risk behaviors (Morokoff et al., 1995), but having a reminder cue (wearing a bracelet) has been shown to increase compliance (Dal Cin et al., 2006). A variety of factors are implicated in the inconsistent use of condoms including race/ethnicity (Leonardo & Chrisler, 1992). For example, Spanish-speaking women report having fewer sexual partners as well as reduced condom use (Zambrana & Ellis, 1995).

Patricia Morokoff, Lisa Harlow, and Kathryn Quina (1995) summarize their review of barriers to condom use: Infrequent and irregular usage is associated with being married and monogamous, being less educated, drinking alcohol, sexuality with a main partner rather than a client, beliefs that there is little one can do to protect one's self from sexually transmitted disease, distaste for condoms, and lack of control over decision making. A fascinating study of the role played by alcohol found that women who either consumed or expected to consume alcohol reported elevated confidence that they could detect a partner's potential for HIV infection through simple interaction—a detection strategy known to be ineffective (Monahan et al., 1999).

The need to seek information about one's sexual partners is clear. Fully 5% of women surveyed for the National AIDS Behavioral Surveys described a high-risk sexual partner (Grinstead et al., 1993). For Latina women, higher education was associated with having a riskier partner, whereas the reverse was true for White women. Fully 17% of women in this study who reported no high-risk behaviors for themselves were unsure of the risk status of their partners. Such uncertainty is especially common among ethnic-minority women, older women, and less-educated women. In another study of men injected-drug users, half reported a relationship with a woman non-user who was unaware of the man's drug habit (Rhodes et al., 1990). African American women's heterosexual risk is further aggravated by higher rates of bisexuality among Black as compared to White men (Leigh, 1995). In a study of 105 HIV-positive women in New York City, fully 54% reported engaging in unsafe sexual behavior during the past 90 days (Simoni et al., 2000).

Thus, interest among psychologists in the role played by interpersonal power and sexual communication in relationships has grown substantially (for example, see Quina et al., 2000). As we saw previously, the sexual **script** outlined by the **double standard** portrays men as sexually assertive and women as passive. Power to negotiate safe sexual practices is

implicated in condom usage among African American (Bowleg et al., 2004) and European American heterosexually active adolescents (Gutierrez et al., 2000) and Mexican-born married women (de Snyder et al., 2000). In one study of decision making, if the man made the decision, only 12% of these couples used condoms more than half the time. This figure jumped to 49% when women made the decision, and to 32% when both partners decided (Osmond et al., 1993). Through all these factors runs a strand of power—the more powerful person, both personally and interpersonally, controls how sexuality is practiced (Amaro et al., 2001; Pulerwitz & Dworkin, 2006).

Power in an intimate relationship involves two key dimensions that may be important in communication about safe sexual practices: *Relationship Control* and *Decision-Making Dominance* (Pulerwitz et al., 2000). Two central indicators of relationship control are women's projections of their male partner's response (of violence and anger) to a request to use a condom, but it is not confined to the sexual arena. For example, other signs are doing what one's partner wants to do most of the time and having a partner dictate what one wears. Decision-making dominance includes deciding whose friends the couple interacts with, whether they engage in sexual relations, and what they do together. In a study with 388 mostly Latina women, women with higher levels of these types of relationship power were 5 times as likely as less powerful women (matched on a variety of sociodemographic and psychosocial factors) to report consistent use of condoms (Pulerwitz et al., 2002).

Prevention programs aimed at women must foster women's empowerment in negotiating sexual encounters and in ending those that put them at risk (Croteau et al., 1993). They must also be sensitive to the social context in which risky behavior is enacted, especially regarding cultural differences related to race/ethnicity and socioeconomics (Scott-Sheldon et al., 2010). Technological advances (such as the female condom and a microbiocide that kills the HIV virus but that can be used safely as a vaginal gel, foam, or sponge) would help to give women direct control of their own protection.

Living with HIV. The second focus of health psychologists studying HIV-related behaviors has been on women infected with HIV. For example, women delay seeking medical care for themselves 1.6 times more often than men, often because women are caring for others (including a child in the household) and are without insurance (Stein et al., 2000). HIV-infected women commonly struggle with depression, apprehension, sadness, helplessness, anger, and fear (Morokoff et al., 1995), as well as social discrimination and stigmatization (Teti et al., 2010). Even women's participation in the workplace can be affected (Barkey et al., 2009). The potential and need for interventions (Webel, 2010) to help HIV-infected women improve the quality of their lives is critical.

HEALTH CARE PRACTICE

Although women are disproportionately heavy users of the medical system, the medical system has not been a consistent health promoter for women. We have seen that women have been excluded from research central to their health needs, although women-centered work is in progress. We also have seen that misperceptions of women's bodies that overemphasize reproduction and ignore other symptomatology, such as gender-specific signs of cardiovascular disease, have biased women's interactions with the health care

system. Probably the most egregious example of women's questionable treatment centers on surgeries.

Surgeries

Leslie Laurence and Beth Weinhouse (1994) detail how current surgical practice affects women's health. They acknowledge that surgery performed appropriately and skillfully saves many lives, and their purpose is not to undermine surgery itself. However, there are patterns of surgical use that raise some very serious questions. Of the top ten inpatient surgeries, one is unique to men (prostatectomy) and three to women: episiotomies (an incision between the vagina and rectum meant to speed childbirth), Cesarean sections, and hysterectomies.

Hysterectomy. Approximately 600,000 hysterectomies are performed in the United States every year, costing more than $5 billion and affecting more than one of every four American women by the time they are 60 years old (CDC, 2005).[11] This makes hysterectomy the second most frequent major surgical procedure among women of reproductive age. However, experts report that anywhere from 20% to 90% of them are medically unnecessary (Laurence & Weinhouse, 1994). Looked at another way, 80 to 85% of hysterectomies are elective in that other treatment options are available and untried. Only 15% of hysterectomies are performed because of uterine cancer, the most compelling reason for removal. At this rate, it is projected that 40% of American women will have their uterus removed during their lifetime; more than one-third will not have their uterus by age 50.

The most common reasons for hysterectomy before age 50 are uterine fibroids and endometriosis (a disease of the uterine lining). Fully one-third of premenopausal women have fibroids, most of which naturally shrink as menopause approaches. An American woman is two- to three-times more likely to have a hysterectomy than her counterpart in England, France, or West Germany, and her chances increase if she sees a male physician. Hysterectomy is more likely among poor women, women without a college education, and African American women, and it even was abused as a form of involuntary sterilization for poor Black women. There are complications possible with this surgery that make it a choice that should not be approached casually.

Cosmetic surgery. We typically think of medicine as promoting health and of surgical procedures as serious, invasive activities with risks made acceptable by pressing health threats. Elective cosmetic surgery stands in contrast to this image if its outcomes are considered trivial or not worth the risks of intervention. Diana Dull and Candace West (1991) interviewed both cosmetic surgeons and their clients to understand how they reconcile this apparent contradiction. They found that both physicians and their patients justify their involvement by thinking of cosmetic surgery as a form of reconstructive surgery that legitimately is designed to improve physical functioning and minimize disfigurement. These procedures ignore women's psychological problems that may underlie their endorsement, such as excessive approval seeking (David & Vernon, 2002) and media exposure to idealized body images (Harrison, 2003).

[11]An informative website for information on hysterectomy can be found at http://womenshealth.gov (retrieved October 2011).

Box 11.6

Breast implants have an outer shell of silicone that is filled with either silicone or saline (sterile salt water). Although silicone-filled implants had been used since 1964, the FDA didn't request that manufacturers register reports of serious health problems with implants until 1984, still didn't require manufacturer's safety data until as late as 1991, and then virtually banned their use in 1992. Such "correction" for small breasts is a medically named deformity ("micromastia"). The most common complications include capsular contracture (a buildup of scar tissue that made breasts hard and misshapened), implant rupture or deflation, and the need for follow-up surgeries (Bren, 2000). Implants interfere with mammography, making breast cancer harder to detect. Most American women who seek breast implants do so for cosmetic reasons (Latteier, 1998).

These cosmetic motivations are compromised when implants collapse (as in the photograph). The U.S. Food and Drug Administration offers a handbook with information for consumers about breast augmentation at: http://www.fda.gov/ cdrh/breastimplants/indexbip.html (Retrieved October 2011).

Photograph copied with permission of Walter Peters, Ph.D., M.D., F.R.C.S.C., University of Toronto, as posted on the FDA's website: http://www.fda.gov/cdrh/breastimplants/breast_implants_photos.html

The American Society of Plastic Surgeons (ASPS, 2011) released a press statement in February of 2011 reporting that 13.1 million cosmetic procedures were performed in the United States in 2010, up 5% from 2009. Their list of invasive procedures (totaling 1.6 million) was topped by breast augmentation (296,000; up 2%), nose reshaping (252,000), eyelid surgery (209,000), liposuction (203,000), and tummy tuck (116,000); their list of less invasive procedures (totaling 11.6 million) was led by botox injections ("botulinum toxin type"; 5.4 million).

The targets for much of these surgeries are middle-aged women whose attitudes about cosmetic surgery are shaped by body dissatisfaction, appearance investment, aging anxiety, and television exposure (Slevec & Tiggemann, 2010). Not surprising, anti-aging fears fuel many women's purchase and use (ironically with skepticism) of anti-aging products (Muise & Desmarais, 2010). However, interest in cosmetic surgeries is not confined to older women. College women's interest is increased with their weight, body dissatisfaction, internalization of media messages, and being teased about their physical appearance (Markey & Markey, 2009). Negative consequences, such as threatened sexual esteem, even extend to young women's dissatisfaction with the appearance of their genitals (Schick et al., 2010).

Although cosmetic surgery may be a more dramatic health risk than many of us are willing to take, most women (including myself, I confess) engage in arguably health-threatening practices (Saltzberg & Chrisler, 1995). Make-up can cause allergic reactions in as many of one-third of its users; fashionable shoes (along with weighty purses) are related to foot and back problems; allergies are common from scented products; long hair and dangling earrings get caught in machinery; fashionable clothing can restrict movement, including escape from danger; body piercing and tattooing can lead to infections; and so on.

Indeed, one can (although rarely) contract HIV from tattooing, yet I myself have a tattoo on my ankle. At some level, we might begin to think of these as forms of self-mutilation, to question who does and who doesn't routinely do these things, to think about how they maintain stereotyping about acceptable femininity (Tiggemann & Hodgson, 2008; Toerien et al., 2005), to consider how these practices might be related to the social standing of the groups most likely to engage in them (Jeffreys, 2000; Lienert, 1998), and to link these practices with pressures related to finding intimate partners (Hill & Durante, 2011).

Health Care Policy

All of this leaves us with a very basic question: Does the health care system promote women's health? We know that health care policy in the United States is in crisis and is a major economic and political issue hotly and repeatedly debated at the federal level. Two central problems confronted by health-policy reformers focus on cost and access. In 2009, over 23 million American women (15% of all women) were not covered by health insurance (*Statistical Abstracts of the United States*, 2011, Table 155). Over 5 years, the number of women without health care coverage grew three times faster than the number of uninsured men, and older women are 20% more likely to be uninsured than men of their age (Lambrew, 2001). About half of all uninsured women work part-time and are married, with many older women being ineligible for Medicaid in contrast to their covered spouse.

Disparities exist by race and ethnicity. For example, a higher percentage of Hispanics (32.4%) and Blacks (21%) were not covered by health insurance in 2009 than Whites (15.8%) and Asian Americans (17.2%; *Statistical Abstracts of the United States*, 2011, Table 155). Obviously, household income also makes a difference, with the uninsured rate rising to 31.9% of Americans living below the poverty line. Cheryl Travis and her colleagues (1995) considered how insurance coverage affects women and women's health (also see Travis & Compton, 2001).Underemployment, part-time employment, and employment in small businesses not offering health insurance are associated with being uninsured, and women (especially racial and ethnic minority women, older women, and single heads of households) hold a disproportionate number of these jobs. Most disturbing is the finding that insurance may affect treatment. For example, Travis and her colleagues reviewed 400,000 records of patients with heart disease and found that those with private insurance were twice as likely to receive heart bypass surgery as those on Medicaid (reported in Travis et al., 1995).

Health care policy in general has revolved around three major conceptual strategies: single-payer government-based systems (like Canada's), employer-mandated plans, and market reform (Travis et al, 1995). All strive toward universal coverage at reduced cost. Single-payer systems cover everyone, with the government picking up the tab; employer programs require employers to pay into a general public pool (pay) or provide minimum coverage for employees (play); and market reforms rely on tax deductions, credits, or vouchers. Employer plans are especially likely to miss women because coverage is determined by employment in regulated settings.

Travis and her associates conclude that for reform to truly benefit women, health care policy must adequately define what needs and treatments are legitimate; empower individuals to take control of their own health; and value diversity, inclusiveness, and equity in

health care provision. Furthermore, it is clear that this debate must be informed by health psychologists.

A recurrent theme that silently hovers in the background of some of the health literature blames women for failing to promote their own health. For example, it is frustrating to find high rates of cervical cancer among groups of women who avoid regular Pap smears; to record late breast-cancer detection rates for women who fail to do routine breast exams and shun mammography;[12] and to find condom avoidance and needle sharing even among those who know better. Who's to blame? It's tempting to point wagging fingers at women, but this reflects the person-blaming perspective we rejected earlier.

A fuller picture needs to view women within the contexts of their lives (for example, see Sheffer et al., 2002), and we saw examples of this perspective throughout this chapter. Is a poor woman to blame for inadequate gynecological care when 44% of ob/gyns don't accept Medicaid patients (Travis et al., 1995)? Is a woman to blame for not using a condom when the expectation is that women control contraception but its practice depends on a partner's cooperation? Is risk of HIV contraction such a big threat when one lives in a crime-ridden neighborhood and can barely put food on the table? Is liposuction worth the pain and cost if it relieves the shame of being viewed as fat and out of control? Even the very definitions of what it means to be fit and healthy vary among women and men, with women's definitions more conflated with having an "appropriate body shape" (Wright et al., 2006).

Not surprisingly, power, control, and agency play important roles in women's health. For example, **agency** was associated with better health outcomes for women with rheumatoid arthritis (Trudeau et al., 2003); feelings of having little control were related to negative birthing experiences (Baker et al., 2005); and self-efficacy beliefs predicted responses to pain (Jackson et al., 2002). As the field of health psychology burgeons, a fuller contextual account of women's lives must be understood to simultaneously empower women to promote their own health and give them the means to do so.

CHAPTER SUMMARY

Psychology plays an indispensable role in understanding and promoting the physical health and well-being of women. A feminist focus on women's health is needed to ensure adequate research of those health issues that disproportionately or uniquely affect women; to provide a holistic understanding of women's sexual, reproductive, and general health needs; to counter androcentric assumptions about disease, prevention, and health; and to explore the apparent paradox of women's longer life spans and greater morbidity. A key to doing this is to consider gender as a marker from which to launch further explorations of health patterns, rather than a cause in and of itself.

Turning to women's sexual well-being, a mechanical view of human sexuality ignores the socioemotional function sexuality plays in the lives of both women and men. Although residuals of a subtle double standard in sexual attitudes and behaviors may persist, there

[12]A review of studies with U.S. ethnic-minority women documents various barriers to mammography use, including low income and lack of health insurance, lack of physician recommendation, lack of trust, language barriers, and transportation difficulties (Alexandraki & Morradian, 2010). Not surprisingly then, interventions that are culturally tailored and that address logistical barriers prove most effective (Masi et al., 2007).

are substantial individual differences, subgroup sociodemographic factors, and contextual variations, making this a more complex area than simple intergroup gender comparisons can capture. Parallel complexities emerge in discussions of menstruation, "PMS," and reproduction, including childbirth, miscarriage, and abortion. Folk wisdom evoking psychological disturbance is debunked, or at least called into question, by growing bodies of research evidence.

Less thoroughly studied than women's reproductive health, women's mortality and morbidity, like men's, are affected by a wide array of chronic diseases, with cardiovascular diseases and cancers topping the charts. Research on cardiovascular diseases challenges the simple extension of findings from men to women, beginning with differences as fundamental as onset (later for women), presenting symptoms (fewer myocardial infarctions), different markers (missed by stress tests and searches for narrowed arteries), expectations (leading to misdiagnosis), and risk factors. HIV has risen to become a leading cause of death for American women aged 25 to 44, and is most commonly transmitted to women worldwide through heterosexual relations. Effective prevention strategies need to be sensitive to women's social contexts, including their disempowered status in interpersonal relationships.

The mission of health care practice, to heal, is seriously undermined by questionable patterns in rates of hysterectomy and by the expanding popularity and invasiveness of cosmetic surgery. As health care policy reform continues to be a pressing sociopolitical and economic issue, the input of health psychologists will be integral to the development of women-friendly and inclusive health care policies. The themes that run through each of these areas are that women's health is understudied and mythologized, but this is changing as fundamental understandings of power and empowerment come to the forefront of our theories and research.

SUGGESTED READINGS

McHugh, M. C. (2006). What do women want?: A new view of women's sexual problems. *Sex Roles, 54*, 361–369.

In this engaging and accessible paper, Maureen McHugh provides a women-centered view of women's sexual desire and problems that expands on the perspective taken in this chapter about the over-"medicalization" of women's sexuality.

Chrisler, J. C. (2011). Leaks, lumps, and lines: Stigma and women's bodies. *Psychology of Women Quarterly, 35*, 202–214.

Joan Chrisler uses ideas from feminist and terror management theories and about stigma to take a closer look at women's bodies when menstruating (leaking), fat (lumpy), and old (lined).

Bobel, C. (2006). "Our revolution has style": Contemporary menstrual product activists "doing feminism" in the Third Wave. *Sex Roles, 54*, 331–345.

Chris Bobel's in-depth content analysis of websites and "zines" provides a provocative look at how young feminists take action against the control of women's menstruation (and more broadly) women's health. This paper can serve as a jumping-off reading for further

exploration of the web on this and other topics (e.g., safer sexual practices; Noar et al., 2006) related to women's physical health and well being.

Simoni, J. M., et al. (2010). HIV/AIDS among women of color and sexual minority women. In H. Landrine & N. F. Russo (Eds.), *Handbook of diversity in feminist psychology* (pp. 335–366). New York: Springer.

Jane Simoni and five of her colleagues take a more targeted and insightful look at women and HIV that expands upon the general overview provided in this chapter. Additionally, one of the authors, Keren Lehavot, is part of a podcast discussion with Caroline Huxley and Lisa Rubin about three studies they conducted with sexual minority women (published in *Psychology of Women Quarterly*, 35[3]) available at *pwq.sagepub.com*.

Toerien, M., Wilkinson, S., & Choi, P. Y. L. (2005). Body hair removal: The "mundane" production of normative femininity. *Sex Roles, 52*, 399-406.

The meaning of an often unexplored, everyday part of many women's lives is discussed by Merran Toerien and her colleagues in ways that are challenging and thought-provoking.