CHRISTINA LEE

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THE SOCIAL CONTEXT OF WOMEN'S HEALTH

A central characteristic of male-dominated societies is that they implicitly define men as the norm, as standard human beings, and women as 'other'. Almost universally, human cultures are basically patriarchal in structure; they construct men's interests and concerns as more legitimate and more central than women's, and position men and men's lives as worthy in themselves, while regarding women as valuable chiefly in terms of their value to men, their relationships with men, and their differences from men (Millett, 1970). This cultural perspective has meant that theory, research and application in most academic fields have focused primarily on men, and health research has been no exception (Stanton, 1995). This, together with linguistic traditions that equate 'man' with 'adult human' and regard 'woman' as a special case, has meant that the study of 'women's health' has until recently been restricted to obstetric and gynaecological issues, and has tended to assume that the only interesting thing about women's health is reproductive capacity (Ussher, 1992b).

This traditional, patriarchal perspective has been challenged by feminist researchers who take a woman-centred perspective on health, one which starts from a perception that women's perspectives, women's subjectivity, are as legitimate as are men's. 'Women's health', from this perspective, is much more than obstetrics and gynaecology. Several health psychologists have argued that 'women's health' must be defined as broadly as possible, including all those diseases and physical processes which occur in women, and emphasizing those which occur frequently in women, those which are unique to women, and those which are more common among women than among men (Chesney & Ozer, 1995; Rodin & Ickovics, 1990). Arguments are made for the importance of understanding women and heart disease, women and stress, women and autoimmune diseases, women and smoking (e.g. Stanton & Gallant, 1995b).

However, if one argues that the psychology of women's health must encompass absolutely everything which is relevant to the health of women, then the study of women's health risks becoming a fairly

random selection from an endless series of discrete topics, related only trivially to each other. While such an approach can cover important topics in women's health it lacks a conceptual focus.

The central issue for this book is the social construction of gender. From a psychological point of view, the unique aspects of women's health are those which are affected by women's social roles, and not purely by their biology. This book explores the ways in which social myths and stereotypes about appropriate or 'natural' behaviour for women impact on their well-being. An emphasis on social contexts and their impact on women's lives also means that a focus on specific illnesses and risk factors is seen as less important than an analysis which deals primarily with the essentially social nature of gender and of sex roles. This means that the book omits a number of topics which are central to women's physical health, most importantly heart disease and cancer. While these are the major causes of death and ill-health among women, it is not clear that women's social roles play a major part in women's experiences of these conditions.

WOMEN, MEN, AND MAJOR CAUSES OF DEATH

Recent volumes on the psychology of women's health (e.g. Adesso, Reddy & Fleming, 1994; Niven & Carroll, 1993; Stanton & Gallant, 1995b) have focused on the two major contributors to death and ill-health among Western women, cancer and heart disease. While these are clearly topics of major importance for women's health, as indeed they are for men's health, they are peripheral to a psychology of women's health which focuses on the social construction of gender. There are differences between men and women in the aetiology and prognosis of cardiovascular diseases, in the commonest sites of cancers, and in reactions to treatment (e.g. Lerner & Kannel, 1986; Meyerowitz & Hart, 1995). However, these differences are to a large extent biological rather than social or psychological, and there is little evidence for major psychological differences between women and men in how they deal with the crisis of life-threatening illness. Thus, in a book which aims to explore aspects of society which make women's health-related experiences different from those of men, these medically important topics are of limited relevance.

Of course, both heart disease and cancer can be approached from a social perspective. Although coronary heart disease is less common in women than in men, rates of mortality and of long-term disability are higher for women (Wenger, Speroff & Packard, 1993), and there is some evidence to suggest that this is because women are likely to receive less effective treatment than are men (e.g. Young & Kahana, 1993). In general, however, research seems to suggest that the major risk factors of smoking, sedentariness, stress and social isolation are broadly the same for

women and for men (e.g. Shumaker & Smith, 1995), and that the central experiences associated with heart disease, such as pain, anxiety, intrusive medical procedures, and major life changes, are also much the same for women as they are for men. What is needed is not so much a search for women's unique psychological experiences of heart diseases as a less biased programme of biomedical research and intervention.

A similar argument may be raised for cancer. Men and women tend to develop different types of cancer, with breast cancer being the most commonly diagnosed cancer in women, and prostate cancer in men, although lung cancer is the next most common for both sexes (American Cancer Society, 1994). It is argued (e.g. Meyerowitz & Hart, 1995; Wilkinson & Kitzinger, 1994) that research on cancer in women has tended to focus on cancer of the breast and reproductive organs, and to emphasize physical appearance and sexuality rather than other aspects of women's experiences of cancer and its treatment. But again it would seem that the experiences of pain, intrusive and noxious treatment, physical decline and incipient death may show more similarities than differences between the genders.

WOMEN'S HEALTH OR WOMEN'S ILLNESS

To a large extent, the study of 'women's health' has in fact been the study of women's illness, with an emphasis on specific risk factors and health-related behaviours. Major texts on women's health emphasize heart disease, cancer, menstrual and reproductive disorders, and behaviours such as smoking, drug use and medical screening. These are important topics, but they reflect a particular perspective on the psychology of women's health, with an emphasis on specific illnesses, specific causes of death, and intra-individual factors, rather than on the woman in a complex social and cultural context.

This perspective arises from the empiricist and reductionist approach which psychology has traditionally taken to its subject matter. The empiricist position emphasizes experimental control and the study of individual phenomena independently of their contexts, and this leads naturally to a reductionist focus on intra-individual factors. The primary aim of this book is to present an alternative perspective, to examine the psychology of women's health by examining the contexts within which women live.

Further, the book examines issues which are relevant to the everyday lives of all women throughout their lifespans, rather than focusing on illness and death, and on specific 'health behaviours'. While the experiences of women undergoing treatment for cancer, substance abuse or HIV/AIDS are important topics, the emphasis here is on everyday life

rather than on major health crises. The book explores women's experiences as parents, as family members, as employees and as members of society, demonstrating the ways in which social inequities and social assumptions about womanhood influence every aspect of women's lives, and thus their physical and emotional health.

The primarily social and integrative perspective of this book is supported by the fact that it adopts an explicitly feminist approach. Psychology has traditionally taken the view that researchers should aim to be value-free and should endeavour, as much as possible, to leave social and political perspectives out of research. Clearly, however, all research has a political dimension. Mainstream psychological research on cigarette smoking, for example, which focuses on the individual and ignores the social and economic context within which individual decisions are made, is just as political as is research which focuses on the economic environment that supports individuals' decisions to smoke (Biglan, Glasgow & Singer, 1990).

Despite psychology's aspirations to the value-neutral methods and models of classical physics, individual human beings cannot be understood without an appreciation of their sociocultural contexts (Sarason, 1981). Prilleltensky (1989) has argued that psychological research is always political. Research which ignores the social context, which treats it as a neutral background or as an inevitable aspect of an immutable reality, is politically conservative rather than neutral, seeking solutions to human problems in individual adaptation rather than in social change (Bailey & Eastman, 1994; Kipnis, 1994; Spence, 1985). Conversely, a psychology of women's health which starts from the perspective of the social construction of womanhood is inevitably oriented towards social explanations and social solutions.

FEMINISM, SCIENCE AND THE PSYCHOLOGY OF WOMEN'S HEALTH

Feminism and social issues

While the psychology of women's health does not inevitably require a feminist approach, the sociocultural perspective does lend itself to a more political analysis than is usual in psychological work, and thus it is useful to discuss the range of views, encompassed by the term 'feminism', which underlie the research and scholarship reviewed in later chapters.

Three major types of feminism are usually distinguished (e.g. Riger, 1992), although these perspectives often overlap in practice. *Liberal feminism*, firstly, is based on the assumption that sexism and inequity are not inherent in the structure of society, but arise incidentally from individuals' socialization experiences and expectations. Sexism is self-

perpetuating, because each successive generation is exposed to the same socialization processes. Yet at the same time it is readily changeable through strategies which raise people's awareness of social inequities. Change, according to this perspective, requires the promotion at an individual level of liberal values such as tolerance and respect for diversity, and the identification and modification of legislation, socialization practices and social institutions which cause specific inequities. This perspective sees social institutions as essentially benign and egalitarian, and sexism as accidental and readily eradicable through fairly minor changes to the detail of cultural institutions and customs.

Radical feminism, by contrast, takes as its foundation the view that power inequities between men and women are not accidental, but inherent in the structure of human society. This position holds that the dominant cultural discourses of patriarchal societies position men as 'naturally' superior to women. Social institutions, including law, government, education, employment and childcare systems, militate against women's freedom to live as they choose and to participate in society as the equals of men. By extension, radical feminism holds that changes to sex-based inequities will not result from the promotion of liberal or tolerant attitudes or from changes to the detail of our social lives, but only from fundamental change to the structure of society and the assumptions which underlie social organization.

A third perspective, *socialist* or *Marxist feminism*, extends the radical argument by proposing that capitalism and patriarchy are intrinsically connected and that the creation of a non-sexist society would require the dismantling of capitalism and its replacement with a radically different social system which acknowledged the role of women's unpaid labour in the maintenance of society.

These three approaches all identify fundamental inequalities between men and women, and regard these inequalities as unjustifiable. They differ radically, however, in their perspectives on the source of the inequity and thus in their views of the action required to change the situation. For example, despite equal-pay legislation in the majority of Western societies, women still earn significantly less than men (e.g. Australian Bureau of Statistics, 1995; Social Trends, 1995; US Bureau of Labor Statistics, 1991). From a liberal feminist perspective, this difference may be explained by socialization and education practices which discourage girls from entering high-paying and high-status occupations. Therefore, efforts to increase women's financial power should focus on raising girls' academic self-confidence and encouraging girls to consider taking the 'hard' options at school.

A radical feminist perspective, by contrast, would see this difference as arising from a social structure which values and rewards traditionally male occupations, such as the building trades, more highly than traditionally female occupations, such as nursing, and from a structure

which places the unpaid burden of childcare and domestic labour inequitably on individual women. From this point of view, individual women's attitudes and choices are less important than the social forces which maintain an inequitable structure. Finally, a socialist feminist perspective would argue that the capitalist system relies on the exploitation of male workers, who in turn can only survive and raise families by exploiting their female partners, and that the balance can be redressed only by a revolutionary political change in the relationship between labour and capital.

Feminism and science

The idea of feminist science may seem alien to the psychologist who adopts a traditional, empiricist approach to knowledge, with its assumption of the unbiased, value-neutral observer. Feminist approaches to scientific epistemology, however, are based on the assumption that human observers are never unbiased. The social sciences in particular cannot be conducted from a position of neutrality, so it is important to acknowledge and explore the nature of the observer's bias.

Again, three main perspectives can be identified (Harding, 1986). *Feminist empiricism* adopts traditional scientific methods, with their emphasis on objectivity, replicability and experimental control, but aims to develop hypotheses, and interpret findings, with a conscious avoidance of sexist assumptions. This is perhaps the most common approach to research in the psychology of women's health, and the one which is most compatible with research traditions in psychology more generally. From this perspective, feminism in research means avoiding sexism through attention to women's perspectives, including such strategies as the inclusion of female subjects and of topics of particular relevance to women, avoidance of inappropriate over-generalization from male research samples, and avoidance of the interpretation of gender differences as evidence of the inferiority of women (Denmark, Russo, Frieze & Sechzer, 1988; McHugh, Koeske & Frieze, 1986).

A second perspective, *feminist standpoint* epistemology, rejects the notion of a single universal truth, holding instead that what is true depends on the point of view of the observer. Feminist standpoint approaches do not attempt to achieve experimental control by removing the event under investigation from its context. Rather, they take the individual-in-context as the basic unit of analysis and examine the role of social structures, social expectations and social constructions in the development of individual patterns of behaviour (Striegel-Moore, 1994). This perspective tends to be associated with the use of a broader range of scientific methods. Qualitative and exploratory methods, such as focus groups, semi-structured interviews and participant observation, are seen as having a role in the acquisition of knowledge which is equal to,

although different from, that of more traditional empirical approaches. This research perspective is also associated with a different relationship between researcher and participants. Participants are viewed as collaborators in the research process, rather than as objects to be observed, and participants' perspectives on the topic and the research process are viewed as legitimate sources of hypotheses, methods and interpretations (Riger, 1992).

A third perspective on research, *feminist postmodernism*, takes a more radical perspective. Postmodernism regards all knowledge as socially constructed through language. Since we can have no other access to reality than through language, it is possible to regard reality itself as existing only as a social construction. The main tool of postmodernism, discourse analysis, seeks to analyse and to deconstruct this socially created reality, in order to demonstrate its arbitrariness (Gavey, 1989).

To an empirical scientist, the differences between standpoint epistemology and postmodernism may seem quite minor. Both reject the concept which is central to empirical science, that of an absolute external truth, in favour of the acceptance of multiple perspectives and multiple realities. There is, however, an essential difference in that standpoint epistemology requires the researchers to make an explicit judgement about the value of a particular standpoint for specific political or social aims, while postmodernism takes as its central assumption the arbitrariness of all standpoints, including feminism.

These three perspectives are very different, and thus the styles of research which arise from them are very different. For example, research on eating disorders which uses traditional psychological methods tends to emphasize the personal characteristics of women who develop eating disorders, and to assume that these characteristics are the major cause of disordered eating and should be the major focus of interventions. Standpoint-based research is more likely to examine social stereotypes of an attractive female body, media images of women, social pressures which make appearance salient for women, and broader social structures which lead to women being seen as objects for men's gaze rather than people in their own right, implying that these social factors are the major cause of disordered eating. A postmodern perspective might focus, not on the individual nor on the social structure which constrains that individual's choices, but on the way in which society constructs the concept of attractiveness and the role of body weight in that construction.

The three broad categories of feminist research, like the three broad categories of feminism, have in common an assumption that women's lives cannot be understood independently of their social context, whether that context is seen as essentially benign but in need of slight rearrangement, as fundamentally inequitable, or as totally arbitrary. Any approach to the psychology of women's health which emphasizes social

context, then, will demonstrate considerable overlaps with these feminist perspectives.

GENDER, HEALTH AND SOCIAL CONTEXT

So what is the social context in which women lead their lives? One of the paradoxes of research in gender and health is the consistent finding that women are sicker than men but live longer (Doyal, 1995). In Australia, for example, life expectancy at birth is 79.9 years for women, 73.4 for men, but in the 1989–1990 National Health Survey 75 per cent of women reported a recent illness, compared with 60 per cent of men (Australian Bureau of Statistics, 1995). In the US, women are 25 per cent more likely to report that their activities are restricted by health problems, and are bedridden for an average 35 per cent more days per year, than are men (US National Institutes of Health, 1992). Further, women report twice as much anxiety and depression as do men (Paykel, 1991). Living longer does not necessarily mean a healthier old age either; older women have higher rates of arthritis, Alzheimer's disease, osteoporosis and diabetes than do older men (Heikkinen, Waters & Brzezinski, 1993). And health inequalities are even greater in developing countries, where the limited health services, in common with other scarce resources, tend to be used by men rather than women (Doyal, 1995).

A feminist approach argues that women's poorer health is explained by the fact that women are socially disadvantaged in terms of education, income and political influence. Although gender-equality laws have been enacted in the majority of developed countries over the past few decades, these have had little effect on women's status, quality of life, or access to traditionally male privileges. Consistent evidence from many countries supports the view that in most aspects of social life women continue to be seriously disadvantaged by comparison with men. Much of this research is summarized in later chapters, but national surveys (e.g. Australian Bureau of Statistics, 1995; Social Trends, 1995) are consistent in showing that women have less money than men, less financial security, less desirable employment, and less political and social power.

In Australia, for example, only 64 per cent of adult women are in paid employment of any kind, compared with 84 per cent of adult men. Women are concentrated in a small number of poorly paid occupations, with over half of female workers in clerical and sales positions, and are much more likely to be employed on a part-time or casual basis, with an associated reduction in security and work-related benefits (Australian Bureau of Statistics, 1995). Very similar patterns of employment are observable in the USA (US Bureau of the Census, 1992a), Sweden (Rosenthal, 1994), and the UK (Social Trends, 1995).

Traditionally, women have received less education than men. In the UK, 49 per cent of adult women have completed high school, compared with 55 per cent of men (Social Trends, 1995). The comparable figures in Australia are 53 per cent of women and 60 per cent of men, while 6 per cent of women and 10 per cent of men have university qualifications (Australian Bureau of Statistics, 1995). It is notable that this trend is changing. Among Australians aged under twenty-five, women are more likely than men to have completed high school and to have a post-secondary qualification, while among British school leavers, girls are more likely than boys to succeed in completing university entrance qualifications (Social Trends, 1995). However, educational qualifications remain gender segregated. Only 13 per cent of engineering students are women, compared with 85 per cent of nursing students (Australian Bureau of Statistics, 1995). Female graduates continue to earn less than male graduates, a difference which is explicable mainly by their field of study. Thus, women have less money and fewer earning opportunities than men, even before the inequitable impact of child rearing and unpaid domestic labour have an effect on career progression.

Socioeconomic status, however it is measured, is a strong predictor of longevity and of health (Adler et al., 1994; Carroll, Bennett & Davey Smith, 1993), and women are over-represented in the lower socio-economic levels. In the USA, 64.2 per cent of the adult poor are women (Gimenez, 1989). In Australia, 57 per cent of adults living on government benefits are women. Averaged across all adults and all sources of income, Australian women's incomes are 55 per cent of men's. Even when full-time paid workers only are considered, Australian women earn only 82 per cent of the earnings of men (Australian Bureau of Statistics, 1995). Similarly, US women earn 72 per cent of US men's income (US Bureau of Labor Statistics, 1991), while in the UK the median income for women is 75 per cent of that for men (Social Trends, 1995). The differential remains even when men and women are matched for occupational classification, and when men's greater likelihood of paid overtime is taken into account (Australian Bureau of Statistics, 1995).

SOCIAL MYTHS AND THE PSYCHOLOGY OF WOMEN'S HEALTH

A small number of pervasive myths about women and women's behaviour may explain a large proportion of this inequity. This book deals specifically with four myths which cover many of the aspects of women's social position that relate directly to their health. These include the 'raging hormones' myth, the hypothesis that women's normal hormonal function renders them inherently unstable, while men's does not; the 'motherhood' myth which positions women as naturally better fitted

than men to care for children and which has the effect of restricting women's value as people to their reproductive capacities; the 'angel in the house' myth, which promotes the view that housework, childcare and family care are naturally the work of women, and thus prevents them from reaching their potential in other fields; and the 'woman as object' myth which positions women as objects for the male gaze, valuable according to the extent to which they are physically attractive and potentially sexually available to men.

Naturally, there are many other topics in which women's health is clearly embedded in a relevant social context but which I am unable, for reasons of space and time, to include.

One of the most important topics which has had to be omitted is that of the health of minority women, including indigenous women, women of colour, immigrant women, and women members of ethnic, religious and cultural minorities. Indigenous people, particularly those who have been colonized by members of dominant and powerful Western cultures, experience very poor health. Although mortality statistics do not necessarily reflect the whole experience of women's health, the difference in life expectancy for indigenous and non-indigenous women in Australia – 63.8 and 79.9 years respectively – is so large that it cannot be ignored (Australian Bureau of Statistics, 1995). The social impact of racism, which means that members of ethnic minorities have reduced educational, vocational and developmental opportunities and thus poorer health, is well documented (e.g. Funkhouser & Moser, 1990). Racism combines with sexism to make the position of minority women, both in terms of their social opportunities and in terms of their physical and emotional health, doubly disadvantaged (Reid & Comas-Diaz, 1990). This is an enormous topic, which must be dealt with in a way which sympathetically describes the different positions of indigenous minorities, indigenous majorities, immigrants, descendants of immigrants and of slaves, and members of religious or cultural minorities, and which really necessitates another, different, book.

Other specific groups of women could be the subjects of analyses within the framework of this book. I have included a chapter on lesbian women, because these are a group of women who are uniquely challenged by patriarchal structures, but several other non-ethnic minorities have had to be omitted. Disabled women, for example, are argued to be doubly affected, firstly by their disability and secondly by sexist assumptions that their value as people is diminished because they are unable to fulfil some aspects of a traditional female role (Solomon, 1993).

Another important topic which has been omitted is that of abuse, both physical and sexual, particularly that occurring within families. Patriarchal family structures and men's greater physical strength and sense of entitlement mean that men tend to be the perpetrators, women and children the victims, of abuse (Browne, 1993). There is extensive evidence

linking a history of abuse with a wide range of negative physical and psychological outcomes, as well as with increased risk of self-harm and substance abuse (e.g. Koss, 1990). However, the patriarchal notion that men have the right to control and dominate members of their families tends to render sexual and physical violence within families invisible.

It is worth noting that men, like women, live in a social context and that their health is also constrained by social myths and expectations. A focus on women's health should not be taken as an indication that men have a straightforward and uncomplicated relationship with society, with social constructions of masculinity, and with their bodies. The fundamentally gendered nature of society does affect and restrict men (August, 1985), although in different ways and perhaps to a lesser extent than it does women. Research which considers the effect of socially constructed gender roles on men's health is growing steadily in quality and quantity. Liberation from restrictive gender-based roles, for example through a more nurturing approach to fatherhood, has the capacity to enhance men's well-being and social responsiveness, and such changes can only be beneficial, not only to men but to the women and children with whom they live (Silverstein, 1996).

While this book, then, is by no means comprehensive in its coverage of topics which are important to the psychology of women's health, the aim is to focus on selected topics in a way that illuminates the central social myths that limit and constrain women's lives and thus their physical and emotional well-being.

OUTLINE OF THE BOOK

Part I deals with the 'raging hormones' hypothesis. The concept that women are more constrained by their animal nature than are men, less able to transcend their biology, has a long history in the Graeco-Roman and Judaeo-Christian traditions (Wooley, 1994). In particular, the assumed role of women's reproductive organs as the source of disturbed and antisocial behaviour has an extensive and well-documented history. In modern times, this concept is expressed in the assumption that women's behaviours, thoughts and emotions are uncontrollably determined by their hormonal systems, while men's are not (Ussher, 1992b). The reason why normal healthy endocrine function is seen as sinister among women but not among men may be traced back to the notion of man as the standard, normal human being and the assumption that any variation from this 'standard' must be problematic or at least inferior. This myth is explored through reviews of evidence in three areas menstrually related distress, postpartum depression, and menopausally related distress. In all three areas, the research evidence indicates that: hormones actually have very little impact on behaviour or emotion,