# GENDER AND HEALTH: WOMEN'S HEALTH

# Importance of Studying Women's Health



- What is women's health?
- Why is it important to focus on women's health?

# Women's health has been marginalised



- Prior to 1990 – **limited research** attended to women's health issues
- Women have been **ignored** in general medical research
- 'Women's health' has been inappropriately **reduced** to '**reproductive health**'
- Women have had health information **withheld** from them 'for their own good'.

# Cartwright Inquiry in New Zealand 1987-1988



- Responded to **unethical experimentation** on women at National Women's Hospital.
  - 1966 - women with **major cervical abnormalities** were studied **without** definitively **treating them**, and without their knowledge or consent.
  - By **1987** many had **developed cervical cancer** & some had died.
- Exposed a core dynamic of twentieth century medical practice:
  - **Arrogance**: Doctors know best, are supremely objective, rational and scientific.
  - **Patients**, particularly women, considered **irrational**, hysterical & incapable of understanding & making **health choices** for themselves.

# Women's indictment of the medical system in 1970s NZ…



"*We have been treated like children, neurotics and idiots… We have been given prescriptions, drugs, injections, incisions and stiches. We have been told our pain is imaginary when we could feel it in our guts. We have been forced to bear children we did not want… We have had to beg and plead, and pretend we were mad to get sterilisations and abortions…We have not been listened to. We have had enough.*" (Broadsheet Collective, 1974, p. 4, Broadsheet)

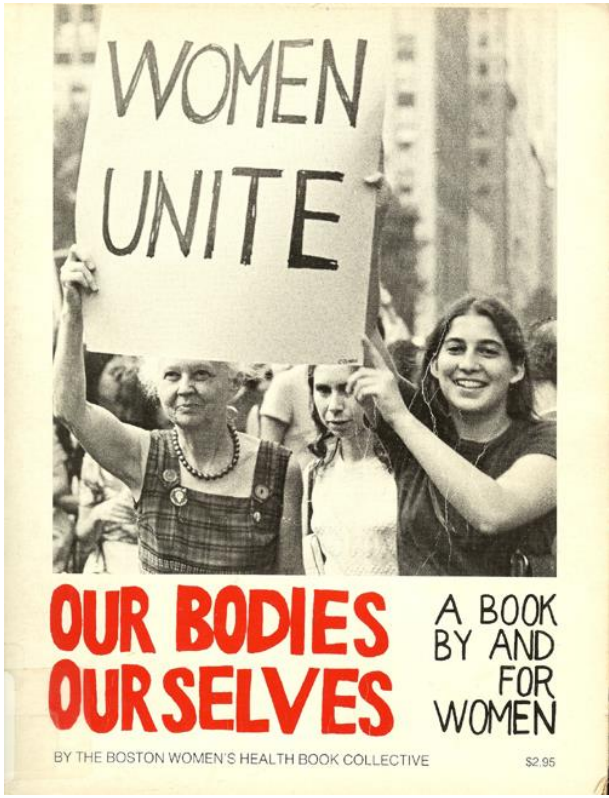
# The Women's Health movement



- **Asserted women's rights** to: medical information, bodily integrity & autonomy; reproductive choice; freedom from violence; equity in society, work & pay; access to education.

- *"Women's health is concerned with maintaining a positive state of physical and mental wellbeing… women's health does not just occur in hospitals or doctor's waiting rooms, is not just concerned with mothers and babies, reproduction, childrearing and food, and is not only about women specific illnesses and treatment services. Women's health issues focus on the principles of prevention, involvement and equity."*

(New Zealand Women's Health Committee Report to the Board of Health, 1988).



# Women's health psychology



- Emerged in courses and texts in the **1990s**.
- Some **areas converge** with research & theories of **general** health psychology - in common with men
- Also areas where women have **unique/different** issues.
- Recognises women are **diverse** group.
- Holds women's health impacted by **economics, social practices, cultural, political & relational** contexts, at different life stages.
- About how **behaviours, attitudes, lifestyles, & interactions** between **psychological & physical** health influence women's wellbeing within diverse sociocultural contexts.

# Some topics of relevance to women's health psychology



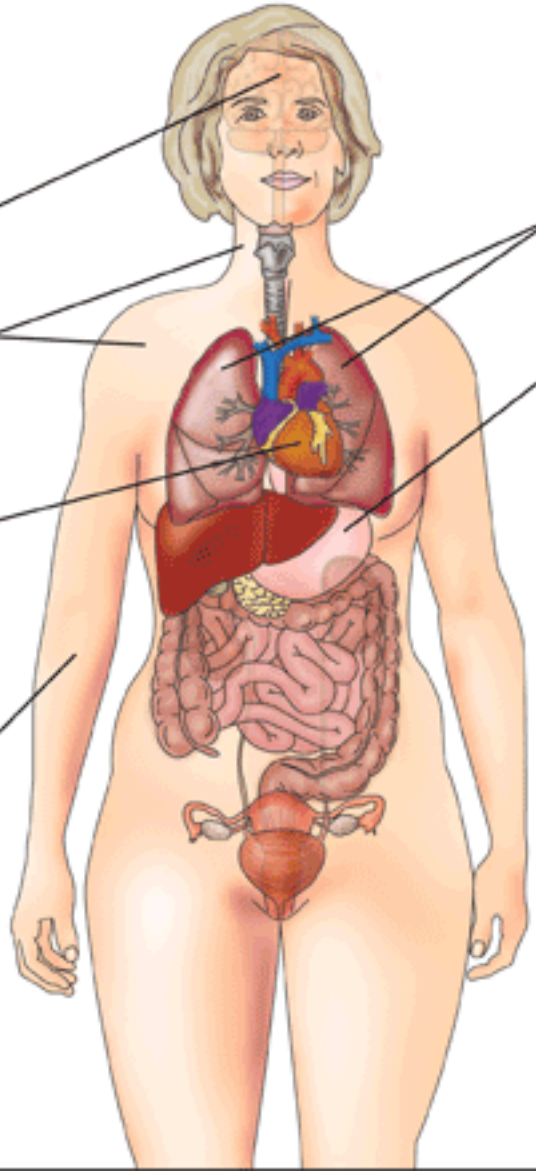
- **Heart disease** – biology or bias?
- **Breast cancer** – anxiety, over-diagnosis & young women
- **Violence** against women – health impacts and cultural scaffolding
- **Chronic pain & gender bias** - fibromyalgia
- **Body image**, weight stigma & health impacts
- **Infertility** impacts, coping & culture.
- **Lesbian health** – minority stress.

# Heart disease - Biology or bias?



- More women than men die from **coronary heart disease** (CHD) yearly
- No 1 killer of women in NZ- 50 a week
- **Many risk factors in common with men**
- **Additional factors for women:** smoking when young, diabetes, poverty, depression, anxiety.
- **Under-researched.**
  - 50% of cardiovascular disease trials conducted between 2006 & 2010 did not include **gender analysis**

# Signs of a Heart Attack



**Head**
Lightheadedness

**Arm(s), Back, Jaw, Neck, Between Shoulders**
Pain, discomfort, numbness

**Chest**
Pain, pressure, fullness, or squeezing (lasts more than a few minutes or comes and goes)

**Skin**
Cold sweat

**Lungs**
Trouble breathing (shortness of breath)

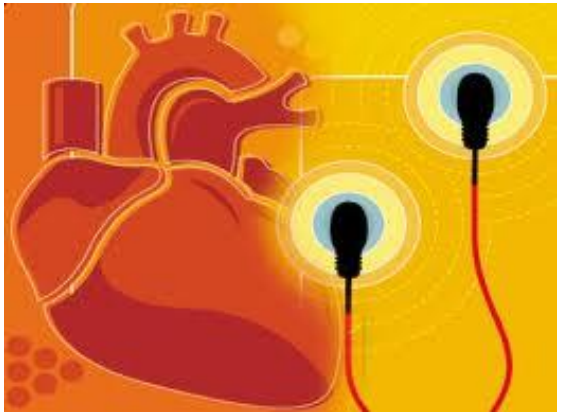
**Stomach**
Upset stomach, urge to throw up

**Other Signs**
In addition, some women may feel very tired, sometimes for days or weeks before a heart attack occurs. Women may also have heartburn, a cough, heart flutters, or lose their appetite.

# CHD Treatment



- Less aggressive in women than in men (Steingart et al., 1991)
  - Women are **half as likely to be recommended cardiac catheterization** (test that determines heart disease severity).
  - Women are less likely to receive **angioplasty** and **coronary bypass** than men



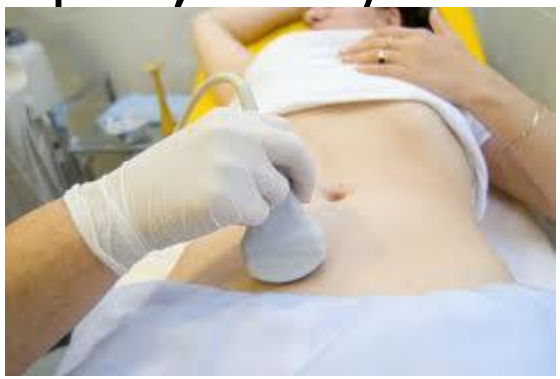
- Recent study of **emergency patients** with similar presenting symptoms: Paramedics gave **morphine** to **men** who report pain but <u>not</u> women.

- **Gender bias exists** even when there are really clear diagnostic & treatment protocols – likely to be worse when there aren't e.g. chronic pain.

# Breast Cancer



- Breast Cancer
  - #1 **leading cause** of cancer deaths in women
  - **High levels of anxiety** around BC prevalence & death rates among women (Galgut, 2010; Altheide, 2002; Lerner, 2001; Lupton, 1994)



# Breast cancer anxiety



- Medically reclassified as **chronic disease**, not acute.
  - **Acute** - come on abruptly & run a short, severe course
  - **Chronic -** last prolonged time & come & go
- Yet one of the diseases **most feared** by women.
- Most common response to diagnosis (own or another's) is **anxiety/dread.**
- **Societal discourses** feed women's anxiety:
  - high prevalence, death rates, & risk reduction
  - 'the lump', the 'hidden disease' requires constant vigilance (Lupton, 1994).
- BC anxiety is associated with **reluctance to be examined** (by GP or self), present for mammography & BC treatment.

# Noticing BC symptoms

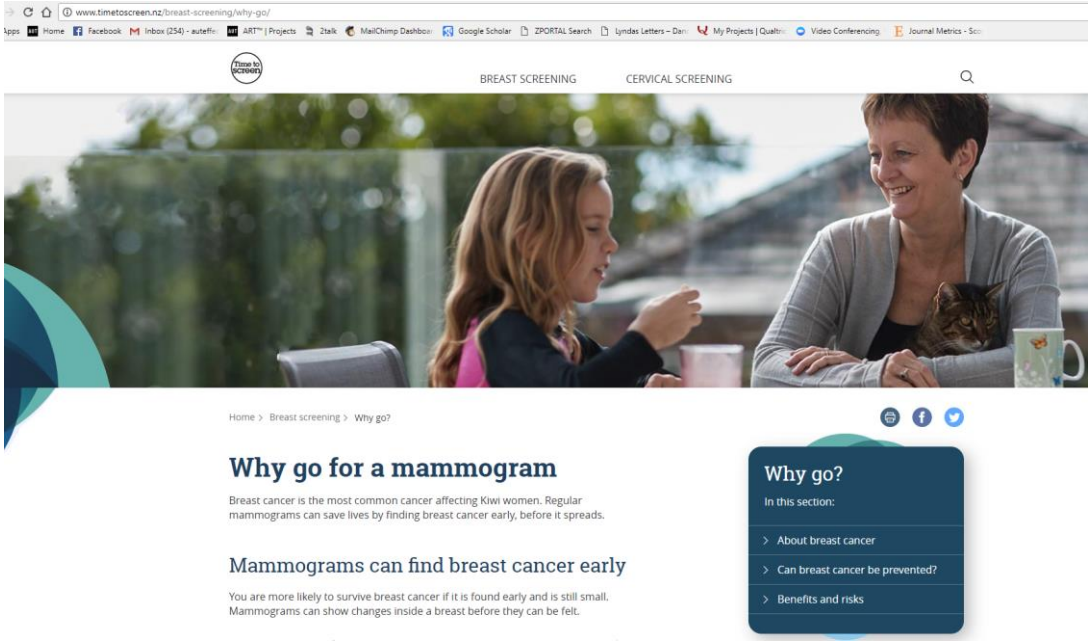


*"I felt very alone. I felt a great weight of loneliness, And I became extremely anxious. This anxiety stayed with me throughout the whole process. My heart started to pound, and almost instantaneously I had flash-backs to my aunt on her death-bed, dying not an easy death, from breast cancer some years ago"* (Anne, in Stephenson 2014).

# BreastScreen Aotearoa



- Screening is presented as a way to save one's life.
- "You're mad if you don't"
- https://www.youtube.com/watch?v=pfZGAtO9nQE



# Mammography and over-diagnosis



- **COCHRANE REVIEW** "Screening for breast cancer with mammography" (Gotzsche & Jorgensen, 2013)
  - 7 trials, 6,000,000 women, 39 to 74 years, randomly assigned screening mammograms or not.
  - If 2000 women are screened regularly for 10 years:
    - **1 woman will avoid dying** from breast cancer
    - **10 healthy women**, who would **not have been diagnosed** without screening, **will have breast cancer diagnosed and be treated unnecessarily**; **4** of these women will have a **breast removed**, **6** will receive **breast conserving surgery**, and most will receive **radiotherapy**.
    - **1800** will be alive after 10 years; without screening **1799** will be alive.
    - **200+ women will experience severe psychological distress including anxiety for years due to false positive findings.**
- All women invited to screening should be fully informed of both the benefits & harms.

https://www.cochrane.org/

# Are more young women being diagnosed with breast cancer in NZ?



- Public perception that breast cancer now has a younger face.

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health

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Spike in breast cancer rates places financial pressure on district health boards

Last updated 05:00, May 28 2017

ANDI CROWN

Maddy Cooper took Herceptin after being diagnosed with breast cancer. She says the drug worked well for her.

Breast cancer rates among New Zealand women are rising at faster than predicted levels, and the increased demand for life-saving drugs has blown a hole in the budget of at least one district health board.

The latest available figures show 3301 women were diagnosed with breast cancer in 2015, 300 more than the Ministry of Health had projected.

In the Nelson-Marlborough region, the number of women seeking Herceptin, a drug which treats around one in five breast cancer sufferers, had doubled in the past 12 months.

# NZ BC mortality and young women (2)



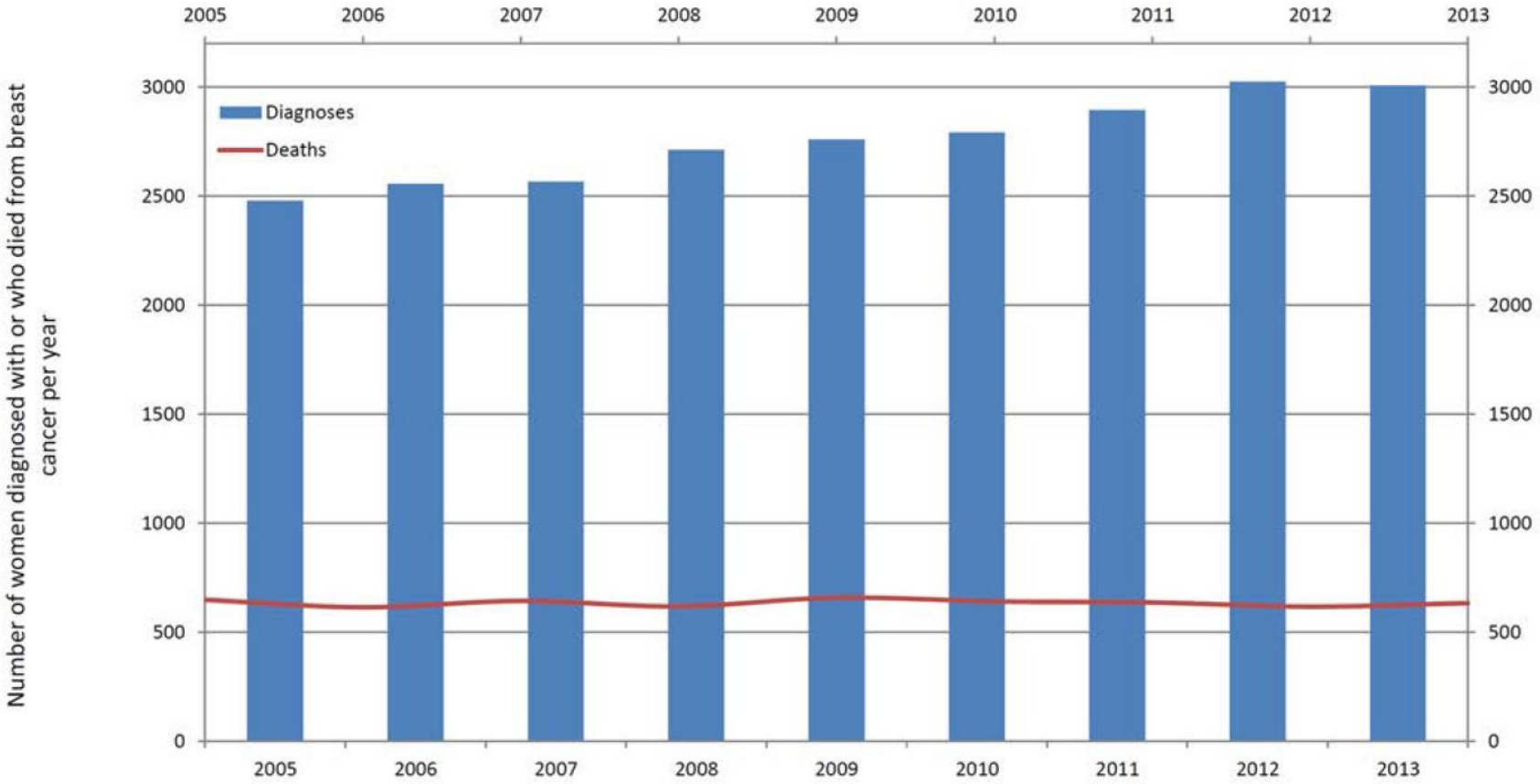



**Figure 5** The total numbers of women being diagnosed each year from 2005 to 2013 and the number of women dying from breast cancer in the same years.

# Young women and breast cancer in NZ



- **Young women** are no more likely to be diagnosed with breast cancer than they were **20 years ago**.
- More women are being diagnosed overall, fewer are dying.
- Why the perception that more young women are affected?
  - **'Going public' & shock value** – media influence
  - **High profile diagnoses** – Kylie Minogue, Sheryl Crow, Christina Applegate
  - **Over-diagnosis & public health messaging** contribute to BC anxiety.

# Violence against women



- Physical, psychological, & sexual abuse, isolation & economic control (Ministry of Women's Affairs, 2013).
- **Coercive control**: 'the entrapment of women in personal life' (Stark, 2007).
- '**Gender-based violence**' (GBV) is a developing term (Council of Europe, 2007).
  - Based on how a particular society assigns & views **gender roles & expectations**

# Research into health impacts of violence against women



- Mainly focusses on intimate partner violence (IPV)
- Fanslow & Robinson (2004): Random sample of women aged 18-64 in **Auckland & Waikato** (n=2,855).
  - Lifetime non-partner physical violence: **15% A, 17% W.**
  - Lifetime physical or sexual intimate partner violence (**IPV**): **33% A, 39% W.**
  - Victims of **IPV** **twice** as likely to have visited a healthcare provider in the previous month.
  - IPV significantly associated with **current health**: self-perceived poor health, physical health problems (eg, pain), mental health & suicide attempts.

https://www.anrows.org.au/

- ANROWS (2016): **Burden of disease** (impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators)
- Impacts of intimate partner violence (IPV) in Australian women 18-44.
  - IPV adds 5.1% to burden of disease
  - Higher contribution than any other risk factor in the study (including tobacco use, high cholesterol or use of illicit drugs).

# Family Violence Death Review Committee in NZ



- *The **unnatural death** of a person (adult or child) where the suspected **perpetrator**(s) is **a family or extended family member**, caregiver, intimate partner, previous partner of the victim, or previous partner of the victim's current partner, & where the death was an episode of family violence and/or there is an identifiable history of family violence*
- **Does not include**: suicides; assisted suicides; & deaths from chronic illness associated with family violence.

Definitions

**Abuse history:** The ongoing patterns of coercive and controlling behaviours used throughout the intimate relationship, including after the relationship ceases.

**Predominant aggressor:** The person who is the principal aggressor and has exercised coercive control against their intimate partner.

**Primary victim:** The person who has experienced ongoing coercive and controlling behaviours from their intimate partner.

# Family Violence Death Review Committee Report 5: 2009 –2015



Table 3: Roles of offenders in IPV death events by abuse history, New Zealand, 2009–15

| Role of offender in the abuse history and role of offender in the death event* | IPV death events with an abuse history n=83 | |
|---|---|---|
| | n | % |
| **MALE PA** | | |
| Male PA kills female PV | 45 | 54 |
| Male suspected PA kills female suspected PV | 13 | 16 |
| Male PA kills female PV's new or ex-male partner | 6† | 7 |
| Male PA kills female PV and her new male partner | 1‡ | 1 |
| **TOTAL MALE PAs** | **65** | **78** |
| **FEMALE PA** | | |
| Female PA kills female PV | 1 | 1 |
| Female PA kills male PV | 1 | 1 |
| **TOTAL FEMALE PAs** | **2** | **2** |
| **FEMALE PV** | | |
| Female PV kills male PA | 12 | 14 |
| Female suspected PV kills suspected male PA | 3 | 4 |
| Female PV and her new male partner kill male PA | 1# | 1 |
| **TOTAL FEMALE PVs** | **16** | **19** |
| **TOTAL IPV DEATH EVENTS** | **83** | **~100** |

**IPV =** intimate partner violence.

**PA =** predominant aggressor.

**PV =** primary victim.

# Coercion tactics



Table 6: Coercion and control tactics used by predominant aggressors analysed in police death reviews, New Zealand, 2009–15

| Coercion tactics | |
|---|---|
| **Violence** | • Threatened to kill her and her children if she left him and strangled her to unconsciousness so she knew that he meant it<br>• Held her hostage for extended periods of time or in remote areas in order to perpetrate extreme and terrifying attacks on her<br>• Repeatedly raped her |
| **Intimidation** | • Kept one child with him when she left the house so she had to return<br>• Tracked her down when she left and reinstated the relationship by moving into her home<br>• Responded with extreme jealousy every time she went out, which meant she was scared to acknowledge people in the street and found it safer not to leave the house<br>• Put a gun in her mouth and threatened to discharge it<br>• Threatened to harm vulnerable family members, or her children if she attempted to leave or failed to comply with his demands<br>• Used recording devices to monitor her conversations or activities<br>• Checked her cellphone<br>• Threatened to leave her with nothing if she left the relationship<br>• Required her to do humiliating or degrading things and then threatened to disclose these to people |

# Control tactics



| Control tactics | |
|---|---|
| **Isolation** | • Destroyed phones so she could not seek help<br>• Destroyed her relationship with her friends and monitored all her community connections<br>• Used his elevated status in the community to ensure no one would be likely to believe her if she shared what was happening<br>• Repeatedly called her at work and was rude to her work colleagues<br>• Assaulted or threatened to kill family, whānau and friends who attempted to intervene to protect her (including pointing guns at them) |
| **Deprivation, exploitation and micro-regulation of everyday life** | • Opposed her undertaking further study to improve her employability and damaged her electronic devices so she struggled to meet her study requirements<br>• Required her to get permission to use bank accounts, limited her finances or monitored her spending<br>• Took her benefit money and spent it on alcohol for himself, leaving her with little money to buy food for her children<br>• Controlled her access to vehicles<br>• Required her to comply with his trivial demands (eg, specifying how he liked his food prepared, timing her on the school run, making her get him alcohol and cigarettes on a daily basis)<br>• Provided her with detailed lists of how she could improve herself in order to be a better partner |

# Family Violence Death Review Committee Report 5: 2009 –2015



- Agencies and professional '**empower**' women to separate
- But **physical separation** does not mean safety:
  - Dobash and Dobash, national study on Murder in Britian: "Men simply would not 'allow' it to end & might go to great lengths to ensure that it continued, including persistent phoning, uninvited visits to her home, stalking, & threats of violence, murder & suicide."
  - Not a **choice-based decision**, impeded by the predominant aggressor's coercive & controlling behaviours.
- 2009–2015, 55% of NZ offending male predominant aggressors either **believed** female primary victims had committed **infidelity** or had new male partner.
  - Meyer, S. (2012). Why women stay: A theoretical examination of rational choice and moral reasoning in the context of intimate partner violence. *Australian & New Zealand Journal of Criminology*, *45*(2), 179–193. https://doi.org/10.1177/0004865812443677
  - **Children** & **Finance** important factors

# Cultural scaffolding of sexual violence against women



- Elements of **gender socialisation** support the practices of rape & sexual assault (Gavey, 2005)
- Male '**active sex drive**' vs female '**passive gatekeepers**'
- '**rape culture**' E.g. raised by "Roast Busters" incident
- Sills et al (2016) interviews with young people in NZ:
  - victim-blaming, "slut-shaming," rape jokes, the celebration of male sexual conquest, & demeaning sexualized representations of women are prevalent.
- Health impacts – e.g. sexual coercion, & limits on women's ability to choose – e.g. relationship forms, practices like 'safe sex'.

# Women's use of violence



- Women slightly more likely than men to **report** using **physical aggression** against intimate partners (e.g. Archer, 2000).
- Only **physical aggression**, does not place occurrence of women's violence within **broader social, cultural, or historical context**.
- **Conflict Tactics Scale** - problematic decontextualised categorisation of violent acts.
- Did not examine **sexual assault, stalking, or coercive control**; much higher rates of these types of violence committed by males (Straus, 1999; Tjaden & Thoennes, 2000)
- NZ FV death review:

Box 1: Complex layers of entrapment experienced by the female primary victims who killed their male predominant aggressor (n=16)

1. **Social isolation, fear and coercion created by the predominant aggressor:**
   - Six women were living with patched gang members; none of these women were separated.
   - Two women had previous partners who were patched gang members and their families also had numerous gang connections.
   - Fifteen women were not separated at the time of the IPV death event; two of these women were planning to separate.
2. **The indifference of powerful institutions to the victim's suffering:**
   - Ten of the women had sought help for IPV from the police.
   - One woman had contacted the police over 30 times throughout the relationship.
3. **Coercive control aggravated by the structural inequities of gender, class and racism:**
   - Twelve were Māori women; their level of entrapment is further compounded by the ongoing impact of colonisation.
   - Eleven women were from neighbourhoods in the highest deprivation quintile (NZDep quintile 5).

# Chronic pain



- Women consistently report a **higher prevalence** of chronic pain than men (Croft et al., 2010).
- At least 3 theories:
  - **gender-role theory** that assumes it is socially more **acceptable** for women to report pain,
  - **exposure theory** that suggests women are **exposed** to more **pain risk factors**, and
  - **vulnerability theory** proposing that women are more **vulnerable** to developing **musculoskeletal pain** (Picavet, 2010).

# Fibromyalgia



- Pain without a cause is pain we can't trust… we assume it's been chosen or fabricated (Jamison, 2014)

- *"I use the word 'suffer' not for pity, or attention, and have been disappointed to see people online suggest that I'm being dramatic, making this up, or playing the victim to get out of touring."* Gaga

# The Girl Who Cried Pain: Bias Against Women in the Treatment of Pain



- Women **report pain more** frequently to health care providers,
- More likely to be **discounted** as "**emotional**", "psychogenic" or "not real", and less likely to be treated (Institute of Medicine, 2011).
- Men get **pain relief**, women get **sedatives**.
- Some paradoxical reasons suggested:
  - Women report more **coping mechanisms for pain**, & therefore regarded as needing **less treatment** – resistance to being a '**suffering woman**'
  - Women **look** less 'in pain' as they are **socialised** to pay more attention to their **appearance**
  - Men with chronic pain tend to **delay treatment** therefore more **aggressively** treated when they show up
  - Medical bias towards discounting the emotional or psychological components of the experience of pain (Hoffman & Tarzian, 2001).
    - "**Pain that gets performed is still pain**" (Jamison, 2014).
    - https://www.theatlantic.com/entertainment/archive/2017/09/lady-gagas-illness-is-not-a-metaphor/540369/

# Infertility and prevalence



- **Defined:** The **inability to conceive** a pregnancy after one year of unprotected coitus or the inability to carry a pregnancy to a live birth

- Experienced in **1 in 6 couples** of reproductive age (Fertility Society of Australian, 2013).

# What causes infertility?



Goldman et al. (2000) list:

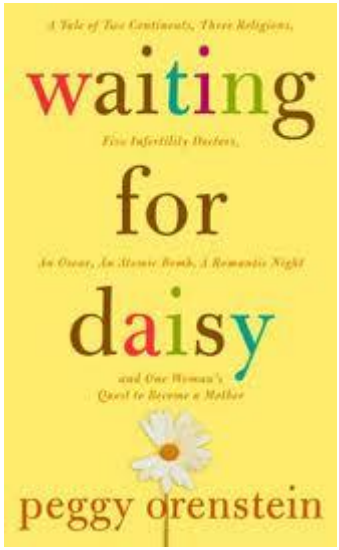
- **Delayed** childbearing
- Undetected **pelvic inflammatory disease** due to increased number of STDs (including gonorrhoea and chlamydia)
- Use of **substances** such as caffeine, nicotine, alcohol
- Chronic **stress**
- Exposure to **work and environmental health hazards**

- Often infertility is **not** attributable to <u>one single cause</u>
  - 35-40% of infertility cases attributed to **male factors** (e.g., abnormal sperm count or mobility, injury to reproductive organs, retrograde ejaculation)
  - 35-40% of infertility cases attributed to **female factors** (e.g., aging or depleted oocyte reserve, anovulation, structural abnormalities of the uterus)
  - 20% from **both** members of the couple

# Psychological Effects of Infertility



- Elevated psychological distress in both men and women.
- Women's **sense of self** more affected than men
  - Due to **socialised** pressure
  - Default **motherhood**
  - **Stigma** of childlessness
- Effects for women related to narrative of 'challenge' vs 'loss'
- Can lead to strain on **relationship**, not usually break-up.
- Very **dependent on culture**: pro-natal, women's roles, acceptability of childlessness, availability of other options e.g. adoption.



# Infertility Treatments and Stress



- **Intervention options** include:
  - hormones, artificial insemination, range of variations in in-vitro fertilisation, ovum donation
- These options may produce considerable **stress**, challenge **couple's coping** resources, overall **QOL**
- **Strain and pressure** to continue on with treatment
  - **Financial hardships**
- Women report experiencing **considerable relief** when they stop & explore alternatives (e.g., adoption, surrogate motherhood, remaining childless)
  - But each have their own challenges as well

# Sociological perspectives on infertility



- Prior to 2000, infertility as medical issue, with psychological consequences.
- Now – recognised infertility experiences as shaped by **social context**.
  - Must see **parenthood as desirable** to become 'infertile'
  - Generally **not located in individual** bodies – couples are infertile
  - Generally no **pathology** – absence of desired state
  - Variety of viable alternatives to '**cure**'
- Drawing on the **cultural resources** that are available to them:
  - define their ability to have children as a problem, define the nature of the problem, construct an appropriate course of action.

# Conclusion



- Before 1990s, **women were ignored** in health research
- Most health topics can be explored using a women's health lens.
- Some big issues identified by women in the 1970s remain: e.g. gender bias in medical practice, gendered inequalities in society.
- Research must continue to explore women's **health psychological factors** in the context of the **social determinants of health and wellbeing.**

# Further reading



- Journals
  - Psychology of Women Quarterly.
  - Feminism & Psychology.
  - The Sociology of Health & Illness.
- Books
  - Women's health psychology / edited by Mary V. Spiers, Pamela A. Geller, Jacqueline D. Kloss, 2013.
- Websites
  - Women's Health Action; https://www.womens-health.org.nz/
  - Auckland Women's health Council; http://www.womenshealthcouncil.org.nz/