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Social, Biomedical, and Feminist Models of Women's Health

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Integrated models of women's health address the contributions of socially and culturally constructed concepts of caring and curing as well as health practices, medical care, and social investments in the prerequisites for health. These conceptualizations of health differ radically from narrow biomedical models that only acknowledge prevention, detection, and treatment of disease.

What Is Women's Health?

Health activists' quarter century of struggle to place women's health on the national agenda has been partly realized as evidenced by growing attention to women's health issues in many arenas. However, despite the high level of interest, what constitutes this field remains poorly defined. In search of a paradigm, Margaret Chesney and Elizabeth Ozer (1995:4–5) have proposed a framework to organize and "integrate competing approaches to the field of women's health." Their model includes seven content areas: reproductive health, diseases more common in women than men, leading causes of death among women, gender influences on health risk, societal influences on women's health (norms, roles, and poverty), violence against women, and women and health care policy. Although Chesney and Ozer urge attention to the distinct contributions of conceptual models in anthropology, sociology, psychology, and medicine (as well as the variety of research processes and methods used in health research), they do not compare conceptual approaches. We share their desire for new paradigms. "Laundry lists" of health issues are not enough. But where do we start?

In our view, a first step is to recognize how research and public policy have been predominantly biomedical—focusing on a limited range of diseases and conditions taken out of the context of women's daily lives

and felt needs. From a biomedical perspective, health is the absence of disease and infirmity. In contrast, the World Health Organization (WHO) has defined health broadly, within a social rather than biomedical frame, for nearly half a century. For WHO, health is a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." However, this broad social model of health has not been used often in the United States to shape research and policy.[1]

We believe that it is useful to contrast some fundamental differences between biomedical and social models of women's health. Feminist models, which spurred national interest in women's health over the past three decades, are themselves inherently social and thus discussed within that framework. We also note the emergence of mind-body models both within and separate from biomedicine. These models emphasize psychological and spiritual dimensions of health that are less often included in discussions of women's health. All conceptualizations of health are dynamic and changing. The breadth and depth of work on women's health that researchers, clinicians, and health advocacy groups have produced over the past three decades have laid the groundwork for new ways of thinking about what actually produces health, not only for women but for families and communities.

As the complexities and differences in women's health take center stage, as they do throughout this book, referring back to underlying conceptual models will help put the various dimensions of health and healing into clearer perspective. Sociologists have long argued that the whole is always more than the sum of its parts. To comprehend the whole of any woman's health or all women's health, it is essential to recognize how partial each of the parts is likely to be. All of us are more than an aggregation of body parts, cells, social actions, or social statuses. No single or singular view of women's health will adequately reflect the complexities of women's lives, although dominant biomedical models are often taken to represent "all" of women's health.

Our critique of biomedical models that dominate thinking about health in the United States is not intended to discount or leave unacknowledged the very real contributions of many individuals who have worked long and hard to change biomedicine to better meet women's needs. What we are suggesting here is that dominant biomedical conceptualizations of health, with their narrow disease-focus, inadequately represent health because they leave out, or only nominally consider, the social forces and contexts that shape women's health and women's lives.

A distinctly social focus is also absent in some, although not all, of the emerging mind-body models. In addition, models that generalize about the needs or nature of disease processes in "all women" ignore the very fundamental differences in what different women need—and how they are likely to respond to medical care.

Within biomedicine, feminist perspectives have spurred recognition of how gender affects the etiology, natural history, and treatment of disease. Results include recent policy changes that ensure inclusion of women in clinical trials and all aspects of biomedical science (discussed in chapter 21). Efforts to incorporate recent research on psychosocial factors in the etiology of disease and gender-related health practices in the use of medical services broaden the biomedical model.[2] But in our view these efforts, no matter how useful, do not adequately represent health. Although these models may recognize social and behavioral dimensions of health, they do so largely within the framework of clinical practice issues. The underlying social dynamics of what actually *produces* health for different groups of women are not integral to biomedical models.[3]

Why Women's Health Needs to Be Reconceptualized

In our view, models of health that reflect the social, not just the biological, dimensions of health and illness must emerge to make space for understanding differences in what women want and need to realize the vision of health set forth by the WHO. These models also need to incorporate psychological and spiritual dimensions of health and healing that have particular significance to women who see these as contributing to their ability to resist and recover from illness.

At the national level, partial and incomplete views of what "needs to be done" to promote women's health are gaining momentum—largely in calls for more biomedical research and wider access to medical services. Although medical care contributes to women's health and well-being, its importance should not be overstated or accepted uncritically. To move beyond a narrow disease-focused model of women's health, we might start by rethinking where health is located.

If we conceptualize women's health as *embedded in communities*, not just in women's individual bodies, we lay a foundation for envisioning very different models of women's health from those that now predominate. Attention to the broader base of what actually *produces* health (as

contrasted with managing disease) suggests that social investments in a variety of areas are necessary to promote women's health.[4] When we look closely at the variations in women's health statuses and experiences, the need for doing this becomes clear.

Some Social Features of Health

To conceptualize broader models of health, it is useful to consider what the WHO describes as the prerequisites for health: freedom from the fear of war; equal opportunity for all; satisfaction of basic needs for food, water, and sanitation; education; decent housing; secure work and a useful role in society; and political will and public support.[5]

Each of these prerequisites for health is stated in gender-neutral language, yet access to these prerequisites is shaped by gender as well as social class and many social and cultural factors. For example, the threat of war reduces women's health not only directly through the threat of death, rape, or destruction of working and living conditions but indirectly through emotional stress related to the survival and safety of communities and family members and the disruption of education. Equal opportunity implies elimination of inequalities for women based on gender, race, social class, and other social characteristics such as age, sexual practices, and disabilities that limit the pursuit of health. The quality of housing, education, food, heating, water, and other necessities of life reflect the resources of entire communities and societies.

The importance of political will and support for women's health deserves particular attention. The recent history of women's health movements, especially differences among groups of women, discussed throughout this volume, illustrates how critical these factors are in redefining what is considered important in science and society. Having access to information about the multiplicity of dimensions of women's health is essential to mobilize political support for a broadened vision of what actually contributes to all women's health and well-being.

Too many agendas to promote women's health in the United States seem to take for granted that women *have* the prerequisites for health. This fallacious assumption ensures that the centrality of these prerequisites to health remains submerged, or even repressed, in public policy and in the wider cultural discourse. Moreover, improving the biomedical knowledge base and clinical services for women begs the question of how

such improvements will actually benefit women who don't have these basics, even if they manage to gain access to medical care—something that is increasingly problematic in the United States.

Scholars have never fully untangled exactly how improvements in working and living conditions, improvements in medical care, changing economic conditions, and profound changes in patterns of education, employment, marriage, and family life affect patterns of health and illness. Yet we recognize that these dimensions are, in fact, interrelated and consequential. For example, education, which is highly related to socioeconomic status, has clear health effects for women. Data from the National Center for Health Statistics (1995:108) reveal a clear gradient in mortality for white women and for women of all races by educational attainment. In 1992, the death rate was twice as high as for white women and women of all races ages twenty-five to sixty-four who had less than twelve compared with thirteen or more years of education. If national health statistics routinely included information on health status by educational attainment, might the importance of education for women's health be more widely recognized?

Data on health by socioeconomic status is difficult to obtain in national statistics (see chapter 2). When race, but not socioeconomic status, is used in national statistics, the real effects of socioeconomic status are obscured. Health status differences among women within racial/ethnic groups are particularly important to identify because they provide clues to differences between sociocultural and socioeconomic factors that affect health status and thereby suggest different strategies for change. For example, some immigrants have better health and birth outcomes than native-born members of the same racial/ethnic group despite similar poverty levels (Kumanyika and Golden 1991; Scribner and Dwyer 1989).

Because women's health is interdependent, the health of impoverished women affects the health of women in more comfortable circumstances. Examples abound. The spread of HIV, antibiotic-resistant strains of tuberculosis, teen pregnancy, homelessness, and all forms of violence as well as the growing ranks of the uninsured or underinsured affect everyone not only materially but in terms of the kinds of people some Americans are becoming—armed, fearful, and uncaring beyond immediate circles of family and friends. Thus threats to women's health include more than microorganisms, degenerative diseases, bad habits, or failure to map the human genome fast enough to save us from our own bodies! To construct more complete and inclusive models of women's

health, models capable of addressing differences and complexities among women, we have to look at some specific limitations of dominant models.

Biomedical Models

Since the U.S. Public Health Service (1991:149, emphasis added) adopted this biomedical conceptualization of women's health, it has been used widely in government and medicine.[6] "Women's health is devoted to the preservation of wellness and prevention of illness in women, and includes *screening, diagnosis and management of conditions* which are unique to women, are more common in women, are more serious in women, [and] have manifestations, risk factors or interventions which are different in women."

The emphasis on the preservation of wellness implies that women have wellness to preserve, but where health comes from, or what is to be done if women do not have health, remains invisible at best or gets glossed over or denied. The biomedical focus on diseases or "conditions" in women is reinforced in the media and in public policy. Cultural metaphors widely used to describe detecting and curing diseases derive from warfare[7] and stir individual and collective action to demand more biomedical interventions. Screening is, in fact, prevention only to the extent that early detection increases the likelihood of early treatment and cure. Americans "race to the cure," declare "war" on cancer, and seek to triumph over the "killer diseases."

The media, in concert with medical experts, promote unrealistic views of miracle cures and prematurely report progress. In contrast, the media pay very little attention to the downside of modern medicine—"cures" that don't actually work and treatments that carry more risk than meets the eye or that contribute little to improved health outcomes. In this cultural context, rational and irrational beliefs about curing support heavy private and public investments in biomedicine.

Efforts to optimize health for individuals through advances in biomedicine consume a growing proportion of what are termed "health expenditures." Conceptualizations of what health *is* reflect this new "market metaphor" of medicine (Annas 1995). The multibillion-dollar annual budgets of the National Institutes for Health, including the commitment to the Human Genome Project, coupled with investment tax credits to the biotechnology industry, are all part of public investments in a narrow

range of health resources. Healers, who were transformed into professionals early in the twentieth century, are now being transformed into "providers." Increased expenditures on medical care services inevitably deplete national resources available for critical social investments that promote health such as education, job training, environmental safety, and housing.

Rather than promoting women's health through improvements in these key social areas, national efforts to improve women's health have largely been directed toward making biomedicine more complete and more inclusive of social factors in health. The focus on social factors has been directed to a narrow range of primary prevention activities—largely individual responsibility for personal health practices such as diet, exercise, and avoiding tobacco, which reduce the risk of disease. (Controversies over these approaches to promoting women's health are explored in chapter 5.) Policymakers are eager to promote prevention to reduce costs of medical care. Social and behavioral scientists are increasingly asked to figure out how to do it better, more often, and more cost-effectively. Market concerns drive much of this "outcomes research" designed to rationalize health care service delivery. In medicine, encouraging women to improve health practices is viewed as supporting the "war on disease" while also "saving money."[8]

This is, of course, one of the areas of contradiction in women's health. Greater attention to behavioral factors in health *can* enhance development of risk reduction interventions that meet the needs of distinct populations—smoking cessation designed for low-income pregnant women or for older women. Social and behavioral knowledge can also improve diagnosis and treatment by expanding clinicians' perceptions of sources of women's ill health. Improvements in screening and treatment for battered women have resulted from broader perspectives. For example, Carole Warshaw (1993) and others have called for changes in how women who suffer injuries are treated by emergency personnel. Rather than simply treating a broken nose without considering how it got broken, new clinical protocols help assess how injuries occurred and open opportunities for referring women to supportive community-based shelters and counseling services. These are some of the positive aspects of biomedical approaches to utilizing social and behavioral knowledge. But if we are not careful about how we think, such "improvements" can obscure the likelihood of seeing the social roots of such problems—in gender rules and roles and in social inequities that strain interpersonal relations and undermine human civility.

Mind-Body Models

Emerging mind-body models start with the assumption that the mind and body interact in complex ways.[9] Because these approaches are so varied, characterizing them is problematic. Overall, these models all challenge the dualism of allopathic medicine, which separates mental/emotional states from physical symptoms. Some do this through links with traditional nonwestern healing systems and include spiritual as well as psychological precepts. A few explicitly link these models with social or feminist perspectives. Christiane Northrup, former president of the American Holistic Medical Association, attempts to do this.[10] In her view, "Since Everywoman's problem occurs in part because of the nature of being female in this culture, which programs us to put the needs of others ahead of our own, we need to make radical changes in our minds and lives to get and stay healthy" (Northrup 1994:xxv). Northrup lays out a forceful argument that surgery, drugs, and even good nutrition and health practices are not enough to promote healing. The emotional matters that brought about the physical symptoms must be resolved for real healing to occur.

Mind-body precepts pose a double-edged sword for many women. The assumption of and focus on psychogenesis, the psychological causes of physical disease, have been used in the past against women by physicians. To the extent that women's health problems have been viewed as psychogenic, inaccurately portrayed as "all in the head," most physicians have viewed them as unworthy of scientific investigation or clinical attention.[11] The stigma associated with psychogenic disorders has contributed substantially to women's dissatisfaction with conventional medical treatment. If new research in psychoneuroimmunology and other areas scientifically demonstrates how what happens psychologically and emotionally "gets into the physical body," emerging mind-body paradigms may challenge the biomedical paradigm in critical ways that will benefit women. But paradigms are not easily overturned, and mind-body approaches are likely to meet stiff resistance.

Anthropologist Bonnie Blair O'Connor (1995) points out that there are many nonbiomedical health belief systems in the United States, and they are growing in popularity. These range from folk medicine to newer developments in holistic health and healing.[12] Traditional and alternative healing practices also offer competing paradigms. The popular natural health movements have made an impact on conventional medicine.

Some physicians now offer "complementary medicine," and the National Institutes of Health established an Office of Alternative Health (1994).

Social Models of Women's Health

Neither biomedical nor mind-body models adequately address differences and disparities in women's health within or across social groups. Nor is it clear what direction these models provide for preventing health problems that are rooted in social and cultural factors. The primary prevention model itself, taking action to avoid disease, seems particularly ill-suited for reducing many of the physical and emotional conditions that threaten women's health and well-being. For example, trying to prevent the health consequences of violence (injuries, emergency department visits, mental health problems) does not get to the core social, economic, and cultural factors that cause the violence that "causes" injury! Similarly, focusing only on the medical consequences of unwanted pregnancies, drug addiction, and many other conditions ignores both the causes and consequences of larger social, economic, political, and cultural forces.

Physicians themselves increasingly question medicalizing social problems as medical problems (Schwartz 1995). Social and behavioral scientists have long recognized that women's health problems must be understood as socially, culturally, and economically produced. They are not isolated, individual, biological events that can be explained outside the contexts in which they emerge.

At the same time, demedicalizing health problems carries certain risks. American society is rife with dualistic thinking—medical versus social; responsible versus not responsible; organic versus psychogenic. Raising questions about the nature of health issues raises questions about who will be held responsible for them and who will pay for the medical care that they generate. Tensions over personal responsibility for health are likely to escalate as the social costs of health rise. Living and working conditions, which are changing rapidly (see chapters 6 and 7), will create profound challenges to women's health in the decades to come.

New models must reflect the interconnectedness of working and living conditions, individual health behaviors, and positive biomedical contributions to health and well-being. Such models are needed to develop effective social and public health policy. As a society, we can ill afford to

view women's health predominately as the domain of biomedicine and ignore the social forces that actually create—and destroy—health.

More inclusive visions of women's health (that reflected the WHO perspective) have emerged from consumer-oriented and feminist women's health movements in the 1970s. Groups such as the Boston Women's Health Book Collective, the National Black Women's Health Project, and the National Women's Health Network (see chapter 3) envision health, and solutions to health problems, from social perspectives. Feminist conceptualizations of health, like those of many social and behavioral scientists, typically emphasize the ways in which working and living conditions as well as personal health practices create health. The recent scramble for health care reform (more accurately, medical care insurance reform) diverted attention from more fundamental health issues and entrenched biomedical definitions of health even further into public consciousness.

Uniquely, feminist models place women at the center of the analysis, not at the periphery, and emphasize how gender as well as other social roles and rules affect women's health. Feminist models have not, however, always adequately addressed health issues of women whose life circumstances vary by race, class, or a variety of status characteristics, locations, or identities. Tensions and conflicts have erupted over the centrality of particular medical services and social policies for various groups of women (as we discuss in chapter 3). There have also been significant disagreements over what certain biomedical developments, particularly in the areas of manipulative reproductive technologies and genetics, offer or threaten.[13]

Developing more inclusive models of health requires recognizing and dealing with complexities and differences in women's lives. Educational levels, income, culture, ethnicity, race, and a host of other identities and experiences shape women's health. Living and working conditions themselves are shaped by education, economic trends, housing, and other conditions that produce health and prevent illness. Thus health is created in complex, interactive ways that cannot be reduced to any one dimension.

Despite the actual complexities of health, its contours have been described quite well in simple, understandable terms. In the introduction to the popular health book *Our Bodies, Ourselves*, the Boston Women's Health Book Collective describes health this way: "Though medical care sometimes helps us when we are sick, it does not keep us healthy. To a great extent what makes us healthy or unhealthy is how we are able to live our daily lives—how we eat, how we exercise, how much rest we get, how much stress we live with, how much we use alcohol, cigarettes, or

drugs, how safe or hazardous our workplaces are, whether we experience the threat or reality of sexual violence" (1992:13).

Feminist conceptualizations of women's health such as this one clearly link the source of health to communities, where food, housing, education, and environmental hazards—the prerequisites to health—are located. Feminist thinking about health also laid important groundwork for expanding the WHO concepts of what produces health. In communities, women not only need to be free from the fear of war but from all forms of violence. American society must come to terms with this prerequisite to health, or all of the breast cancers "caught early," the chronic diseases avoided through positive health practices, and the benefits of new technologies will be undermined and overshadowed. The specter of women being screened annually for a multitude of diseases but remaining fearful of leaving their homes—or perhaps worse yet, fearing to remain in them—raises uncomfortable questions about how narrowly women's health is often defined.

Crafting More Inclusive Models

In carefully crafted inclusive models of women's health, the health of men, children, parents, and life partners would take on particular importance. Extending the analysis of health to include significant others in women's lives in no way dilutes the importance of women's health in its own right. Rather, it underscores the importance of gender in the production and maintenance of women's health. Women from all walks of life emphasize the need to be free from the fear of violence, in all its many sociocultural forms—including violence among men who are women's kin. Addressing violence against women outside the context of male as well as female gender expectations and opportunities is unimaginable. So is the issue of equality of opportunity, a looming challenge for an increasingly divided society. How can the social forces of caring be mobilized—to create health for wider communities, not only for ourselves in personal spheres?

The challenge is to craft inclusive models of health that can mobilize social forces for caring, curing, and concern in new ways to contribute to women's health both as individuals and as members of communities, in their social relations as well as in their bodies. By arguing that women's health resides in communities, we open up new questions about how to balance resources for biomedicine, for promoting individual health practices, and for improving working and living conditions.

As a society, Americans face difficult choices about how to allocate resources to improve women's health. Grafting psychosocial factors onto biomedical models may lead to incremental improvements in primary prevention, screening, and treatment, but these are not adequate substitutes for providing the prerequisites for health. Nor does such grafting even begin to address women's differences and the complexities of meeting their health needs. Women's needs also shift and change as demographic trends in immigration, internal migration, marriage and divorce patterns, and fertility all interact with underlying economic forces.

Troubling social trends make it imperative to develop more inclusive models to guide policymaking, research, clinical practice, and individual behavior. How we think about health shapes cultural beliefs about what women "need" to maintain or improve their health. Currently, biomedical models support excessive investments in medical services without consideration of the underlying social forces that generate health and well-being. As the American economy merges with global economies,[14] excess medical care costs reduce job creation and provide incentives to hire part-time or temporary workers instead of permanent employees who have traditionally received medical benefits from their employers. The stakes are high because jobs are essential for maintaining the prerequisites for health as well as gaining access to medical services. Without creating and maintaining social relationships and institutions that actually produce health, including economically and culturally viable communities in cities as well as suburbs and exurbs, efforts to reduce the burdens of disease and the costs of biomedicine will remain unrealized.

The need for critical thinking about women's health grows daily. Overinvestment in biomedicine, particularly those elements that contribute little to actual improved health outcomes, consumes resources that could be used to extend useful medical care to everyone. Social commitments to education, preserving the environment, spurring economic development, creating safe living and working conditions, and finding new ways to support families and communities are central to an inclusive vision of women's health. Important relational concepts such as caring deserve more recognition. Few research resources are available for studying how caring facilitates health and healing. Caring is not easily measured by checklists of "caring behaviors" or "social supports." These indicators hint at, but miss, the essential experiential aspects of caring or feeling cared for, not only when people are sick but as part of human growth and development. The subjective, experiential dimensions of

health and healing, addressed in the qualitative social sciences, in some areas of nursing, and in emerging mind-body paradigms deserve greater attention. So do alternative healing practices and the contributions of a much wider array of healers and helpers than are generally acknowledged under the rubric of "health care workers."

There are no easy recipes or simple formulas for moving beyond narrow biomedical models. A necessary first step is to expand our conceptual and empirical understanding of what actually creates women's health. Collaboration between diverse groups will be needed to enlarge public understanding of how social forces, not just pathogens and biological matter, contribute to women's health. Expanding conceptual and empirical understanding of what actually creates women's health is a daunting task, but if women do not undertake this endeavor, who will?

NOTES

1. This definition first appeared in the 1948 Constitution of the World Health Organization, Geneva. It is reprinted in WHO documents and is widely used throughout the world (see, e.g., Downie, Fyfe, and Tannahill 1990). The WHO is organized into regions, with the United States and Canada falling in the Americas. WHO activities in this region are coordinated under the Pan American Health Organization (PAHO). In practice, PAHO efforts focus heavily on health and development issues in Latin America. The United States and Canada share many health issues with the developed region of Europe and participate in some activities of the WHO Regional Office for Europe. Canada's health policies and medical care systems have developed in the directions set out by the WHO, whereas this has not been the case in the United States. Milio (1989) provides an excellent overview of Canadian health policies. Under the leadership of Ilona Kickbusch, WHO has focused on broad issues in women's health. For a recent example of European perspectives on women's health in WHO, see the "Vienna Statement on Investing in Women's Health in the Countries of Central and Eastern Europe" (1994).

2. Travis (1988) provides an extensive review of biopsychosocial models of women's health.

3. Recent extensive critiques of dominant biomedical models in relation to women include the works of Fee and Krieger (1994), who focus on lack of attention to social class particularly, and Rosser (1994), who focuses on the androcentric bias and denial of diversity in clinical medicine. Rose (1994) takes up the issue of why the sciences have not adequately addressed the needs of women and how that might be changed. Marmor, Barer, and Evans (1994) provide an excellent overview of how U.S. health policy has ignored the centrality of social factors as determinants of health.

4. Our thinking continues to evolve as we struggle with how to present these

issues. Our previous efforts to specify the key elements of feminist perspectives on women's health have appeared in Lewin and Olesen (1985), Ruzek and Hill (1986), and Ruzek (1986, 1993). These ideas have also informed the direction of the courses developed through the Women, Health, and Healing Program.

5. These are described in detail and analyzed by Downie, Fyfe, and Tannahill (1990:62).

6. For example, this definition was adopted 16 September 1994 by the National Academy for Women's Health Medical Education (NAWHME), a joint program of the Medical College of Pennsylvania and the American Medical Women's Association.

7. For a discussion of the metaphors used recently in medicine see Annas (1995).

8. Annas (1995) argues that these mixed metaphors of the medical care world confuse matters and were a factor in the demise of national health reform.

9. The ideas of mind-body medicine are spreading rapidly through the work of clinicians who write for educated lay as well as health professional readers. References to the scientific studies (from widely ranging disciplines) on which their ideas are based are well documented in these works. See also the work on consciousness, spirituality, and medicine by Shealy and Myss (1987). Deepak Chopra (1990, 1994), executive director of the Institute of Mind-Body Medicine and Human Potential, Sharp HealthCare, San Diego, has popularized key mind-body concepts. Proponents of mind-body perspectives also attempt to move the ideas that are particularly well supported by scientific evidence into mainstream medicine. See also the American Holistic Medical Association (1990). Also along these lines, the Society of Behavioral Medicine has launched *Mind/Body Medicine, A Journal of Clinical Behavioral Medicine* under the editorship of Richard Friedman and Herbert Benson and an editorial board of distinguished scholars and clinicians. Western scientific methods may not be fully appropriate for researching some of the central features of these paradigms (i.e., intuitive and spiritual dimensions of health caring and healing).

10. The emerging mind-body paradigms, as they relate to women, are found in the work of Christiane Northrup (1994), who includes an extensive directory of resources ranging from scholarly and popular publications to organizations, products, and practitioners who specifically address women's energy systems and their relationships with psychological issues relating to reproductive organs in particular. Northrup's perspectives build on the feminist psychological perspectives of Anne Wilson Schaef (1992) and proponents of the natural or alternative health and healing practices.

11. Increasingly, physicians recognize that women with breast cancer have better outcomes if they receive support from other women. Efforts to provide group psychological counseling to improve recovery may accelerate given that some research shows that women who perceive themselves as having high-quality emotional support even have an enhanced immune response (Levy et al. 1990). Northrup (1994:288–89) finds considerable evidence of psychological associations between breast cancer and emotional factors in the development of disease. She emphasizes that looking for psychogenic factors in cancer should not be misinterpreted as blaming women for "bringing it on themselves."

12. There is growing interest in African American folk healing: see, for example, Fontenot (1993) and Snow (1993). Interest in herbal and natural health increased as concerns over conventional medicine increased (Weiss 1984).

13. For discussions of these controversies, see especially Lasker and Borg (1994), Rothenberg and Thomson (1994), Rothman (1989), and Stephens and Wagner (1993).

14. For easily accessible views of the changes that the American economy (and society) are going through, see especially the work of Graef (1992), Harrison (1994), Schwartz and Volgy (1992), Sklar (1995), and Toffler and Toffler (1994).

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[2]

Patterns and Puzzles:
The Distribution of Health and Illness among Women in the United States

DEBORAH L. WINGARD

Deborah Wingard takes an epidemiological approach to describing health and illness among women in the United States. Here she focuses on variations in mortality, morbidity, fertility, and life expectancy among women from different racial/ethnic groups and age groups. Wingard emphasizes that there is considerable variation in women's health status within as well as between racial/ethnic groups. By studying "patterns and puzzles" in these variations, the complex relationships among social, behavioral, cultural, economic, and biological factors that are associated with women's health and longevity may become better understood.

Women's health is not constant but varies tremendously among socioeconomic and racial/ethnic groups. Women's health also varies by age, geographic area, and time and differs substantially from men's health. To understand this diversity and work toward social equity in health, we must accurately assess these variations and then focus research on reasons for social, racial, and gender differences in health.

Most research to date has focused on white men, reflecting the fact that this research occurred primarily in countries where the most common racial group was Caucasian and where on average men died at a younger age than women. It had also been assumed by most researchers that the process of disease causation and progression was largely the same in men as in women and did not differ by racial/ethnic status. We now know that risk of disease and progression of disease vary by gender and racial status. By studying variations in health by gender and race, we may gain insights into the complex relationships between biological, behavioral, and social factors that influence health and longevity.

In this chapter, I provide an overview of variations in women's health