CHAPTER 11

Psychology, Gender, and Health

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An important component of the feminist movement has been the women’s health movement. The basis for the women’s health movement has been a belief that when women know more about their bodies, they are empowered by that knowledge and can make well-informed health choices. One of the best books to come out of that movement is Our Bodies, Ourselves, written and regularly updated by the Boston Women’s Health Book Collective (1972, 2011).

In this chapter we discuss some of the health topics that are specific to women. These include the menstrual cycle and reproductive health topics such as contraception,

1 This chapter focuses on physical health, and we use women throughout to refer to people with any combination of the following organs: a uterus, vagina, clitoris, and so on. Here, women is not used to refer to people’s gender identity. Thus, this chapter generally focuses on the health of cisgender women, a subset of transgender men who have female organs, nonbinary individuals who were assigned a female gender at birth, and a subset of transgender women who have sought medical or surgical transition.

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pregnancy, childbirth, abortion, miscarriage, and infertility, as well as breast cancer and cervical cancer. We also review several health topics that are specific to transgender people, such as pubertal suppression and gender-affirming surgery. We give brief information on the physical and medical aspects of each of these topics and concentrate on the relevant psychological research that has been conducted. Ideally, we would also include research on health topics for nonbinary people, such as those who identify as genderqueer. However, almost no research has been conducted with these individuals. Of course, some nonbinary people were assigned a female gender at birth and may have a vagina, uterus, or other female reproductive organs. In certain cases, it may be possible to generalize very cautiously from some research on individuals with female reproductive organs (e.g., cisgender women), but not always. It is important that the experiences of nonbinary people be included in medical and psychological research.

First, let’s review the overall statistics on gender and health and how women and transgender persons fare in the health care system.

**Gender and Health**

**Women and the Health Care System**

Feminists have long been critical of the treatment of women in the health care system (Landrine & Klonoff, 2001; Travis, 1988a, 1993; Travis & Compton, 2001). Among those criticisms are the following:

1. The physician–patient relationship reflects the subordinate status of women in society, with the physician (usually male) having power and control over the female patient.
2. Historically, the medical profession actively discriminated against women as practitioners (Walsh, 1977). And while women now earn 48% of MD degrees (Association of American Medical Colleges, 2011), they still often receive their medical training in an atmosphere that is hostile to women. The status of nurses (over 90% of whom are women) in relation to physicians also reflects the higher status of male-dominated professions and the lower status of female-dominated professions (World Health Organization, 2011). Moreover, among academic physicians, women are paid less than men, even after taking age, experience, specialty, rank, and research funding and productivity into account (Jena et al., 2016). Yet a recent analysis indicates that mortality and hospital readmission rates are lower for elderly hospitalized patients with female physicians (Tsugawa et al., 2017).
3. Medical care offered to women is often inadequate, irresponsible, or uncaring. As many as 70% of hysterectomies (surgical removal of the uterus) are unnecessary (Broder et al., 2000). Women are 55% more likely than men to receive a prescription for an anti-anxiety drug or an antidepressant during an office visit with a physician (Simoni-Wastila, 1998; Svarstad et al., 1987), leading some to conclude that women’s physical health problems are likely to be misdiagnosed as psychological.
4. Medical research conducted on women is often irresponsible or simply missing. For example, far more contraceptives have been developed for women
than for men, and thus the health risks associated with them have been borne disproportionately by women. One notorious example is the Dalkon Shield, an intrauterine device (IUD) that was withdrawn from the market after 17 women died of pelvic inflammatory disease directly traceable to the IUD (Travis, 1988a). Class and ethnicity are also factors relating to irresponsible medical research. For example, the initial field trials for the birth control pill, whose risk was unknown at the time, were conducted among poor women in Puerto Rico. Yet women often have not been included in clinical trials of drugs or other medical interventions, and even when they have been, gender has not been analyzed, so it is impossible to tell whether the drug is as effective in women as it is in men (Harris & Douglas, 2000; Melloni et al., 2010).

Regarding the last point, these problems with clinical trials were documented in a scathing 1992 report by the U.S. government’s General Accounting Office. A number of women in Congress successfully introduced legislation, passed in 1993, requiring that clinical trials involving a disease found in both women and men be carried out in a way that allows the researchers to determine whether the treatment affects women or members of ethnic minority groups differently from others. Efforts such as this demonstrate how the women’s health movement has fostered tremendous changes in health care policy (Helmuth, 2000).

Transgender Persons and the Health Care System

An important issue in gender and health is the treatment of transgender persons in the health care system. Transgender women and men have unique health needs, many of which can be complicated by their experience of marginalization, prejudice, and discrimination. The following are some of the issues regarding the treatment of transgender persons in the health care system:

1. Research on transgender health issues is limited (Strousma, 2014). Large-scale studies that assess the risk for particular diseases or clinical trials of treatments within the transgender population remain scarce. In particular, there is a serious need for evidence-based research on pubertal suppression (see Chapter 7) and gender-affirming therapies for transgender persons, including hormonal therapy and surgical therapy. Research on transgender health is necessary so that transgender persons can make informed choices about their health care in consultation with their health care providers.

2. Of the existing medical research, transgender persons are often objectified and/or misgendered (Strousma, 2014). In particular, medical research has long prioritized gender assigned at birth.
3. Structural factors—such as poverty, incarceration, and gaps in insurance coverage—limit access to health care for multiply marginalized groups. For example, many insurance plans do not cover expensive gender-affirming therapies, and transgender persons who are also low-income, incarcerated, or people of color are especially likely to lack access to affordable and adequate health care. Indeed, a large-scale national survey of transgender persons’ health needs, funded by the Network for LGBT Health Equity, found that 19% of respondents lacked insurance coverage (Grant et al., 2011).

4. Discrimination and prejudice create barriers to health care for many transgender persons. The Network for LGBT Health Equity study found that 19% of respondents reported that they’d been denied health care because of their gender identity and that 28% had experienced verbal harassment in a medical setting (Grant et al., 2011).

5. Access to gender-affirming therapy is limited by the shortage of medical doctors who are knowledgeable about and comfortable providing care to transgender persons. One national survey found that nearly two-thirds of transgender persons reported that their doctors were unaware of transgender health needs. Currently, most medical school curricula do not address transgender health issues (Obedin-Maliver et al., 2011).

For the health needs of transgender persons to be treated appropriately and sensitively, these concerns will need to be addressed. The trans activist movement has fueled many recent changes in health care policy, some of which were written into the Affordable Care Act—often referred to as Obamacare—which was signed into law by President Barack Obama in 2010. For example, the health care law prohibits discrimination against LGBT patients.

Health Issues at the Intersection of Gender, Ethnicity, and Class

Feminist theory and intersectionality emphasize the importance not only of gender, but of ethnicity and social class as well. That principle is important as we consider the health care system.

Around the world, being born female is dangerous to your health, especially if you are also poor. For example, although pregnancy and childbirth are relatively safe in the United States—only 1 woman in 3,700 dies from them—an African woman’s chance of dying from pregnancy or childbirth is 1 in 16 and an Asian woman’s is 1 in 65. Many of these deaths are due to poverty and lack of access to medical care. Malnutrition is a major factor in pregnancy-related deaths and many other conditions as well. In many areas, when food is scarce, men and boys receive the best and the most.

In the United States, boys and men have a higher death rate than girls and women at every age, from conception to old age. More male than female fetuses are conceived, yet more male fetuses also die before birth. At age 100, women outnumber men by a 5:1 ratio. A baby born in the United States today is expected to live approximately 79 years (Arias et al., 2017). However, life expectancy varies considerably at the intersection of gender and race/ethnicity. For example, the average life expectancy is approximately 81 years for White women and 77 years for White men, but 78 years for Black women and 72 years for Black men.

Data on the 10 leading causes of death for women and men are shown in Table 11.1. You’ll notice striking gender differences as well as gender similarities. Suicide and homicide are more common among men than women, yet heart disease and cancer are the top two causes of death for both women and men in all ethnic groups.
TABLE 11.1  Ten leading causes of death for women and men, by racial/ethnic group (percentage of deaths within each group).

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
</tr>
<tr>
<td>Cancers</td>
<td>21.3</td>
<td>22.5</td>
</tr>
<tr>
<td>Heart disease</td>
<td>22.4</td>
<td>23.2</td>
</tr>
<tr>
<td>Accidents/injuries</td>
<td>4.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td>5.9</td>
<td>6.2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2.2</td>
<td>4.6</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>6.7</td>
<td>3.2</td>
</tr>
<tr>
<td>Alzheimer's disease</td>
<td>5.4</td>
<td>3.1</td>
</tr>
<tr>
<td>Liver diseases</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pneumonia and influenza</td>
<td>2.2</td>
<td>*</td>
</tr>
<tr>
<td>Kidney diseases</td>
<td>1.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Suicide</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Assault (homicide)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Septicemia</td>
<td>1.5</td>
<td>2.3</td>
</tr>
<tr>
<td>Hypertension</td>
<td>*</td>
<td>1.9</td>
</tr>
</tbody>
</table>

* Cause is not in the top 10 for that group.

Source: Data from Kochanek et al. (2016).

Note: The U.S. government continues to categorize by race and Hispanic origin separately, such that Hispanic persons may also identify as belonging to another racial/ethnic group. Data for White and Black persons are for persons of non-Hispanic origin only. Data for American Indian and Asian/Pacific Islander persons include persons of Hispanic and non-Hispanic origins.
Women of color have several special health concerns (Ro, 2002; Travis & Compton, 2001; Walters & Simoni, 2002; Williams, 2002). For example, women of color experience higher rates of infant mortality than White women. This in turn is related to higher rates of low-birth-weight babies among women of color. And this in turn is related to more frequent adolescent childbearing among people of color. That is, adolescent mothers are more likely to have low-birth-weight babies, who have a higher death rate.

Chronic diseases are more prevalent among women of color than among White women. Examples include diabetes, high blood pressure, and heart disease.

Women of color are overrepresented among the poor. We have, then, a combination of sexism, racism, and poverty contributing to reduced access to necessary health care. This in turn creates more health problems for these women. There is an urgent need for equal access to health care.

In addition, research evidence demonstrates another health risk for multiply marginalized women: stereotypes and discrimination. In one study, researchers used Claude Steele’s stereotype threat manipulation (discussed in Chapter 3). African American and White college students were placed in either a stereotype threat condition or a control condition and then worked on some difficult tests (Blascovich et al., 2001). African American students under stereotype threat not only performed worse but also exhibited larger increases in blood pressure compared with White or with African American students not under stereotype threat. And high blood pressure is a major risk factor for heart disease.

In another study, African American and White women were asked to imagine that they had been wrongfully accused of shoplifting in a department store and then to speak in their own defense (Gyll et al., 2001). African American women, but not White women, reacted with elevated blood pressure. Stereotype threat and incidents of discrimination may be chronic, repeated stressors that pose serious risks to one’s health, particularly for women of color and poor women.

**Menstruation**

**Biological Aspects of the Menstrual Cycle**

The average female person is born with about 400,000 **follicles** in her ovaries, each containing an **ovum**. During a menstrual cycle, one egg is released from a follicle, traveling down the fallopian tube for possible fertilization and implantation in the uterus. Figure 11.1 shows a diagram of female reproductive anatomy.

We can separate the menstrual cycle into four phases, each describing the state of the follicle and ovum within that phase (see Figure 11.2). The first phase is the menstrual phase, beginning on day 1. Yet, physiologically speaking, it actually represents the end of the cycle. Next, extending from about day 4 to day 14 is the **follicular phase**. During the follicular phase, a follicle matures and swells. The follicular phase ends when the follicle ruptures and releases the egg; this marks **ovulation** and the beginning of the ovulatory phase. The next phase is the **luteal phase**, during which a group of reddish-yellow cells, called the corpus luteum, forms in the ruptured follicle. Then, the menstrual phase begins again, marked by **menstruation**, when the endometrium (i.e., the inner lining) of the uterus, which had built up in preparation for nourishing a fertilized egg, is sloughed off. The days we provide are approximate, because every person’s menstrual cycle (more specifically, their menstrual and follicular phases) varies in length. In general, if an egg is not fertilized, menstruation begins 14 days after ovulation.
FOCUS 11.1

GENDER AND INFECTIOUS DISEASE

Infectious diseases—such as HIV, diarrheal diseases, influenza and other respiratory diseases, and Ebola—are among the top 10 causes of death worldwide (World Health Organization [WHO], 2017). In lower-income countries, these diseases have especially high and devastating death tolls. So what’s gender got to do with any of this?

Researchers at WHO (2011) provided a detailed framework for analyzing how gender and gender roles impact infectious disease transmission and outcomes. They noted how it is crucial to consider not only biological aspects of gender but also psychological aspects of gender when analyzing gender and infectious disease. For example, biological aspects of gender can influence immune responses (see Chapter 10). Pregnancy is also included here; for example, during the 2009 H1N1 (swine flu) pandemic, pregnant women in their third trimester were especially vulnerable to the disease (WHO, 2009). Psychological aspects of gender can also influence infectious disease transmission and outcomes; these aspects include gender norms and behaviors, gendered division of labor, and gendered access to and control over resources and decisions.

The WHO researchers described how these biological and psychological aspects of gender can influence disease transmission and outcomes at four levels:

1. **Vulnerability to infectious disease.** Gender can affect our risk and vulnerability to specific infectious diseases, particularly through the gendered division of labor. Consider, for example, how women are typically responsible for meal preparation. In lower-income countries, solid fuels (e.g., wood, coal) are often used for cooking, which makes women in those contexts more vulnerable to pneumonia and lower respiratory diseases (WHO, 2006).

2. **Exposure to pathogens.** Gender can influence our exposure to infectious disease. For example, because the female role typically includes caring for sick relatives, women are more often exposed to pathogens. During the 2014–2016 Ebola outbreak in West Africa, women’s traditional roles in caregiving, performing funeral rites, and cross-border trading resulted in more women than men contracting and dying from the disease (Manivannan, 2015).

3. **Response to illness.** Gender can impact how individuals respond to illness, especially in obtaining access to health care. Here, gender inequality has life-or-death consequences. For example, in many parts of the world, sons are more valued than daughters and are thus given better access to health care. One study in India found that parents are more likely to vaccinate boys than girls against diseases such as measles (Corsi et al., 2009). Similarly, gender inequality in household decision-making power extends to health care; 54% of married women in South Asia do not have the ability to make decisions about their own health (UNIFEM, 2009).

4. **Effectiveness of public health interventions.** To be effective, public health interventions must be targeted and communicated in a way that is sensitive to gender. For example, if women are expected to be responsible for carrying out aspects of a public health intervention—such as changes in cleaning the home, preparing food, or caring for children—then public health officials need to communicate directly with those women. In some countries, this may involve taking into account restrictions on women’s access to public spaces as well as their lower literacy rates.

Of course, good science is essential to our understanding of how the biological and psychological aspects of gender apply at each level of analysis. That means we need to collect data and compute statistics on gender and infectious diseases. However, many communities and organizations responsible for such statistics do not take the psychological aspects of gender into account.
These cyclic phases are regulated by hormones that act in a negative feedback loop with one another (Figure 11.3), so the production of a hormone increases to a high level, producing a specific physiological change. The level is then reduced through the negative feedback loop. Here we are concerned with two basic groups of hormones—those
produced by the ovaries, most importantly estrogen and progesterone, and those produced by the pituitary gland, most importantly follicle-stimulating hormone (FSH) and luteinizing hormone (LH). We also need to consider regulation of the pituitary by the hypothalamus, an important region of the brain on its lower side (Figure 11.3), by gonadotropin-releasing hormone (Gn-RH). The overall pattern of the negative feedback loop is that the activity of the ovary, including its production of estrogen and progesterone, is regulated by the pituitary, which in turn is regulated by the hypothalamus, which is sensitive to the levels of estrogen produced by the ovaries.

The regulation of the menstrual cycle involves interactions among the levels of these hormones. The pituitary secretes FSH, which signals the ovaries to increase production of follicles, which then secrete estrogen and progesterone, in turn regulating FSH and LH levels.

**FIGURE 11.3** Schematic diagram illustrating the negative feedback loops controlling hormone levels during the menstrual cycle. FSH and LH are produced by the pituitary gland and influence production of estrogen and progesterone in the ovaries. The hypothalamus is sensitive to levels of these hormones and, in turn, regulates levels of FSH and LH.

**Source:** Based on Belliveau & Richter (1970). Figure created by Janet Hyde.

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**Follicle-stimulating hormone (FSH):** A hormone secreted by the pituitary that stimulates follicle and egg development.

**Luteinizing hormone (LH):** A hormone secreted by the pituitary that triggers ovulation.

**Gonadotropin-releasing hormone (Gn-RH):** A hormone secreted by the hypothalamus that regulates the pituitary's secretion of hormones.
of estrogen and to bring several follicles to maturity, thus initiating the follicular phase. The resulting high level of estrogen, through the feedback loop, signals the pituitary to decrease production of FSH and to begin production of LH, whose chief function is to trigger ovulation. Temporarily, FSH and LH induce even more estrogen production, which further lowers the amount of FSH. At this point the level of LH spikes, causing the follicle to rupture and release the egg. The corpus luteum then forms in the ruptured follicle. The corpus luteum is a major source of progesterone. When progesterone levels are sufficiently high, they will, through the negative feedback loop, inhibit production of LH and simultaneously stimulate the production of FSH, beginning the cycle over again.

Estrogen has a number of functions and effects in the body. It maintains the lining of the vagina and uterus and provides the initial stimulation for breast growth. Its nonreproductive functions include increasing water content and thickness of skin and slowing growth rate. At the beginning and the end of the menstrual cycle, estrogen is at a low level. In between these two times, it reaches two peaks, one immediately prior to and during ovulation, the other in the middle of the luteal phase (Figure 11.2).

Progesterone is especially important in preparing the uterus for implantation of the fertilized ovum and maintaining pregnancy. Because the corpus luteum is a major source of progesterone, progesterone level peaks during the luteal phase and is otherwise low.

Dysmenorrhea

Painful cramps during menstruation are called dysmenorrhea. Some women get menstrual cramps regularly, some women get them some of the time, and some women don’t get them at all. For those who do experience dysmenorrhea, the menstrual phase can be a challenging time. It is very difficult for a person who does not experience severe dysmenorrhea to understand precisely how it feels to those who do experience it. Traditional medical remedies have not been completely successful in treating the problem. Over-the-counter drugs such as Midol help some people some of the time, but they do not help everyone. For some, healthy habits—such as adequate sleep, exercise, and a healthy diet—and managing stress may be helpful in limiting the pain.

Menstrual cramps are caused by prostaglandins, hormone-like substances produced by many tissues of the body, including the lining of the uterus (Deligeoroglou, 2000). Prostaglandins cause smooth muscle to contract and can affect the size of blood vessels. Women with severe menstrual pain have unusually high levels of prostaglandins. The high levels cause intense and painful uterine contractions; these contractions in turn choke off some of the uterus’s supply of oxygen-carrying blood, which only increases the pain. Prostaglandins may also cause greater sensitivity in nerve endings. The combination of the uterine contractions, lack of oxygen, and heightened nerve sensitivity produces cramps.

As a result of this analysis of the causes of cramps, antiprostaglandin drugs are now used in treatment. The drug is mefanamic acid and is sold under brand names such as Ponstel. Other, similar drugs are Motrin, Naprosyn, and Anaprox.

Psychological Aspects of the Menstrual Cycle

The perception that girls and women experience personality or mood changes depending on the phase of their menstrual cycle is common. Yet, do empirical data support this notion? Here we will examine the evidence on the nature and extent of these moods and
behavior shifts and their relationship to the hormone cycles occurring during the menstrual cycle.

One approach to this question is to ask women to report retrospectively their symptoms and moods at various phases of the cycle. Unfortunately, such studies are largely useless because retrospective accounts, particularly of such subjective phenomena as moods in relation to one’s menstrual cycle, are notoriously unreliable and have not been demonstrated to correlate with other indicators of premenstrual symptoms (Haywood et al., 2002; Marván & Cortés-Iniestra, 2001).

Another approach is to ask women to complete daily diaries throughout the cycle. Ideally, this is done across several menstrual cycles in a diverse sample of women. For example, one well-designed study followed a random sample of Canadian women between the ages of 18 and 40 for 6 months (e.g., Romans et al., 2013; Romans et al., 2017). Participants were given smartphones and completed surveys on their moods, health, stress, and social support at the same time each day. The researchers also asked the women each day if they had gotten their period, and then determined women’s menstrual phases based on that information. The results showed that fluctuations in some of the women’s moods (e.g., sadness, irritability) were greater during the menstrual and premenstrual phases than during midcycle. Yet these effects were very small. By contrast, women’s reports of stress, health, and social support had much larger correlations with their mood fluctuations. And while women’s reports of feeling like they wanted to cry were higher during the premenstrual and menstrual phases, there were no differences in actual crying. In sum, the results of the research suggest that there are small fluctuations in mood corresponding to the phases of the menstrual cycle, at least in some women, but that factors such as stress, health, and social support are more important.

Might these mood changes somehow be linked to changes in hormone levels occurring during the menstrual cycle? For example, it seems that high levels of estrogen (at ovulation) might be associated with positive moods, but low levels of estrogen and progesterone premenstrually might be associated with negative moods. Yet, this conclusion has long been criticized on a number of counts (Hardie, 1997; Parlee, 1973; Stanton et al., 2002). First, virtually all of the data (with some exceptions discussed below) presented to support this conclusion are correlational; correlation does not imply causation. In other words, the data simply demonstrate a correlation between cycle phase or hormone levels and mood, but they cannot tell us that hormones actually cause or influence mood. Indeed, we could just as easily conclude from these data that the direction of causality is the reverse—that psychological factors affect hormone levels and menstrual cycle phase.

One approach in responding to the issue about correlational data involves examining how oral contraceptives—which involve altering the monthly cycles of estrogen and/or progesterone—might shape the links between moods and menstrual phase. Oral contraceptives may be monophasic (pills that provide a steady high dose of both estrogen and progestin, a synthetic progesterone, for 20 or 21 days) or triphasic (pills that provide 15 days of estrogen, followed by 5 days of estrogen-progestin, similar to the natural cycle, but at higher levels). A review of such studies found that women taking triphasic pills show the same kinds of mood changes as women not taking any oral contraceptives (Oinonen & Mazmanian, 2001). Because triphasic pills produce an artificial hormone cycle that parallels the natural one, these findings suggest that monthly hormone fluctuations may be linked to mood fluctuations. Moreover, monophasic pill women tend to show greater mood stability compared with triphasic pill and nonpill women. Therefore, it appears that the steady high level of both hormones leads to a steady level of mood.
A second criticism of this area of research is that the term premenstrual syndrome (PMS) is poorly defined. For example, the range of symptoms is broad, including a variety of physical, psychological, and behavioral features. In addition, which days of the cycle count as “premenstrual”? It would be worthwhile to know what proportion of women experience premenstrual symptoms, but because the concept is so poorly defined, estimates of this proportion vary from 25% to 80% (Stanton et al., 2002). In view of the vagueness of the definition, it is not surprising that these estimates are not consistent, and until the “syndrome” is more clearly defined, we can have no really accurate estimate of its incidence. At least from these data it seems fair to conclude that premenstrual syndrome is far from universal among women.

A third problem with this area of research has to do with participants’ expectations. Many women are socialized by various forces (e.g., menstrual drug ads) to expect to feel more negative feelings premenstrually. In turn, those expectations may shape how women perceive or attribute their moods (Romans et al., 2017).

A subtle problem of interpretation exists in menstrual cycle research. A typical conclusion is that symptoms increase or that mood is negative premenstrually. Perhaps, however, the premenstrual state is the usual one, and what occurs is really a decrease in symptoms, or a positive mood shift, at ovulation. This is essentially a problem of establishing a baseline of behavior—and what should that be? Should it be the average for men? Or are men irrelevant to this research? These are complex questions.

Also noteworthy are the tremendous cultural influences on menstrual cycle mood shifts (Wood et al., 1996). In many societies and religions, a menstruating woman is seen as unclean, and many taboos arise to prevent her uncleanness from spreading to others (Golub, 1992). For example, she may not be permitted to cook while menstruating, or she may even be isolated from the rest of the community in a separate hut outside the village. Such superstitions become subtler in modern America, but they still persist. For example, many women abstain from sexual activity during their periods. There is also considerable evidence of cultural influences on menstrual distress. An analysis of over 200 advertisements for menstrual products in popular women’s magazines indicated that the common theme was heightening insecurities (Simes & Berg, 2001). The ads talk about the possibility of “accidents,” embarrassment, “getting caught” having your period (i.e., others find out), feeling dirty or unclean, and odor. Drug ads, of course, emphasize pain and their products’ ability to relieve PMS. The sign over the aisle in Walgreen’s calls them “feminine hygiene” products—“hygiene” meaning practices such as cleanliness that preserve health. If a menstruating woman has to use hygiene products, she must be unclean. Is all this so different from the menstrual hut?

Just as feminist approaches to science often highlight alternative interpretations of phenomena, the perspectives of different ethnic groups can suggest new interpretations. For example, many American Indian women believe that menstruation is a time of centering and balancing oneself (Hernandez, 1990). The menstrual flow out of the body washes away impurities and the negative things that have occurred during the month. Reflecting their close connection to nature, American Indian women refer to the menstrual period as being “on the moon,” which is considered a positive time.
The Social Construction of PMS

The diversity of women’s premenstrual experiences across cultures and history supports a feminist interpretation that premenstrual syndrome is socially constructed. As we discussed in Chapter 6, the expression of emotions is carefully regulated by gendered display rules. For most emotions—love, sadness—it is far more acceptable for women to express them than for men. Anger is an exception. The expression of anger by men is tolerated; it is not for women. The expression of anger by women is socially unacceptable in large part because it interferes with the performance of their gender role, which requires nurturance and emotional support to others. Nonetheless, many women have plenty to be angry about—lower status jobs, unequal pay for equal work, and gender-based violence, for example.

So, while many women feel angry or irritable, expressing or even feeling these emotions is a serious deviation from social norms. This creates the need for a socially acceptable explanation for their emotions. Enter PMS.

From a psychological or social constructionist point of view, PMS can be seen as an attribution for particular emotions (attributions for emotions were discussed in Chapter 6). A woman experiences or expresses a particular emotion. To what does she attribute it? If the emotion is a socially unacceptable one, such as anger or irritability, she and others seek a socially acceptable attribution, and society makes PMS a readily available attribution. Magically, she isn’t really angry; she is just in that temporary state of insanity, PMS. With a single stroke of attribution, her emotion no longer violates social norms, but at the same time, any real feelings of true anger she may have, perhaps toward her husband or her boss, are also brushed away. So, while her anger becomes temporarily acceptable, it remains impotent and ineffectual.

Practical Implications

In assessing the practical implications of research on mood shift and menstrual phase, some important considerations should be kept in mind. First, the magnitude of the mood shift depends on the individual woman. Certainly in practical situations, the magnitude of the mood shift is most significant. For instance, it is much more essential to know that a particular woman experiences mood shifts so small as to be unnoticeable in her work and interpersonal relations than it is to know that she experiences slight mood shifts detectable only by sensitive psychological tests. Hence the most important characteristics are individual ones, just as they are for men.

Second, in making practical decisions about hiring people, performance is certainly more crucial than mood. Research on performance—such as intellectual or athletic performance—generally shows no fluctuations over the cycle (Golub, 1992; Stanton et al., 2002). Research has found no fluctuations in academic performance, problem solving, memory, or creative thinking (Golub, 1992). Thus there is no evidence of cycle fluctuations in the kinds of performance that are important on the job.

In one particularly interesting study, female pilots were tested in a flight simulator to assess their performance in the mid-luteal and menstrual phases (Mumenthaler et al., 2001). The results indicated no significant difference between performance in the two phases and no significant correlation between performance and estradiol (an estrogen) or progesterone levels. The flying public should be happy to know about this one.

There’s one exception to this pattern, however. Some studies have found menstrual cycle fluctuations in three-dimensional spatial ability (Hausmann et al., 2000; McCormick & Teillon, 2000; see Chapter 8 for more on spatial abilities). Spatial test
performance is highest during menstruation, when estradiol and progesterone levels are low. Interestingly, spatial performance is positively correlated with women’s testosterone levels and negatively correlated with their estradiol levels (Hausmann et al., 2000). In addition, one study found that women’s spatial scores during the menstrual phase did not differ significantly from men’s (McCormick & Teillon, 2001).

In summary, the research suggests that menstrual cycle changes in hormone levels are linked to mood fluctuations in at least some women. Women show substantial variability in these menstrual cycle–mood relationships (Kiesner, 2011). Importantly, there is no evidence of fluctuation in performance. The existing research has many problems: Most of it is correlational in nature, and expectations complicate interpretations. Cultural factors may also contribute to mood shifts.

**Menopause**

### Physical and Psychological Changes

As women age, their ovaries also age and reduce their production of estrogen. In turn, ovulation and menstruation ceases. After 12 months of amenorrhea (the absence of menstrual periods), a woman is considered to be menopausal. On average, menopause (the cessation of menstruation) begins around age 51. A number of symptoms may occur at this time, including vasomotor symptoms (e.g., “hot flashes,” night sweats), vaginal dryness, and sleep difficulties (Al-Safi & Santoro, 2014).

How common are these symptoms? The Study of Women’s Health Across the Nation studied over 16,000 American women from diverse racial/ethnic groups during the menopausal transition. About 60% to 80% of those women reported experiencing vasomotor symptoms, peaking just before actual menopause (Gold et al., 2006). While vasomotor symptoms are experienced across racial/ethnic groups, the rates are highest among African American women (Gold et al., 2006). In addition, the study found that sleep difficulties occur in nearly 40% of women during the menopausal transition (Kravitz et al., 2003). For most women, these symptoms subside within a few years.

Just as there is a stereotype that the menstrual cycle affects mood, there is a stereotype that menopausal women are depressed and irritable. Yet the evidence indicates that depression incidence is no higher during menopause than at other times in a woman’s life (Avis, 2003). For women who do experience depression during the transition to menopause, vasomotor symptoms and sleep difficulties appear to be responsible (Bromberger et al., 2007; Shifren & Schiff, 2010).

In general, the evidence indicates that menopause does not bring on an avalanche of problems, whether one looks at well-sampled studies of middle-aged women or compares middle-aged women with other age-groups. A few limited symptoms do appear, particularly hot flashes and sleep difficulties.

### Treating Menopausal Symptoms

Some menopausal symptoms appear to be related either to low estrogen levels or to hormonal imbalance. Evidence for this point of view comes from the success of estrogen replacement therapy (ERT, such as Premarin) and hormone replacement therapy (HRT, such as Prempro), which involves both estrogen and progesterone, and possibly testosterone as well. HRT is successful in relieving low-estrogen menopausal symptoms such as hot flashes, night sweats, osteoporosis (brittle bones), vaginal discharges, and vaginal dryness (Shifren & Schiff, 2010; Wright et al., 2002). Osteoporosis increases the risk...
of broken bones, such as hip fractures, which may lead to death. Also, 80% of people with osteoporosis are women (Shifren & Schiff, 2010), so this is a serious women’s health issue.

Yet each woman must weigh the possible benefits of HRT against the dangers. HRT increases the risk for heart disease, breast cancer, and endometrial cancer, particularly for older women or after extended use (Chen et al., 2002; Shifren & Schiff, 2010; Wright et al., 2002).

In a startling move in 2002, the National Institutes of Health (NIH) stopped a clinical trial of the HRT drug Prempro with menopausal women (Enserink, 2002). The NIH did not stop the other treatment group in the study, who were taking ERT only. The reason for the dramatic action was that women in the HRT group had a higher incidence of heart attack, stroke, breast cancer, and blood clots, compared with the placebo control group. That is, HRT was increasing rather than decreasing the rates of heart attack and stroke.

Does this mean that all women should stop HRT? Not necessarily. The ERT group was doing well, so no concerns were raised about receiving only estrogen. The study was investigating long-term use of HRT and stopped the HRT group at 5 years. Short-term use of HRT for 1 or 2 years is probably safe for most women. Moreover, the increase in risk from HRT might seem small to women who are having serious difficulty with menopausal symptoms. For example, women who become depressed after many months of hot flashes and trouble sleeping show improvements in mood with HRT (Soares et al., 2001).

The picture on ERT and HRT is complex and speaks to the importance of individualized evaluation and treatment for each woman, taking into account her particular pattern of symptoms and how distressed she is by them. Women who are otherwise at risk for heart disease, stroke, or endometrial or breast cancers—for example, women who are overweight or who have a family history of one of these diseases—are generally advised to consider alternatives to HRT (Shifren & Schiff, 2010). In sum, each woman must make this decision for herself, in consultation with her health care provider.

We have a strong cultural bias toward expecting menopausal symptoms. Any quirk in a middle-aged woman’s behavior is attributed to “the change.” It simultaneously becomes the cause of, and explanation for, all the problems and complaints of the middle-aged woman. Given such expectations, it is not surprising that the average person perceives widespread evidence of menopausal symptoms. Ironically, idiosyncrasies in women of childbearing age are blamed on menstruation, whereas problems experienced by women who are past that age are blamed on the lack of it.

Reproduction and Health

Contraception

Detailed information on the various methods of contraception is available elsewhere (e.g., Hyde & DeLamater, 2017). Here our focus is on the psychological aspects of contraceptive use.

Each year in the United States more than 600,000 teenage girls become pregnant. About 2 in 10 White women and about 4 in 10 Black and Latina women become pregnant by age 20. Nearly all of these pregnancies are unintended. Although the rate of unintended pregnancies in the United States is down overall, it is highest among poor women (Finer & Zolna, 2016). Contraception can be prohibitively expensive, around $600 per year for oral contraceptives (i.e., the pill). We will return to this point shortly.

Even though many highly effective contraceptives are available, about 10% of women at risk of unintended pregnancy (i.e., sexually active and not wanting to get pregnant) use no method of contraception (Daniels et al., 2014). Among 15- to 19-year-olds, this proportion is 18% (Jones et al., 2012).
Around the world, contraception is a crucial women’s health issue. When women can plan their pregnancies and space them farther apart, everyone is better off: Infant mortality declines and women’s physical and mental health benefit (Guttmacher Institute, 2011; Sonfield et al., 2013). In addition, some contraceptive methods (e.g., the pill, IUD) have numerous benefits beyond avoiding unintended pregnancy, such as reducing dysmenorrhea, excessive menstrual bleeding, and acne (Jones, 2011).

Unfortunately, millions of women who do not want to become pregnant do not use contraceptives, either because they lack access or because they fear side effects or health risks (Sedgh, Ashford, et al., 2016). Many of these fears are unfounded and stem from a lack of education about contraceptives. Cost can also be an issue. Many contraceptive methods are expensive—especially when added up over many years of use. In the United States, the Affordable Care Act originally required that private health insurance plans cover contraceptives. However, the requirement for contraception coverage was eliminated by President Trump in October 2017.

**Pregnancy**

The 9 months of pregnancy are divided into three trimesters of 3 months each, and each has its own set of physical and psychological developments. In the first trimester, the first issue is finding out that one is pregnant. Home pregnancy tests—which work by detecting human chorionic gonadotropin hormone (hCG) in urine—are widely available and generally accurate if done correctly. They are most accurate if done with undiluted urine and after a period has been missed.

The first trimester is the time of morning sickness (feelings of nausea and sometimes vomiting, which actually occur at any time of day), yet about 25% of women do not experience it. Fatigue is very common at this stage and is often intense. The levels of estrogen and progesterone sharply increase as the developing placenta vigorously produces both hormones. Although cultural myths describe pregnant women as either radiantely happy or exceptionally moody, research in fact shows that pregnancy is a time of neither heightened well-being nor heightened emotional turmoil (Striegel-Moore et al., 1996). Many women, though, feel anxious about miscarriage.

As pregnancy progresses, most women feel an increasing attachment to the developing fetus. They may do much to promote the health of the baby, such as eating well, not smoking, and maintaining a drug-free lifestyle. They also imagine what their baby will be like and spend time preparing for the baby’s arrival. These are all signs of maternal–fetal attachment (Salisbury et al., 2003).

During the second trimester, the woman’s belly begins to expand noticeably. She can also feel the fetus’s movements; this experience of quickening can promote maternal–fetal attachment. Morning sickness has probably disappeared, but the woman may experience edema—water retention and swelling—in areas such as the ankles, feet, and hands. Psychologically, the second trimester tends to be relatively calm, with worries about miscarriage past.

By the third trimester the belly—and the uterus inside it—are large, causing some women to feel awkward or uncomfortable. The expanded uterus puts pressure on the lungs, causing shortness of breath, and on the stomach, causing indigestion.
The physical and psychological changes of pregnancy are strongly influenced by many contextual factors in a woman’s life: whether she wanted to become pregnant; whether she can afford to have a child; whether she can afford adequate, nutritional food for herself prenatally; and whether she has a supportive cohabiting partner or spouse (Zimmerman-Tansella et al., 1994).

A feminist analysis of the experience of pregnancy is captured by one author: “I am not a patient, and I am not a child” (Rudolsdottir, 2000). In the United States and other Western nations, pregnancy has been medicalized. As part of the process of medicalization, the physician is cast as the knowledgeable authority, and the woman may be treated as a child, lacking the knowledge and ability to make good decisions herself.

**Childbirth**

Childbirth, too, has been medicalized, with an emphasis on giving birth in a hospital equipped with fancy instruments and monitors. When one of us (JSH) was born in 1948, her mother had a general anesthetic and missed the whole event. She was kept in the hospital for 2 full weeks afterward—partly because that was typical for the time and partly because she was an “old” mother at age 35.

Since then, women have engaged in resistance against the medicalization. Beginning in the 1960s the Lamaze method of childbirth became popular. It allows women to control the pain of childbirth and to give birth while fully awake, with little or no use of anesthetics. Since then, other approaches to childbirth (e.g., the Bradley method) have emerged. Home births and being under the care of a midwife rather than a physician are also increasingly popular options today as women seek a less medicalized childbirth and more control over their experience. With home birth, rates of obstetrical interventions are lower and rates of vaginal birth are much higher than with hospital birth (Snowden et al., 2015). Planned home births can be a safe option for women and their babies when their risk of complications is low (de Jonge et al., 2015). For the best outcomes, each woman should make the many choices about childbirth methods and setting in consultation with her health care provider.

Every birth is unique and shaped by multiple factors, including the woman’s health, her psychological and emotional resources, the setting, the health care providers and social support that are present, and so on. The goal is to have not just a healthy baby, but also a healthy mother. Each woman needs to discuss her options with her health care provider and have the information to make childbirth choices that are the best fit for her and her baby.

Childbirth occurs in three stages. In the first stage, the cervix must dilate to 10 centimeters. It is important to remember that there is much variability from one birth to the next; just as every woman is unique, so is every birth. Some women may take a few days to dilate the first 2 to 3 centimeters, perhaps feeling nothing, while others may dilate more quickly. Getting from 3 to 10 centimeters is more intense, however, and can often take 8 hours or longer. This happens as uterine contractions are fueled by the release of the hormone oxytocin. At the start of labor, these contractions typically feel like menstrual cramps, until they begin to rise and fall at regular, predictable intervals. The pain of the

*PHOTO 11.4* A doula provides continuous physical, emotional, and informational support to a woman before, during, and shortly after childbirth. Having a doula can improve birth outcomes.

*Cervix:* The lower part of the uterus, forming a passageway to the vagina.
The contractions becomes intense and can be made worse by anxiety and dehydration. For some women, medical pain management is helpful at this stage.

Having a doula present can be helpful with pain management, too, and may help reduce complications (Hodnett et al., 2013). A doula provides continuous physical, emotional, and informational support to a woman before, during, and shortly after childbirth. This might entail providing massage, reassurance, and social support, as well as information about a woman’s options in childbirth. During this physically demanding process, it’s especially important for the woman to feel supported and relaxed, and to stay as hydrated and nourished as possible. A doula typically assists with those needs as well.

The second stage of labor involves the actual delivery of the baby. This can take a few minutes to a couple of hours, depending on a variety of factors, including the position of the mother and the size and position of the baby. After the baby has been born, the third stage—delivery of the placenta—occurs. This usually takes only a few minutes and involves much less effort than the previous two stages.

In the postpartum period, many new mothers may feel overwhelmed by the immense responsibilities of the maternal role; the physical changes of pregnancy, childbirth, and perhaps breastfeeding; and the sudden deprivation of sleep. For women with adequate social support and financial resources to provide care for themselves and their newborn, the stress and anxiety of the postpartum period are lessened. For women who don’t have supportive partners or family members, or who must quickly return to work, the challenges of this transition are exacerbated. While some degree of emotional ups and downs is common at this stage, more severe experiences of irritability, anxiety, and sadness may be symptoms of postpartum depression. Postpartum depression occurs in up to 19% of mothers, and women with a history of depression are at highest risk (O’Hara & McCabe, 2013). The prevalence is higher among lower-income women, who also have reduced access to treatment (Zlotnick et al., 2016). Postpartum depression can interfere with a mother’s ability to care for herself and her newborn and, like depression at any stage in life, can be very dangerous if left untreated.

**Abortion**

In the United States, 42% of unintended pregnancies end in abortion (Finer & Zolna, 2016). Each year, about 56 million abortions are performed worldwide (Sedgh, Bearak, et al., 2016). In the United States, the abortion rate continues to decline; there were 926,200 abortions performed in 2014 (Jones & Jerman, 2017). About three-quarters of the American women who choose abortion are low-income (Jerman et al., 2016). Yet, because federal (and most state) Medicaid funds cannot be used to pay for an abortion, low-income women often struggle to find the cash to pay for an abortion, which is typically around $500 during the first trimester. Here we briefly discuss two methods: surgical abortion and medical abortion (see Hyde & DeLamater, 2017, for a more complete discussion).

The most commonly used abortion method is surgical abortion (more specifically, vacuum aspiration). It is done on an outpatient basis with a local anesthetic. The procedure itself takes only about 10 minutes and the woman stays in the doctor’s office, clinic, or hospital for a few hours. The woman is prepared as she would be for a pelvic exam, and an instrument is inserted into the vagina (Figure 11.4) to open her cervix. Next, a tube is inserted through the cervical opening until one end is in the uterus. The other end is attached to a suction-producing machine, and the contents of the uterus, including the
In a vacuum aspiration abortion, a tube is inserted through the vagina and the cervix into the uterus. The uterine contents are then suctioned out.

Source: Based on Belliveau & Richter (1970). Figure created by Janet Hyde.

Fetal tissue, are sucked out. Vacuum aspiration is a very safe procedure and is safer than pregnancy (Hatcher et al., 2004).

Within the first 10 weeks of pregnancy, a woman may choose a medical abortion. This involves taking a medication (typically, mifepristone). The medication causes the lining of the uterus to be sloughed off. About 31% of abortions in the United States are medical abortions (Jones & Jerman, 2017). Medical abortion can be done at home and is very safe (Ngo et al., 2011).

Women choose abortion for a variety of reasons. The most common reasons reported by women are that they cannot afford financially to have a baby, that it is not the right time to have a baby, and that their partner is not supportive of the pregnancy or that the relationship with their partner is unhealthy (Rocca et al., 2013). In short, women consider multiple aspects of their situation and take the decision seriously.

It is a commonly believed myth that having an abortion is an extremely stressful event that causes mental health problems. Yet this myth has no scientific evidence supporting it. Reviews of research on the psychological outcomes of legal abortion indicate that mental health problems are rare and that, in fact, most women are more distressed before the abortion than after it (Adler et al., 1990, 1992; Adler et al., 2003; Major et al., 2009). One large study found that the risk for psychiatric disorder did not increase in the year following abortion, but did increase following childbirth (Munk-Olsen et al., 2011).
When evaluating the evidence about the psychological consequences of abortion, it is important to disentangle women’s emotions about an abortion from those about an unwanted pregnancy. A well-conducted study of ethnically diverse women obtaining an abortion found that women felt more regret, sadness, and anger about the pregnancy than they did about the abortion (Rocca et al., 2013). Moreover, those women reported feeling more relief and happiness about having an abortion than about having an unwanted pregnancy. Still, a mix of negative and positive emotions was common. Recall that a feminist analysis reminds us to examine the social context of women’s emotions. Among women who had made efforts to avoid getting pregnant (e.g., using contraception), who had difficulty making the decision, or who felt their partner was not supportive of their choice, there were higher levels of negative emotions after the abortion (relative to other women who’d obtained an abortion). Nonetheless, 95% of the women reported feeling that having an abortion was the right choice for them, even if they also felt some negative emotions.

Political bias has fueled abortion myths and plagued the research on women’s post-abortion mental health (Joffe, 2013). The most widespread methodological flaws in abortion research have to do with finding an appropriate comparison group, using valid measurement of psychological outcomes, studying diverse populations of women, and accounting for women’s pre-abortion mental health. A review of the research on the long-term psychological outcomes of abortion found that the poorest quality studies reported the worst outcomes for women, while the highest quality studies reported better outcomes (Charles et al., 2008).

In the United States, many state legislatures have restricted women’s access to legal abortion, such as by requiring waiting periods, mandating that women view fetal ultrasounds or hear fetal heartbeats, and lowering the gestation limit (that is, denying access to legal abortion after a particular point in pregnancy). One analysis found that, in 23 out of 33 states with laws requiring pre-abortion counseling, the laws required conveying medically inaccurate and blatantly false information that, in turn, interfered with women’s ability to give informed consent (Gold & Nash, 2007).

Thus, it is also important to consider the possible consequences of restricting abortion. What are the implications for women who are denied abortion? One study compared women who obtained a legal abortion just before the gestational limit in their state to women who were denied an abortion for seeking one after the limit (Biggs et al., 2017). It found that women who were denied an abortion experienced more mental health problems (such as depression and low self-esteem) initially, but that the two groups were comparable 5 years later.

We should also consider the psychological consequences for children whose mothers sought an abortion but were denied one. In some countries, access to abortion requires obtaining official approval. In Czechoslovakia, for example, researchers followed 220 children born to women who were denied abortion (the study group) and 220 children born to women who had not sought an abortion (David, 1992; David & Matejcek, 1981; David et al., 2003). The researchers followed the children from childhood through adolescence and into early and middle adulthood. By age 14, 43 children from the study group, but only 30 from the control group, had been referred for counseling. Although there were no differences between the groups in measured intelligence, children in the study group did less well in school and were more likely to drop out. At age 16, the boys (but not the girls) in the study group more frequently rated themselves as feeling neglected or rejected by their mothers and felt that their mothers were less satisfied with them. When in their early 20s, the study group reported less job satisfaction, more conflicts...
with coworkers and supervisors, and fewer and less satisfying friendships. Several other studies have found results similar to the Czechoslovakian study (e.g., David et al., 1988). These results point to the serious long-term psychological consequences for children whose mothers would have preferred to have an abortion.

Abortion myths are linked to abortion stigma and the social judgment of women who have abortions. Out of fear of judgment, many women keep their abortions secret (Harris, 2012), which can further fuel the stigma. A review of studies on abortion stigma found that women who had abortions were afraid of social judgment and felt a need for secrecy (Hanschmidt et al., 2016). In turn, keeping their abortion secret was linked to increased psychological distress and social isolation.

In sum, scientific evidence indicates that legal abortion is safe for women. Yet there appear to be long-term negative consequences for children born to women denied access to abortion. Abortion myths and stigma may contribute to restrictions in abortion access and to women’s distress about abortion.

Miscarriage

Much like abortion, miscarriage is common but often kept a secret. Miscarriage refers the spontaneous demise of a fetus before the 20th week of pregnancy; after 20 weeks, this is referred to as a stillbirth. About half of all fertilized eggs die, but most of those miscarriages happen before a woman has missed a period. About 20% of known pregnancies end in miscarriage, most often during the first trimester. Depending on how early in pregnancy the miscarriage occurs, symptoms vary but may include painful cramping and unusually heavy bleeding. In some cases, it may take weeks or require surgical or medical intervention to help the woman’s body pass the fetal tissue. Although many women blame themselves for miscarrying, miscarriage is most often the result of a genetic defect or chromosomal abnormality that prevents the fetus from developing normally. Most women who miscarry go on to carry a healthy pregnancy to term.

Miscarriage is a potentially devastating experience; anxiety, depression, and even posttraumatic stress disorder are common and may last for 6 to 12 months or longer (Lok & Neugebauer, 2007). For many, a miscarriage is experienced as the death of one’s child or a future child (Séjourné et al., 2010). Many women search for deeper meaning in the experience (Nikčević & Nicolaides, 2014). Nonetheless, women’s psychological experiences of miscarriage are diverse and depend on contextual factors, such as whether the pregnancy had been planned or wanted (Shreffler et al., 2011). For women who do not want to be pregnant, a miscarriage may come as a relief.

A review of qualitative research on women’s experiences of miscarriage revealed four major themes (Radford & Hughes, 2015):

1. What I feel. Women described a need for recognition and acknowledgment of their emotions and physical symptoms. Many women reported intense and deep feelings of isolation, loneliness, grief, shock, denial, and bereavement. While others’ expressions of empathy were described as helpful, many women felt abandoned by their health care providers after the miscarriage.

2. Care for me, communicate with me. Women described a need for communication and information about the physical and emotional aspects of miscarriage and what to expect. They reported that the lack of information made them feel helpless and that the situation was out of their control.

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3. *Me, my baby, and others.* A loss of the rights and identity associated with motherhood and a sense of personal failure were described. Women felt that others didn’t respond sensitively to the miscarriage, so they were reluctant to discuss it.

4. *Help me cope with the future.* Women wanted guidance on how to move forward after the loss and reported that the most helpful support came from other women who had miscarried.

In sum, miscarriage is common and yet rarely talked about. It can be a deeply distressing experience for women and may be accompanied by physical trauma. The psychological consequences for some may last many months or even years and depend on women’s social context.

**Infertility**

Having a sense of control over one’s childbearing is important to women. Just as the woman with an unwanted pregnancy may feel distress about the options available to her, a woman who struggles to become pregnant feels distress about her limited options. And just as abortion and miscarriage are rarely talked about openly, infertility is often kept secret. See Chapter 7 for more discussion of infertility.

**Breast Cancer**

About one out of every nine women in the United States has breast cancer at some time in her life; it is the most common form of cancer in this population. While it is rare in women under 25, a woman’s chances of developing it increase every year after that age. Every year, about 41,000 women die of breast cancer in the United States (U.S. Cancer Statistics Working Group, 2016). Although it is extremely rare for men to develop breast cancer, about 450 men die of it each year.

Research on breast cancer among transgender men and women is scarce. The limited available research indicates that, while the occurrence of the disease in transgender people is very rare (Brown, 2015; Brown & Jones, 2015), evidence-based screening guidelines are sorely needed (Pivo et al., 2017). It is unclear how the risk for transgender men and women compares with that of cisgender women. Factors such as hormone therapy (i.e., receiving testosterone or estrogen) may increase risk for both transgender men and women. For transgender men, risk may also depend on whether and how much breast tissue patients have had removed (Pivo et al., 2017). Conducting large-scale studies to estimate breast cancer risk and describe breast cancer experiences among transgender men and women is crucial. Most of the available research has used samples of cisgender women; thus, that research comprises our review.

Given that breast cancer is fairly common, doctors recommend that women should do a breast self-exam monthly. For some transgender men, similar recommendations may...
The U.S. government describes disability as including hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty (e.g., having serious difficulty walking), self-care difficulty, and independent living difficulty. At the intersection of gender and disability, there are considerable persistent inequities.

Over 20 million American women and girls live with a disability (U.S. Census Bureau, 2013). In nearly every racial/ethnic group, women have higher rates of disability (Miles-Cohen & Signore, 2016). Moreover, relative to men with disabilities, their rates of poverty are more severe (Nosek, 2016), which can contribute to and exacerbate health disparities.

Women with disabilities are more likely than nondisabled women to have inequitable and inadequate access to health care, increased prevalence of complications, and diminished quality of life (Miles-Cohen & Signore, 2016). Relative to nondisabled women, women with disabilities have reduced physical activity, higher rates of obesity, higher rates of chronic diseases such as asthma and diabetes, and higher smoking rates (Parish et al., 2016). These are serious health disparities.

In many ways, women with disabilities experience double jeopardy in that they are marginalized because they are both women and persons with disabilities. Similarly, queer or trans women with disabilities or women of color with disabilities may face triple jeopardy. Their experiences as individuals belonging to multiply marginalized groups mean that, in many instances, they face considerable barriers to adequate health care.

Women with disabilities may face architectural barriers to health care, such that health care facilities are not accessible. For example, many women with ambulatory disabilities do not get regular Pap tests (discussed later in this chapter) because examination tables are not accessible to them (Signore, 2016). Women with disabilities may also face attitudinal barriers, including discrimination and stereotyping from health care providers (Saxton, 2016). Doctors and nurses might tell a patient that her health care needs are too excessive and cannot be met. This is illegal; health care providers cannot deny care to someone because they have a disability.

Researchers agree that there are at least two things we need to do to reduce these barriers for women. First, we need to conduct much more research to learn about the health and health care needs of women with disabilities. There is scant research on the health of queer or trans women with disabilities (Tarasoff, 2016) or women of color with disabilities (Correa-de-Araujo, 2016). Second, we need to provide patient-centered, integrated care to women with disabilities. This refers to health care that is characterized by a great deal of collaboration and communication among doctors, nurses, and psychologists.

FOCUS 11.2
HEALTH AT THE INTERSECTION OF GENDER AND DISABILITY

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be appropriate (Pivo et al., 2017). Given that breast tissue changes across the menstrual cycle, premenopausal women should do the breast exam midcycle (not during one’s period). Fear may prevent some people from doing a self-exam or from seeing a doctor immediately when they discover a lump. This is unfortunate because the chances of recovery improve when breast cancer is detected and treated early. Today, the majority of people who get breast cancer will survive it, especially if it is discovered at an early stage.

Most breast lumps are benign. For example, some lumps may be cysts (fluid-filled sacs, also called fibrocystic disease or cystic mastitis) or fibroadenomas. Thus, while the fear of cancer is understandable, it’s important to remember that most lumps are not cancerous.
If breast cancer is diagnosed, what is the best treatment? Most often, some form of mastectomy (i.e., surgical removal of breast tissue) is performed. In radical mastectomy, the most aggressive form of this treatment, the entire breast as well as the lymph nodes and underlying muscles are removed. This method is more likely to be used if the cancer has spread to the muscle and lymph nodes. In modified radical mastectomy, the entire breast and lymph nodes, but not the muscles, are removed. In simple mastectomy, only the breast, and possibly a few lymph nodes, is removed. In partial mastectomy, or lumpectomy, only the lump and some surrounding tissue are removed.

Breast cancer rates, diagnoses, and treatment differ at the intersection of gender, race/ethnicity, and social class. For example, while breast cancer is more common among higher-income women, lower-income women and women of color have higher rates of mortality from it (Harper et al., 2009; Ward et al., 2004). White and higher-income women have greater access to diagnostic tools, such as mammography, which aids in early diagnosis and is key to survival. By contrast, for lower-income women and women of color, who have reduced access to mammography, breast cancer is diagnosed at later stages, resulting in increased mortality. Although clinics like Planned Parenthood provide free or reduced rates for mammography, women in rural communities are often geographically isolated from such facilities.

With regard to the psychological consequences of breast cancer diagnosis and treatment, about 30% to 40% of women report feeling increased depression and anxiety around the time of diagnosis (Compas & Luecken, 2002). It is important to note that there is great variation from one woman to the next. While the majority of studies show good adjustment after mastectomy (Helgeson et al., 2004), lumpectomy is associated with better body image and sexual functioning postsurgery than more radical surgeries (Moyer, 1997).

Many women experience considerable psychological distress during the time from discovery of a lump through diagnosis and treatment. It is important for them and their partners to have counseling available. In many towns, the American Cancer Society organizes support groups for breast cancer patients. Today, support groups are popular for dealing with just about every situation. As psychologists, we must raise this question: Are support groups effective for breast cancer patients? One study compared the effects of peer support groups for women with breast cancer with the effects of educational classes focused on relevant information (Helgeson et al., 2000, 2001). While the peer support groups provided no benefits to quality of life (compared with no intervention), the education intervention provided both immediate and long-term benefits with quality of life. Peer support groups may be helpful to some women but may actually be harmful to others so that, averaged over everyone, they appear to provide no benefit (Helgeson et al., 2000).

Breast cancer survivors are at increased risk for depression. For women who become depressed, cognitive behavioral therapy with a trained therapist is very effective (Antoni et al., 2001; Antoni et al., 2006). This form of therapy has been shown to result in lower depressive symptoms even 5 years later (Stagl et al., 2015).
One study compared breast cancer survivors with matched controls (Cordova et al., 2001). The cancer survivor group did not differ from the controls on measures of depression and well-being, indicating good overall adjustment. The researchers went beyond studying possible problems of adjustment, also considering the possibility of posttraumatic growth. Posttraumatic growth refers to positive life changes following highly stressful experiences and appears to develop soon after a breast cancer diagnosis (Danhauer et al., 2013). Breast cancer survivors showed significantly more posttraumatic growth than the controls, particularly in relationships with others, appreciation of life, and spiritual growth. Humans are resilient, and we must remain open to the potential for growth in the midst of trauma.

**HPV and Cervical Cancer**

Cervical cancer (i.e., cancer of the cervix) is far less common than breast cancer in the United States. For example, in 2013, there were 11,955 new diagnoses of cervical cancer but 230,815 new diagnoses of breast cancer (U.S. Cancer Statistics Working Group, 2016).

What is remarkable about cervical cancer is that doctors know what causes it. Cervical cancer is caused by the human papillomavirus (HPV). There are multiple strains of HPV that are sexually transmitted, some of which cause genital warts. Here we focus on the strains that cause cervical cancer; these strains are considered high risk. While nearly all women will have an HPV infection at some point in their lives, most will not develop cancer. This is because most HPV infections do not involve the high-risk strains.

It can be difficult to know if you or your partner is infected with HPV, but a simple, painless screening technique can be used to detect HPV infection in women. The Pap (short for Papanicolaou) test involves scraping cells from the opening of the cervix and examining those cells for abnormalities (see Figure 11.5). Anyone with a cervix should have a Pap test done annually, up to age 65. If HPV is detected, it is typically advised simply to monitor the infection, since most infections will clear up on their own. If the infection does not go away on its own, gynecologists can treat the infection with a variety of procedures to prevent it from developing into cervical cancer (National Cancer Institute, 2009).

Despite the availability of this highly effective screening technique, many women and transgender men with cervixes do not routinely get screened for HPV (Agénor et al., 2014). Discrimination by health care providers is one barrier to routine HPV screening. For example, one study found that lesbian, bisexual, and queer women as well as transgender men who reported being discriminated against because of their gender expression were more than three times less likely to get regular Pap tests (Johnson et al., 2016).

In addition, doctors may not perform Pap tests on lesbian women, mistakenly thinking that women need this test done only if they have sex with men (Marrazzo, 2004). And some lesbian women think they don’t need to be tested for sexually transmitted infections if they aren’t having sex with men (Marrazzo et al., 2005; Polek & Hardie, 2010). In fact, being sexually active with anyone, regardless of their gender, increases risk for HPV infection. Health care providers must also be welcoming and sensitive to the needs of transgender men and nonbinary people who may have a cervix and who may feel uncomfortable or embarrassed requesting cervical cancer screening (Johnson et al., 2016). If you have a cervix, you need to have regular Pap tests.

At the intersection of gender and class, financial barriers may limit access to Pap testing. Women of lower socioeconomic status are less likely to be screened for HPV and cervical cancer (Selvin & Brett, 2003). Poor women and women without health
FIGURE 11.5 Tools for a pap test, which detects HPV infection. Anyone with a cervix needs a regular pap test, regardless of gender identity.


insurance may skip their annual Pap test because of the cost. Some clinics, such as Planned Parenthood, offer free or reduced rates for cervical cancer screening. Yet if a person does not live near such a clinic, they may not be able to access this health care.

Cervical cancer risk is higher among women of color than among White women (Rositch et al., 2014). The incidence of cervical cancer is highest among Latinas (Ward et al., 2004), and the death rate from it is highest among Black women (Beavis et al., 2017). These racial/ethnic disparities may also stem from the cost of HPV screening.

Like all sexually transmitted infections, HPV carries a stigma. HPV stigma can be internalized, leading to self-consciousness, shame, and embarrassment. Some women feel ashamed or embarrassed for having HPV (Daley et al., 2010; Kahn et al., 2007). In turn, these emotions can prevent women from getting their annual Pap test or from monitoring an existing infection. The stigmatization of HPV may also prevent some infected people from telling their sexual partners about the infection, which increases the spread of HPV.

HPV is preventable. In 2006, the U.S. Food and Drug Administration approved two vaccines—Gardasil and Cervarix—to prevent infection with two strains of HPV that cause 70% of cases of cervical cancer (Koutsky et al., 2002). The Centers for Disease Control and Prevention recommends that all children (regardless of gender) be vaccinated against HPV beginning at age 11 or 12. While public health efforts to vaccinate boys and men were initially weaker than the efforts to vaccinate girls and women, this trend appears to be changing. Men can develop oral, anal, or genital cancers from high-risk HPV, but their risk of developing cancer from HPV is lower than women’s. Nonetheless, if men are not vaccinated against high-risk HPV, they may transmit the virus to other unvaccinated partners.
The United States has very low HPV vaccination rates, with only 37.6% of girls and 13.9% of boys getting vaccinated (Elam-Evans et al., 2014). There is controversy over vaccinating adolescents against a sexually transmitted infection because some parents worry that the HPV vaccine may encourage youth to be sexually active. There is no evidence that vaccination increases sexual activity.

**Trans Health Issues**

Transgender people need health care for many of the same health problems that cisgender people have: tobacco use, alcohol abuse, reproductive health, and cancer, as well as mental health issues (to be discussed in Chapter 15). As discussed earlier, health care provided to transgender people in the United States is lacking. Major barriers to adequate healthcare for trans people include social barriers such as the experience of discrimination from health care providers (who need better education about trans issues), structural barriers such as insufficient insurance coverage, and geographical barriers such as living in a rural community with reduced access to adequate health care.

In addition, many transgender people desire gender-affirming therapies to make their body and presentation match their gender identity. These and other components of health care are medically necessary for the well-being of transgender people (Coleman et al., 2012). For example, voice and communication therapy may be provided to help the person speak in the range typical for their gender identity and communicate nonverbally in ways that match their gender identity (see Chapter 5). For some transgender women, facial hair removal by electrolysis or other methods may be desirable. Supportive therapy for the transgender person and their family may also be beneficial for reducing stress. Medical and surgical transition are also options. We briefly review some of the interventions that may be used in medical and surgical transition for transgender women and men.

**Medical Transition**

The medical and surgical transition, in which a person’s body undergoes a range of medical and surgical interventions designed to match their gender identity, are important to many, but not all, transgender people. A range of interventions is now possible, and different individuals will choose different interventions. The World Professional Association for Transgender Health (WPATH) has set standards of care for transgender people, including standards for medical treatment (Coleman et al., 2011; see also Hembree, 2009). Before medical treatments can occur, assessment and referral by a mental health professional are required.

For early adolescents, *pubertal suppression* is a medical option that delays the onset of pubertal changes. As discussed in Chapter 7, pubertal suppression buys some time for an adolescent to mature and make a well-informed decision about whether to go through medical or surgical transition before endogenous puberty starts. If the adolescent decides not to pursue transition, the pubertal suppression treatments can be stopped and the effects reversed. However, if the adolescent decides to transition, the process will be simpler after having prevented pubertal changes. For example, for a transgender man, mastectomy wouldn’t be necessary because pubertal suppression would have prevented breast development. Preliminary evaluations of pubertal suppression indicate that, in young adulthood, transgender individuals treated in this manner function as well
psychologically as cisgender individuals do, in contrast to the strong gender dysphoria they had before treatment (de Vries et al., 2014).

Medical transition involves hormone therapy with estrogen (to feminize the body) or testosterone (to masculinize the body) and may also include hormone blockers (e.g., to block the secretion of endogenous testosterone in transgender women). This type of therapy is only partially reversible and is typically applied only with older adolescents (i.e., after age 16) and adults who are capable of making a definite decision about wanting to transition. Transgender men may choose hormone therapy with testosterone, which can lead to a deeper voice, growth in facial hair, growth of the clitoris or phallus, and a decrease in body fat percentage. The testosterone, which is usually injected, typically causes menstruation to stop. For transgender women, hormone therapy with estrogen results in breast growth, fewer erections, and increased body fat that creates feminine curves.

While additional high-quality research on the effects of hormone therapies is needed, evidence suggests they are beneficial for the well-being of transgender persons who receive them (White Hughto & Reisner, 2016). In-depth discussion of the effects and experiences of hormone therapy and medical transition are available elsewhere (e.g., Deutsch, 2014, 2016).

Surgical Transition

Surgical transition can include several types of surgical treatments. These treatments are irreversible and should be chosen only by a mature adolescent over the legal age of consent or an adult. The typical requirement is that the individual lives as a member of the gender with which they identify for at least 12 months, to ensure that the transition is truly workable and desirable. We introduce some of these treatments here; in-depth discussion of the effects and experiences of surgical transition are available elsewhere (e.g., Chyten-Brennan, 2014; Deutsch, 2016).

“Top surgeries” involve surgical treatments to alter the chest. Some transgender men choose to undergo reconstructive chest surgery, which involves the removal of breasts. Some transgender women choose to undergo breast augmentation.

“Bottom surgeries” involve surgical treatments to alter the genitals or internal reproductive organs. For transgender women, these surgeries may include penectomy (removal of the penis), orchietomy (removal of the testes), vaginoplasty (creation of a vagina from the skin of the penis), clitoroplasty (creation of a clitoris), and vulvoplasty (other surgery to create a female-appearing vulva). For transgender men, bottom surgeries might include removal of the uterus (hysterectomy), fallopian tubes, and ovaries; metoidioplasty or phalloplasty (to create a penis); and scrotoplasty (creation of a scrotum and insertion of artificial testes). Metoidioplasty involves releasing the clitoris, which enlarges with hormone therapy, to create a penis, whereas phalloplasty involves creation of a penis from tissue such as the forearm. These penis-creating surgeries are difficult and often not completely successful, so many transgender men decide against them.

According to research, the adjustment of transgender people who choose surgical transition is significantly better following surgery. A review of studies of vaginoplasty in transgender women found that results vary in terms of the functionality of the vagina, concluding that sexual function and patient satisfaction were “acceptable” (Horbach et al., 2015). In one study, 86% of transgender women were satisfied with their surgery to create a vagina, and 89% of transgender men were satisfied with their surgery to create a penis (De Cuypere et al., 2005). Another study of transgender men and women found
that none expressed regret about having chosen surgery (Johansson et al., 2010). In that sense, then, these gender-affirming surgeries are successful.

Still, it is important to note that many transgender people do not seek the full range of these medical and surgical interventions. Some may choose to undergo some treatments but not others. For some, a social transition seems to be all that is needed or wanted. And to the extent that people do not feel forced to fit into one of the two gender binary categories, surgery may feel unnecessary.

### Experience the Research

**Women’s Experience of PMS**

Interview four female friends on the topic of PMS. Ask each the following questions and record their answers:

1. Do you experience PMS?
   
   [Continue with questions 2 through 7 if the answer is yes; use questions 8 through 11 if the answer is no.]

2. How do you define PMS?

3. What symptoms of PMS do you experience? Include both physical symptoms and psychological symptoms.

4. About how frequently do you experience PMS? That is, out of 10 menstrual periods, for how many of them do you experience PMS?

5. About how long do the symptoms of PMS last for you? How many days before your period do they begin? For how many days do they last?

6. How much does the PMS interfere with your functioning? Do you continue pretty much as you normally would, or do you have to stay in bed for a while?

7. How do you treat the PMS? Do you take any medication for it? If so, what? Is it effective? What symptoms does it relieve? If you do not take any medication, how do you try to relieve the PMS symptoms?

   [This ends the questions for those with PMS.]

8. How do you define PMS?

9. Do you have any ideas about why you don’t have PMS?

10. Do you experience any symptoms or changes throughout your menstrual cycle? Do you experience any symptoms during your menstrual period, such as cramps?

11. How do you feel about women with PMS?

What can you conclude from your interviews? How common is PMS? What are its symptoms? How do women cope with it? How do they define it?

### CHAPTER SUMMARY

This chapter examined how women and trans people are treated by the health care system. At the intersection of gender, ethnicity, and social class, health and health care are affected.

The evidence on whether women experience menstrual cycle fluctuations in mood and whether these shifts are caused by fluctuating hormone levels was considered. Although many studies have been conducted on these

(Continued)
questions, there are fundamental problems with the research. Our conclusion is that some, though not all, women experience menstrual cycle fluctuations in mood. Moreover, culture plays an important role in the construction of these experiences.

At menopause many women experience hot flashes, but research on psychological symptoms such as depression and irritability indicates no increases compared with other stages of life. The physical symptoms such as hot flashes are related to declines in estrogen levels.

Several topics under the broad umbrella of reproduction and health were reviewed. Worldwide, contraception is a major public health issue for women. The ability to plan and space one’s pregnancies is crucial to one’s health. Pregnancy and childbirth are highly medicalized health experiences. Feminists have advocated for women having greater autonomy and decision-making power during these points in the lifespan.

Research on the psychological consequences of having an abortion indicates that it is generally not a traumatic experience. However, children born to women who were denied an abortion do show problems of adjustment.

Miscarriage is very common, yet rarely talked about. Many women experience miscarriage as the death of a future child, which can be psychological and physically traumatic. We need to provide more sensitive care to women who miscarry.

Two types of cancer: breast and cervical were discussed. Women with breast cancer are at increased risk for depression. Cognitive behavioral therapy is effective for treating depression. Following treatment, most women do well psychologically, and there is some evidence of posttraumatic growth.

Regular Pap tests and vaccination can help to prevent cervical cancer, which is caused by HPV. The stigma of sexually transmitted infections can present a barrier to the screening and treatment of HPV as well as to disclosure to partners. Regardless of gender identity, people with cervixes need regular Pap tests to screen for HPV and cervical cancer.

There are major barriers to adequate health care for trans people. Some trans people seek gender-affirming therapies to make their body align with their gender identity. Medical transition and surgical transition are important to many, but not all, trans people.

In all of these cases, individuals should learn more about the functioning of their bodies to make informed choices about their health care. It is also important to inform oneself about the psychological aspects of one's health issues.

SUGGESTIONS FOR FURTHER READING


