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Problematic Women: Psychology, Gender, and Health in North America

Mulheres Problemáticas: Psicologia, Gênero e Saúde na América do Norte

Mujer Problemática: Psicología, Género y Salud en América del Norte

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Abstract
Taking its cue from the medical field, psychology has long been curious about the relationship between biological sex and illness just as societies have long been interested in regulating women's bodies. From 19th Century gender differences scholarship through 20th century activism this article introduces the gendered history of psychology and health. Offering a general overview of the past and more recent feminist present within a North American framework. Taking as its base foundation the intellectual shifts away from an exclusively individualistic lens towards one that now emphasizes systems and society; referred to as the difference between a "women-as-problem" and a "women-in-context" approach. Topics addressed include early gender differences scholarship, mental health costs and gendered violence; dual impact of the paradigms of masculinity, perversity in medicating and treating a woman's psychological condition which result from living in a patriarchal societies; constructs of female sexual dysfunction, and more. We encourage South American scholars to take up the call to more thoroughly explore and expand on the histories of gendered health and psychology within regional and historical time sensitive contexts.
Keywords: history, health, psychology, feminism, gender

Resumo
Frente ao campo da medicina, a psicologia tem dedicado discussões sobre a relação entre sexo biológico e doença, assim como as sociedades que, há algum tempo, se interessam em regular o corpo das mulheres. Este artigo apresenta a história de gênero da psicologia e da saúde, a partir das pesquisas de diferenças de gênero do século XIX, por meio do ativismo do século XX. Além de oferecer uma perspectiva sobre o feminismo presente no quadro norte-americano, sobre o diálogo entre presente e passado. Sendo assim, A reflexão se desloca de uma produção intelectual com lente exclusivamente individualista para uma que agora enfatiza os sistemas e a sociedade; referido como a diferença entre uma abordagem "mulheres como problema" e "mulheres em contexto". Os tópicos abordados incluem a relação de diferenças de gênero com bolsas de estudos, custos de saúde mental e violência de gênero; impacto duplo dos paradigmas da masculinidade, perversidade em medicar e tratar a condição psicológica de uma mulher que resulta de viver em sociedades patriarcais; construtos da disfunção sexual feminina e mais. Encorajamos pesquisadores da América do Sul para fomentarem as discussões exploratórias e profundas da história de saúde e psicologia de gênero- dentro de contextos regionais e históricos, sensíveis ao tempo,
Palavras-chave: história, saúde, psicologia, feminismo, gênero

Resumen
Siguiendo la propuesta del campo de la medicina, la psicología ha sentido curiosidad por la relación entre el sexo biológico y la enfermedad así como las sociedades han estado interesadas desde hace tiempo en regular los cuerpos de las mujeres. Desde las diferencias de género en subsidios en el siglo XIX hasta el activismo en el siglo XX, este artículo introduce la historia de género de la psicología y la salud. Ofrece una visión general del pasado y del más reciente feminismo en un ámbito norteamericano. Tomando como su base fundamental el intelectual se aleja de una lente exclusivamente individualista hacia una que enfatiza los sistemas y la sociedad; se refiere a la diferencia entre los enfoques "mujeres-como-problema" y "mujeres-en-contexto". Los temas abordados incluyen subsidios anticipados considerando las diferencias de género, costos de salud mental y violencia de género; doble impacto de los paradigmas de la masculinidad, la perversidad en medicar y tratar de la condición psicológica de una mujer que resulta de vivir en una sociedad patriarcal; constructos de la disfunción sexual femenina, y más. Alentamos a los académicos sudamericanos a que atiendan al llamado para explorar y expandir profundamente las historias de salud y psicología de género en contextos regionales e históricos sensibles al tiempo.
Palabras clave: historia, salud, psicología, feminismo, género

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Freud listens to the troubled young woman, considers, then gives his verdict. He can tell her the cause of her illness, if she follows his instructions she can be well again.

Although psychoanalysis is no longer psychology's reigning therapeutic approach, its traditional gendered relationship between male scientific expert and female patient remains alive; if subliminal, dynamic in psychological thinking about health and illness (Marecek & Hare-Mustin, 1991). Taking its cue from the medical field, from its beginnings, psychology has been curious about the relationship between biological sex and illness, asking questions such as: Is one sex more prone to mental or physical illness? If so, what factor accounts for such a difference? Is it nature? Nurture?

The answers given to these questions have varied widely, depending on who is answering, either in their area of expertise and/or their historical context. This article will introduce the history of psychology of health and gender, exploring both, the field's past and its current state. This history will be primarily North American in focus; we hope this article will inspire South American scholars to explore what the history of this topic looks like in their own home country or region.

Nineteenth Century Scholarship on Gender Differences

Discussions of gender differences in health within North American academic psychology really got their start in the late nineteenth century, when women began to be allowed to pursue higher education. Women entering the discipline of psychology were struck by their male professors and colleagues' assumptions about the female body and psyche (Rutherford & Granek, 2010). At the time women were thought to be more fragile, easily exhausted by mental, as well as physical labor. Many academics harbored doubts about the wisdom of women pursuing higher education for this reason—it was thought that study might permanently damage the female body, possibly even resulting in infertility (Diehl, 1986). Functional periodicity, a common view, held that women experienced debilitating emotional and physical effects during menstruation, making women inferior, unreliable workers. When psychologists discussed psychological gender differences, they tended to simply import cultural stereotypes, for example, when discussing the emotionality of men and women (Shields, 2007).

Many psychologists also embraced the variability hypothesis, the view that men varied more broadly than women on any given trait, thanks to evolution. On this view there were both more male 'geniuses' and male 'imbeciles', and more women of average intelligence, for example (Shields, 1975, 1982). This theory had the advantage of justifying the status quo—with the variability hypothesis social inequality between the sexes was understood as the result of natural differences, not discrimination.

Such views struck the first generation women in psychology as convenient, and a number took action, using their research programs to put such claims to the test. Mary Whiton Calkins used the female students of Wellesley College to test the variability hypothesis (Nevers & Calkins, 1895); Helen Thompson Woolley wrote her dissertation on *The Mental*

Traits of Sex (Thompson, 1903), and Leta Stetter Hollingworth tested both, the variability hypothesis (Hollingworth, 1914b) and functional periodicity (Hollingworth, 1914a). This research tended to be much more careful and critical than the research it was responding to. Woolley summed up the existing field of psychology of sex in the following terms:

> There is perhaps no other field aspiring to be scientific where flagrant personal bias, logic martyred in the cause of supporting a prejudice, unfounded assertions, and even sentimental rot and drivel, have run riot to such an extent as here. (Woolley, 1910, pp. 340-341)

Woolley and her peers also tended to emphasize the confounding influence of the social environment on women's psychological traits, something other researchers ignored (Sheilds, 1975b). This was particularly relevant given how sharply curtailed Victorian women's social roles were. As psychologist, Amy Tanner, expressed the problem in 1896, "The real tendencies of women cannot be known until they are free to choose, any more than those of a tied-up dog can be" (Pettit, 2008, p. 150). Despite the merits of these women's research, the mainstream response was dismissive, and psychology of sex continued to embrace the variability hypothesis and functional periodicity well into the 20th Century. Woman as the weaker, sicker, and more emotionally volatile sex was to be a persistent idea in psychology.

20th Century Scholarship and Activism

Although there were occasional discussions of the psychological characteristics of men and women (see Bryan & Boring, 1944, 1946, 1947; Boring, 1951 for a variation on the variability hypothesis and Seward, 1944, 1946 for another review of differences emphasizing social influences), it was not until the 1960s and 1970s, with advent of the feminist and women's liberation movements, that psychology seriously revisited the issue of gender. In 1963 Betty Friedan's *The Feminine Mystique* sparked widespread discussion about women's social role. The book had psychological implications, since Friedan's thesis was that the neuroses of many housewives were the result of their restricted intellectual and social activities—there was nothing wrong with them that meaningful work and social equality couldn't cure. Phyllis Chesler's book *Women and Madness* (1972) raised similar issues regarding psychiatry and psychology, pointing out the illogical and sexist nature of many of the clinical interpretations of women's mental illness. Women were pathologized, both, for not sufficiently conforming to feminine norms and for being too feminine—the default assumption was female illness (see also Marecek & Hare-Mustin, 1991).

Feminism's mantra "The personal is political" meant that within psychology the experiences of everyday women were embraced as a legitimate source of knowledge (Kim & Rutherford, 2015). Inspired by such personal knowledge, feminist psychologists tackled some of the field's most obvious problems, such as the sexual relationships between counselors and clients (Hare-Mustin, 1974). Their efforts led to the creation of American Psychological Association's Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice, and, after much resistance, a prohibition on sex between therapists and clients (Kim & Rutherford, 2015). Similarly, feminist psychologists and sociologists helped to reconceptulize concepts

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like rape as symptoms of a patriarchal society, rather than as the result of individualistic pathology (Brownmiller, 1975; Russell, 1975) and have consistently battled theories of rape as sociobiological determinism (Sunday & Tobach, 1985; Travis, 2003). This blend of activism and research fits well into the feminist concept of consciousness-raising—age-old, familiar problems took on new significance as telling symptoms of a larger pattern of patriarchal oppression. Even though, is not to say that it has been or is always a harmonious coupling (see Rutherford & Pettit, 2015).

The increasing theoretical sophistication of the feminist movement soon led feminist psychologists to question the objectivity of the scientific project itself. Naomi Weisstein's 1968 paper "Psychology Constructs the Female" pointed out various forms of experimenter bias, and critiqued psychology for being too focused on internal factors (traits) to the exclusion of external factors (social context) (Weisstein, 1971; Rutherford, Vaughn-Blount, & Ball, 2010). As a result, Weisstein argued, psychology could not legitimately claim to know anything about the experience of the female—the claims of male psychologists were nothing but "fantasy." Others have critiqued psychology for its failure to use female subjects (in both human and animal research) (Beery & Zucker, 2011; Carlson & Carlson, 1961; Dan & Beekman, 1972), for the dominance of men at every level of the experimental and publication process (Rix, 1990; Walker, 1991), and the bias inherent in masculine approaches to science (Keller, 1985/1995; Rutherford, 2015; Sherif, 1998).

Such critiques raise the possibility that minor adjustments to psychology's methods might be insufficient to address the epistemological challenges raised by feminism, and a completely different approach to science might be necessary. Three distinct feminist approaches to bias in psychology resulted: feminist empiricism, feminist standpoint science, and postmodern feminism (Harding, 1986; Riger, 1992). Feminist empiricism has most in common with mainstream positivistic psychology, advocating for a stricter conformity to rigorious scientific methods to eliminate bias. Although, some changes need to be made to these methods to address sexist assumptions, feminist empiricism is optimistic about science as a means to accurate knowledge. In contrast, the feminist standpoint approach emphasizes the formative nature of the identity of the researcher, and therefore, argues that women must develop uniquely new paradigms and models to adequately describe female experience. The best known example of this approach is Carol Gilligan's research on women's moral development (Gilligan, 1982), which rejected the categories of Kohlberg's moral theory as inadequate. Finally, the postmodern feminist approach holds that objectivity in science is impossible, and instead, emphasizes the role of power in the creation of knowledge. Although, these three feminist approaches are incompatible in many of their specific recommendations, they hold in common the view that scientists ought to practice reflexivity, becoming aware of their biases, and critical of their methodological decisions.

Such caution is particularly necessary in research on psychology of women, given its 19th Century roots in research on individual differences. Initially, as we have seen, researches focused solely on comparing men and women, and assumed the existence of substantial differences between the sexes. However, in conjunction with the growth of feminism, the psychology of women was reborn with a more critical approach (the first psychology of women textbook [Bardwick, 1971] was published in 1971). In 1974, Eleanor Maccoby and

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Carol Jacklin, published an extensive review of sex differences research which found very little evidence for sex differences (Maccoby & Jacklin, 1974). In fact, these differences research review, which covered more than 1,400 studies, probably underestimated the number of studies which found gender similarities, given the lack of incentive to publish such mundane findings (Unger, 1979). That same year Sandra Bem offered an alternative to psychological personality tests which measured subjects' masculinity and femininity (Bem, 1974). The Bem Sex Role Inventory (BSRI) moved away from conceptualizing masculinity and femininity as opposite ends of a continuum; adding androgynous traits to the inventory in addition to masculine and feminine attributes.

Rhoda Unger's "Toward a Redefinition of Sex and Gender in Psychology" (1979) provided another critique of differences research. In this article Unger distinguished between sex and gender, defining sex as an inborn, biological variable, and gender as the result of social construction; and pointed out the degree to which the two had been conflated in most psychological research. Unger argued that distinguishing between sex and gender in research would help to keep researchers from conflating gender and sex differences and help make clear that the differences between men and women result from a combination of physiological, biosocial, and environmental factors. Unger (1979) also pointed out the ultimate fruitlessness of much sex differences research: "When an assumed sex difference is investigated and found to be nonexistent, the argument simply shifts to another ground" (p. 1087). Following Unger, psychology of women researchers have adopted the sex vs. gender convention and have attempted to move beyond differences research.

The Health Impact of Gender and Sexism

Rather than starting with the assumption of sex differences, modern feminist research tends to start the assumption that patriarchal and sexist systems impact the psychological and physical wellbeing of, both, male and females. Rather than simply focusing on the deficits of women and the advantages of men in patriarchal societies, this approach also highlights women's strengths and men's deficits. For example, although men are the financial winners in a patriarchal system, which one might expect to lead to health benefits, men's restricted emotional expression due to gender norms may have serious health costs (Wong, Pituch, & Rochlen, 2006). Similarly, although women are at higher risk in a number of domains due to their sex, they often demonstrate unexpected resiliency, thanks to some of the psychologically healthy avenues for coping open to them in a patriarchal society (e.g. Fallon & Jome, 2007). In other words, the impact of gender on health is expected to be complex and very context dependent.

Perhaps one of the most pervasive costs to being a woman is her significantly higher risk for gendered violence, such as sexual harassment, domestic violence, sexual abuse, rape, and even murder by a romantic partner (Koss et al., 1994). This gendered violence comes with a high physical and psychological cost, for example PTSD after rape is common (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992), as is physical illness due to the emotional trauma of persistent partner abuse (Follingstand, Brennan, Hause, Polek, & Rutledge, 1991). The concept of rape culture describes patriarchal power systems and the processes of socialization that leads to men feel entitled to exert their dominance over women's bodies,

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and to use violence in that process (see Holmstrom & Burgess, 1983; Rutherford, 2011; Ullman, 2010).

The existence of rape culture also helps to explain the complexity of women's psychological responses to violence. Women may practice denial about the violence they experienced, perhaps because they are resistant to disempowering themselves by identifying themselves as a victim; perhaps because they desire to remain in relationship with the perpetrator; perhaps because they receive external pressure to do so (from the perpetrator or society at large; see Jonzon & Lindblad, 2004 and Staller & Nelson-Gardell, 2005 on the hazards children and adolecents face in disclosing sexual abuse). As a result, many women internalize the violence, blaming themselves or their actions for their abuse. This response to trauma can result in depression, anxiety, low self-esteem, and learned helplessness. Since society does not validate the experience of victims of violence, but instead tends to abet and sanction male aggression, women are vulnerable to "gaslighting"—being told that the violence never occurred—which can lead them to doubt their judgment experience of reality (Rush, 1996; Benjamin, 1996).

The emotional costs associated with gendered violence may begin to explain the fact that women are at a significantly higher risk of depression than men (Kessler, 2003). In fact, women experience higher rates of a wide range of mental illnesses, including, in addition to depression (Kessler et al., 1994), anxiety disorders and eating disorders (Peat & Muehlenkamp, 2011), and personality disorders (Landrine, 1989). Women also attempt suicide at three times the rate of men (Centers for Disease Control and Prevention, 2014). Explanations for women's greater emotional distress have ranged from the biological (hormones), to the psychological (social roles which both put women at greater risk for trauma and allow expression of distress; cognitive styles such as learned helplessness and rumination) to the societal (violence, economic inequality).

Postpartum depression, premenstrual syndrome, and premenstrual dysphoric disorder are disorders particular to women which have received significant attention in research within psychology of women. Although these were traditionally been accepted as hormonal in origin, feminist scholars have pointed out the vague definitions of the disorders (Chrisler, 2000/2004) and offered competing or complimentary societal explanations (Abrams & Curran, 2009; Caplan, McCurdy-Myers, & Gans, 1992; Chrisler, Johnston, Champagne, & Preston, 1994; Held & Rutherford, 2012; Johnston Robledo, 2000). In this view, women experience distress prior to menstruation or after birth. In large part because of the societal pressures, for example, new mothers experience depression, both, because of expectations they will be overjoyed at the new baby and because of the lack of social support post-birth in most western households. Therapists operating from a feminist perspective tend to respond to women's psychological struggles by focusing on the social context, attempting to raise their client's awareness of the power of oppressive systems in their life, while at the same time, respecting the client's perspective on their life.

A similar perspective, but aimed at explaining the psychology of men is gender role strain paradigm (GRSP), an concept introduced in Joseph Pleck's *The Myth of Masculinity* (1981). Gender role strain paradigm suggests that many of the pathologies typical to men have their origin in a strong and highly limiting gender paradigm that prescribes what it means to be

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masculine. Strain occurs when these norms are violated, which prompts the man involved to assert his masculinity through stereotypical, usually harmful means (Levant, 2011). Using the sex/gender distinction advocated by Unger (1979), GRSP views masculinity as something socially constructed and varying over time and in different cultures. This introduces a certain optimism into the picture—although, masculinity in the West has traditionally been associated with psychologically harmful traits such as dominance and aggression, masculinity is malleable and could be altered to include a more heathy balance of characteristics.

However, despite this theoretical flexibility, paradigms of masculinity in the present day remain powerful. In fact, due to rapid societal moves toward gender equality have contributed to a crisis of masculinity, the confusion and insecurity many men feel about their masculinity has resulted increased pressure to follow stereotypically masculine scripts (Levant, 1997). This has resulted in resistance to feminist critiques, and even the rise of anti-feminist and openly misogynistic groups (Levant, 2011). It is not only women who are harmed by these behaviors; men's health is affected by their adherence to masculine scripts requiring restricted emotional expression, self-sufficiency and detachment from relationships, professional achievement, toughness to the extent of indifference to their own health needs, and a wiliness to resort to aggression and violence. Men are at greater risk of a wide range of negative behaviors (Brooks & Silverstein, 1995); they are more likely to be "parents estranged from their children; the homeless; substance abusers; perpetrators of violence; prisoners; sex addicts and sex offenders; victims of homicide, suicide, war, and fatal automobile accidents; and fatal victims of lifestyle- and stress-related illnesses" (Levant, 2011, p. 766).

A central concept in GRSP is alexithymia, which describes the condition of lacking the vocabulary to describe emotions. The Normative Male Alexithymia Hypothesis (NMA) suggests that alexithymia is the normal result of gendered socialization (Levant, 1992). Alexithymia results when gendered socialization places pressure on boys to suppress their emotions, rewarding masculine displays of toughness or "masculine" emotions (such as anger), and punishing the expression of vulnerability or stereotypically feminine emotions. As a result, boys do not develop vocabulary to describe their emotional states. When paired with a similar female socialization which, in contrast, encourages the exploration and expression of emotion, the results of traditional gendered socialization reinforces the perception that men are naturally less emotional than women.

However, the traditional masculine ideology of extreme differences between the sexes is damaging to all concerned. Although, such an ideology benefits men by keeping them in a privileged position relative to women; and men who belong to racial and sexual minorities, there are also health costs for all parties. Men who cannot measure up to cultural norms for masculinity experience distress and anxiety, and even men who successfully conform to the norms can experience alexithymia, which impacts their healthy coping and communication about their emotional life (Sánchez, Greenberg, Liu, & Vilain, 2009). Such restriction of emotional vocabulary can mean that men's resilience in the face of traumatic or stressful events is significantly affected—rather than being able to seek emotional relief through healthy outlets (such as seeking relational support, or giving voice to their feelings), men with alexithymia may resort to aggression, violence, substance abuse or other forms of toxic masculinity.

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Research from the GRSP perspective has resulted in a number of useful scales, such as the Male Role Norms Inventory—Revised (MRNI–R) (Levant & Richmond, 2008) and the Normative Male Alexithymia Scale (Levant et al., 2006) to assess an individual's conformity to traditional masculine norms and his level of alexithymia. Studies have found that adhering to traditional masculinity ideology is correlated with higher levels of alexithymia (Levant, et al., 2003), and that that NMA can be reduced with an educational program (Levant, Majors, & Kelley, 1998; Levant, Halter, Hayden, & Williams, 2009). In general GRSP appears to offer a helpful perspective on masculinity, allowing for acknowledgement of both, the privilege, but also, the costs of being male.

Although, we have mentioned women's greater emotional expressiveness as a strength relative to men, one implication of the restricted emotional expression in men is the disproportionate share of emotional labor that falls to women. Women's nurturing role in heterosexual relationship is, perhaps, the most obvious example of this. Women offer listening, counsel, emotional support, and affirmation for their male partners as a matter of course, and often without receiving the same level of care in return (Bartkey, 2002; Daniels, 1987; Erickson, 2005). In their parenting role, too, women tend to do greater emotional work in addition to regular caregiving and household chores. Women also experience the expectation to provide unpaid emotional labor in their workplace, and are frequently found in greater numbers in caretaking jobs or jobs which emotional labor is built into job performance expectations, such as waitressing or other service jobs (see Hochschild, 1983). This dynamic is a source of economic injustice—emotional labor is an undervalued entity, jobs which require significant emotional labor are often generally poorly compensated, and women generally do much unpaid emotional work even in higher status jobs, such as university professor (see Bartkey, 2002; Wharton, 2009).

Such emotional exploitation is reinforced, both, by early socialization of girls to adopt a supportive role, and the economic and relational costs to women who refuse to engage in nonreciprocal emotional labor. Besides these costs, there is likely a significant psychological cost involved in constantly taking another perspective and suppressing one's own emotions about a situation. This, it has been theorized, may lead to a loss of identity separate from another and a loss of ability to trust one's own perception of reality (Wharton, 2009). The silencing that occurs as a result of women's constant taking on of masculine perspective no doubt contributes to their acceptance of sexist situations or relationships. Adopting the concept introduced by W. E. B. Du Bois to describe the black experience, feminists have referred to the situation of women who must maintain her own perspective and yet learn to function in a masculine world as double consciousness (see Carter-Sowell & Zimmerman, 2015). Double consciousness is likely psychological formative, making it difficult for women who spend their life taking on a male perspective to speak and be assertive, even when not doing so, has severe consequences for their wellbeing.

Recent Developments and Debates

In recent years, one approach to the psychological complaints of women has been to offer new diagnostic categories and medications to address the complaints. While this approach makes sense from a positivistic approach, to psychology that is focused on

internal psychological factors, this approach has been critiqued by feminist psychologists. Part of the critique comes from a more general critique of the overmedicalization of normal psychological states and the proliferation of diagnostic categories in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Greenberg, 2013). But this type of critique takes on an extra urgency when such new medications and categories target women. From a feminist perspective, there is an extra level of perversity in medicating, or otherwise, treating a woman's psychological condition which has resulted from simply living in a patriarchal society (e.g. see McHugh, 2006; Liebert, Leve, & Hui, 2011).

A recent example of this sort of problematic expansion of pathologies is the 2015 FDA approval of the drug Addyi, popularly known as "female Viagra" to treat inhibited female sexual desire, a condition described by a new diagnostic category in the DSM-5, female sexual interest/arousal disorder. The trials of Addyi showed only a modest effect on sexual responsiveness, as well as some serious side effects (Nagoski, 2015). Feminists raised questions about the degree to which this was in fact a medical issue, suggesting that women might be encouraged to take a powerful drug for a problem that was in reality social or relational in nature (see Kaschak & Tiefer, 2001; Tiefer, 2001, 2010; Teifer, Tavris, & Hall, 2002).

A feminist interpretation of female sexual dysfunction starts with the dynamic of gender inequality, which might result in sexual frustration in myriad ways—because of a male partner's selfishness or ignorance about female pleasure,and also,the greater female share of household duties and emotional labor which might result in exhaustion or conflict with a partner, etc. Further, it may be that women's sexual drives were not in fact defective, but only seem so given a comparison with a male standard of sexuality or pressure from partners with interest in more frequent sexual activity (Bancroft, 2002; Wood, Koch, & Mansfield, 2006). By ignoring these issues, the makers of the drug in fact, ignored the unique characteristics of female sexuality, and simply used a model that have worked for men, despite the known differences between male and female sexuality. Given the strong profitability of drugs like Addyi, however, there seems to be a small chance that drug companies and other stakeholders will stop offering exclusively biological solutions to women's (perceived) health problems.

A more positive recent development has been the expansion of psychology of women to include the concept of intersectionality. Intersectionality emphasizes the complexity of identity with the idea that an individual's multiple identities affect each other—making their effect multiplicative rather than additive. This means, for example, that a black woman experiences a very different variety of sexism than does a white woman; or racism than does a black man. Implicit in the concept of intersectionality is a critique of the limited perspective of second wave feminism—the leaders of the women's liberation movement tended to be white, and often saw race as a separate issue, rather than looking at the role of power holistically (Moraga & Anzaldúa, 1981/2015; Hooks, 1981). However, intersectionality is one of the core concepts of third wave feminism, and holds much promise for future research on gender and health.

From an intersectionality perspective, discussing what kind of impact gender has on health is simply too broad—instead, one must look at the impact on a particular minority or subgroup of women. A similar critique has been made about class: much feminist scholarship has focused on the problems of upper and middle class women, and ignored the issues unique to poor women (Reid, 1993). Following the critique of psychology's research subjects as WEIRD (from

Western, Educated, Industrialized, Rich, Developed countries) (Henrich, Heine, & Norenzayan, 2010), present day psychology of gender attempts to locate its claims about men and women and to expand its research base beyond western universities. Findings on the experiences of gender from other cultures are seen to be enlightening and theoretically fruitful.

An important element of this shift away from exclusively western perspectives on women has been a move away from exclusively individualistic lens towards one that emphasizes systems and society. This has been referred to the difference between a "women-as-problem" and a "women-in-context" approach (Rutherford, Marecek, & Sheese, 2012; Crawford & Marecek, 1989). A "women-as-problem" approach emphasizes the various psychological deficits of women relative to men. Although, it does not see these as natural deficits but the result of sexist socialization, it nonetheless locates the problem as internal to the woman, and proposes solutions that target women's traits or behaviors. In contrast, a "women-in-context" approach looks to the social context for clues as to why a particular behavior might be an adaptive response, given institutionalized sexism. This approach suggests a more radical solution to gender disparities in health—psychologists should look to dismantle systemic sexism in their work.

Interestingly, the words "woman" and "problem" have been regularly paired. From the use of "The Woman Problem" to describe the late 19th Century discussion of women's proper role in society, to E. G. Boring's use of the term to describe the lack of eminent women in psychology (Boring, 1951), to Betty Friedan's description of suburban feminine malaise as the "problem that has no name," women have been seen as uniquely problematic. With the benefit of more than a century of discussion of the psychology of gender, however, we have been able to see that the problem lies elsewhere—not in a woman's sick body or fragile psyche, but in society's views of her, in the power structures that benefit from the weakness and oppression of others.

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