Women's Health Psychology

Edited by

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Foreword

Nancy E. Adler, PhD

Women's Health Psychology provides an important overview and analysis of key issues affecting women's health and well-being. In 2010 I had the privilege of chairing an Institute of Medicine (IOM) committee charged with evaluating progress in women's health research. The committee was composed of eminent researchers and clinicians representing a wide range of aspects of women's health. The committee considered whether the right questions had been asked about women's health, whether the right methods had been used to answer those questions, and whether the findings had been communicated effectively and had resulted in better health outcomes for women. In reading the contributions to *Women's Health Psychology*, I was struck by the resonance between the lessons the committee learned from our review and this volume.

The first thing that struck me was the broad perspective that the editors of this volume took in defining women's health. Women's health has sometimes been defined narrowly, referring only to health associated with women's reproductive organs and hormones, but this view has evolved. Just as the IOM committee embraced a wider definition that included diseases that are more prevalent among women than among men, present differently (e.g., differences in age of onset or in typical presenting symptoms), respond differently to treatment, or represent a major burden of illness for women, this book covers an impressive array of health issues that affect women and/or differ in their impact for women than for men. Although one section of the book deals specifically with reproductive health, spanning menstruation and sexual health, infertility and pregnancy, breastfeeding, and menopause, the remaining sections cover a wide swath of health problems. The authors of the various chapters highlight both commonalities and differences in the etiology and treatment of these conditions.

In addition to considering a wide range of health conditions, the editors have also included chapters that deal both with sex differences (those caused by biological differences between the sexes) and gender differences (those caused by socially determined factors to which men and women are differentially exposed). The IOM committee observed that the social determinants of women's health had received relatively less attention than the biological underpinnings. Social determinants are important in understanding how gender effects impact on health, as well as in understanding, within groups of women, why there are marked disparities in health status between those who are socially disadvantaged versus those who live in more favorable social conditions. *Women's Health Psychology* highlights the critical role of these factors in the initial section that discusses the intersectionality

among different bases of social disadvantage. The stage is set by considering the historical context and then discusses two domains in which women encounter social threats to their health: employment and intimate partner violence.

Finally, almost every chapter in this volume touches on the importance of quality of life, not just longevity. Women live longer lives than do men, but they suffer more years of disability. The burden of diseases such as Alzheimer's, which occur primarily late in life, fall disproportionately upon women. Even earlier in life, women are more prone to diseases that are not fatal but that interfere with well-being and full functioning. These include autoimmune diseases, depression and other mood disorders, and unintended pregnancy. The IOM committee observed that relatively less attention had been paid to nonfatal diseases and that less progress had occurred for many of these disorders. This volume underlines the importance of well-being and the burden to women of health challenges such as irritable bowel syndrome, rheumatic disease, multiple sclerosis, and Alzheimer's. Importantly, it also includes chapters that analyze the role of risk factors such as alcohol and tobacco use, weight and eating disorders, sleep and sedentary behaviors that may contribute to a range of diseases and that may impair quality of life.

In sum, this volume covers a wide array of conditions, causes, and approaches to understanding and improving health among women. It will serve as a valuable reference for health and mental health providers, researchers, and those in training for professional or research careers.

Preface

In the 1990s, when specific courses and texts in women's health psychology emerged, Annette Stanton and Sheryle Gallant (Stanton & Gallant, 1995) commented on questions they faced relating to the advisability of presenting such specialized content. Both the empirical foundations and the reasons for separating women's health psychology from "general" health psychology were questioned. At that time, the study of women's health psychology was just beginning to blossom. For the first time, the United States was seeing the development of organizations such as the Office of Research on Women's Health in 1990, national initiatives to include women in clinical health trials (the Women's Health Equity Act, 1990), federal research requirements to include women and individuals from diverse ethnic-racial groups (the NIH Revitalization Act of 1993), physician (the Council on Graduate Medical Education, 1995) and clinical psychology (the American Psychological Association) training in women's health. In the years following, several U.S.-based programs and organizations became cornerstones in the field of women's health, including the American Medical Women's Association, Division 35 of the American Psychological Association (i.e., Society for the Psychology of Women), the Office of Research on Women's Health, the Society for Women's Health Research, and the Women's Health Initiative (WHI).

From that foundation, the interest and impact of women's health and women's health psychology continues to be evidenced by the increase in women's health programs instituted by hospitals and universities and the number of professional organizations that have identified women's health as a focus area. General booksellers now have entire sections devoted to narratives and educational information on women's health for consumers. One of the questions facing us at the inception of this book was whether the research work in women's health psychology has kept pace with the interest it has garnered.

In this second decade of the 21st century, the empirical foundation of women's health psychology has become both broader and deeper. It has grown into a specialty area that in some instances converges with research and theories of general health psychology in common with men while in other instances reflects unique or different needs of women. Perhaps one of the major advancements is that today, more than ever, the field of women's health psychology recognizes that women are a diverse group. There is also more attention to the idea that women's health can be impacted by a variety of factors related to economic and social backgrounds and practices, as well as cultural, political, and relational contexts, and that women will face a variety of issues during different life stages related to reproduction, family, and work.

With these issues in mind, *Women's Health Psychology* was designed to focus on important health psychology issues of women spanning from young adulthood to post-menopause. It is intended to describe how behaviors, attitudes, and lifestyle choices influence women's health, to examine interactions between psychological and physical health, and to present these findings within a developmental and diverse sociocultural context.

Our goal is to present current research in women's health psychology that incorporates the broad and diverse context of women's lives. The book is divided into four sections. The first section of the book considers several important general issues of historical and current context for women's health that help to expand thinking related to intersections of women's health with wider social issues, employment, and relationships. The section "Well-Being and Health Challenges" includes chapters related to a number of behaviors and conditions known to enhance and/or compromise healthy lifestyles among women. The manifestation of addictive behaviors (namely smoking and alcohol use) among women and strategies tailored *to women* and *for women* are presented. The importance of physical activity and sleep throughout women's lives, coupled with the impairments related to sleep disturbance and sedentary lifestyle, are highlighted. The growing epidemic of obesity, along with eating disorders and body image, are addressed within a sociocultural context. Likewise, the increasing popularity of cosmetic treatments and their hypothesized underlying motives are discussed. The next section presents a range of reproductive health topics that women encounter during their lifespan including sexual health issues, decision-making surrounding childbearing, breastfeeding, and menopause, as well as topics that may be experienced by a subset of women, including premenstrual dysphoric disorder, infertility, and psychiatric symptoms during the perinatal period. The final section, "Disability and Chronic Conditions," opens with a chapter on women's responses to disability followed by chapters dealing with some of the more important health threats and chronic conditions experienced by women. These include the experience of cancer in women, the psychology of irritable bowel syndrome, neurological disorders in women, and converging issues in heart disease, stroke, and Alzheimer's disease in women.

Authors were invited to provide a critical review of an area, focusing on one to two key issues and to address, where possible, how the health behavior, reproductive issue, or disorder might interact with developmental milestones or cultural, socioeconomic, or social identity (e.g., gender orientation or disability). We anticipate that this book will be useful to a broad range of practitioners, including psychologists, mental health counselors, physicians, nurses, allied health professionals, and medical social workers as well as students, educators, and researchers in the medical and social sciences who are interested in the evidence-based foundation for offering effective services to women.

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Stanton, A. L., & Gallant, S. J. (Eds). (1995). *The psychology of women's health: Progress and challenges in research and application*. Washington, DC: American Psychological Association.

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Finally, with this book, we pay homage to the generations of women who came before us and those who will come after, united in our engagement in multiple roles that influence women's physical, psychological, and spiritual health and well-being (including roles as mothers, sisters, daughters, wives and partners, primary caretakers, workers, and friends).

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Section I

WOMEN'S HEALTH IN CONTEXT

CHAPTER 1

Historical Roots of Women's Healthcare

Heather Munro Prescott and Wendy Kline

INTRODUCTION

From childhood to old age, what it means to be female in American society has changed over time. There is a large body of literature on the history of women's health in the United States, and this subject continues to draw major interest from scholars and lay readers alike. As 21st-century politics reminds us, the role of reproduction and female sexuality in contemporary society are regularly up for debate. What distinguishes women from men—the capacity to conceive—is both a physiological and a historical phenomenon. As this chapter illustrates, the relationship among women, their bodies, and what is considered "healthy" is grounded in particular assumptions and contexts. As a result, medical theories and diagnoses sometimes radically reverse course when social conventions change.

This chapter approaches the history of women's health from a thematic perspective, offering readers a sense of the myriad issues that have confronted women over the past century. Topics include child and adolescent health, sexuality and sex education, birth control, pregnancy and childbirth, reproductive rights, the women's health movement, abortion, sterilization abuse, sexual assault, and gender equality in medical research. It is by no means comprehensive, but taken together, the issues fleshed out here illustrate the contested terrain that women still encounter when negotiating their healthcare. Understanding the origins of contemporary women's health issues is a crucial step toward improving the psychology of women's health today.

CHILD AND ADOLESCENT HEALTH

During the early 20th century, pediatricians and other medical experts argued that high rates of infant and child mortality were caused by mothers' lack of accurate scientific knowledge about how to prevent and manage childhood diseases. The solution to this problem was to make motherhood more "scientific" by instructing women to rely on pediatricians and other scientific experts for advice on the proper ways to raise healthy children. These principles of "scientific motherhood" were promoted in high school and college courses in home economics, advice manuals, government pamphlets issued by the U.S. Children's Bureau, and popular advice columns in women's magazines. By the 1920s, women had become accustomed to seeking childcare advice from medical and scientific experts rather than from neighbors, friends, and relatives (Apple, 2006).

Women reformers of the early 20th century were also instrumental in gaining

congressional support for the Sheppard-Towner Maternity and Infancy Act (1921). This law appropriated federal funds for maternal and child healthcare for low-income families free of charge. Unfortunately, conservative male politicians in Congress opposed this program and refused to reauthorize the program in 1927 (Muncy, 1991).

School boards attempted to control the spread of disease by requiring schoolchildren and adolescents to be vaccinated against smallpox, diphtheria, and other diseases before attending school. Then as now, some parents objected strongly to compulsory vaccination. Some believed that vaccination was dangerous, whereas others resented the intrusion of state officials into private family matters. In order to prevent the spread of disease and protect the health of students, schools began in the 1890s to hire physicians as medical inspectors. These physicians identified a set of diseases that seemed to be caused and/or exacerbated by the environment of 19th-century schools, many of which lacked adequate light, ventilation, heat, or sanitary facilities. Medical experts noted that American schoolrooms, especially those in urban areas, were breeding grounds for the spread of disease, and they called for reforms that would eliminate hazards to student health. At the same time, child welfare reformers successfully lobbied for legislation that outlawed child labor and mandated school attendance through the age of 16 in most states (Meckel, 2002).

During the late 1910s and 1920s, the educational psychologist Lewis Terman argued that public schools should do more than detect and prevent illness: They should treat physical illnesses and defects that could affect students' academic success. Terman proposed that schools hire nurses, who would not only examine students at school but also follow up on cases by visiting the students' homes to ensure that medical treatment was being followed. Terman also realized that many families, especially immigrant, urban, and rural poor families, could not afford medical care on their own. Therefore, he argued that the second essential step in promoting the health of students was to create medical clinics in the nation's schools. Terman's suggestions met with fierce opposition from the American Medical Association (AMA) and other medical organizations, who saw this as the first step toward "socialized medicine." Terman replied that free medical and dental clinics for the nation's children and youth were no different from universal public school education supported by taxpayer dollars. Opposition from the AMA led public schools to abandon school medical clinics as a healthcare strategy and limit their role to ensuring that students were properly vaccinated and in sufficiently good health to attend school (Sedlak & Schlossman, 1985).

ADOLESCENT GROWTH AND DEVELOPMENT

Surveys of schoolchildren and child laborers conducted by public health officials during the late 19th and early 20th centuries illustrated the negative effects of modern industrial life on young bodies. Physicians found that native-born, White, middle-class children who did not work for wages were on average larger and heavier than immigrant, working-class children of the same age. They also found that children who endured too much pressure in school had smaller and weaker bodies than those whose education

was more suited to their age. At the same time, surveys indicated a steadily declining age of menarche and sexual maturity among children of the white, native-born middle classes (Tanner, 1981). Today, pediatricians attribute this decline in the average age of puberty to improvements in nutrition and child health, but in the late 19th and early 20th centuries, this change was alarming, especially for adolescent girls who were menstruating earlier but marrying later. Some parents and doctors tried to slow girls' physical maturation by eliminating foods that were considered "stimulating," such as cloves, pickles, and meat (Brumberg, 1997).

By the 1930s, a substantial amount of data had been accumulated on the average heights and weights of the nation's children and youth and incorporated into standardized height and weight charts. One of the main tasks of pediatricians in the post–World War II era was to measure their patients' growth and development against standardized tables of height and weight. Initially, deviation from the standardized norm was taken as a sign of disease or malnutrition, but soon "abnormal" height itself became a disease in need of treatment. This medical demarcation between "normal" and "abnormal" was reinforced by gender expectations for girls and boys. Experts warned that "tallness can be a real handicap for a girl," especially in the postwar era when women were expected to marry and have children. Girls could be "saved from spinsterhood" by receiving a new "wonder" drug—the synthetic estrogen diethylstilbestrol (DES), which when administered during early puberty would keep their adult height within socially accepted norms.

Children who were considered below average in height received the height-enhancing human growth hormone (hGH). This drug was initially developed to treat pituitary dwarfism, but soon anxious parents were bringing short children, boys especially, to pediatric endocrinologists in the hopes their children could attain a "socially acceptable height." These "wonder drugs" did not always live up to their promise, as tall girls continued to grow and short children did not reach their predicted height. Moreover, these treatments often caused severe medical problems. Tall girls who received synthetic estrogen experienced weight gain, nausea, vomiting, and extremely heavy and painful menstrual periods. Later in life, these women were more likely to develop fertility problems and cancer of the breast and reproductive organs.

During the 1980s, women who had received DES as teenagers organized Tall Girls Inc. Like other women's health organizations that emerged out of the second wave of feminism, this group criticized the medical profession's unethical treatment of girls and women as research subjects. Tall Girls, Inc. also helped promote pride among and social acceptance of tall women. Although growth attenuation still continues today, being a tall woman is no longer a "pitiable fate" but a ticket to a career on the runway or basketball court (Cohen & Cosgrove, 2009).

At the same time, the average age at which children first exhibit development of secondary sexual characteristics has steadily declined over the past 50 years: It is not unusual for breast development to occur in girls as early as age 7, and for testicular enlargement to occur in boys as young as age 8. Some experts blame the declining age of puberty on a host of modern societal ills, including pesticides and other environmental toxins, hormones in meat and milk, the

epidemic of obesity in American society, and the ubiquity of sexualized messages in the mass media that some believe may trigger changes in the brain that in turn promote sexual development. At the same time, the average heights of adolescents have increased, which means that heights that were considered average in the mid-20th century (5 feet 2 inches for women, 5 feet 6 inches for men) are now below average. As tall stature in women has become not only acceptable but desirable, many parents show a preference for tallness in both girls and boys. Some pediatric endocrinologists recommend giving the hormone lupron to early-developing girls not only to slow their sexual maturation but also to ensure that they reach their full adult height (Cohen & Cosgrove, 2009).

SEXUALITY AND SEX EDUCATION

During World War I, the incidence of sexually transmitted diseases among American young people increased dramatically. Although sexually transmitted infections (STIs) had vexed medical experts for centuries, infection rates as high as 25% in some regions gave new urgency to campaigns to eliminate these deadly scourges. At the same time, it was becoming clear that young people's sexual practices were changing radically. Dr. Max J. Exner, Public Health Officer for the Young Men's Christian Association (YMCA), reported that more than half of his sample of 948 college men had engaged in sexual practices of some kind. More than 60% had practiced "self-abuse" (masturbation), 17% of these had also engaged in intercourse, and 2% described engaging in "various perverted practices," which Exner did not specify. Studies of the sexual behavior of female college graduates conducted by Clelia Duel Mosher at Stanford, and by New York City Corrections Commissioner Katherine Bement Davis in the 1910s and 1920s, indicated that similar changes were occurring on a smaller scale among female undergraduates. Reformers had long been concerned about "declining morals" among working-class, immigrant youth. The fact that "respectable" college and university students were also engaging in such "radical" sexual practices was disturbing to many parents, health professionals, and educators in public schools (Munro Prescott, 2007).

To address these concerns, public health experts created new initiatives in what they called "social hygiene," a term that represented both a euphemism for the control of "venereal diseases," as well as a new approach to prevention of these afflictions. Social hygiene differed from earlier "purity crusades," which shielded young people from moral and physical dangers via a "conspiracy of silence" about sexual matters. Social hygienists attacked the sexual double standard, supporting total abstinence before marriage for both men and women. Yet, social hygienists believed education rather than scare tactics was the best way to protect the health of the nation's youth. Social hygienists believed sex education was especially important for female students, because so many young women became teachers and mothers. Yet they were also concerned about preserving sexual propriety; therefore, they developed separate curricula for each gender and insisted that girls should receive instruction in sex education separately from boys. Even then, sex education programs advocated total abstinence before marriage. Nevertheless, sex education programs were

as controversial then as they are now, and supporters of these programs tended to camouflage their efforts by using titles such as "family and marriage education" to describe their courses (Moran, 2000).

The social hygiene movement eventually paved the way for significant changes in theories about adolescent female psychology. Before the 1920s, most writers on adolescent female psychology argued that healthy female development involved protecting the young girl from premature awakening of sexual instincts and longings. Rather than label these girls as delinquents, experts in adolescent mental hygiene revised their views of female adolescent psychology and made sexual curiosity and a certain degree of sexual experimentation a normal part of healthy female development. In fact, mental hygiene experts worried more about girls who did *not* adopt an avid interest in the opposite sex by the middle years of adolescence. Mental hygienists argued that such girls might become lesbians or otherwise fail to attain a normal adult feminine role (Lunbeck, 1994).

Efforts to control the spread of sexually transmitted diseases led some gynecologists to recommend routine pelvic examinations for young women who were about to be married. The cytological cancer-screening vaginal smear, developed by George Papanicolaou in the 1920s, became a fundamental part of the move toward routine annual gynecological checkups following World War II (Casper & Clarke, 1998). Yet, routine pelvic examinations for young teenage patients were controversial. Most gynecologists recommended that this procedure be avoided except in cases of gross physical disease, and even then should only be performed under anesthesia (Munro Prescott, 1998). By adopting such a course, noted one gynecology textbook from the 1930s, "there will be less danger of inducing morbid introspection and of engendering psychosis that cannot fail to have an unfavorable effect on the patient" (Sturgis, 1962).

Nevertheless, during the 1940s and 1950s, a few gynecologists began to suggest that regular gynecological exams and Pap smears should be made part of standard medical care for adolescent girls (Allen, 1958; Schauffler, 1964). These gynecologists argued that routine care during adolescence was crucial because of two major demographic trends at this time: First, the percentage of married teenaged girls increased markedly. By 1959, 47% of all brides had married before the age of 19, and the percentage of girls married between 14 and 17 had grown by one-third since 1940 (Bailey, 1988). Second, Alfred Kinsey's study entitled *Sexual Behavior in the Human Female* disclosed that more than 50% of the women in his sample had engaged in premarital sex (Kinsey, 1953). In a paper presented at the 91st Annual Meeting of the American Public Health Association in Kansas City in 1963, Helen Manley, Executive Director of the Social Health Association of Greater Saint Louis, commented on the problems that resulted from the rise in early marriage and motherhood. Manley observed that between 1940 and 1958, the overall marriage rate had increased by 231%, but the number of teen marriages had grown by 500%. Half of all teen brides were pregnant at the time of marriage (Manley, 1964). Like now, health experts like Manley were concerned about growing rates of teenage pregnancy, but these experts were concerned not only with unwed mothers but also with the problems of *married* teenage mothers. Manley was part of a larger cohort of women reformers in the city of Saint Louis who,

beginning in the 1920s, attempted to stamp out prostitution and venereal disease through aggressive public health campaigns and sex education programs in youth groups and public schools (Wagman, 2009).

As a result of these reform efforts, sex education programs were gradually incorporated first into colleges and universities and later into public high schools during the 1940s and 1950s. During that time, support for sex education emerged amidst intense concern about the consequences of adolescent sexual behavior, especially increasing rates of "illegitimate" pregnancies and a growing incidence of sexually transmitted diseases. Although many of these anxieties targeted young people of color and low-income whites, the "declining morals" of white, middle-class, suburban teenagers were also cause for concern. Unlike our own day, creation of sex education programs following World War II inspired very little popular opposition at the time, partly because these programs emphasized that sexual intercourse should be reserved for marriage (Freeman, 2008).

At the same time, experts warned of the social and medical dangers of early marriage. Manley observed that the rate of divorce for teenage marriages was three times higher than that for older couples, with three out of every four teenage marriages breaking up. Young people who were wed before age 20 not only shortened their own schooling but also affected the health of the next generation. Teenaged parents had a higher percentage of premature babies, leading to higher rates of illness and death resulting from lack of prenatal care (Manley, 1964).

These anxieties about the dangers of teen marriage for girls also appeared in epidemiological studies of cervical cancer. Several epidemiological studies published in the 1950s and early 1960s indicated that women who married before age 20 appeared to be at higher risk for this disease. Some speculated that women who had multiple "broken marriages" were especially susceptible. Isadore D. Rotkin of the Cancer Research Project at the Kaiser Foundation in California elaborated on this research, and found that age at first coitus was the most significant variable distinguishing cervical cancer patients from controls. In a study of more than 400 patients, 85% of whom were Caucasian, twice as many cancer patients as controls began coitus at ages 15 to 17, comparatively few began after age 21, and almost none started as late as age 27. Rotkin hypothesized that some kind of infectious agent transmitted by male partners was a contributing factor, and that the adolescent cervix was especially vulnerable to "epithelial transformation" by exposure to such an agent. Although Rotkin acknowledged that measures aimed at improving male sexual hygiene could reduce the incidence of the disease, he argued that postponement of marriage for young women—and limitation of sexual intercourse to marriage—was the most effective means of prevention (Rotkin, 1967).

These findings lent further weight to the argument that regular gynecological exams and Pap smears should be made part of standard medical care for adolescent girls. Edward Allen, Professor of Obstetrics and Gynecology at University of Illinois, observed that: "Further advances in the detection of early pelvic cancer will probably not occur until we educate our young women as to the ease and necessity of routine pelvic examination before the sex inhibitions become so fixed" (Allen, 1954). Allen's allusion to "sex inhibitions" indicates that more was at stake than accurate

diagnosis of gynecological disease: He and other gynecologists were worried that many of the adolescent girls they saw in their practices had an "unhealthy" attitude toward their genitals, expressed in excessive modesty or anxiety in regards to this area of their bodies. Physicians claimed that the pelvic exam helped foster normal sexual adjustment within marriage frigidity, dyspareunia (painful intercourse), sterility, and hostility toward her spouse (Schauffler, 1964).

Sex education programs came under increasing attack not during the conservative 1950s, but during the late 1960s, led by anticommunist organizations and the early beginnings of an organized religious right. By the end of the 20th century, opposition to increasingly controversial topics, such as condoms, HIV/AIDs, and gay, lesbian, bisexual, and transgendered sexual identities, led to the creation of the abstinence-only programs we are familiar with today (Freeman, 2008). Many parents object to mandatory vaccines that prevent the human papilloma virus (HPV), which has been linked to cervical cancer. These parents claim that mandatory vaccination violates parental rights and "promotes promiscuity" by protecting girls from the consequences of their sexual behavior (Charo, 2007).

THE BIRTH CONTROL MOVEMENT

In the 21st century, women face numerous options for controlling their fertility, from barrier methods to hormonal contraceptives. Yet despite an increase of choices, birth control remains controversial and fraught with complications. More and more women have come to rely on hormonal methods, which are highly effective in terms of preventing pregnancy, but also introduce new health risks and side effects into otherwise healthy patient populations. In addition, the question of choice has become more complex, as individuals and groups debate the safety and legitimacy of certain types of hormonal contraceptives, as well as their use on minority populations and the disabled.

The term "birth control" was coined by Margaret Sanger, the leading activist for contraceptive prevention in the 20th-century United States. Specializing in obstetrics, she witnessed women struggling to deliver and raise baby after baby in crowded urban conditions with little money or power. She recalls the many women who begged her to tell them the "secret" to preventing conception. All she could recommend, however, were condoms or withdrawal, both of which required the cooperation of the male partner. She vowed to make this her lifelong crusade—making birth control accessible to all women. She began publishing *The Woman Rebel* in 1914, a magazine intended for working women to educate them about sexuality and contraception. She also used this publication to challenge the Comstock Law, in effect since 1873, which prohibited the importation and mailing of contraceptive information and devices in the United States. She used the term "birth control" in her magazine to replace more awkward phrases such as "family limitation" or "voluntary motherhood" (Chesler, 1992). After seven issues of the magazine, the paper was shut down, deemed "unmailable" by the U.S. Post Office (under the Comstock Obscenity Laws). In 1916, Sanger opened the first birth control clinic in Brownsville, New York. Although the clinic did not stay open for long, the experience made her realize the importance of obtaining medical support for birth control.

Although birth control was not openly discussed in public in the early 20th century, there was plenty of evidence it was already in use, at least within certain socioeconomic groups. College-educated, middle-class white women demonstrated, by a dramatic drop in fertility, that they were practicing some form of birth control in the 1920s. Katharine Bement Davis's massive 10-year study (published in 1929), entitled *Factors in the Sex Lives of Twenty-two Hundred Women*, revealed the extent to which certain women were familiar with forms of birth control. Seventy-four percent of 1,000 college-educated women who were queried admitted to using some form of contraception, although information on birth control had "virtually been driven underground." Many middle-class social reformers couched their concern in eugenic terms, fearing that the Anglo-Saxon population would soon be overcome by immigrants and African Americans. Over the course of the 20th century, the White middle-class birthrate had dropped by nearly half, from seven to just over three children per woman. Although Teddy Roosevelt and others had sparked a widespread concern about "race suicide" at the turn of the century, the white middle-class birthrate dropped even lower in the 1920s. The rate of childlessness reached a record high in the 1920s and 1930s, and the birthrate would not actually begin to increase until the postwar era (May, 1995).

Though the declining birthrate demonstrated that many women (predominantly in the middle and upper classes) still managed to gain access to birth control, it was not widely talked about in public. Most professionals, including physicians and even feminists, avoided such a controversial topic, which they believed might undermine their credibility. Physicians, as James Reed points out, had "no strong motive for a positive attitude toward birth control," often because they, too, were concerned about the declining birthrate and the change in sexual mores. As a result, physicians "betrayed a startling reticence and lack of information on the subject." They often perceived contraceptives as both morally and physically dangerous. Since its antiabortion campaign in the 1870s, the profession regarded itself as "the gatekeepers of women's virtue" (Chesler, 1992; Reed, 1978).

Given the reluctance of medical professionals (and even many feminists) to support her cause, Sanger took another approach. Rather than directly challenging the Comstock Law, she sought to reform it. She toned down her argument that women had a right to control their own bodies, instead marketing her crusade as a public health campaign. She began pushing for a "doctors only" bill that would exempt doctors from criminal prosecution. Eventually, this strategy would prove effective. With massive financial backing from her wealthy second husband, Noah Slee, Sanger helped establish the first birth control firm that would sell birth control devices directly to doctors, the Holland-Rantos company (Tone, 2001). This approach encouraged more doctors to support the medicalization of birth control, providing a financial incentive. For example, they could purchase diaphragms directly from Holland-Rantos, then prescribe them to their patients at a profit. In the 1930s, for example, doctors marked up the price of individual diaphragms anywhere from 75 cents to more than $3, depending on the design (Tone, 2001).

Two events in the 1930s further legitimized the use of physician-controlled contraceptive use. First, in a landmark decision,

U.S. v. One Package of Japanese Pessaries (1936), the U.S. Supreme Court permitted the modification of the Comstock Law to allow physicians (only) to order contraceptives through the mail. Second, the American Medical Association voted in the following year to endorse physician-prescribed contraceptives. As a result, birth control gained legitimacy in the eyes of many people. In the process, however, birth control fell under the direction of doctors rather than women—a far cry from what many envisioned. Some historians have viewed Sanger's collaboration with the medical professionals as a betrayal of Sanger's earlier commitment to grass-roots feminist birth control activism. They have also rightly criticized Sanger for tacitly endorsing the population movement's tendency to focus their population control efforts on poor people of color in the United States and developing countries (Gordon, 1990).

The *One Package* decision only affected federal laws regarding contraception, but individual states could and did impose additional restrictions on the sale and distribution of contraceptive advice and devices. The state of Connecticut had one of the most restrictive laws in the nation: Even physicians were prohibited from giving contraceptives to their patients, and the law did not make any exceptions for women whose health or lives would be endangered by pregnancy (Garrow, 1998). Connecticut did, like many states, have a compulsory sterilization law for women who were deemed "unfit" to reproduce by the state, but it imposed severe restrictions on voluntary sterilization for women who requested this method of fertility control. Women had to be married, and the number of children they had plus their age had to equal 30 or more (Kluchin, 2009). Consequently, sterilization was the only legal means of contraception in Connecticut (Garrow, 1998).

In 1958, Dr. C. Lee Buxton, chair of Yale Medical School's department of Obstetrics and Gynecology, and three of his patients filed a lawsuit claiming that Connecticut's laws prohibiting the sale, distribution, and use of contraceptive drugs and devices were unconstitutional. The suit reached the U.S. Supreme Court in June 1961, but the court dismissed the case because no state laws had been violated. Yet, the court opinion that accompanied the decision also declared that Connecticut's laws were "dead words and harmless, empty shadows." On November 1st of that year, the Planned Parenthood League of Connecticut, led by Buxton and Planned Parenthood's Executive Director Estelle Griswold, decided to test the validity of the court's opinion, and opened a birth control clinic in New Haven. Nine days later, Buxton and Griswold were arrested for violating state laws outlawing contraception. The defendants appealed their case all the way to the U.S. Supreme Court, culminating in the court's decision in *Griswold v. Connecticut* (1965) declaring that Connecticut's birth control law unconstitutionally intruded upon the right of marital privacy (Johnson, 2005).

The *Griswold* decision only applied to married individuals. Although Connecticut removed restrictions on contraception for the unmarried as well, most states were silent on the issue of whether the unwed had the same privacy rights. Massachusetts and Wisconsin explicitly outlawed prescribing or distributing contraceptives to unmarried individuals (Pilpel & Wechsler, 1969). In 1967, the Boston vice squad arrested contraceptive salesman Bill Baird for "crimes

against chastity" when he gave a can of Emko contraceptive foam to an unmarried teenaged girl following a lecture at Boston University. Two years later, Baird was again arrested after a demonstration at Northland College in Ashland, Wisconsin. In 1972, the U.S. Supreme Court heard the criminal case against Baird, and declared in its decision *Eisenstadt v. Baird*: "If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child" (Munro Prescott, 2007).

The introduction of hormonal contraceptives guaranteed that birth control would remain steadfastly under the control of doctors. When the U.S. Food and Drug Administration (FDA) approved the first birth control pill in 1960, debates about contraceptive use took on a whole new turn. Emerging at the dawn of the sexual revolution, the pill raised expectations that women were sexually available. By 1965, more than 6 million women had taken oral contraceptives. Planned Parenthood noted that 70% of all women using its services for birth control chose to get a prescription for the pill. By 1990, more than 80% of American women born in the postwar era had tried it (Watkins, 1998). The pill offered many advantages over barrier methods of birth control: It was highly effective, convenient, and entirely separated from the act of intercourse. It also did not require the consent or even awareness of a male sexual partner. Both doctors and female patients initially expressed enthusiasm for this new form of birth control. Yet, by the end of the 1960s, many had lost confidence in this new form of birth control.

The first pill, Enovid, contained approximately 10 times the amount of progesterone and 4 times the amount of estrogen used in later doses. Many women suffered from severe side effects, including blood clots and heart attacks. In 1969, the U.S. Senate conducted hearings on the safety of the pill, resulting in the requirement that makers of the product include a patient package insert warning of potential side effects of the pill. As a result, pill use dropped by 20%, but it remained the most popular contraceptive.

Other controversies continued to complicate the debate surrounding hormonal contraceptives. Growing cynicism and a rising women's health movement (see later section) raised new questions regarding the validity of prescribing hormonal contraceptives to millions of healthy women. Many people accused scientists and doctors of using women as guinea pigs whose health was expendable in the name of scientific research. One of the most controversial forms of hormonal birth control was Depo-Provera, which was injected intramuscularly every 90 days to prevent ovulation. Although highly effective in preventing pregnancy, Depo-Provera's availability to and higher use among poor and minority patient populations before it received FDA approval in 1992 generated concern among activists that the drug was a dangerous tool for population control advocates. Journalists reported that women were lining up by the thousands for contraceptive injections in developing countries, funded by international family planning organizations. One Namibian physician noted that injections were "simply banged into black and colored women, without discussion, explanation or even permission" in the 1980s (Lindsay, 1991). These reports generated concern about racist population control policies, and also drew attention to poor scientific research methods.