Chapter 23

A feminist perspective on the use of self-regulation theory in health psychology

H. Lorraine Radtke

Department of Psychology, University of Calgary

Janneke van Mens-Verhulst

Department of Clinical and Health Psychology, Utrecht University

SUMMARY

Within the field of health psychology, the biopsychosocial model predominates, with a focus on cognitive processes and individual behaviour change. Of particular interest to us are the self-regulation models, which are central to the study of both health promotion and intervention. For the most part, these are put forward as generic models with universal applicability. Terms reflecting a person's social locations, such as *gender*, *sex*, *ethnicity*, *race*, and *social class*, do not generally appear in the indexes of classic texts on the theory. On the other hand, the emerging field of critical health psychology now offers alternative perspectives (e.g., Crossley, 2002), and growing interest in the implications of gender and other diversities challenges any universal claims made by health researchers (e.g., Kazarian & Evans, 2001; Ussher, 2000). In this chapter, we critically evaluate the Common Sense Model (CSM) from a feminist perspective and focus specifically on what an intersectionality perspective has to offer.

HEALTH PSYCHOLOGY AND DIVERSITY

Interest in social locations/identities and health typically appears within the field of health psychology as an interest in diversity. This includes gender as well as culture, race/ethnicity, and sexuality. Published texts on women and health have been around for some time (e.g., Blechman & Brownell, 1988); more recently, a number of collections exploring cultural differences have appeared (e.g., Kazarian & Evans, 2001), including some focussed on women and culture (e.g., Ussher, 2000). As interest in sociocultural difference is growing within the field of health psychology, this would seem to be an opportune time to critically evaluate how health psychologists take social and cultural differences into account. Our aim in this chapter is relatively modest. We critically evaluate a prominent theory within health psychology, the self-regulation approach to health and illness, from a feminist perspective and focus specifically on what an intersectionality perspective has to offer. In effect, we enter into a dialogue with Self-regulation Theory and suggest that Intersectionality Theory might render Self-regulation Theory more useful to health psychology in addressing diversity and incorporating a feminist perspective in its account of gender and other differences.

INTERSECTIONALITY

Intersectionality Theory originated in the feminist research literature in the context of understanding difference, and refers to the notion that dimensions of difference are intertwined and operate simultaneously (e.g., Crenshaw, 1991; McCall, 2005). In other words, individuals are located at the intersection of social categories such as gender, race/ethnicity, age, sexuality, and so on. The term 'social category' is used in a provisional way to refer to socially meaningful distinctions that are socially constructed, unstable, contested, and relational. Indeed, 'social location' better captures the geographical metaphor of intersectionality than does 'social category'. It is understood that relevant dimensions of difference change over time and have histories related to the local context. Identity and power are also important concepts within Intersectionality Theory; an individual's social locations have implications for her identities and for the power relations in which she is embedded. Importantly, the social and power relations constituting gender, race, and so on, come together in an individual woman's life and make a qualitative difference in her day-to-day actions and interactions with others. They are not simply additive, nor can their effects be separated. Thus, gender difference cannot be separated from race difference, ethnic difference, and so on. Furthermore, such social locations are not only produced by power relations, they also produce power, in the sense that they have implications for what an individual may or may not be able to do. This view of social location is further complicated by the multifaceted nature of difference, where social categories such as gender are conceptualised as multi-dimensional, that is, as having cultural, social, psychological, and biological aspects.

As yet, there is a relatively small amount of published research explicitly adopting such an approach (e.g., Pinto, 2004; Sokoloff & Dupont, 2005; Yoder & Berendsen, 2001). Burman's (2004) critical essay on incorporating difference into service design and delivery is one of the few that is relevant to health psychology. She draws from two research projects: one on suicide and self-harm among South Asian women and the other on domestic violence among minority women. She argues that one of the consequences of not attending to the intersection of gender, race, and culture is 'race anxiety'. Service providers feel ill-equipped to assist women from cultural communities other than the dominant, white British culture, and fear being racist by offering them inappropriate treatment. Ironically, the upshot is that the women receive no services, and racism is perpetuated through the assumption that, for example, domestic violence is normal for that community. An intersectional perspective would lead service providers to consider how they themselves and all women seeking assistance are located at the intersection of gender, race, and culture. Consequently, interventions must be designed accordingly, and service providers need to be cognisant of the power relations not only within a woman's cultural community but within the service delivery context as well.

While preparing this chapter, we discovered a new edited volume on intersectionality and health. With a focus on race, gender, and class, the editors argue that "intersectional analysis can ... help provide a theoretical foundation for claiming health as a human right" (Schulz & Mullings, 2006, p. 15). Specifically, the aim is to understand "how gender, race, and class structure social relationships in ways that produce differentials in health and disease" (p. 7). Such scholarship supports our claim that how health psychology incorporates diversity into theory and practice requires close scrutiny.

Intersectionality Theory foregrounds identity, difference, social location, and power. Hence, we use the following inter-related questions to organise our critical evaluation of some carefully selected texts on self-regulation: (a) How is the self conceptualised? (b) How are differences conceptualised? (c) How is social location incorporated? and (d) How are power relations addressed?

SELF-REGULATION THEORY - THE CSM

Historically, Self-regulation Theory, as put forward by Carver and Scheier (1998) "concerns mostly behavior at the level of interest to personality-social (and health, organizational, clinical, and counseling) psychologists" (p. 1). Self-regulation Theory owes much to cybernetics (Carver & Scheier, 1998), and although a number of different models have been developed, they share the following characteristics: (a) cognition, affect, and behaviour are regulated to meet set goals and adjusted as the context changes; (b) there is a continuous process of setting goals, developing strategies to meet those goals, and revising goals and strategies; (c) 'feedback loops' involving set goals as the reference point for evaluation are the mechanism through which goals and strategies are revised — success could entail achieving similarity or dissimilarity to the goal; and (d) the evaluation of success involves a comparison process where distance from the set goal is evaluated, adjustments are made accordingly, and the distance is retested until the cycle is stopped (Cameron & Leventhal, 2003). For purposes of this chapter, we focus on Leventhal's Common Sense Model (CSM), which was developed specifically within the context of health and illness in the 1980s (Leventhal, Meyer, & Nerenz, 1980) — we draw on Cameron and Leventhal's (2003) recently edited volume with chapters largely informed by the CSM. The CSM has received considerable attention for its proposal that illness representations are formulated in five content domains (identity, timeline, consequences, cause, and control), which shape goal setting, the procedures adopted to meet those goals, and the appraisal criteria. Our attention, however, will be concentrated on the processes involved.

On the surface, the CSM appears promising from an intersectionality perspective. For instance, in the introduction to their edited volume, Cameron and Leventhal (2003) include a brief section entitled 'Self-regulation within the social and cultural systems'. In addition, there are chapters on gender and culture. They further claim that the CSM better addresses health issues than Carver and Scheier's earlier version because it focuses on content in the form of the interpretation and cognitive representation of illness rather than emphasising abstract processes. Our choice of the CSM as the focus of critical analysis is due then to its closer ties with health psychology and its promise for incorporating diversity. We turn now to our four questions.

Self

As Leventhal, Brissette, and Leventhal (2003) put it:

> the self remains the primary agent of self-regulation; more importantly, the process of self-regulation makes use of subjective information, symptoms, and emotional states that are not directly available to observing others. In fact ... individuals hold different views about their health and the nature of their health conditions than do their family members … and the health professionals with whom they consult … In such circumstances, individuals seem to reject input from social sources by virtue of

> it being inconsistent with personal experience. Social influence and input alter self-regulation, but they do not define it entirely. (p. 56)

This view pits a rational, autonomous self against an external world of social influence. The individual is accorded agency in interpreting experience, making decisions, and evaluating the success of actions. Baumann (2003), for example, refers to the individual as an "active problem-solver" (p. 243). However, there is an underlying mechanism (e.g., "the process of self-regulation makes use of") that contradicts the agency implied elsewhere (e.g., "individuals seem to reject").

In other accounts of the CSM, the self is described as a knowledge structure that can be theorised in the same representational terms as can illness (Brownlee, Leventhal, & Leventhal, 2000). Thus, the CSM individualises self and fixes it as relatively stable, operating within rational decision-making rules associated with a mechanistic self-regulatory system, while at the same time attributing agency to it. Therefore, it faces challenges in trying to make good on its promise of attending to the socio-cultural context and difference.

Differences

A real weakness of the model is the insufficient attention paid to all the conceivable layers of difference, that is, the biological, psychological, relational, social, and cultural. For proponents of the CSM, biological and social differences are of some interest, but primarily in relation to how they shape an individual's representations. In fact, the only dimension of difference that is frequently discussed pertains to the accuracy of individual's representations. Within the CSM, people are treated as 'common-sense scientists', who construct representations of 'illness threats' much as a scientist constructs a model of a disease. These representations are then used to develop goals, strategies for achieving those goals, and criteria for assessing the success of the strategies. As this language implies, the CSM takes differences into account in cognitive terms.

For example, in their chapter on gender stereotypes and cardiac health, Martin and Suls (2003) explain women's poorer outcome after myocardial infarction (MI) compared to men as follows: "in traditional marriages women tend to be the domestic and socio-emotional caretakers" (p. 229). Hence, the problem is that women overdo it post-MI, because they "may feel compelled to reassume domestic burdens prematurely" (p. 229).

Subsequently, women's interpretations and standards are highlighted as the problem; men are explicitly excused from blame. At least, this is what the following suggests:

> We are not contending that women who are cardiac patients are 'forced' to reassume domestic responsibilities by other members of the family (i.e., their husbands). Rather, we believe that the division of labor in the traditional marriage reifies the wife as the provider of meals, as laundress, etc. For many wives, foregoing these responsibilities would be a source of stress for them because of the identity crisis that might result from giving up these tasks..." (p. 229)

So, the division of domestic labour according to gender, which is in effect a social relationship with a complex history, both local (i.e., the history of a particular partnership) and beyond (i.e., over historical time and place) becomes reduced — and individualised — as a matter of identity and reluctance to delegate. This reduction is accompanied by introducing the man as standard:

> Interestingly, when men have a heart attack, however, there appears to be a different standard or expectation involved; for them, an extended rest period seems quite appropriate... (p. 229)

And almost inevitably, the proposed solution is to ‘alter maladaptive or incorrect gender stereotypes’ and possibly provide counselling where the need for assistance from the spouse is outlined. Thus, identifying women as deficient and in need of treatment is an unfortunate consequence of reducing gender difference to a cognitive layer with men’s functioning as the point of reference.

Of course, gender is not the only social category of difference that the CSM reduces to cognitive differences. There is, for example, a notable lack of concern for differences in socioeconomic status, sexuality, religious orientation, ability status, education, and so on. Moreover, no consideration is given to the potential unique effects of multiple points of difference, that is, the intersection of differences.

Social Location

Such lack of consideration for individuals in their social contexts, be that personal relationships, social groups, or the larger culture, appears to contradict the intentions of the CSM’s proponents. For example, Cameron and Leventhal’s (2003) introductory chapter includes a brief description of the connection between self-regulation theory and the socio-cultural context as follows: (a) self-regulatory processes occur in a socio-cultural context; (b) individuals develop knowledge structures of illness, health, and treatment methods based on their experience in various social contexts both close to home, e.g., the family, and further away, e.g., society; (c) coping with illness and healthy social practices are constrained and enabled by social and economic resources; and (d) all aspects of the self-regulation system are influenced by the socio-cultural context, e.g., self-definition, goals, and affect. Moreover, by the authors’ own account, “illness behavior is best understood within the social context and by considering the congruence and incongruence of self-regulation systems among those involved” (p. 6). Thus, it seems the CSM aims to account for diversity even though it is rarely reflected in practice.

An additional problem is the model’s individualistic notion of self. Ironically, an example focused on infants that was meant to illustrate how self-regulation is a fundamentally social process draws attention to this limitation. Infants are described as having ‘instincts and skills’ (presumably ‘naturally’ given at birth, i.e., biologically-based) that ensure others will care for them. This is described as the earliest expression of self-regulation: “Infants regulate their emotions and physical selves (they self-regulate) by virtue of their ability to evoke and extract needed resources from their social environments” (p. 55). Note, the language here: virtually everything the infant needs is self-contained; the mother and her milk are reduced to being ‘resources in the social environment’. No relationship is theorised between the two selves, mother and child; the ease with which a biological account of the motivation for the child’s actions is assumed without question here is a harbinger for the implicit, and occasionally explicit, privileging of biology within the CSM. Also important, a single standard for the normal development of self-regulation is offered; culture and social circumstances are mere background, contributing variability along a continuum of optimal conditions. What counts are the individual infant’s abilities.

Two other chapters further illustrate the limitations in how the CSM deals with social location. Martin and Suls (2003) focus on “how common-sense beliefs and performance standards regarding gender influence self-regulation in the context of

cardiac disease" (p. 220). As we noted in the previous section, gender and gender stereotypes are treated as straightforward cognitive representations. "Based on the differential exposure and attention given to male rather than to female cardiac patients ... laypeople are likely to recall more male than female acquaintances who have suffered from heart disease" (p. 224) and "...laypeople are likely to conceptualise the typical Coronary Heart Disease [CHD] victim as male and therefore be slower to entertain the possibility that a woman might be experiencing an MI" (p. 224). In other words, women with symptoms of cardiac disease take longer to seek treatment than do men because they misunderstand it to be a 'male disease' based on their using the availability and representativeness heuristics to guide their decision-making. Consequently, while gender as social location appears in the form of "differential exposure and attention given to male rather than ...", it nevertheless is pushed aside as the focus turns to individual, cognitive processes (i.e., expectations that a CHD victim will be male).

In her chapter, 'Culture and illness representation', Baumann (2003) expresses concern about decontextualising and individualising social problems. She argues that it is important to understand how local social conditions, such as poverty, contribute to illness; how the self-regulation process varies in less individualistic cultures; and how local knowledge might be recruited to facilitate health interventions. Surprisingly, in using the CSM as a framework, she uncritically adopts its universalist and individualist assumptions, offering a contradictory discussion of the place of culture in the CSM. Following the model, she turns culture into a matter of cognition as opposed to something people produce: "The culture and the experiences of the individual are melded into their mental representations and health practices through the processing of information about the external and internal environments" (p. 243). Moreover, in discussing 'other' cultures, she points out the socially constructed nature of their health knowledge: "Folk illnesses are culturally constructed categories that may be in conflict with the biomedical paradigm" (p. 244). Yet, the biomedical paradigm is not included as a knowledge system that has been socially constructed within a particular cultural context. Taking a cross-cultural perspective (Seeley, 2003), Baumann highlights the five content domains of illness representations as universal; culture introduces variability only in the form of content. Gender and other types of diversity are absent from the article, thus further underscoring the assumption of universality.

Power Relations

There is no explicit uptake of the concept of power in the texts reviewed. In fact, there are several places in the texts where power relations are relevant but were not considered. For example, Baumann's (2003) analysis does not recognise that the very notion of 'illness representations' arises in the context of a particular culture, and power relations are involved in assuming universal psychological structures. Similarly, the 'differential attention to male cardiac patients' noted by Martin and Suls (2003) implicates power relations within the health care system and raises the issue of potential gender bias. We can only interpret their silence on the matter as meaning that they viewed this point as irrelevant. In contrast to Martin and Suls' analysis, we would argue that the explanation for poorer post-MI outcomes among women may be found in the power relations associated with gender, and specifically, within heterosexual marriages. In addition, within the CSM literature 'expert' or 'scientific' knowledge is generally pitted against 'common sense' or the knowledge of 'lay people'. It is taken for granted that experts with the technological tools and objective wisdom to diagnose an individual's biological status are needed to assist in the self-regulation process: Because

"the perceptual input provided by the body is often vague and diffuse" (Leventhal et al., p. 55), the individual's self-knowledge, for example, pain perception, and reality may not match. Consistent with medical discourse, biology is privileged, that is, the effectiveness of any strategy adopted by an individual is to be determined by its "relationship to the individual's biological status" (Leventhal et. al., 2003, p. 54). Consequently, the self-regulator is placed in a subordinate position in relation to medical authority. That 'biological status' itself may be open to interpretation and that justification is needed for privileging the doctor's perceptions over the patient's and the biological over the social are not considered (for some recent feminist perspectives on this, see Birke, 2000; Klinge & Bosch, 2005; Kuhlmann & Babitsch, 2002). In short, a power perspective highlights quite different aspects of the processes involved when people deal with illness and receive care.

In conclusion, our critique of the CSM centres on four main points: (a) the CSM posits a rational, fixed self, who is both agent and component of a mechanistic self-regulatory system; (b) the CSM has a cognitive bias and therefore fails to incorporate non-biological and non-psychological differences, specifically the relational, social, and cultural, in any useful way; (c) the proposed self-regulatory system is individualistic and assumed to be universal, but with variations in content related to culture; and (d) the CSM ignores power relations. In other words, Self-regulation Theory seems to be weak in precisely those areas where Intersectionality Theory has strengths. Nevertheless, close study of the CSM suggests that there is more space than currently utilised to address these points: we turn to this point in the following section.

INTERSECTIONALITY THEORY AS CORRECTIVE*?*

Our critique of Self-regulation Theory is similar to others found in the developing field of critical health psychology (e.g., Crossley, 2000), but instead of rejecting the CSM outright in favour of some alternative, we want to argue for its rehabilitation through the incorporation of insights from Intersectionality Theory (for a less optimistic view on the potential rehabilitation of theories such as Self-regulation Theory, see Stam, 2000). We do this for pragmatic and political reasons. Given the prominence of the CSM within health psychology, a revision that is sensitive to culture and power will have significant impact on research and practice in the direction our critique points to. At the same time, bringing a feminist theory into a mainstream discipline such as health psychology is a potentially important means of encouraging interdisciplinarity and in particular strengthening the connections between feminist studies and more traditional fields (McCall, 2005).

The question we address in this final section of our chapter is whether it is possible to use Intersectionality Theory to revise the CSM and address its weaknesses. To this end, we consider a number of contributions that Intersectionality Theory might make to the CSM.

First, Intersectionality Theory posits a self that is multiply positioned and constrained by power relations. Drawing on this notion of self then, a self-in-process, a self always under construction and located at varying cross-points in the network of power relations associated with social distinctions such as gender, ethnicity, and so on, would replace the fixed, rational self of the CSM. In addition, although we do not have the space here to elaborate on this point, replacing the linear self-regulation process characteristic of the CSM with self-regulation based on a non-linear dynamic systems

approach (Van Dijkum, 1997) would allow for the complicated multiplicity characteristic of intersectionality.

Second, Intersectionality Theory highlights difference and social location. For the CSM, differences and social locations can be translated into 'moderators' that influence the strength and/or direction of the relationship between the independent and dependent variables or 'mediators' that explain an existing relationship (Baron & Kenny, 1986). Similarly, Leventhal et al. (2003) propose to deal with self-knowledge and social factors in this way. This seems remarkably like intersectionality, that is, illness representations cannot be separated from the individuals who construct them, and these individuals' understandings of illness will be shaped by gender, ethnicity, socioeconomic circumstances, sexuality, and so on. Consequently, illness representations always reflect the individual's social location; highlighting this dependency would move the CSM away from its one-sided cognitivism and individualising tendencies.

Third, Intersectionality Theory leads us to be critical of arguments for universality. Clearly, the CSM reflects Western intellectual and cultural traditions in its emphasis on rationality, linearity, and a fixed self. These assumptions are also embedded in Western medical discourse. Therefore, the assumption of a universal self-regulation process should simply be abandoned. Instead, the appropriateness of the CSM for particular cultural contexts should be critically evaluated a priori and treated as a matter requiring justification.

Fourth, Intersectionality Theory recognises gender, ethnicity, and so on, as power relations. The debatable point however is whether you can reduce these power relations to variables, as the CSM would do, and still produce knowledge informed by those power relations. Part of our optimism about the rehabilitation of the CSM comes from studies on intersectionality that have treated diversity relations as 'incomplete proxies' (e.g., McMullin & Cairney, 2004) or 'provisional' categories through reducing them to categorical variables (e.g., McCall, 2005). In these studies, power relations are treated as an integral component of the formation of the categories as well the analysis. In short, infusing the CSM with the insights of Intersectionality Theory would yield a self enabled and constrained by the complex power relations of diversity.

A final point we wish to make about the CSM and power is the need for a reflexive stance. The CSM conceptualises people as interpreters of stimuli, whether they are bodily symptoms or public health campaigns. The proponents of the CSM, both researchers and health care providers, simply need to conceptualise themselves in the same terms. In other words, the CSM could explicitly acknowledge that both expert and layperson actively interpret new knowledge available to them through the lenses of past history and present perspective.

What might an application of the rehabilitated CSM look like in practice? As an example, we use Martin and Suls' (2003) research addressing why women have poorer post-MI outcomes than men. First, with regard to self, we would be interested in the patients' multiple positioning, that is, not only gender but also ethnicity and socioeconomic status (and possibly other social locations as well) and the relationship between the patients' location at the intersection of multiple power relations and post-MI outcomes. Second, with regard to differences and social location, we would be especially interested in differences that matter to the patients (e.g., do they identify as members of a particular ethnic group?) and also incorporate the historical context because the meaning of differences such as gender vary by cohort. Third, with regard to self-regulation, we would consider the links between the patients' multiple positioning

and the hypothesised stages of self-regulation (representation, coping, appraisal). Furthermore, we would explore the patients' concerns post-MI, their efforts to develop an identity as (wo)men post-MI, their perspectives on what they need to successfully recover post-MI and what they perceive as gaps between what they need and the care available to them. We would also explore what they are doing to manage post-MI, from their point of view. In that way, we would gain an understanding of the inter-relations among the biological, cognitive, affective, social, and cultural layers of difference. Fourth, with regard to power relations, we would explore the discourses about ill (wo)men that constrain and enable their understandings of their illness, treatment, and recovery Furthermore, the patient perspective could be compared with the health care provider perspective without privileging one account over the other in order to critically evaluate the problems patients encounter post-MI. We would also be interested in exploring how the patients' relationships with their partners (if relevant), dependent children, employers and colleagues, and with their health care providers are related to post-MI outcomes. Finally, researcher reflexivity would be an integral part of the research process, and at every step, there would be sensitivity to the possible relevance of other social locations such as age, class, and ethnicity. Naturally, the implementation of these recommendations remains to be realised and might present challenges we are not able to anticipate at the moment. Our goal here has been to provide a concrete set of research questions generated from a rehabilitated CSM.

In conclusion, in this chapter we have offered a critique of the CSM that was informed by Intersectionality Theory and critical health psychology. We have also argued that the CSM could address some of these criticisms by adapting insights from Intersectionality Theory into its framework. Specifically, abandoning the individualistic, universalising focus of the CSM and incorporating greater emphasis on social location, difference, and power relations could contribute to changes in health care research and practice that would enhance sensitivity to diversity.

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