

Gender and Psychosocial Impact in Coronary Vulnerability in Men and Women

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“A DISEASE OF MEN AND THEIR LIFESTYLE”: CONSTRUCTION OF SOCIAL REPRESENTATION OF CORONARY HEART DISEASE

Cardiovascular diseases are a major health problem of epidemiological significance in Argentina. It is the second cause of death in male and female adults between 35 and 54 years of age, and it is the first cause in men of this age group. In Argentina, the death ratio for cardiovascular diseases between men and women is 3-4 males per female, and is one of the factors determining early excess male mortality. (1) This largely impacted on the difference in life expectancy rate at birth between men and women in all the country in 2005-2010: 79.10 years for women, and 71.60 years for men, with a gap of 7.5 years between the two genders. According to the same source, the data for the city of Buenos Aires were slightly higher than those for the rest of the country: 79.39 years for women and 71.80 for men, with a gap of 7.6 years. (2) During the first half of the XX century, cardiovascular diseases were considered a “men’s disease”, while a new perspective based on the increased number of cases in the female population begun to be considered from the second half of the XX century to the present. (3)

It is important to highlight that today, despite the scenario changes due to higher female incidence, the imaginary about coronary heart disease still considers it a “men’s” disease, with a high incidence after the age of 35 and strongly influenced by psychosocial factors as part of its risk construction. (4) Possibly, such imaginary is supported by the way in which the epidemic began (a disease of men in their productive age) and the fact that the age gap between men and women for disease onset (at least until the age of 55 years) was preserved, even though the number of women affected continues growing.

Fortunately, the increasing incidence of ischemic heart disease is currently being accompanied at the international level by awareness of female specificity on this issue, leading to developments that, nevertheless, are not fully available to medical professionals responsible for the care of these female patients in the

country. As an informative summary, the main contributions to understand the difference in how men and women get ill, consult, and die as a result of this type of health problem are:

- Identification of specific risk factors. (5)
- Specific presentation of the disease in women. (6)
- Improvements in early detection. (3)
- Specific clinical cardiac treatment. (7)
- Higher mortality in women with this disease compared to men. (8)

Moreover, the fact that it was considered a “men’s disease” does not mean that the particular risk construction was widely studied in these patients. In general, the various aspects of everyday life and subjectivity that affect their fragility have not been studied. As referred to by some authors, (9, 10) the real needs and practices of men - “supposedly taken into account” in the conformation of the universal subject of modernity- are unknown, a matter that the Studies on Masculinity are trying to solve in general terms (11), and particularly in the field of health. (12, 13)

In this regard, and in line with the latest advances, our work intends to contribute from a subjective perspective to a problem with very high social cost, in order to identify exclusive factors that help understand the specific and differential risk construction according to gender. Identifying those factors may contribute to improve quality and life expectancy in both men and women, and also advance in the degrees of gender equity and quality of care for patients. (14, 15)

Since 1998, this team has been doing research on the relationship between gender and coronary heart disease in the Research Institute, School of Psychology, at the University of Buenos Aires. The framework to approach this study is represented by the junction of Social Sciences in Health (also known as Collective Health or Social Medicine, depending on the country of reference), Psychoanalysis and Gender Studies, and qualitative research is conducted to clarify the generic forms of getting ill, consulting, and receiving medical care. This approach allows creating an analytical model to encompass health, subjectivity and gender,

with special emphasis on the way social asymmetries between men and women cause disparities in living conditions, differentially determining the health-disease-care process in both generic groups. (16)

Our starting point is the consensus on the multiple etiologic determinants of this condition. Psychosocial factors are added to traditional biomedical risk factors, (17) which may in part explain the differences in incidence of coronary heart disease in both genders. (18)

Thus, we have explored within the psychosocial factors, how these patients construct their male and female subjectivities. This exploration had not been addressed before, and can provide tools to improve avoidable health inequity.

This article presents a synthesis of the results of four research projects on this topic, conducted by this team over the past 14 years. (19-22)

HOW PSYCHOSOCIAL VULNERABILITY IS SPECIFICALLY CONSTRUCTED. CORONARY HEART DISEASE IN WOMEN

Based on the way in which subjects construct how they are, live, get ill and die, ways of being related to gender and associated to ideals and differential social life demands have been identified for men and women. As a result of concomitant changes in men's and women's social roles, these ways of being have been varying over the past 50 years. Thus, a scale including these variations has been created, which sets traditional, transitional and innovative forms for male and female genders to identify their specific impact on heart health. As an example, it is pointed out that the traditional model would act as "baseline". When it comes to women, this model corresponds to a female type associated with maintaining the sexual division of work established by the requirements of the modern industrial model in need of women-mothers who care for the domestic space and future workers, and of male wage earners in the public space who undertake the role of financial providers of their households. The model implies a division of roles by gender and an asymmetrical power relationship between them, by which men obtain more social privileges and liberties than women. The transitional model would include a similar division of roles and power but more tempered and democratic than in the previous model. Conversely, innovative forms do not share a defined pattern except for their diversity, as they include a wide range of binding and subjectivity construction modalities, in which maternity for women and the imposed financial provision exclusive for men are considered an option rather than a mandatory issue in the construction of a life project. On the other hand, women's labor insertion, varying by social sectors, is a condition for the self-sustenance inherent to this model, whether they live alone, as a couple or with their families.

These models represent life ideals from which male and female subjects see themselves and are seen by others. Therefore, they are closely related to the

construction of their life projects, their wishes, and the contents of their self-esteem.

Passing judgment on the values upon which subjects base their self-esteem has been extensively studied in our setting as risk factors, and in some cases, as "triggers" of acute coronary events. (23) Therefore, identifying specific male and female modes, segmented by the social group constitution of these ideals, has been one of the major research contributions presented by this article to the psychosocial factors impacting on coronary risk construction. Vulnerability is considered a risk structure modality characteristic of chronic diseases that are not resolved by being exposed to a factor but by long-term construction associated to modalities and living conditions.

For that reason, the first two research studies surveyed men and women after an acute coronary event, from two social environments (interviewed in one public and two private hospitals) in the city of Buenos Aires, which revealed two specifically female and male modes to build psychosocial risk for coronary heart disease. Semi-structured interviews to male and female patients with acute coronary syndrome were conducted with a comparative qualitative design, and then they were compared with interviews in a control group of men and women hospitalized in the clinical medicine unit of the same health care center for other conditions and with similar socio-demographic characteristics.

Regarding the female population, women interviewed with coronary heart diseases from low economic sectors, showed traditional female patterns: it was their first marriage, motherhood was the center of their lives, and they were housewives or domestic workers. So far, these characteristics had been seen as "protective factors" for this type of conditions, considering successful women as the only vulnerable ones, who are perceived and act as "indispensable", multi-task persons, who work outside their homes in competitive jobs, and who apparently resemble "men". However, we confirmed that women from popular sectors did not follow the expected pattern, but were overexerted and had the "superwoman syndrome", (24) which had remained invisible. In this case, the superwoman shows characteristics inherent to the popular urban sectors, in which women who live in a subsistence economy assume the belief that they should find a solution to everything, a risk that increases in times of worse living conditions. When this overload, associated with social factors, is added to the fact that women –for psychological reasons linked to the subjectivity model of the traditional female gender– show a tendency to overexert themselves, the increase of this psychosocial risk factor is exponential, thus intensifying their coronary risk.

Among women from middle and upper sectors with heart conditions, hyperactive women who "cannot stop" were detected, with a fine sense of what is happening but a great difficulty to address and solve

the problem. They tend to be perfectionists and omnipotent, with a hurried pace of life and difficulties in articulating areas. Therefore, the inclusion of these women into modern life and the labor market as full-time employees has confronted them with diverse conflicting areas: work, family, personal development, current aesthetic ideals, etc., for which they are very self-demanding, without flexible expectations. This puts them in a red zone of risk and may confront them with *dying in the attempt*. In this social sector, they are superwomen who, instead of adapting ideals and articulating areas, set aspirations at maximum self-imposed pressure. A self-imposed pressure that increases with the fact that they usually work alone, overloaded with demands, thus increasing risk. Today, this syndrome is considered a female-specific stressor associated with coronary risk; on the other hand, it allows identifying supportive activities and team work as protective factors, since they promote psychosocial aspects that contribute to a healthy heart.

The social imaginaries about coronary heart disease as “men’s disease and their way of life” have characterized these women as masculinized, distorting the perception of reality, as it is the woman who pays the cost of becoming autonomous in a world where the valued model is traditionally male. Therefore, the occupational stress which those women are exposed to is more complex than considering it as the result of being subjected to the same demands as men. (25-27) It is a specific demand directed to women who should “act like men” in a working environment that, in general, does not value the characteristics women have to offer, except for the less-qualified and less-paid care activities. Since the prestigious high-income world often devalues most of the female styles, it demands of women twice the effort it asks men for the same tasks, encourages them to adopt masculine styles, and then it accuses them of losing femininity.

IT IS NOT JUST A WOMEN’S PROBLEM. MEN WITH CORONARY HEART DISEASE FROM A GENDER PERSPECTIVE

Even when the trend is to consider gender approach as a synonym of female specificity, the first two research studies included a population from both sexes and worked within a comprehensive, broad-based framework using male gender markers to identify psychosocial risk markers for coronary heart disease in male subjects.

Thus, men with coronary heart disease from the same two social sectors as women with the same condition were studied and compared with control groups of similar socio-demographic characteristics. The comparison between the two male groups revealed that coronary subjects interviewed from both social groups showed higher level of education compared with their control counterparts, related to pursuing academic credentials associated with high standard expectations of work performance.

In turn, they showed a reproductive pattern char-

acteristic of the social model of postmodernity masculinity, with the ideal of building a nuclear family as a means of “organizing one’s life”, with a trend to longer stable relationships than their control groups.

Their income was higher than that of subjects without heart disease from each social group, which is associated with being branded as the rich of the neighborhood (the most successful, included and demanded ones from each social group), whose counterpart is the cost of being overadapted to the model of modern masculinity of each social group. And since the overadapted psychological mechanism has been largely associated with psychosomatic phenomena, (28) this form of including the social ideal contributes to increase the risk.

Another feature observed is that they conceptualized themselves as exceptional; therefore, it was difficult for them to understand that they might undergo a coronary event, let alone on their way toward success. This analysis focuses on one of the hard cores of risk construction in terms of subjectivity and gender in men with heart disease, because it is difficult for them to give up the struggle, even when they are aware of it, to reach the ideal of masculinity for which they are socially (as well as by themselves) accepted, but whose counterpart is the vulnerability for these type of problems.

A common trait found among men with heart disease from both groups was the coexistence of lack of awareness of the severity of what was happening in their bodies and a post-diagnosis consideration that an angina (or heart attack) “was something that could happen to them”. This is because they perceive themselves as if they were on the verge of a nervous breakdown, and know, because they belong to the male gender, that it could be in the form of an acute coronary event, but since they are exceptional even in that group, it is not going to happen to them.

Therefore, even if they can rationally describe the features of their way of life, which are connected to the morbid process, such as a life of excesses, self-demanding, enduring to the point of breakdown, highly responsible and unable to delegate tasks, idealists with difficulties in adapting to reality and in caring for themselves, this knowledge functions as rationalization, and not as appropriation of experience for a change, because it cannot function as a tool for early consultation and self-care due to the invisibility of the costs of applying and managing social hegemony for those who exercise it.

Regarding the differences between the masculine modes in the two social sectors studied, a passive attitude towards life was observed in the lowest sectors, which leads them to repress their anxiety, their nerves and their anger. It is difficult for them to control (or negotiate) their impulses and to perceive the “bodily self” as being part of their identity because of the command of industrial modernity to split body and mind.

The hypothesis that coronary heart disease is asso-

ciated with lifestyles and with men's perception as being superheroes is confirmed in the upper sector. For them, part of the main content of the deed is to care for others and become a "being-for-the-other", which places material and economic welfare of the family as a value over their own health and well-being. This is constitutive of traditional self-esteem in the male gender, which tends to consider that they will be more valued as they are "more for the others", showing difficulties to find a balance between their own needs and those of the significant ones.

Regarding the self-perception of possible triggers of acute coronary event, there are overlaps between the two social groups, mostly referring to situations in which it became clear that the image they tried hard to argue about themselves vanished against other significant ones. These situations were more traumatic because of the difficulty for these individuals to identify that the current painful situation that appeared as an accident was actually the corollary of a process that was constructed over time by the very same limitation to perceive its development.

Most of them refer that when faced with being unwell, they tend to withdraw into themselves and try to solve the problem on their own, without anyone's help because they trust no one; this is typical of these subjects, and it is a specific factor of psychosocial vulnerability.

Triggers of morbidity places them in self-demanding situations, where the effort to be at the same level of a high ideal of success or having an impeccable image of themselves, sets a type of male gender that inhabits the body with behavior that results in increased coronary risk.

In terms of work, men with coronary disease are the most integrated and successful of each social group, and they work more hours per day than subjects without coronary disease from their same social group. They prefer to work alone, and they do it in groups provided they are the leaders or coordinators, as opposed to the control group subjects, who value sharing responsibilities. While for men with coronary disease "the other" is someone who bothers, is a waste of time, or is someone useful only for being guided, for healthy subjects in the control group, "the other" is someone to share with, to help and be helped.

A striking feature is that they are more dissatisfied in the workplace than their control group with a similar type of work. It reinforces the idea that some of the differences between men with and without heart disease lie in the gap between very high expectations and reality presented by men with heart disease, and not only in the impact reality has on them. (29) It is the way they relate to reality what makes them vulnerable.

Regarding the use of free time, most men with heart disease from the lowest sector report they do not enjoy it but use it to perform activities to supplement their meager income, which indicates that, for good

and bad reasons, men affected by heart disease have incorporated the idea of productive time over leisure time. The subjects from the highest sector panic about free time, which appears almost totally regulated by or taken up with work from which "they escape". Men with heart disease from the upper sector were found to have difficulty in enjoying holidays, despite their financial resources to do so. This is proof that the difficulty to enjoy free time is psychological.

As a final thought, it can be said that subjectivity causing coronary risk in this group is the result of a way of living with high social value, and whose counterpart is the high cost of morbidity and mortality.

To summarize the findings of these first two research studies, it can be pointed out that they have shown some features of the particular modes of constructing psychosocial vulnerability for coronary heart disease in men and women aged between 35 and 55 from two social sectors in the city of Buenos Aires. Vulnerability is associated both with what happens to subjects and what subjects "do" and with the significance of such practices for themselves.

GENDER BIASES IN THE QUALITY OF CARE EQUITY

The third research study was based on a qualitative and quantitative design, and its primary objective was to explore the prejudice or concepts in cardiologists that produce a bias in gender equity for the care of cardiovascular diseases. The findings confirmed that physicians tend to treat male and female patients differently, facing the risk that some of these differences may have negative effects on the diagnosis and care of women. (30)

Conceptually, gender inequity in quality of care occurs when:

- Equal care is delivered to both sexes when needs are not equal.
- Different care is delivered when needs are equal.
- Care delivered reinforces gender stereotypes. (31, 32)

The secondary data for this research study were collected from the 1996 and 2000 National Surveys of Coronary Care Units, (33) which reported that women who had suffered acute myocardial infarction (AMI) underwent fewer coronary angiographies than men with the same condition, and fewer indications of thrombolytics and angioplasty as treatment methods. According to recent studies, this situation persists. (34, 35)

The most widespread explanation as to why women with AMI have a higher fatality rate than men is attributed to age, since women have infarctions at an average age 7-10 years older than men. In different series, this explanation turned out to be controversial, and the differences observed in the therapies suggest that factors associated with medical strategies or concepts could explain it. Within this approach, proven effective treatments for secondary prevention were

less indicated in women.

With the purpose of collaborating to broaden the perspective and *make numbers talk* the qualitative part of the same research study was conducted by interviewing cardiologists from public hospitals, private clinics and community hospitals from the city of Buenos Aires. This part of the research study allowed identifying at what levels of daily practice the avoidable differences occur, which are evident in *the large numbers*. (30, 36, 37)

The analysis shows that the fact that coronary heart disease commonly occurs in men and that its presentation is nonspecific in women affects medical behavior. Physicians tend to treat all male and female patients based on how cardiac conditions occur in the male population, with a general trend to underestimate the specificity presented by women with the same condition. There is a difficulty among physicians to think and act in clinical situations according to how each gender gets ill. This is the reason why the difference tends to inequity in the quality of care. This issue has been studied in other conditions, and has been called the *Yentl syndrome*. (38) This syndrome shows that women should behave, get ill, and consult as men in order to be “seriously” considered in our societies, because behaving and getting ill differently from men condemns them to be treated as second-class patients. The effect of nonspecific presentation of coronary symptoms, more common among women, is that physicians take a longer time to diagnose, which hinders early and effective care. On the other hand, the short time available to devote to each patient as a result of institutional pressures to speed up the number of tasks due to the imperative of efficiency, makes the situation more difficult, with a worse impact on women who have a “gender trend” for speaking about their private lives during the visit, and take longer to explain their discomfort. It is important to note that longer interviews are required to make an appropriate differential diagnosis, not confused with other conditions as is often the case and was evidenced in our fourth research study.

The professionals interviewed refer that female patients are generally more “complaining”, hindering the medical interview. In addition, it is hard for women to make early consultations in this area, because they are not considered as a risk group due to the social imaginary that this disease is present “exclusively in men”. They tend to be more trained to consult about their reproductive health. This raises the need for information and awareness campaigns targeting women on their specific coronary risk, to promote early consultation. These medical biases in addition to the characteristics of women consultation result in later diagnosis, increasing the risk of a condition for which great progress has been made in early intervention in recent years. This reality has been under-reported, because it was assumed that women consulted earlier than men in health care services.

But when “opening” the information by specialty, it was found that this does not occur in cardiology, since they are not perceived as a risk group. In contrast, it was found that once women are diagnosed, they respect and adhere to treatment more than men.

CAN ANY CHANGE OCCUR?

It is encouraging that the professionals interviewed agree on their expectations about the need to change medical attitude and address these challenges. Studies already published in different areas consider the need of having more information on the specific modes men and women get ill, consult and are cared for, as part of the specialty training. This differential and specific information would contribute to make more accurate diagnoses, as well as improve professional monitoring, and therefore the treatment and prognosis of patients with heart disorders.

GENDER AND CORONARY RISK IN THE CITY OF BUENOS AIRES: CONTRIBUTIONS TO HEALTH PROMOTION

The recent fourth research study was carried out through an invitation of the Women’s Directorate [Dirección General de la Mujer] of the Government of the City of Buenos Aires, in order to have resources to promote coronary health in women from this district. To this end, the design had the distinctive feature of including interviews to specialists in gynecology -as well as in cardiology- and phone surveys to women from the general population of the city. This variety of sources allowed diagnosing the different aspects of the issue: those who see patients when the health problem is already there, those who have a good opportunity to implement preventive action since they see female patients of various ages, and women from the general population, who need information to care for their health. The interviews were made in three health care facilities, which receive patients from the same socio-economic sectors in the Autonomous City of Buenos Aires.

In contrast with the results of 2003, great progress has been made in the results of the interview to cardiologists regarding the visibility of gender bias in some aspects of cardiology practice over the past 10 years. Respondents are more aware of the importance of identifying differences in the most frequent presentations of acute coronary syndromes between men and women. On the other hand, when they were asked about the characteristics of women in their consulting population, they reported that those from middle and upper middle sectors have a greater perception of risk, possibly because they are more influenced by the media, which have issued preventive messages to women from that social sector during this period. Both findings mean a significant advance to continue strengthening measures so that women from other social sectors can be included.

Furthermore, great difficulty was identified in evaluating the specificity of psychosocial risk of

coronary heart disease in general, particularly in women. Physicians were able to identify them properly when they were similar to those of women from the social sectors who consult in each of the health care centers chosen for this research study and to the models that are similar to those of men. This implies that identification of psychosocial factors tends to be based on experience and informal circulation of stereotypes rather than on reception of specific scientific information.

Even in those cases in which they expressed their interest in psychosocial factors throughout the interview, they have found it difficult to identify them in their practice in the absence of biomedical risk markers, which they are more experienced to observe. Possibly some of these difficulties are due to the research in this field that has been conducted using qualitative methods and comes from other disciplines in the field of health. For this reason, it is necessary to develop training and promotion of these findings from an interdisciplinary perspective, so that professionals can have a broader framework that systematically contributes to their diagnostic tools, in addition to their experience.

The interviews to specialists in gynecology were carried out in the same health care centers under the premise that it is one of the most consulted specialties by women of all ages. For this reason, gynecology could help in the prevention of heart health in women as an already successful opportunity. To that end, professionals were asked if they were adopting medical behaviors that contributed to heart health promotion and early detection of coronary risk in their female patients. As general conclusion of these interviews, most respondents feel that they are often the only physician to see women periodically in their adult life, and therefore, they refer working on prevention, monitoring specific risk factors like smoking, hypertension, cholesterol, diabetes, etc.

They consider that coronary risk is constructed over the women's lifetime and is eventually triggered at menopause, as opposed to the other health care center, where risk is considered to start at this stage. However, even when risk construction is understood in a differential mode, management of risk factors at an operative level usually begins at the premenopausal stage (since 40/50 years old).

Similarly, there were various opinions about how they determine of this health issue. While gynecologists from one of the centers consider that only biomedical factors are coronary risk factors, dismissing the social and psychological aspects of coronary heart disease, in the other center they acknowledge the importance of social and psychological factors in determining coronary risk, and therefore the incidence that life crises may have on the health of female patients. From this viewpoint, they value the importance of the information about how to act preventively on these fields, since they consider that "what is not done in

the first 30 years of age is paid at the age of 60". They identify the need for information so that consultation becomes an opportunity to track the risks being constructed during lifetime and early preventive intervention can be a way to stop its construction. Thus, they implement this view when adopting comprehensive preventive measures, many of which contribute to preserving heart health.

These measures are focused on three aspects: a) in obstetrics, to seize the opportunity of consultation of pregnant women to screen for other conditions, b) to refer to Mental Health, particularly in critical situations (menopause, surgery, reproductive problems, divorce), because all these situations pose the need to work through grief, which could trigger episodes of depression and influence on the general health, particularly on coronary risk, and c) to take into account the diversity of educational access for the consulting population, in order to express preventive messages properly and in accessible language depending on the cultural status, so that they can be understood and capitalized.

The third part of the research study consisted in a phone survey to women from the general population of the city of Buenos Aires, who were asked about risk assessment in women, identification of their own coronary risk, identification and characterization of the particular way women see "female stress", relationship between stress and coronary heart disease, and their perception of coronary risk prevention.

Their responses revealed that women consider that in terms of the life cycle, menopause is a stage in which parenting, employment, caring for parents/elder relatives and partner can coexist; therefore, in terms of psychosocial risk, they are more exposed to "the one in the middle" or "the shock-absorber syndrome" stress.

And finally, their responses suggest some effective preventive measures on topics related to quality of life and living conditions they consider increase their coronary risk:

- The right to play and not to be so demanded in childhood, and that this can be maintained over life.
- Teaching women the importance of enjoying time for themselves.
- Becoming aware that the burden of responsibilities and current division of labor by gender contribute to risk in women.
- Perceiving that increased risk in women is not only due to their insertion in the labor market, but also that this is accompanied by lack of redistribution of household work and institutional or family support for parenting.

GENERAL CONCLUSIONS

In conclusion, this is a brief presentation of the findings from four research studies conducted in Argentina on the psychosocial aspects of coronary risk

construction and quality of care for men and women with heart disease from a gender perspective. It is expected to be of interest to health care professionals who address these issues in order to encourage interdisciplinary work, including subjective and social aspects in medical practice for prevention, care and rehabilitation of men and women affected by heart disease.

Conflicts of interest

None declared.

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