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An abstract of
a thesis submitted to the Faculty of Emory College of Arts and Sciences
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Abstract

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Some of the first topics that come to mind when thinking of LGBT health include the sexual health of men who have sex with men (MSM), as well as transgender individuals' experiences in obtaining the resources they need to transition. One topic within LGBT health that has been acknowledged, but not as thoroughly studied, is the experience of queer women in health care.

This study contributes to filling the gap in research of queer women within the U.S. healthcare system. Also, it proposes new methodological approaches that can potentially expand what we can conclude from large data sets. To explore queer women's experiences in healthcare, semi-structured interviews were conducted, along with photo-elicitation, as opposed to the surveying methodology more common to research studies on this topic. Semi-structured interviews allowed data collection to resemble more of a conversation than a round of question-and-answer. Photo-elicitation, a process in which study subjects view an image and respond to what it makes them think of and/or feel, was a useful method for gathering experiences that are not easily asked forthright in an interview.

Atlanta serves as the primary study site for the experiences of queer women within the healthcare system. This study location offers a range of new insights, given that current research emphases are on the cities of New York, Los Angeles, San Francisco, and Chicago. While

Atlanta is a major U.S. city as well, its place in the American South led to the collection of rich data from participants.

The initial questions of this study concerned patient interactions with OB/GYN physicians, but these quickly expanded into different fields of medicine. After just one interview, it became evident that focusing on only one field of medicine was barely scratching the surface of queer female health experiences. Subjects discussed their experiences as queer female patients in psychiatry, counseling, the emergency room, primary/general care, and even in oral surgery. Due to the wide scope of experiences expressed through subjects' medical narratives, one can observe how heteronormativity and androcentrism influence all fields of medicine for queer female patients.

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Acknowledgments

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The Emory Anthropology Department is also significantly responsible for the completion of my thesis. Without the help and organization of Dr. Phillips, Heather Carpenter, and the other honors students in my cohort, this thesis would be of much lower quality.

I am also incredibly grateful for the subjects who volunteered to participate in this project. Without their personal, moving contributions, this thesis would not have had any chance of reaching its full potential.

Lastly, but not of least importance, I must acknowledge how grateful I am for the support of everyone who has listened to the stresses and successes of this thesis, from beginning to end. My adviser, committee members, the Anthropology honors program, as well as my parents and friends, have all been incredibly patient and understanding as I have vented, worried, and celebrated successes with them.

The lack of even one person mentioned in this section would have had a noticeably negative effect on my thesis.

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Prologue

My first interview for this project was on the day before Halloween 2019. It was rainy, and the interview itself had been hastily scheduled. I got out of class at around 11:30 and saw that the potential subject — Anna, you'll meet her later — had responded to our email thread on setting up a time and place to do the interview, and had graciously informed me that she would be on Emory's campus for the next few hours and would be willing to do the interview that day if I was able. (I made myself able by skipping my two afternoon classes.)

I was incredibly nervous. For some time, I had been anxiously worrying to my advisor about what would happen if I didn't get any interviews for my project. I didn't understand why someone would be willing to give up an hour of their free time to talk with a total stranger about the very personal topics of health and sexual identity for no monetary gain. Rather than an icebreaker, I felt like a manic chainsaw attacking a delicate ice sculpture. I was terrified to say the wrong thing and offend the interviewee. I had daymares about bringing up triggering events for them and making them cry, have an anxiety attack, or get so angry that they would yell and storm off (or, in a Skype interview, less-dramatically log off).

Thankfully, none of those things happened. Anna was a very kind, bubbly person who made it feel as though you had been friends with her for years, even if you'd only been talking for thirty minutes. We jumped from talking about backward Southern Baptists to how everyone infantilized female suicide hospitalization patients. Throughout all of the interviews, I discussed topics such as having nightmares about being pregnant, straight people performing mental gymnastics to avoid the thought that someone may be queer, and how it felt for people in positions of power to belittle you and not believe your truths — just to name a few.

It’s been a great privilege to hear these women’s stories and be able to share them with others. Each subject was understanding, kind, and willing to politely overlook my stumbling nerves when they occurred (they never went away, and I don’t think they ever will in situations like these). I hope that through these narratives, readers will be empathetic towards the unfortunate circumstances described and optimistic about the positive ones.

A Note on Terminology

This senior thesis is concerned with the common themes and concerns of queer female medical patients with their healthcare providers in the United States. It is both a mouthful and a handful of a project. When people verbally asked me what my thesis was about, it became a habit of mine to draw in a breath before describing it. I also had to think through how to describe it so that the individual I was talking to would understand what I was researching. To academics and people in the LGBTQ community, I would say something along the lines of, "I'm doing my thesis on queer women's experiences with healthcare providers." To peers who (based on my knowledge) were not a part of the LGBTQ community, I would say, "I'm doing my thesis on gay women's health." To family members (none of whom have a bachelor's degree) and random people who I knew nothing about, I said, "I'm doing a project on (gay) women's health." The word *gay* is in parenthesis because, depending on the circumstance, I would sometimes leave it out altogether.

Many LGBT individuals associate the term *queer* with its historic use as a homophobic slur used to oppress. However, some within the LGBT community have reclaimed *queer* as a non-derogatory term for self-identification. It has been argued that this act of linguistic reclamation empowers the formerly targeted group and also lessens the negative impact of its use as a slur (Popa-Wyatt 2). Nonetheless, *queer* can generate discomfort and conflict. So, why didn't I just call this thesis "The *Gay* Female Medical Narratives" or "The *Lesbian* Medical Narratives?"

The answer is that queer is not synonymous with gay or lesbian. *Gay* and *lesbian* refer to sexual orientations, while *queer* embodies ideological and performative opposition to heteronormativity as a whole. Of course, an individual can identify as gay or lesbian (or bisexual, or transgender, or any other sexual or gender orientation) as well as queer. The distinction between *gay* and *queer* mainly refers to the divide in the LGBTQ community between those who are "respectable" and those who challenge the status quo of heteronormativity (Whittle 201).

To illustrate the distinction between gay and queer, I will compare two 30-something-year-old white individuals, both native to the American Midwest, who were identified as male at birth: *Queer Eye* star Jonathan Van Ness is queer, whereas former 2020 Democratic-Nominee candidate Pete Buttigieg is gay and not queer. Van Ness (he/him/his pronouns) previously identified as a gay man, and recently disclosed that he more closely identifies as nonbinary and genderqueer (Van Ness). However, even before he came out as nonbinary, he did not force himself into being a "respectable" LGBT person but instead embraced, and continues to embrace, deviances from traditional gender norms for himself and others.

Buttigieg, on the other hand, is distinctly Not Queer. He adheres to traditional male gender norms and makes an effort to fit neatly within heteronormative society. Buttigieg embodies the "respectable" LGBT individual who wants straight people to know that he is *just* like you, except that he is not heterosexual (Gessen). He does not advocate for any significant deviance from sexual or gender norms the way that Van Ness, or queer culture in general, does.

The title of this thesis is not meant to imply that all of the subjects are queer. Rather, their actions and experiences are queer because they oppose heteronormativity in medical settings.

Introduction

This thesis addresses the experiences of queer women as medical patients in the U.S. healthcare system. The primary research questions of this project are as follows:

How does the assumption that women are only sexually active/romantically involved with men influence their sexual health, mental health, and overall confidence in the U.S. medical system?

Are there distinct features of medical fields that may make them more or less prone to making heteronormative/androcentric assumptions than others?

What are some key demographic features that may influence queer female interactions with healthcare providers? Does the age of the patient, the age of physician, race/ethnicity, gender performance, or location influence these interactions at all?

This project took place in Atlanta, Georgia. Atlanta is a unique fieldsite in that it is in the deep South but is also a significantly large metropolitan area with transplants from all over the country and the world. Atlanta's plethora of job opportunities, colleges and universities, and progressive reputation has attracted a large LGBT population. Its large LGBT population provides an ample source of participants, and also a high possibility of subjects from regions typically underrepresented in queer research studies, such as rural areas, the South, and the Midwest.

My research questions were addressed through an ethnographic approach that combined semi-structured interviews and photo-elicitation. A limitation that I had noticed from the existing research on queer medical patients was that nearly all of them used direct interviews, surveys, and questionnaires, which I perceived as having a high potential for limiting an individual's medical narrative. While the information from these studies is useful and important to know, I was more interested in using ethnographic methods to get a larger scope on physicians' interactions with queer female patients.

This thesis is divided into two primary sections: background information (Abstract, Prologue, Terminology, Introduction, Fieldsite, Literature Review, and Methodology) and results (Photo A – Photo E and Conclusion). The section titled "A Picture is Worth a Thousand Words" provides the glue between the two sections by giving more detailed information about the photo-elicitation process used.

I chose to conduct this study in the way that I did in order to compile common experiences and concerns of the queer female medical patient. These medical narratives can hopefully serve two primary purposes. Firstly, I hope that these narratives will be able to supplement physicians' understandings of how to best treat queer patients beyond a rudimentary knowledge of what 'LGBTQ' stands for. Secondly, a compilation of queer female medical narratives may hopefully provide some comfort to queer patients: that they are not alone in their frustrations as patients, and that they may find some of the subjects' experiences helpful in navigating their own medical journeys.

Fieldsite

"If the dominant LGBT narrative of the twentieth century was a gay boy in the country buying a one-way bus ticket to the Big Apple, the untold story of the twenty-first is the queer girl in Tennessee who stays put."

— Samantha Allen, *Real Queer America: LGBT Stories From Red States*

The above quote by Allen describes the typical LGBT coming of age/coming-out of the closet narrative that surfaced in the latter half of the 20th-century. The white, middle-class gay boy or lesbian girl moves from their current home to a metropolitan gay homeland in which they are finally able to come out and be true to themselves. The gay homeland is almost always one of four cities: New York, Los Angeles, San Francisco, and Chicago[1]. Other locations, especially those that are rural, Southern, and/or Midwestern, are rendered uniformly bigoted and intolerable towards LGBT people. This phenomenon is referred to as *metronormativity* (Stone 1 – 3).

Metronormativity prioritizes the experiences of urban, Northern, Western, and coastal LGBTQ individuals. Since metronormativity stems from the 20th-century coming-out narrative, it also inherently positions the white, middle-class, metropolitan (and very often, male) individual as the central coming-out character. The reality of queer America paints a different picture; 35% of American LGBT people live in the South, which is roughly the same amount of LGBT people who live in the northeast and Pacific regions combined, and 20% live in the Midwest (excluding Chicago). Yet, in a meta-analysis of LGBT single-region studies, 26%

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[1] Stone refers to these four cities as the "great cities" as opposed to the rest of the United States, which are either "ordinary cities" or are rural (p. 2).

focused on the northeast/Atlantic, 30% on the west coast, while only 20% were in the South (Stone 3 – 5).

While there will always be thriving LGBTQ populations in New York and San Francisco, many instead opt to live in the less costly, smaller mid-tier cities of the middle and Southern states (Allen 10 – 11). Additionally, fieldwork in the South has a high potential for yielding novel findings about queer identities, cultures, and trends that likely do not exist in the more studied regions of the U.S.

Specifically, the complex — and often contradictory — culture of the South presents a queer research project distinct from those taking place in the primary four cities discussed above. The American South is a distinct geographic and cultural area of the U.S. that is commonly othered by the rest of the country due to its legacy of slavery and its role in the Civil War. Many white Southerners attempt to distance their heritage from slavery, which is inconsistent with reality. The heritage of the South lies within the racial history that took place there, and is the core element that others the South (Burton 13).

The South is also othered due to its many cultural contradictions. Firstly, the South houses an acute patriotism for the United States. Yet, it is well-known for the kidnapping and forced enslavement of Africans, as well as seceding from the Union (Burton 18). In addition, Southern hospitality has always co-existed with southern violence, due to the racial and gender influence of white Southern masculinity. The predominance of white supremacy in a patriarchal culture produced a Southern version of masculinity that was inherently violent. To retain white supremacy over blacks, as well as dominance over all women, white Southern men learned to incorporate the continual threat of violence into their gender performance (Burton 19).

Lastly, but certainly not of least importance, is the contradiction of Southern religion. As home to the Bible Belt and religious fundamentalism, the stereotypical Southerner is usually Christian. The Christian South is staunchly pro-life, yet also leads the nation in counts of the death penalty. Residents of the Bible Belt give the most to charity and regularly tithe, but do not support food-stamp programs for starving families or healthcare for those who cannot afford it (Burton 24 – 25).

Contradictions of Southern culture are well-observed in how Atlanta reacted to the increased visibility of homosexual life. As life became more urban, and therefore more visible, after World War II, the U.S. government generated legal barriers for public expression of gender and sexual deviance. The policing of queer individuals has its ideological and logistical roots in the American South, and specifically in Atlanta. Post-World War II Atlanta experienced a variety of factors that made it the heart of the criminalization of homosexuality and the homosexual witch hunt. Firstly, mid-1900s Atlanta was the most populous metropolitan area in the South for whites[2]. White men were drawn to Atlanta due to the plentiful social and economic opportunities present there (Howard 110). Within this demographic of twenty to thirty-something white men who lived in the homo-social environments fostered by massive deployment in the 1940s, there was a high potential for homosexual courting to occur (Howard 113).

Secondly, there was increased visibility of both heterosexual and homosexual courtship in public spaces. Specifically of concern was the nighttime parking at Piedmont Park, in which both heterosexual and homosexual encounters took place. Atlanta Baptists publicized the

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[2] "Black Southerners, working within and along the boundaries of a rigidly segregated society, confronted pervasive restrictions on economic and social mobility." (Howard 108); i.e., Black Southerners did not have the same public access and agency as whites during this time period.

homosexual presence in Piedmont Park by printing a report in the *Atlanta Constitution* titled "1,500 Sex Deviants Roam Streets Here."[3] The homosexual encounters were conflated in the media, in which adult men having consensual sex with each other were instead depicted as child molesters (Howard 116).

The Atlanta Police Department became regulators of nighttime parking at Piedmont Park, which led to the police assuming the role of enforcers of sexual order and gender norms. In conjunction with the policing of homosexual men, Atlanta Baptists continued to publicly advocate for legal action against sexual minorities (Howard 119). The core involvement of Baptists and Protestants with the regulation of sexual and gender norms is the final factor that leads to Atlanta becoming the template for public outcry against homosexuality. In post-World War II Atlanta, the legal policies surrounding homosexual men were conceptualized within the conservative Baptist and Protestant communities — in particular, "holders of public office and leaders of religious organizations were often one and the same" (Howard 123). Atlanta set the precedent for public protest of homosexuality for the entire nation; and since Atlanta is in the South, it molded the national view of homosexuality through a Southern perspective.

It should be noted that Atlanta did not retain its initial reaction to homosexuality that developed in the mid-1900s. The Civil Rights Movement of the 1960s created a sociocultural environment in which other social movements — i.e., LGBT rights — could flourish in Atlanta. Following the Stonewall riots of 1969, Atlanta's queer population formed distinct organizations, such as the Atlanta Gay Liberation Front, which was established in 1971 (Fleischmann and Hardman 413 – 414).

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[3] Within the October 11th, 1954 issue.

Communities of queer women specifically also blossomed in Atlanta in the 1970s. Charis Books and More, a feminist bookstore that opened in 1974 and continues to thrive today, provided a nucleus for the lesbian-feminist community. As a community bookstore with feminist ideals and queer female leadership, Charis expanded upon the already burgeoning queer community in Atlanta by creating a space distinctly for queer women (Chestnut and Gable 241 – 243).

The 1980s and 1990s saw further increases in queer organizations as Atlanta's overall population boomed. As queer people established their own spaces in Atlanta, they became a significant constituent population for government officials. It follows that in the 1980s and 1990s, legal protections for queer life emerged. In 1986, the Atlanta City Council amended the city charter to prohibit discrimination based on race, sex, sexual orientation, religion, nationality, age, or handicap. In 1993, Atlanta created a domestic partnership registry for residents and employees and domestic partner benefits for city employees (Fleischmann and Hardman 419 – 422).

In a 2015 Gallup poll studying the percentage of LGBT residents in the fifty largest U.S. metro areas, it was shown that 4.2% of Atlanta residents identified as LGBT. Within the fifty metro areas included, Atlanta had the 19th-largest LGBT population. Considering that eight of the ten lowest metropolitan LGBT populations were in the South or Midwest, Atlanta's LGBT population is regionally robust (Newport and Gates).

Atlanta presents an ideal fieldsite for a queer project because it contains a significant amount of people who identify as LGBT but is also located in a Southern state with conservative politics. As a metropolitan area that is situated in the South, Atlanta contains unique circumstances that would be difficult to see in other locations. However, it is also important to study queer experiences in the South because queer people have and will continue to live there.

Concerns & Experiences of the Queer Female Patient: A Literature Review

To fully understand the relevance and implications of queer women's interactions with healthcare providers in the U.S., several bodies of literature must be outlined in the literature review. Firstly, as in any project on marginalized experiences in healthcare, the contextual definition of illness must be examined. Thus, the first section of the literature review concerns the social meaning of illness, and how that meaning is conveyed throughout society.

The second body of literature focuses on how religion and science intersect to create a distinct form of social control, referred to as *medicalization.* The third section of the literature review discusses how the core facets of the first two sections create impediments to queer women receiving adequate healthcare in multiple fields, such as heteronormativity in medical settings.

The Meaning of Illness

Queer health is a layered study of the biological mechanisms of disease and the social mechanism of illness. The definitions of illness and disease outlined by Kleinman in *The Illness Narratives* provide a robust structural basis for understanding queer patient experiences within health care. Kleinman describes illness as "the innately human experience of symptoms and suffering" (3), which includes how the patient and their social and cultural network experience their illness. Disease refers to the reframing of a patient's illness experience into a biomedical malfunction. In contrast to the biopsychosocial model of disease, which integrates cardiovascular, psychological, and environmental factors into a patient's diagnosis and treatment, the biological disease model reduces the patient to the cellular level and views their disease within a biomedical vacuum (Kleinman 5 – 6).

As Kleinman acknowledges throughout the entirety of *The Illness Narratives,* meanings of illness do not exist in a biomedical vacuum. While there has been a paradigm shift in health and medicine towards precision biomedicine during the last few decades, it cannot compete with the centuries-old precedent of humans using metaphors to understand diseases. It is also nearly impossible to fully separate the reflection of social order from disease metaphors that persist today (Sontag 72). Thus, regardless of the advances biomedicine has made, the experience of illness and the perception of disease is culturally shaped.

Sontag provides a helpful approach to interpreting queer health in *Illness as Metaphor,* and later in *AIDS and Its Metaphors.* Foundational to her claims is the theory that there are specific factors that, combined, assign long-lasting metaphors to diseases and reflect onto the patients who hold that diagnosis.

> Any important disease whose causality is murky, and for which treatment is ineffectual, tends to be awash in significance. First, the subjects of deepest dread (corruption, decay, pollution, anomie, weakness) are identified with the disease. The disease itself becomes a metaphor. Then, in the name of the disease (that is, using it as a metaphor), that horror is imposed onto other things. The disease becomes adjectival. Something is said to be disease-like, meaning that it is disgusting or ugly (Sontag 58).

Sontag's theory of disease metaphor functions in conjunction with Kleinman's claim that the cultural significance of illness lies within the core fears of a society. The Black Death became a symbol for the repercussions of sin, God's punishment, and human suffering; the illness experience of hysteria and widespread anxiety was representative of the rapid social change occurring in the late American 1800s; New England Puritan witchcraft was associated with sexuality and social deviance, and also provided an explanatory model for terrifying, unexplainable illnesses and tragedies (Kleinman 18 – 19).

The witch hunt of Puritan New England and deviance from heteronormativity are unique in that there is no underlying disease associated with either status. Rather, they both represent the societal fears of sexuality and social deviance. Both groups have also been hunted and associated with hell and Satan. Thus, I posit that the status of being queer is an experience similar to, yet still distinct from, Kleinman's illness experience due to the strong societal fear, and therefore oppression, of queer people throughout Western history. Furthermore, Sontag's theory of disease metaphors supplements the queer experience due to the consistent reproduction of negative metaphors associated with sexual and gender deviance. In this project, the queer experience and the illness experience combine to create case examples of the queer experience of illness.

The Intersection of Religion and Medicine as Forces of Social Control

Religion and science are typically seen as belonging to polar ends of a very long spectrum. However, I posit that both work together to enforce social norms, the most notable for this project being heterosexism and androcentrism. In an essay foundational to medicine as a form of social control, Zola claimed that medicine has superseded religion as the primary form of moral ideology and social control (487). As the dominant form of social control shifted from religion to medicine, medical diagnoses were assigned to any identity that strayed from the normative model put in place — i.e., deviances went from being sins to being diagnoses.

Conrad described how medicalization can occur on three levels: conceptual, institutional, and interactional. Conceptual medicalization consists of medical vocabulary and modeling that defines the social problem; institutional medicalization refers to the phenomenon of organizations adopting a medical approach to treating a problem that they already specialize in; and interactional medicalization, which is the primary form seen in this project's interviews, occurs in physician-patient interactions in which a physician uses medical treatments to resolve a social problem (211).

The medicalization of homosexuality developed in conjunction with the policing of homosexuality in the 1940s. American psychoanalysis adopted a heterosexist outlook in which same-sex attraction was perceived as a deviant response to the opposite sex. Deviance from heterosexuality, therefore, became a mental illness that required treatment. Attempted cures of homosexuality varied from the tolerable treatment of psychotherapy to the tortuous treatments of lobotomy, castration, and electroshock therapies (Herek 695).

Inherent within the medicalization of homosexuality is the perception of queer individuals as dangerous criminals. In the second edition of the DSM in 1968, the diagnosis of homosexuality as a mental illness was placed in the sociopathy section, which was described as "crimes against society" alongside substance abuse and sexual disorders (Rothblum 74).

The draconian definition of homosexuality in the second DSM may be attributed to its time — yet, the attitudes of American Psychiatric Association members do not reflect a cultural shift. In a 1991 survey of 2,500 American Psychological Association members, a troubling variation in gay-affirming practice was perceived. Within the sample, “biased, inappropriate, or inadequate practice was found in the understanding, assessment, and intervention concerning a wide range of topics such as identity development, lesbian and gay relationships, and parenting” was observed (Rothblum 74 – 75). Thus, while official policies may have changed, it is plausible for homophobic attitudes to persevere in the fields of counseling and psychiatry.

Health & “Women’s Health”; Male as Default and Heteronormativity in U.S. Biomedicine

A silent foundation to Western society is that what is male is default, whereas what is female is atypical. The male default is seen in how we group people and organizations — such as how there is a National Basketball Association (NBA) and a Women’s National Basketball Association (WNBA). The male default is also seen in gendered languages such as Spanish and French, in which mixed-gender groups are unanimously referred to with generic masculine pronouns — even if only one out of one hundred people in the group is male (Perez 4 – 7). The medical system is no exception to male as default.

Western society has followed a historic precedent that male and female bodies are more similar than not, with exception to size and reproductive functions. The patient norm of a 150-lb white man has set the parameters for what is typical, and anything outside of that domain — people of color, women, people who are under- or overweight — becomes abnormal and atypical. The male body is the human body, and vice versa (Perez 196).

Even diseases are gendered; coronary heart disease (CHD) is commonly seen as a male disease, with the female CHD experience being either erased or designated as atypical due to the discrepancy between female and male heart attack symptoms. In contrast to male heart attack symptoms, women often present with stomach pain, breathlessness, nausea, and/or fatigue in lieu of any chest pain. Due to the male as default paradigm in medicine, women with CHD are more likely to be misdiagnosed and die of a heart attack than men (Perez 218).

The male-as-default physician is directly born from their medical training. Perez cites that:

> A 2008 analysis of a range of textbooks recommended by twenty of the 'most prestigious universities in Europe, the United States and Canada' revealed that across 16,329 images, male bodies were used three times as often as female bodies to illustrate 'neutral body parts' (197).

Women's health issues are not completely absent from medical training curricula. However, the presence of female-specific content is primarily restricted to reproductive health (Verdonk et al. 139). Additionally, in an audit of a medical school's course syllabi and objectives, it was observed that most sex and gender-based content focused on sex differences in physiology and anatomy, and gender differences in disease risk and prevalence, with little (if any) attention given to sex and gender-based variations in diagnosis, prognosis, treatment, and outcomes (Song et al. 96 – 97).

The limited scope of women's health taught in contemporary medical programs is not due to misogynistic administrators and institutions. Rather, the body of knowledge that medical education curricula are based on also defaults male. Clinical studies that inform medical curricula are dominated by male subjects. Even when the topic being studied applies to both men and women, women are mostly excluded as subjects.

Reasons given for female exclusion typically include not wanting a woman’s menstrual cycle to confound the study results, a fear of negatively affecting a woman’s fertility or pregnancy, and the belief that the disease is more common in men than in women. Based on these limitations, a majority of clinical results are not applicable to women — yet, the results from these male-only studies are often extrapolated for use with female patients (Verdonk et al. 138).

Obstetrics and gynecology are among the limited group of medical fields that exclusively serve female patients. Yet, they nonetheless suffer from androcentrism and heteronormativity — and perhaps to a greater extent, since the field is focused on women and can more directly enforce female gender norms. However, the fields of childbirth and women’s health were not always constricted within the male-dominant biomedical hegemony. Before the construction of obstetrics and gynecology, there was midwifery.

Midwifery is arguably the oldest branch of medicine, with records dating back to antiquity. Until the 1600s, historical records unanimously showed that midwifery and childbirth were restricted to the woman's domain and that men were largely excluded (Varney and Thompson 4). As medical knowledge advanced in 1600s Europe, so did the knowledge of female anatomy and bodily processes, including that of childbirth. Male surgeons quickly recognized childbirth as a gateway into the medical field and began incorporating it into their medical practices (Varney and Thompson 22 – 24).

As surgeons began to displace midwives, the cultural perception of childbirth changed as well. During the era of midwives, childbirth was a natural process, whereas the era of surgeons introduced the medicalization of childbirth. Surgeons reasoned that if childbirth was viewed as an illness rather than a natural process, their services would be more likely to be sought (Dundes 637).

One direct outcome of the rise of obstetrics has been the change in the normative birthing position. Dundes outlines how in the midwife era, kneeling, squatting, sitting, and standing were nearly universal birthing positions (636), whereas the flat dorsal position (lying flat on the back) only came into being in 1834, and was justified with the claim that the convenience of the physician was of most importance (639). The supplantation of midwifery by obstetrics reflects how historically, the male biomedical hegemony has overpowered perspectives that are concerned with female comfort and well-being.

Male dominance also created the need for a birth control movement. In the mid-1800s, male physicians attempted to phase midwives out of practice via anti-abortion rhetoric. In 1880, the common practice of medical abortion became illegal throughout the United States for the first time. Women quickly resisted the anti-birth control movement with “voluntary motherhood” (Gordon 21). “Voluntary motherhood” referred to the practice of women refusing to have sex with their husbands in order to control the circumstances in which they would have children. However, the “voluntary motherhood” ideal was constricted to middle and higher class white women who actually had the agency to refuse the sexual advances of men (Davis 207 – 208).

The prevalence of the American eugenics movement of the late 19th and early 20th centuries also influenced the birth control movement (Davis 213). Davis accurately summarizes that the birth control movement “had been robbed of its progressive potential, advocating for people of color not the individual right to birth control, but rather the racist strategy of *population control*” (215). Thus, while white women may perceive birth control as a method of controlling their life paths, women of color may be hesitant to embrace birth control due to its historical use in racialized forced sterilizations.

Since cisgender same-sex relationships typically do not produce natural-born children, their reproductive rights have not been as invaded upon to the same extent as other groups rights. While gay men have been consistently prevented from raising children through legal barriers, it is feasible for a same-sex female couple to participate in anonymous sperm donor insemination (Moore and Stambolis-Ruhstorfer 496).

Queer women’s experiences in gynecology are not as clear-cut as their experiences in obstetrics. The male-as-default paradigm affects queer women in a similar way that it affects non-queer women, yet they experience heteronormativity in addition to the default male within gynecology.

If the default patient is male, I posit that he is also cisgender and heterosexual. The default male, in combination with the widespread perception of HIV/AIDS as a gay man’s disease, has created a medical culture in which sexual health knowledge revolves around penises. Many health providers and queer women believe that in the context of two cisgender women in a monogamous sexual relationship, there is little to no risk of contracting sexually transmitted infections and diseases (Marrazzo et al. 11). This perception exists despite thorough evidence that shows the transmission of sexual diseases and infections via oral sex, anal sex, and the sharing of sex toys — none of which inherently include the presence of a penis (Marrazzo 207).

Regarding sexual health, I assert that practitioners work within the framework that what is male is dominant, whereas what is female is passive. Thus, when confronted with a woman in a same-sex sexual relationship, practitioners assume that since there is no aggressor (male anatomy), there is no risk of contracting a sexually transmitted infection or disease. However, in addition to the male default, the role of HIV/AIDS in the perception of sexual health cannot be ignored.

Roughly ten years after Sontag wrote *Illness as a Metaphor,* she revisited the topic of disease metaphor with *AIDS and Its Metaphors* in 1988. Sontag describes how AIDS is unique in that it embodies the metaphors of military invasion as well as pollution. The invasion metaphor is commonly used with cancer, based on the unstoppable growth of cells, whereas pollution commonly referred to syphilis based on its method of transmission (105).

The AIDS epidemic has attained such widespread fear and notoriety that by the late 1980s, it had reached plague status, which Sontag refers to as "judgments on society" (142). However, the moral inflation of AIDS in the 20th-century was only possible due to its sexual transmission, and especially due to its high frequency among Western gay men (148). Thus, fears of contagion took on a specific inflection of invasion from homosexuals, along with other social deviants such as drug users and the third world (153 – 154).

The HIV/AIDS epidemic, in conjunction with the already present male as default paradigm, likely produced the medical and lay perceptions that women who have sex with women (WSW) are not at risk for STDs or STIs. This incorrect approach has acute effects on the health and well-being of queer women.

When WSW and their doctors believe that WSW have a low to none chance of contracting STDs or STIs due to their same-sex sexual practices, it results in WSW using few, if any, precautions to avoid infection. The lack of information given to WSW from their doctors, due to either nondisclosure of sexual orientation or a lack of knowledge on the doctor's part, can produce an increased risk of bacterial or viral infections such as bacterial vaginosis, HIV, or herpes, which can all be passed through sexual practices typical of WSW (Marrazzo and Gorgos 209).

A core facet of androcentrism is that the male experience is universal, whereas the female experience is niche (Perez 12). Thus, the preoccupation of women's health with reproduction makes absolute sense: it is the only aspect of female well-being that directly influences men. It follows that most women of childbearing age in a clinical setting are often persistently asked or forced to take a pregnancy test, despite communicating that they have never had vaginal intercourse or had not had vaginal intercourse recently enough for an unnoticed pregnancy to develop.

After the pregnancy test certifies that the patient is not pregnant, she is often either misdiagnosed or simply sent home with advice to take painkillers. When the root cause of a female patient's condition is not easily found through a pregnancy test or bloodwork, it is commonly "attributed to uncontrollable and unchangeable factors such as biology and emotions than the same health conditions in men, which are more often attributed to controllable factors such as behaviour" (Verdonk et al. 140).

The reliance on female biological factors as explanations for nearly all of women's health issues is tied to the systematic oppression of women and the enforcement of heteronormative gender roles. Klinge describes how biomedicine has not empirically proved a biological basis for female gender roles but has instead reproduced gender roles within the study of biomedicine. Biomedical textbooks assign gender roles when describing human fertilization, in which the main characters of the male sperm and female egg are reduced to their gender stereotypes, such as "the active courageous Rambo Sperm and the passive egg, waiting like the Sleeping Beauty to be kissed by the prince" (Klinge 17).

Biological determinism also reinforces heteronormativity. The concept that a person's reproductive anatomy determines their sexual destiny — especially in the context of a woman's reproductive anatomy — further supports heteronormative beliefs. This construction of the female body augments control over women by reducing them to a vessel for childbirth and male pleasure (Crowder 48). In the medical realm, women are also reduced to their reproductive potential, in that if a woman's health issue does not concern her reproductive capacity, her condition is very likely to be undertreated.

It is commonly understood that childbirth is a painful, sometimes drawn-out process that only women who have given birth can truly understand. Yet, other forms of female pain are overwhelmingly understated compared to the near-universal recognition of the pain of childbirth. The most obvious difference between female and male pain experiences is that for the majority of their lives, women experience pain on a regular basis due to normal biological processes such as menstruation and childbirth. Thus, women learn from a young age to self-treat their mild or moderate pain, whereas men do not (Hoffmann and Tarzian 16).

Additionally, due to Western gender socialization norms, women and men report their pain differently. Women more thoroughly describe their pain sensations compared to men and also include contextual information such as how their pain has affected personal relationships. In contrast, men tend to describe their pain in terms of objective physical symptoms or functional limitations, which more closely aligns with the information healthcare providers seek from patients (Hoffmann and Tarzian 17).

In multiple scenarios, it has been observed that women receive less aggressive medical treatments than men. For instance, in one study male patients were observed to have been given narcotics, whereas female patients were given either significantly lower doses of narcotics or only given sedatives. Women are also less likely to be admitted to the hospital for pain than men. These discrepancies can be attributed to Yentl Syndrome, which posits that women are more likely to receive less aggressive treatment than men until they successfully prove that they are as sick as male patients. After proving that they are as sick as men, women are likely to receive the same treatment as men (Hoffmann and Tarzian 17).

Given these conditions, it is not surprising that queer women have doubts about disclosing their sexuality to their doctors. If a woman's condition of pain is ignored, why would the disclosure of her queer identity produce any positive outcome? That, in addition to the omnipresent threat of homophobia in systems of social control such as the medical system, has created a reluctance for queer women to disclose their sexuality or same-sex partners to their healthcare providers.

Many queer women may not discuss their same-sex sexual practices with healthcare providers for fear of a negative reaction or of a decreased quality of care (Willes and Allen 9 – 10). In Johnson et al., 40% of the lesbian participants believed that disclosing their sexual orientation to healthcare providers would adversely affect their quality of care (24). Yet, a survey conducted over thirty years after Johnson et al. by Willes and Allen found that only 22% of the WSW participants believed that a doctor knowing their sexual orientation would adversely affect their quality of care (21).

The literature review of this project has been helpful for the organization of the results. Narratives from multiple fields and of different perspectives were challenging to cohesively unify within a thesis. The identification of key themes through a review of distinct bodies of literature (on illness, medicalization, and heteronormativity/androcentrism) has provided a strong framework for the display of the subjects' queer illness narratives.

Methodology

"Anthropology, as an academic discipline, has been developed primarily by white Western males, during a specific period in history. Our questions are shaped by the particulars of our historical situation, and by unconscious cultural assumptions."

Sally Slocum, *Woman the Gatherer: Male Bias in Anthropology*

Theoretical Foundations

Data was collected for this thesis through the use of audio-recorded semi-structured interviews and photo-elicitation. The foundational knowledge that the formulation of this thesis was based on — the experiences of lesbian and bisexual women on disclosing or not disclosing their sexuality to healthcare providers observed from Johnson et al. and Willes and Allen — gathered data through the use of surveys. Surveys are of course useful data collectors, yet I found the lack of context and sustained discussion to detract from the real-world applications of the findings. While Johnson et al. and Wiles and Allen reported robust statistics concerning how queer women felt that disclosing their sexuality would affect their medical care, the use of surveys created constrained results. Both studies focused on queer women's experiences within obstetrics and gynecology, due to the assumption that disclosure of a queer identity would only occur in the context of gathering sexual history. Had I also used surveys to collect data, I would have missed out on the experiences of queer women in the fields of therapy, psychiatry, general care, and pediatrics.

Thus, while I had initially tailored the interview questions and thesis literature to queer women's experiences as OBGYN patients, it only took one interview for me to realize that the status of being a queer woman led to concerns in obtaining quality medical care in fields other than sexual health. By allowing subjects to share their experiences without the constraints of rigid surveys or structured interview questions, a more accurate and well-rounded narrative has been produced for each subject.

In addition to Kleinman's definitions of illness and disease, I have also modeled the primary format of my thesis — ethnography — based upon his emphasis of narratives. Past studies of queer women's health have employed surveys and biological testing in order to obtain results, which are of course of great utility. However, I have found Kleinman's theory of the illness narrative to be more conducive to the conclusions I hope to be made from this project. Kleinman describes how:

> … patients order their experience of illness — what it means to them and to significant others — as personal narratives. The illness narrative is a story the patient tells, and significant others retell to give coherence to the distinctive events and long-term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings (49).

In the context of the queer patient, and especially the female queer patient, I find Kleinman's illness narrative to be a necessary component of disseminating their experiences. As women, the subjects of this study have most likely experienced not being fully heard or listened to in systems of control such as medicine. Queer women are distinct in that they experience both androcentrism and heteronormativity. As opposed to the gender role of passivity, I aim for the project subjects to be active participants in telling their stories. Contextual information such as life history, anecdotes, and personal narrative can only come from ethnography.

The incorporation of photo-elicitation in addition to interview ethnography may come off as onerous, yet in reality, the two methods of qualitative research complement each other. Photo-elicitation is the process in which a research subject is shown an image and asked to respond to it in a specific way. I used five photographs for photo-elicitation and conducted that portion of the interview at the very end. I have organized the data results by the photos, labeled as Photo A – Photo E, in the order in which they were presented to the subjects. Within each photo chapter, I analyze the image itself, the respondents' direct responses to it, and how the photo encapsulates specific themes and narratives of the queer female patient's medical experience.

For this project, I asked the subjects to respond to each image based on what it makes them feel or think about. I would usually make a comment on their initial response in order to create a conversation around the photo and get as much of their perception on it as possible.

Photo-elicitation provides a method for extracting trends of changing culture without directly asking heavy questions. Johnson explored the use of photo-elicitation among the traumatized population of Kenyan children who have grown up within the AIDS epidemic and widespread political violence. Johnson was specifically interested in how the concept of childhood has been redefined due to these unique circumstances, and how that experience is represented from the child's perspective. In order to obtain the outcomes of these social shifts from the perspective of the children, Johnson utilized photovoice in conjunction with interviews (141 – 142).

Photo-elicitation has been utilized in a similar way with LGBTQ youth. Research into LGBTQ youth has been on the rise due to the increased acknowledgment of health inequity and inequality, discrimination, and harassment this group faces. What is of concern is that LGBTQ identities and experiences are very likely to not fit within the research systems that are available. Identities are often dynamic, and since there is a large list of gender and sexual identities, it can be difficult to include exhaustive options in surveys and questionnaires (Smith et al. 272 – 273).

Photo-elicitation may be an ideal model for queer and feminist qualitative research due to its empowerment of its subjects. Rather than being asked direct questions such as "when you see a church, what do you think of?" or "how do you feel in medical examination rooms?", photo-elicitation enables the researcher to indirectly ask questions of this nature and obtain more organic and authentic responses from subjects, who usually report their gut reaction to the photograph (Smith et al. 274).

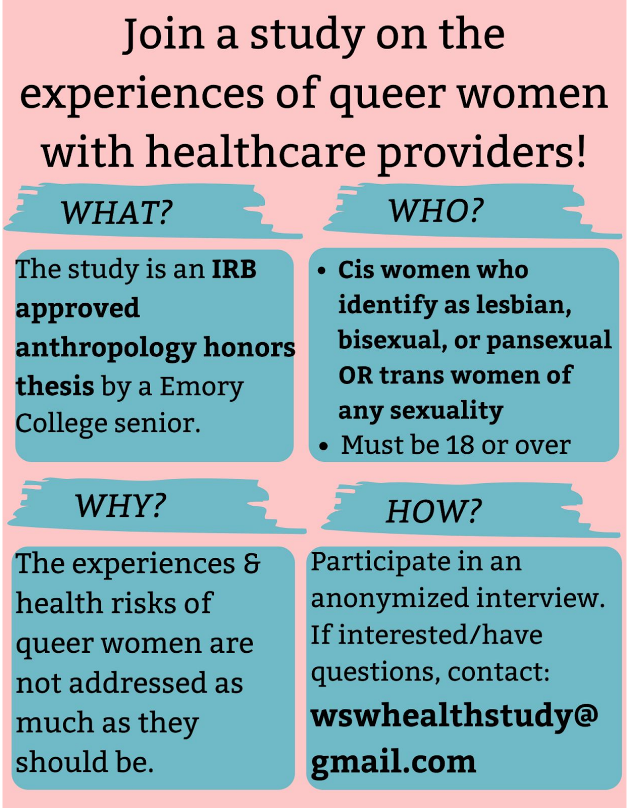
Regarding photo-elicitation, Schwartz describes how "it is not the photographs themselves which inform, but rather, the analysis of them… the analysis of the images is informed by insights gained through ethnographic fieldwork and informant's responses to the photo-sets" (152). I agree with her interpretation and have specifically used photo-elicitation as the primary organization for my results. I chose five photos for subjects to respond to and labeled them Photo A – Photo E during interviews as well as in this written representation.

Therefore, based on the lower social agency typical of my study population, I used semi-structured interview ethnography and photo-elicitation as my primary methods of data collection due to their successful use in similar circumstances.

The specific photos for this project were obtained through rudimentary searches in Google images. When searching for images I ensured that they were free of any copyright by selecting “labeled for reuse with modification” in the tools section of the search engine.

Recruitment, Interviewing, and Organization of Results

Subject recruitment mostly occurred through the physical posting of project fliers throughout Emory University’s main campus, including a coffee shop corkboard, library boards, women’s restroom stalls, and public outside posting boards. I was also given permission to post a physical flier in Charis Feminist Bookstore.



Join a study on the experiences of queer women with healthcare providers!

WHAT?

The study is an **IRB approved anthropology honors thesis** by a Emory College senior.

WHO?

- **Cis women who identify as lesbian, bisexual, or pansexual OR trans women of any sexuality**
- Must be 18 or over

WHY?

The experiences & health risks of queer women are not addressed as much as they should be.

HOW?

Participate in an anonymized interview. If interested/have questions, contact: **wswhealthstudy@gmail.com**

Fig 1: Recruitment flyer; it was posted in public spaces in Atlanta as well as on social media.

The flier was also posted on social media, on my personal Facebook account as well as a Facebook group specific to queer women in the Atlanta/Georgia area. Interested subjects contacted the email address on the flier, and later conversations and arrangements about conducting an interview were addressed via email.

Interviews took place either in person or through Skype. The interviews were audio-recorded by myself with an app on my phone, and I later transcribed the interviews directly. Each subject, as well as any individuals mentioned by name in the interviews, were given a pseudonym that I attempted to make very similar to their given name.

Each time I received an email from a subject expressing interest in participating, I was very pleasantly surprised. I didn’t understand what would make people want to share deeply personal details about themselves to a complete stranger — for while I always assured them that they would be made anonymous, they were telling their experiences to my face regardless. That, in addition to the fact that they were willing to participate for no compensation or reward, made me very grateful for each subject’s participation.

I was also insanely nervous before each interview. I was worried about coming off to participants as a clinical authority that would ask deeply personal questions with a lack of any emotion or consideration. Yet the participants were all eager to share their experiences with me so that they could contribute to my project. My part in the interview process was therefore very easy — I was an active listener to very caring people who wanted to share their experiences for the purposes of contributing to a body of knowledge.

The most difficult aspect of conducting the interviews was when I had to ask questions regarding the sexual health knowledge of the participant. It was one thing to discuss interactions with physicians, and quite another to ask someone if they use any protection during sex. Thankfully, all of the participants answered without blinking and made my anxiety unfounded.

I like to think that I came off to the participants as a friendly, active listener who understood the general places that they were coming from. I tried to make the interviews more like a conversation than a game of twenty questions, and believe that I achieved that, overall.

The shortest interview was 30 minutes and the longest was 2 hours, with most interviews averaging about 45 – 60 minutes. The more interviews I did, the better I became at asking the follow-up questions that produced richer conversations.

After transcribing the interviews, I had to organize the results in a cohesive way that would best display the main themes and experiences of the subjects' narratives. I had anticipated for the data to be focused on OB/GYN experiences and was pleasantly surprised to find that the narratives covered multiple medical fields. The only drawback of this broad data was that it made organizing the results more challenging.

Weaknesses, Strengths, & Future Directions

The primary weakness of this thesis can be attributed to my privilege as a white woman attending a private university. I did not curate recruitment methods that were inclusive enough to ensure equitable reach of queer women of color. I spent a majority of my recruitment efforts on Emory's campus, and as a private university in the American South, Emory is a majorly white space. By focusing recruitment within Emory's campus, the amount of potential non-white participants was inherently limited. Had I gone further out of Emory's realm into the wider Atlanta area, it is possible that more queer women of color would have reached out to participate.

Another significant weakness of the study also stems from my privilege as an Emory college student. After completing three years of college, I forgot how feminist and queer theory terms that are common in academic settings are technical jargon outside of that setting. This weakness on my part was demonstrated after I realized that many subjects, on being asked how their gender performance may have affected their experiences, did not fully understand what I meant by gender performance. While they all answered the question without asking for any clarification, when I began the above question with “do you know what I mean by gender performance?” very many subjects said they were not familiar with it.

The most significant strength of this study is that I grew up with a cultural understanding of being queer in the South. I was raised by my lesbian parents in Norfolk, Virginia and grew up witnessing common experiences of heteronormativity in how others interacted with my parents, as well as myself.

An unanticipated strength of this thesis has been my personal experience in seeking mental health care. Nearly all of the participants have had misogynistic and/or heteronormative experiences when going to therapy or psychiatry. I have been attending therapy, on and off, for roughly four years and was, therefore, able to relate to the participants’ experiences as women seeking mental health care. In addition, two subjects reported being hospitalized for planning to commit suicide. Due to my experience of having been hospitalized for suicide ideation in February of 2019, I was able to relate to and converse with these subjects on with a level of ease that may have been more awkward had I lacked that life experience.

Subject Breakdown

There are nine subjects in this study. Ages range from 18 to 33 years old, with all but three currently residing in Georgia. Six of the nine subjects are white women, two are black, and one is Asian. All of the subjects are cisgender women, but three have close relations to transgender individuals (two have transgender husbands and one has a transgender daughter).

The breakdown of subjects below is listed in order of when the interviews were done, with Anna being the first interviewee and Patricia being the last.

Anna

Anna is a 23-year old white woman who identifies as queer. She is a college student at Emory who plans to become a music therapist in the future. When Anna was very young, her family left their multigenerational roots in Texas when they moved to a small town in the Midwest. Anna's family is very planted in their Baptist roots, especially considering that her father is a Baptist pastor. The Baptist faith is very significant in how Anna's parents conceive of her mental health concerns, in that they consider her mental illness to be the byproduct of sin.

Anna left her Midwest home for Atlanta when she began college at Emory and has remained in the area since. Her narrative consists of negative experiences within therapy, the emergency room, and gynecology.

Heather

Heather is a 25-year old white woman who identifies as a lesbian. She is a graduate student at Purdue University and is studying sociology with a focus on sexual and reproductive rights. Heather was originally from Detroit, Michigan, which she describes as being a liberal upbringing, albeit with conservative parents. She is in a long-term monogamous relationship with her girlfriend of two years.

Heather's narrative consists of uncomfortable interactions with the social authority that medical providers have over patients. She is very knowledgeable about her sexual health concerns, yet often has to convince providers to take her concerns seriously since she is having sex with a woman.

Avery

Avery is a black 18-year-old woman native to Atlanta who identifies as pansexual. Her mother is a lesbian, yet she discusses how her pansexual identity is questioned by her family and providers, if she is not outright accused of lying. Her experiences with healthcare can be summarized as providers accusing her of lying about various things, such as her virginity, pansexuality, and motivation for seeking birth control.

Avery is sexually active and recounts the many difficulties she faces in trying to get birth control that best works for her, which is the Paragard IUD. Avery also displays the willingness to be tested for STDs and STIs, yet providers so far have not tested her unless she says that she is sexually active with a male.

Mackenzie

Mackenzie is a 33-year-old white woman who identifies as bisexual. She was raised in Covington, Georgia and moved to the Atlanta area when she began college at Emory. Mackenzie was previously married to a man, with whom she had a child. Mackenzie's child is a transgender girl who goes by Abigail (pseudonym). She eventually divorced from her now-ex-husband, and this past fall, she married her wife. Mackenzie's narrative includes negative experiences within psychiatry as well as obstetrics, gynecology, and her daughter's experience within pediatrics.

Lydia

Lydia is a 21-year-old white woman who identifies as bisexual. She is from New York City and relocated to Atlanta when she began attending college at Emory. She has not experienced the negative interactions common amongst other participants and also displays trust towards healthcare providers. Her narrative conveys an idealized medical culture in which varied sexual and gender identities are very easily received and treated.

Veronica

Veronica is a 21-year-old Asian woman who identifies as bisexual. She was raised in and continues to live in Norfolk, Virginia and is a recent college graduate who plans to go into youth counseling. Her narrative focuses on the very common experience of seeking gynecologic care and having providers express concern for her lack of birth control, even though it is a moot point since she was only having sex with women at the time.

Emma

Emma is a 27-year-old white woman who identifies as bisexual. She grew up in Chapel Hill, North Carolina, which she describes as the ideal place for queer children to grow up. However, she has very conservative parents who do not agree with her sexual orientation, nor her long-term relationship with her girlfriend.

Emma's narrative focuses on her experience with trying to get treatment for her chronic and severe migraines. She also discusses the trials of being forced to take pregnancy tests and having to see a therapist who was so out-of-scope with queer life that it negatively influenced her quality of care.

Margot

Margot is a 30-year-old white woman who identifies as bisexual. She grew up in rural Indiana and views the higher quality of medical care she has received since relocating to Atlanta as a result of living in a metropolitan area rather than a rural area. She has not personally experienced negative encounters within medicine to the same extent as other subjects but has insight on the heteronormativity of medical care due to the fact that she is married to a transgender man.

Patricia

Patricia is a 31-year-old African-American woman who identifies as pansexual and queer. She grew up in and continues to live in Virginia Beach, Virginia. She is married to a transgender man and describes her marriage as straight-passing when in public. She is employed as an editor of healthcare insurance materials.

A Picture is Worth a Thousand Words: Photo-Elicitation Results

We are now entering the second portion of the thesis — the results. The remaining chapters discuss subject reactions to five photographs that I chose with deliberation. I decided to include five photos because I wanted participants to be able to warm up to the process of photo-elicitation. It is highly likely that most participants were never asked to look at a photo and respond to it just based on what they think of it, outside of taking a Rorschach test.

In a similar vein, I structured the photo-elicitation section to promote a distinct type of narrative. Photos that had more open interpretations were alternated with photos that presented very specific themes so that subjects could create a broad context for their photo-elicitation narrative.

I showed participants Photo A first because it contained many themes relevant to queer women. Elements such as the couch in a clinical setting, maternal images on the walls, and the calm impression of a clinical space provided an entry point for the subject to describe their unique experiences across multiple fields. In contrast, Photo B presented a common discomfort among female medical patients and prompted very strong responses of disgust, fear, and violation. Photo C provided an intermission from emotionally explicit imagery by displaying a muted event of a woman resting in a bed in a hospital room. While Photo C did prompt some severe experiences, the initial responses were not as salient as with Photo B.

Similar to Photo B, Photo D was meant to produce strong reactions upfront. However, those reactions could be either positive or negative depending on the subject’s experiences with pregnancy or childbirth. Photo D was also a useful organization anchor for issues surrounding reproductive rights and the reduction of women's health to reproductive health.

Photo E was placed last with the intent that it could provide a summary of the subject's photo narrative. It is very open, with more positive elements than the other four photos, such as a large space, privacy, open doors, and an inviting color scheme.

In an exercise to start writing the result chapters, I placed all of the interview responses to each photo in a document so that I could try to pick out common themes and ideas. I collected words that appeared often throughout the responses as a method of extracting primary themes, as well as topics that I knew that I wanted to discuss in the chapter. So that readers could have an overview of chapter themes at the very beginning, each chapter starts with an *Interview Keyword Responses* section.

In sum, my goal in constructing the photo-elicitation section was to provide enough opportunity for the subject to describe their narrative outside of a typical interview structure. By placing the photo-elicitation section at the end of the interview, I was able to draw on contexts discussed by the subject earlier in the interview. In addition, I was able to establish at least some rapport with the subject by the time that the photo-elicitation section was reached, which increased their willingness to share personal experiences that were not directly addressed by myself.

Photo A: Therapy and the Facade of Comfort

“The silence depressed me. It wasn't the silence of silence. It was my own silence.”

— Sylvia Plath, *The Bell Jar*

Interview Response Keywords

Anxiety

Fluorescent

Sterile

Cold

Paper gown

Therapy

Couch

Welcoming

Comfortable

Sensitive

Maternal

Photo A presents a space that at first appears very neutral. The walls are a light sage green shade, and the floor is smooth and white. While the room is not intensely clinical, the walls and the counters on the left edge of the photo suggest that it is a doctor's office. Because of its clinical appearance, the couch seems out-of-place.

Photo A reflects a concentrated effort to convey comfort in a clinical setting. The photo was sourced from the U.S. Department of Agriculture's Flickr account. The album that the photo resides within is described as "New office spaces for behavioral health and WIC services at the Lytle Community Health Center...in Lytle, Texas" (Cheung).

Thus, it can be safely concluded that Photo A depicts a room meant to provide counseling services, perinatal/pediatric care, or both. Due to the dual use of this room, the presence of a couch with the sterile room that it resides within makes sense — yet, that does not eliminate the confusion observers feel when seeing the juxtaposition of comfort within a clinical setting.

The confusion of what exactly the room is in Photo A is why I decided to include it. To describe the photo, the subject would have to disclose their ideas about therapy when they notice the couch, and also of a typical medical clinic setting. The large amount of content that subjects can take from Photo A makes it ideal as the first photo they are asked to respond to.

The use of the room is not immediately — or ever — obvious to the viewer. Only one participant questioned the white surface on the countertop and concluded (correctly) that it could be a measuring table for infants. Several participants noted the posters of a mother kissing her infant on the wall, yet they concluded that it was most likely an obstetrician's office.

The dominant immediate response to Photo A was confusion regarding the presence of the couch. Participants were mostly wary; they saw it as a false sense of comfort in a space typically reserved for sterility. By articulating this feeling, participants brought to light how they felt about and within the usual clinical setting.

The couch also reminded participants of therapy. Almost every mention of therapy led to disclosing the negative experiences faced in that realm, which presented a double unpleasantness to patients who found both the clinical and therapeutic to be uncomfortable.

The contrasting key words of “warm” “comfortable” and “welcoming” compared to words such as “sterile” “cold” and “fluorescent” revealed the discordance subjects faced when viewing a room that attempted to incorporate comfort into a clinical space. This discrepancy reveals the broader theme of queer patients not feeling comfortable disclosing all aspects of their lives, including their sexual orientation, to providers.

Disclosure of sexual orientation is a constant presence in any queer person’s life experience — and also serves as an anxiety-provoking circumstance in clinical settings. Most medical intake forms inquire about the patient’s sexual orientation, and when providers ask about the patient’s sexual history, WSW face the decision of either disclosing their orientation or undergoing unnecessary questions or procedures.

While the narratives focused on coming-out in various medical fields, it is almost always necessary in therapy. Based on this inference, Photo A prompts the inclusion of three distinct experiences: sexual orientation disclosure, therapy, and being a patient within a system of medical authority.

Sexual orientation disclosure, colloquially referred to as “coming-out of the closet” or simply as “coming-out,” is a process that occurs in multiple phases for each queer person. Each individual differs, but there select elements that are nearly universal in the coming-out experiences of the average American.

Firstly, the individual recognizes that they deviate from the heteronormativity that is expected of them. Some individuals experience this recognition so seamlessly at such a young age that there is no distinct event or phase for them to even recount. On the other end of the spectrum, some individuals did not realize that they were LGBTQ until later in life. Mackenzie recounted how she did not realize that she was not a straight woman until after she had married a man and had a child with him:

> It wasn't until after I was married the first time that I finally started to kind of come to terms with — I am actually attracted to women, and I always have been and realizing that that could mean something beyond what I had ever been open to admitting. And I was really upfront with my husband at the time about how I was understanding myself, and what that might mean for me.

The next stage of coming-out is when the individual discloses their sexuality to those closest to them, such as friends and/or family. An unacknowledged stage of coming-out is that the individual will face the decision on whether to out themselves for the rest of their lives, in a myriad of situations. Many forms, from job applications to medical intake forms, ask the participant for their sexual identity.

A patient deciding whether or not to come out to a healthcare provider can influence the overall quality of care received. In other instances, individuals may be outright presented with the opportunity to either disclose or not disclose their sexuality — regardless of if their coming-out is relevant to the situation at hand. Heather described the anxiety and discomfort associated with the latter circumstance:

> It’s always nerve-wracking to disclose my sexuality, particularly to older adults. I’m in Indiana, which is a very conservative place, it’s not super queer-friendly. I know that my doctor is supposed to provide me the best care, but I am constantly on guard [because I] know that I have to be my own best healthcare advocate. That I know a lot about queer health because I study it, and also because I live it, so I go in with like, I’m ready to do *work,* rather than to get help or be understood right away. I feel like I have to put on this armor to be ready to go to the doctor and engage with healthcare providers.
>
> I had one doctor one time — we have a good rapport, he asked me how I was doing, whatever whatever. I was being treated for mono at the time, which sucked. So, I was going to this doctor regularly to get checkups… he was asking me: *do you have someone at home, who can take care of you or help you out with this or drive you to your appointment?* I was like, *oh yeah my partner will do that for me.* And he goes, *male or female partner?*
>
> … I had to pause, and I was like, why does it matter? … While I’m very knowledgeable about healthcare services and the way things work, I am not a doctor, I am not a medical professional, I am not trained to notice those threads together. Maybe the fact that I have a female partner means this this this this. But I also just don’t see how that’s important for my care in terms of who’s going to be driving me to my appointment or something like that. There are times where I feel like both doing the work of having to disclose and being asked to disclose when I don’t think it’s relevant, damage[s] the rapport that I have with medical providers. I’ve been very fortunate that I haven’t felt like doctors have been closed off to me or have no idea what to do or what to say, but I definitely have had friends who’ve had experiences like that.

In her narrative, Heather touches on the amount of effort it can take to come out to healthcare providers. Queer patients do not always have providers who can accurately assess the relevance of a queer identity to the patient's health concerns. Rather, in addition to coming-out, the queer patient often has to explain why their sexuality is either relevant or irrelevant to their health, and hope that the provider will listen to their concerns.

Heather faced her dilemma in a clinical setting; yet, many discussions of coming-out to providers revolved around experiences in mental health and therapy, which are inherently emotionally exhausting treatments, regardless of sexual identity. Coming-out to a counselor or psychiatrist is of critical importance to a queer person's comfort in seeking mental health, especially when the patient is in adolescence.

To start on a positive note, Veronica described how when she was questioning her sexuality, the general friendliness of mental health care providers made the session a positive one for her sense of development:

> In high school when I did my first — it wasn't really counseling, it was like a psychologist thing…. I remember at some point I was uncomfortable [disclosing my sexuality], but they seemed nice about it, and I think that was probably why I felt comfortable.

In contrast, Avery's negative experience in an analogous session when she was in middle school hindered her confidence in the development of her sexual identity:

> I [told my therapist], *hey, there's this really cute girl at school, and I don't know how I feel about it, because I have a boyfriend, but she's really really cute and really smart.* So, I was talking with her about it, and she was like, *it doesn't matter, you already got a boyfriend, if you like him, you're not gonna like her.* And I mean, I was in a relationship, but it was still just something I had a question about. Like, *am I possibly bi? I don't*

> *know.* And I guess she was like *no, you're straight, you're dating a boy.* I'm just like, but bi people exist [laughs]. I was very confused.

The therapist's response of, "you already got a boyfriend, if you like him, you're not gonna like her" indicates harsh judgment of Avery's questioning, even though it is psychologically normal for young adolescents to question their sexual identity. The response further implies that Avery's potential bisexuality would lead to promiscuity — a common harmful stereotype of bisexual people that may significantly contribute to the fact that they are more prone to developing mental health issues than heterosexual, gay, or lesbian individuals (Barker 375).

Emma's experience with coming-out to her therapist was not as negative as Avery's, but it was also not as helpful as Veronica's was. Emma described how she had been seeing a psychiatrist who was "really sweet about walking me through [coming-out to my parents]," but whom she had to stop seeing due to her lack of insurance. The psychiatrist referred her to a therapist so that Emma could continue working on her mental health.

> I would talk to her about my relationship with my parents, cause that is still very difficult, it causes me a lot of pain, and I wanted to talk about it in therapy. And it continually irked me that she clearly had so much sympathy for my parents. It's kinda like, you're supposed to be on *my* side. She clearly thought that she was, but she was only advocating for giving them more chances and opening up the relationship more. She'd be like, *well why don't you write them a letter?* And I'd be like, *here's all the reasons, based on my 27 years of knowing them, why that would not work.*
>
> I understand that as a therapist you need to push back on your patients, and people do have patterns that they get locked into that they need help getting out of. I remember getting frustrated at one point cause there was an upcoming conflict with my mom, and I

> was like, *she's coming to Atlanta, these five things will happen, I don't want any of those five things to happen, I just want to avoid that.* And she was like, *you're assuming that she won't have changed in the last 6 months*. And it's like, *yeah, cause she's 55.* Change takes time; I talk to her on the phone every other day, I kinda know where she stands on a lot of these issues. And the therapist very clearly just had a lot of hope for my mom and my dad, and it's like, that's nice and I would also like to share that hope, but I don't. And I'm right, and you don't know them.
>
> I have come to terms with the idea that they will never, ever be okay with me being gay. So I was telling her about that, like, *look, I know that lots of people come around on this issue, maybe they will and that will be great, but I have already accepted that I need to not hope for that. Cause that just leads to a lot of pain and a lot of trying to manage interactions and optimize them.* And she would just continually be like, *maybe this time.* I'd be like, *no.*
>
> I just wanna talk about how to deal with the negative feelings that I will have when something like this is said, which will happen. And then I also would try to talk to her about cutting them off or going more low contact. And she was so clearly not comfortable or familiar with that kind of idea. I feel like she thought that she could therapize me into having a PFLAG[4] family. That is not gonna happen, they are not ever gonna go to therapy[5].

Emma's therapist's inability to adequately provide counseling to a queer patient is obvious from Emma's perspective. However, the therapist's consistent pushing for Emma to somehow make her parents become "a PFLAG family" was actually unproductive and mentally unhealthy for Emma. Unfortunately, therapists not understanding how their queer patients perceive them is not a rare occurrence.

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[4] PFLAG is a national organization that works to support positive relationships between LGBTQ individuals and their families.

[5] Further parts of this section of the interview can be found in Appendix E: Extra Interview Snippets.

Anna described how due to her typical female gender performance, “assumptions [that she is heterosexual] were made without even a question.” She describes a psychiatrist she had previously seen who exhibited heterosexist views that irrevocably affected her quality of care:

> With one specific psychiatrist, whenever he asked if I was in a relationship, I said yes. And then he’d start asking me questions about my boyfriend, and I’d have to correct him — *no, I’m actually with a woman.* I had explained before that the emotional abuse I went through in that relationship, and seeing the mind shift like *oh, this is with a woman.* He had said something along the lines of, *oh, I can’t imagine; two women in a relationship would be very emotionally explosive.* Downplaying the emotional abuse because it’s a woman, and women are very emotional. And I didn’t go back to him, because it made me feel very belittled and like my experience was not valid.

The consistent exhaustion associated with experiences such as this significantly detracted from Anna’s quality of mental health care. As a young woman, her emotional pain was belittled by healthcare providers who operate within the Yentl Syndrome framework. In addition, her queer identity compounded her female undertreatment due to insensitivity on the part of her psychiatrist.

Despite the atonement for heterosexist definitions and diagnoses by the field of psychology, the effects of the queer medicalization from the mid-twentieth century onward continue to influence the treatment of queer patients. Additionally, the consistent undertreatment of female pain specifically affects queer female patients. These influences are best seen through the experiences shared by Anna and Avery.

A common thread through Anna’s experiences is the amount of conviction she must bring with her when describing her health needs to providers. When I asked her how her gender identity and performance may have influenced her experiences, she started by saying that she has an easier experience “because [she is] cis, and also more femme presenting.”

However, female gender performance comes with the potential issue of female undertreatment as discussed earlier. Anna described how in a typical visit to a healthcare provider concerning her chronic pain, her pain is not taken seriously (“because I am a young girl, in their eyes, it’s just *okay, do you have a test tomorrow?”*).

Regarding mental health care, Anna described several circumstances in which healthcare professionals downplayed her suicidal intent due to her gender:

> I once went into an emergency room because I felt suicidal, and so I went in and I couldn’t even say it, I passed in a note. They took me back, and they asked *do you have a test tomorrow? Is there something stressing you that you feel like you need to run away from?* It wasn’t taken seriously. I guess with the connotation of girls being emotional and not knowing how to handle their emotions, I don’t know.
>
> My first inpatient hospitalization, whenever I told them that the trigger was the ending of the relationship in which I was emotionally abused, they were all immediately like *awwww first loves are so hard! I’m so sorry.* And then they released me the next day. I should not have been released.
>
> When the nurses were taking my blood and stuff like that [during the second hospitalization], they’d say *you’re gonna be okay, don’t worry* — one of them even went into a long story about how her dad died, and that she healed from it and now she’s fine — and that’s not like what I’m going through, I don’t know why you’re sharing that with me.

Avery recounted a very similar experience when seeking mental health care:

> A lot of [people] — including my therapists — think I'm just being overdramatic about certain things. Like when I broke up with my boyfriend [of] 6 years, they were just like: *calm down, it's ok, it's just emotions, female hormones*, and I'm like — yeah (this was before I was on birth control) hormones might play a part in it, but I mean, we weren't sexually active, it was just an emotional thing and he cried too, so it seems like we're both having some issues. I feel like that should have been more supported. But they just kind of dismissed me because I was being dramatic or something.

Anna has used her negative experiences to help others. She discussed how two queer friends of hers were hospitalized on different occasions, and that she successfully advocated for their treatment when the medical system was unable to recognize the severity of their conditions. Patient advocacy is a powerful tool for the well-being of queer and non-queer patients alike[6].

Mackenzie has a unique position regarding patient advocacy due to her duality as a bisexual woman and a mother to a transgender child. As a bisexual woman, one of Mackenzie's negative experiences came from a psychiatrist with whom she had a long-standing rapport with. She had seen this psychiatrist four years prior as an undergraduate student. However, Mackenzie identified as straight when she had last seen this psychiatrist but identified as bisexual when she saw her four years later.

> M: Since she had known me four years prior, when I identified as bisexual she used that as an opportunity to say that she thought I had a personality disorder. I forget how she phrased it, she said something like, 'uncertainty about sexual orientation' or like, 'flippant changing of sexual orientation,' something like that. She made it super negative

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[6] A unique example of health advocacy can be seen in the second part of Emma's section in Appendix E: Extra Interview Snippets.

> and she basically said, *I don't actually believe that you're bisexual, because you weren't before, so clearly, you're not now.*
>
> R: Nothing changes, you're identified as straight on your birth certificate.
>
> M: Right?! You married a man, you can't be bisexual! So, that tainted her entire diagnosis. Which particularly in psychiatry is really dangerous. Because the medications that are used to stabilize people with personality disorders so that they can get appropriate therapy and skills is not the same medication that is used for my actual diagnosis. And it has significantly more side effects. It impacts metabolic rate, which is particularly dangerous for me because I have type 1 diabetes. So having something mess with my metabolic rate, then that messes with my insulin needs, and then I'm at a higher risk of diabetic ketoacidosis. So all of it was...*bad.*

Mackenzie's experience of being misdiagnosed based on her bisexuality has grave implications. Not only did she receive unhelpful care, but the event lowered her confidence and self-esteem in future medical situations:

> I think it was also a big part of me just deciding to suppress [my sexual identity] more… So it definitely impacted my relationship with psychiatrists. And I was really careful about what I shared and how I shared it, and how open I was, which meant that it took longer to really get the right treatment plan. To really address my needs.

As a mother to a transgender daughter, Mackenzie expressed frustrations with psychiatrists using the incorrect pronouns and name for her daughter. Her daughter, Abigail, is six years old and has been socially transitioned for over a year. Mackenzie describes Abigail as having long blonde hair and having a very female-presenting wardrobe that includes dresses and sparkly shoes. When preparing to take Abigail to a pediatric psychiatrist, she made explicit requests to the office before the appointment.

> I had called ahead and when I made the appointment, I was like, *please make a note. I understand your records have to use [Abigail's legal name] because it all has to match for insurance purposes. Please make a note to call my child this name [Abigail] and use these pronouns [she/her/hers]. It's really important.*

Despite the effort Mackenzie put forward to ensure that the office would correctly address Abigail, they nonetheless addressed her according to her legal name and male pronouns, starting with when the nurse called Mackenzie and Abigail for intake.

> Then we go to see the nurse for vitals and the nurse calls her name given at birth. I correct her and say, *it's Abigail.* And then we go to sit down, and the nurse starts the whole, asking about trucks and whatever and *oh I bet you're big and strong,* and all these assumptions that adults make about male children, and Abigail looked at her kind of funny, like *what is she talking about?* And looked at me like, *I'm confused.*
>
> And so I corrected again, and I was like, *the name you have there is her legal name and I understand that her record needs to reflect that for insurance purposes, but please call her Abigail.* And [the nurse], not even five minutes later, did it again.
>
> When we went in to see the psychiatrist, the psychiatrist did the same thing. And was really confused, and was this whole elaborate thing [that I had to explain] ... Why am I having to explain this? It's pretty straight forward, this is her given name at birth, it remains her legal name, obviously she was assigned male at birth. I'm telling you, this is the name to use now. These are the pronouns to use now. What's the confusion? Why do you need to know more about this?

Medical authority is a fixture of society that is so deeply ingrained into our ways of being that we sometimes do not notice it. Even medical providers may not notice when their medical authority bleeds into their interactions with patients. The purpose of this first results chapter was to show how queer female patients, who face the impact of both heterosexism and misogyny, are negatively impacted by the authority healthcare providers have. The next chapter explores how invasive medical authority can be within the specific context of gynecology.

Photo B: Restrainment, Invasion, and Gynecology

“All the sacred rights of humanity are violated by insisting on blind obedience; or, the most sacred rights belong ONLY to man.”

– Mary Wollstonecraft, *A Vindication of the Rights of Woman*

Interview Response Keywords

Ugh/Oof
Involuntary intake
Abducted
Restrictive
Uncomfortable

Dying
Speculum
Stirrups
Emergency
Most accessible

Image B was found on the Flickr account of North Coast Outfitters. North Coast Outfitters is a company that produces medical treatment and recovery equipment that can easily be transported and used in emergency situations — thus, they are designed to be lightweight and easy to store and carry (“About Us”).

The image is captioned with “Here is the SR901 with the ‘-OBGYN’ and SR KIT A installed” (Beatty). “SR901” refers to a model of multipurpose medical tables upon which operations, exams, and/or treatments can be carried out. If an SR901 is ordered within a -OBGYN extension, it can come with stirrups (“SR901RTS Series”).

Unlike Photo A, Photo B does not try to present an image of comfort. While Photo A was stuffed with small details that one could focus on if a certain aspect of the photo caused discomfort, there is no potential for redirection in Photo B. Rather, subjects are forced to confront a stark version of a gynecologic exam table in a sterile white backdrop. Many subjects first responded to Photo B with exclamations of shock that were almost instinctive, such as “Oof”, “Ugh”, and “Aah.” The source of Photo B explains its draconian appearance — yet, subjects did not know this when they first viewed it. All that they saw was the harshness of the tool in a terrifyingly vague background.

The severity of Photo B is why I chose to include it. Photo A provided a space for the subjects to explore some general themes of being in a neutral clinic setting, whereas Photo B made them confront a much bleaker scenario. Similar to Photo A, few of the participants had ever seen anything like Photo B in real life. Thus, when asked what Photo B meant to them, they often imagined circumstances in which they would see it. As a result, the participants’ first reactions to Photo B reveal a controlled experience of seeing such a harsh device. The first reactions were very strong due to Photo B's more severe nature and were, therefore, easier to group into distinct categories.

Initial reactions to Photo B were all of fear and/or intense discomfort. Notable first reactions to Photo B resembled scenes from *The X-Files*. First, the subject is kidnapped by a mysterious force and restrained in the device, to be picked and prodded at for some nefarious purpose. Heather, and then Veronica, respectively, describe their gut reactions to the photo:

> I feel like the vibe is, you have been abducted and taken into a warehouse, where they are going to extract organs or experiment on you in some way… the things that are signaling that to me are the curtain… [because] you don't see the walls. And also this looks more like a cot structure than like a traditional examination table. And obviously, you see the stirrups, which always come with this air of discomfort — there's a level of discomfort there because your feet are gonna be put back, you're gonna be put in an uncomfortable position.
>
> The first thing I notice is that it looks really restrictive. It looks like I would not want a gynecological exam there. Cause I'm assuming those [referred to the stirrups] are for the legs… [the curtain] make[s] me feel like it's in a trailer or something, even though the floor suggests it's not.

Based on initial responses such as these, it was an obvious choice to discuss themes of abduction, invasion, and restriction in the Photo B chapter. Similar themes can be extracted from undergoing a routine gynecological exam. The patient must remain flat on their back, with their legs and feet propped up in stirrups, and stare up at the room ceiling. Most patients willingly go through gynecological exams in the above-described position, yet that does not change the sensation of being restrained and limited by a clinical authority.

The intended use of the chair, in addition to the many direct responses to Photo B that included fears of abduction and invasion, made it clear that Photo B would best serve to discuss the queer gynecology narratives.

There was also a marked distinction between the initial and secondary responses to Photo B. While the knee-jerk discomfort was expressed in the initial responses, many participants made other logistical observations of the device, such as that it may be useful in emergency situations as an easily transportable medical device — which is, in fact, its intended use. Thus, in addition to grouping the narratives based on initial responses, there is a later section dedicated to secondary responses.

Initial Responses: Abduction and Invasion

Most participants immediately recognized the device in Photo B as a gynecology exam table. However, Anna's first response to Photo B recounted a more literal iteration of abduction and invasion. Anna initially perceived the device as a gurney with straps, which prompted her to discuss being involuntarily committed to an emergency receiving facility.

> This reminds me of whenever to avoid being 1013'd — for involuntary intake. I had to go voluntarily, so they had to go through the motions of strapping me into something like that and taking me into the ambulance, and it was awful.

Anna's response was unique in that she immediately recalled an experience she had with what she thought was the device in Photo B, rather than creating a hypothetical experience. Being "1013'd" refers to Form 1013, which is an authorization from within the Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD). Form 1013 certifies that a person can legally be involuntarily transferred to an emergency facility due to severe manifestations of mental illness. A person is, as Anna put it, “1013’d” if they present a significant risk of physically harming themselves or others based on recent acts or threats, or if they are not able to care for their physical health and safety to such a degree that their life is endangered. A Form 1013 can be completed by multiple healthcare providers, including a physician, psychologist, clinical social worker, and professional counselor, among others (Risby).

Avery’s hospitalization due to a suicide attempt can also be perceived as an abduction and restrainment narrative.

> So I was there, in that physical hospital, for my physical health for like four days. And it was a very, very trying time. I was hooked up to the IV for 3 days, because I told them that I would drink water and eat and they were like, *we don’t trust you*. So they kept me on the IV till my heart rate went below 200… They took my phone, they told me technically I wasn’t supposed to have anyone there except my mom and my grandmother, but we snuck some people in (laughs). Because my aunt worked at the hospital, my friends were able to come in. Most of my friends are black, but one is Asian, so we couldn’t pretend that she was my sister (laughs).

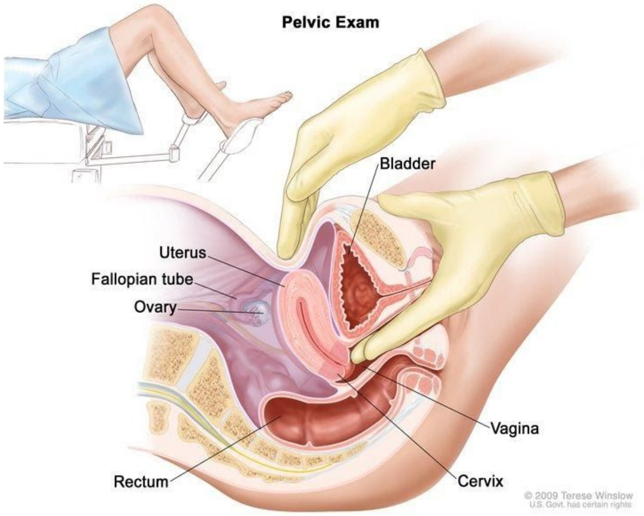
It was not specified whether Avery was 1013’d or was voluntarily admitted, yet even if her hospitalization was voluntary, there are overt themes of restrainment present in her narrative. She was “hooked up to an IV” and her communication networks were severely limited (“they took my phone… I wasn’t supposed to have anyone there except my mom and my grandmother”).

Another similarity between reactions to Photo B and an alien abduction experience involves the invasion of the female body. Rather than starting in circumstances of abduction and restrainment, some subjects jumped ahead in the alien abduction narrative straight to the clinical invasion.

One of the major elements of the typical alien abduction narrative is the invasion of the human body (usually a woman's, sometimes a man's) via some sort of penetrating object by the aliens. Usually this invasion is in reproductive areas, such as a male's penis and a woman's vagina. The intent behind this bodily invasion is to see if the human is a viable carrier or progenitor of an alien-human hybrid fetus or to mechanically impregnate them (Barbeito 207).

Penetration is common in a routine gynecology visit. The pelvic exam, which involves multiple instances of vaginal penetration, may be recommended to patients as a regular part of their visit. A pelvic exam is a physical examination in which a physician observes and/or takes cell samples from the vagina, cervix, uterus, fallopian tubes, ovaries, and rectum. The physician first observes the outside of the vagina for signs of disease, and then the cervix is checked. A speculum is inserted into the vagina in order to widen it so that the physician can observe it for any signs of disease. Next, the provider feels for lumps and abnormalities of the uterus and ovaries by inserting gloved fingers into the vagina and pressing on the abdomen (Pelvic Exam).

Fig 2. Medical illustration of a pelvic exam. For the National Cancer Institute © (2009) Terese Winslow LLC, U.S. Govt. has certain rights.



The set up of a pelvic exam is illustrated in figure two. The patient's legs are in stirrups, and the physician's fingers are so far into the patient that they are touching the cervix. This process has the very important goal of ensuring that the patient does not have any signs of disease in their reproductive organs.

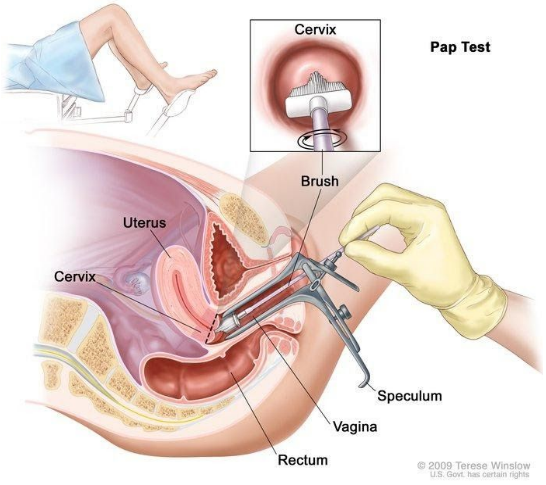
A key element of the alien invasion narrative is the lack of any explanation or consideration given to the abducted human. Unfortunately, a similar circumstance was observed among the participants with their gynecologists, first seen through Avery's experience.

> My first pap smear — well, I don't know what it was. They said it wasn't a pap smear or something — it was like a swab, and I was terrified because she [the doctor] pulled out the speculum and was like… *it's gonna be cold*. And then she was like, *okay I'm about to put it in*. [The doctor inserted the speculum] and I was like, *okay, that wasn't bad.* And then she opened it, and I was like, *I'm gonna die.* And she was just like, *you better stop moving because if it falls out I'm not putting it back in*.

A pap test or pap smear is when the cervix is observed through the speculum and a cell sample is taken with the intent to test for various infections and abnormalities, notably STIs and cervical cancer (Pelvic Exam). As seen in figure three, the pap test is a bit more intrusive and uncomfortable than the pelvic exam. Firstly, instead of one or two fingers, a metal speculum is inserted into the vagina. Then the stirrup is widened by the physician so that a brush can collect tissue samples from the cervix.

Based on this knowledge, it is possible that Avery was not receiving a pap test — perhaps the

Fig. 3. Medical illustration of a pap test. For the National Cancer Institute © (2009) Terese Winslow LLC, U.S. Govt. has certain rights.



physician used the speculum for pelvic exams so that she could more easily observe the vaginal canal and cervix. Regardless, it is obvious that she did not fully explain to Avery what exam was taking place, due to Avery's confusion over the exact exam and the purpose behind it.

Anna described an experience similar to Avery's.

> The one time I went to a gynecologist was awful, because — we're getting into very personal stuff, but I have this condition where it is very difficult, because of trauma, for anything to — ugh it's so hard to talk about — but basically my vaginal muscles clench at the sight of anything coming in. So, they were trying to give me a pap smear, and I almost passed out with pain. I guess they didn't realize that I was actually in pain, so they kept doing it, and it felt very invasive. I wanted them to stop and they didn't take my pain seriously. Another reason why I never went back.

Of all of the negative experiences described within gynecology offices, Anna's arguably displays the most invasive circumstance, which is sadly common during pelvic exams, pap smears, and any other medical procedure in which penetration of the vagina occurs.

Mackenzie remarked on the discomfort that has been routinized in these circumstances in her response to Photo B. Rather than responding to the grim nature of the photo, she immediately said: "Ugh the stirrups. I see stirrups, and I see speculum and I think about why is it so uncomfortable?"

Research supports the fact that the removal of stirrups from pelvic exams and pap tests would improve patients' overall experience, and also make them more likely to actually allow the tests to be done. In a random clinical trial of 197 women, it was observed that the conduction of pap tests without stirrups significantly reduced discomfort, embarrassment, and vulnerability felt among patients, as opposed to pap tests with stirrups (Seehusen et al.).

Despite the data that stirrups make patients uncomfortable, they are still routinely used. This could in part be due to the effects of Yentl Syndrome, considering that stirrups are almost exclusively used with female patients. If there is no consideration of female pain, which Anna explicitly claimed in her narrative, then there is no reason to limit the convenience of the physician.

Prevention

While pap tests and pelvic exams have been shown to be highly unpleasant procedures, it should be noted that they are important to have done, especially for WSW. Cervical cancer is a dangerously common reproductive cancer among women in the U.S. and worldwide. The incidence and mortality rates of cervical cancer have decreased due to the efficacy of cervical cancer screening through the pap test. However, WSW have been observed to underuse medical services in general, and cervical cancer screenings in particular. Negative experiences of queer gynecology patients, such as misinformation about disease risk and preventive health needs, have potentially contributed to this disparity (Tracy et al. 229).

In her narrative, Heather discussed her frustration with having to consistently argue with providers about the preventive care and testing that she needs as a WSW:

> My girlfriend and I are more susceptible to yeast infections and bacterial vaginosis and things like that because of the way our anatomy works when we have sex. And so it's like, *yes you just saw me 6 months ago, but I'm back again*. I constantly have questions like, *is this too frequently to be getting this [symptom/test], what can I do to skirt this?*

> And my doctors don't know what to say. They're like, *well, it happens.* Yeah, but it happens to me a lot.

Heather is a highly educated white woman who has insured access to preventive health services and screenings. While actually obtaining those services is exhausting, she nonetheless accesses them. Queer women who are less educated and/or are nonwhite are significantly less likely to participate in preventive screenings at recommended time intervals (Tracy et al. 233).

The discrepancy between queer and heterosexual women's sexual and reproductive health outcomes can be attributed to the presence or absence of a penis. As discussed in the literature review, the male as default paradigm influences U.S. biomedicine, and in conjunction with the association of the AIDS epidemic with unprotected gay male sex, creates the perception among patients and providers alike that women are not at risk for certain illnesses if they are not having sex with men.

Multiple factors contribute to the discrepancy. As mentioned above, the androcentrism of sexual health movements is partially responsible. Many queer women do not view protection as necessary if they are having sex with a woman. Anna, who only had sexual relations with trans men and cis women[7] said that she did not regularly use any form of protection. She admitted to using protection once, "to see what it was like. Dental dams are really all we ever knew about. But it really wasn't like — *oh, we're gonna engage in intercourse, we should probably use protection.*"

Emma, who has dated men and women, described the discrepancy of using protection with male partners versus female partners.

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[7] Can infer that all of her sexual partners had vaginas.

> I let my first boyfriend pressure me into having sex without a condom at one point. And it was okay, we were exclusive, there was no disease concern. But then I skipped a period… I took five pregnancy tests to make sure [that I wasn't pregnant]. And he was, in retrospect, such a shit about it. I was like, *I'm not pregnant, thank God, everything's okay!* He didn't sound happy and I was like, *what's wrong?* And he's like, *well, I feel like now you're not gonna want to have sex without condoms. I really don't like it that much.* And I was like, *too bad!*
>
> After I got out of that relationship I was like, *oh that was shitty. I'm not gonna let people do that to me anymore.* And then I just went ahead years later and slept with women with no protection whatsoever.

Emma went on to describe the discrepancy of sexual health narratives of queer men compared to queer women.

> With gay men unprotected sex is so stigmatized, and then with gay women it's almost like that sex doesn't even really count. I've been lucky that I've never contracted anything or had a partner that had anything. I hope that, if I had not found a long-term partner soon after I had started dating women that I would have been like, *hmmm, I should start using dental dams or something.*

Part of the fixation of sexual health around penises is due to the lasting impact of the AIDS epidemic. As discussed by Sontag in *AIDS and Its Metaphors,* the AIDS epidemic quickly became associated with unprotected gay sex (148).

Secondary Responses

The knee-jerk reactions to Photo B reveal the plethora of experiences of restrainment and invasion that the participants had faced. However, in the secondary responses to Photo B, participants broadened their own understanding and often accurately proposed a reason behind the grim appearance of the device: that it is designed to be used in emergency situations.

Lydia was unique in that her first response addressed the device's use in emergencies.

> It looks like something for an emergency, like in an ambulance. It's not like a normal — I feel like I haven't seen one of those in person, I've only seen them on TV when they're wheeling someone out. Just, dying or seriously injured.

Heather did not immediately see the device's use in emergencies, but quickly became cognizant of its potential in those scenarios.

> I can acknowledge that if this is the most accessible health care to you then there are definite benefits to having a pop-up set-up, or whatever. But yeah, definitely I would be less comfortable — my natural response would be less comfortable here than in A.

Recognition of the device's use in emergencies was restricted to participants who did not disclose very invasive experiences with devices or setups similar to that in Photo B. Heather and Lydia both saw the potential use of the device in emergency situations due to it appearing very easy to transport. In contrast, Anna and Avery, who both disclosed very invasive experiences with such a device, did not acknowledge its possible use in emergencies.

I do not think that Anna and Avery are too shortsighted to see the device's applications in emergencies. Rather, I argue that their past of invasive encounters colored their expectations of how the device may be used. Instead of seeing how the device could be used to help others, they saw it as a tool to restrict, control, and further invade. The continued reminder of unpleasant gynecologic experiences relates to the primary topic discussed in the next chapter: clinically-related PTSD.

Photo C: Clinical Trauma and the Undertreatment of Female Pain

"Bless her little heart… she shall be as sick as she pleases."

– Charlotte Perkins Stetson, *The Yellow Wall Paper*

Interview Response Keywords

Sad

IV connection

Suicide attempt

ICU

Health being threatened

Needle

Comfortable

Theatrical; not reality

Standard of care

Sterile

Mechanical

Photo C takes place in a hospital room. The focus of the shot is the patient, who is a white woman with blonde hair laying down in the hospital bed. She is wearing a hospital gown, has an IV inserted in her hand, and also has a pulse oximeter (a device that can measure one's pulse by attaching to the fingertip. Her head is turned away from the camera, and there is a blanket covering most of her body. Light filters into the room from the windows, as opposed to the fluorescent lights in Photos A and B. The photo was not given an official title, but when hovering over the image, six keywords are listed as descriptors for the photo: hospital, labor, delivery, mom, medical, and maternity (Parenting Upstream).

I chose Photo C because I viewed it as an image with a calming aura. As mentioned when describing the organization of the results chapters, I chose photos with different themes and levels of intensity. To prevent emotional fatigue — as well as actual fatigue, since photo-elicitation was done at the end of the interviews — I alternated images of high intensity with images of lower intensity. Photo C was intended to provide a break from the negative experiences that I was sure would be potent. Yet, most participants were not calmed or soothed by Photo C at all.

Rather, responses to Photo C convey the subjects' experiences in hospitals, and specifically intensive care situations. Many discussed past experiences in the ICU as either a patient or as the loved one of a patient. Subjects who, I assume, do not have heavy hospital experiences responded to Photo C in a hypothetical frame of mind. These responses consisted of comments on how the photo appeared "comfortable," or how the photo "feels more like TV."

The disparity between the two main categories of responses — post-traumatic recollections versus hypothetical scenarios — mimics the pattern observed with Photo B.

However, Photo C is more of a neutral photo compared to Photo B. Photo B is stark, with a plain white backdrop that forces attention onto the black device, which made all of the responses towards it negative, regardless of if they were real or hypothetical. Photo C, on the other hand, was described by some subjects as appearing more comforting, whereas it triggered past traumas for others.

Unlike in Photo B, the two disparate types of responses do not reflect the actual experiences of subjects. For instance, Anna and Avery are both similar subjects, in that they are both young women who had been hospitalized due to attempting or planning to commit suicide. However, their responses to Photo C were polar. Anna described how in Photo C, "the lighting is a little lower, and she has a nice blanket, and it looks like a bed that is a little bit bigger than normal." In contrast, Avery's first response was: "Sad. I got hospitalized [for attempting to commit suicide] once and was hooked up to an IV, and that was the saddest four days of my life."

Analysis of responses to Photo C revealed a phenomenon that I was previously entirely unaware of: ICU-related Post-Traumatic Stress Disorder (PTSD). It is not within my ability — or right — to judge whose negative experiences outweigh another's. I cannot claim that one person's suicide hospitalization was more or less traumatizing than someone else's. Mental health, and PTSD more specifically, is not a linear equation; it is more comparable to multivariable calculus.

While the experience of a traumatic event is the precursor to PTSD, it is estimated that PTSD develops in only 25 – 30% of individuals who have experienced past traumas (Burki 843). The intricacies of PTSD are amplified by misconceptions about what, and whom, can generate symptoms of PTSD in an individual. One should recall how one of Anna's most hurtful incidents with a healthcare provider was when she told her therapist that she had PTSD from an abusive relationship with an ex-girlfriend, and he made a joke about women being "emotionally explosive."

Long et al. describe the core tenets of PTSD:

> PTSD is characterized by having experienced a life-threatening (or perceived to be life-threatening) traumatic event and subsequently experiencing intrusive recollections of the event (e.g., intrusive thoughts or memories, nightmares), symptoms of hyperarousal (e.g., easy startling, hypervigilance), and avoidant behavior related to the traumatic event (e.g., avoiding thoughts, places, or situations that serve as reminders of the traumatic event) (821).

Long et al. go on to illustrate how the experience of critical illness in the ICU can be a life-threatening event that can continue to intrude upon the patient's mental wellbeing — i.e., that being a critical patient in the ICU can generate PTSD symptoms after release from the hospital. Procedures characteristic of the ICU are invasive due to the dire situation of the patient; airway suctioning, periods of delirium, physical restraints, and impaired mobility and communication are just some circumstances common to the ICU (821).

Based on the confusion and invasiveness of a typical ICU visit, it is not surprising that PTSD may develop in patients after their discharge. It is difficult to treat ICU-related PTSD because their bodies are already undergoing a significant amount of recovery for the issue that had them in the ICU in the first place. Due to this constraint, research on ICU-related PTSD is limited; studies that do broach the topic are questionnaire-based, which presents limited conclusions since PTSD can only be accurately diagnosed face-to-face (Burki 843).

I am not able to diagnose PTSD, but I can see the value of photo-elicitation in that process just from analyzing responses to Photo C. Responses from Photo C revealed participants' past traumas in hospital settings, which they had mostly not mentioned or alluded to until this portion of the interview. For Avery in particular, photo-elicitation revealed experiences that she had not touched upon before that point in the interview. Recall how in the previous section of this chapter, Avery's first response to Photo C was the memory of her suicide hospitalization. She went on to describe the visit in-detail without any prompting from me.

> I was there, in that physical hospital, for my physical health for like 4 days. And it was a very, very trying time. I was hooked up to the IV for 3 days… I told them that I would drink water and eat and they were like, *we don't trust you.* So they kept me on the IV till my heart rate went below like, 200. And every time I see someone in the hospital, every time I see someone in this situation, it's just sad. I've never experienced someone being there for childbirth or something.

This experience would not have been disclosed if Photo C had not been included in the photo-elicitation.

There were two aspects of the above quote from Avery that I found particularly relevant for women's experiences in medicine: "we don't trust you" and "I've never experienced someone being there for childbirth or something."

The implication that childbirth is always a joyous occasion is not an uncommon one to make. Avery's comment highlights the fact that while childbirth is universally understood as painful, its pain is often downplayed through the joy and beauty of new life — that all of the discomfort and pain was worth it. Nonetheless, birth is one of the few (arguably, the only) fields of medicine that openly accepts information about female pain. Fields not related to reproduction are not as generous with believing female pain.

In Photo A, female undertreatment for mental health was discussed. Now, we will dive into the experience of physical female pain being undertreated. Unlike therapy, a queer identity does not necessarily impact physical undertreatment. Rather, the status of being a female — and especially being a feminine-presenting young woman — is the primary factor behind these experiences. A core theme of female undertreatment is the lack of trust many providers entrust in their female patients.

Emma presents one of the most compelling narratives on female undertreatment. I have included a very long excerpt from our interview, because I believe that the context and events that she discusses are better communicated in her own words, rather than in my paraphrasing.

> I'd always had migraines, but I did not know until this started that they had been migraines. I'd always been told they were sinus headaches or stress headaches or whatever, so I had a very developed Aleve and ibuprofen problem. And then one day I got a headache, and I had this procedure where I'd have two Aleve, drink half a Coke and go to bed, and usually that would cover it. One day I got a headache and it didn't go away for the following eight months. And for the first couple of days I was like, oh it's whatever, it's pollen, I'm just stressed out, it's fine. After maybe a week my girlfriend was like, *you have to go to the doctor, this is not okay. If anything else, you're destroying your kidneys, you're taking like five Aleve a day, this is not okay. You need to go to the doctor.* It started at the end of May of 2018, and it took until August [2018] to find a doctor who actually helped.
>
> I [went] to a primary care doctor and she was like, *I don't know, here's some more migraine drugs, but you need to go to a neurologist.* And then she sent me to the most frustrating medical experience of my life. She sent me to this neurologist who I think is a

very good neurologist, probably, in a very fancy midtown practice. And that man did not look me in the eye once, which was intensely frustrating. By the time I got to see him, I had a migraine every single day for two months… my partner and I weren't living together yet at the time, but she had basically moved in just to take care of me. And my mom came down from North Carolina to go with me to the doctor because she was terrified.

So we all go in, and I'm telling him my symptoms, my mom and my partner are joining in, like *please help.* And he's looking at his computer screen the whole time and was like, *yeah, sounds like migraines. Sometimes people get chronic migraines. We'll put you on some different drugs.* And the first drug he put me on, made me so stupid. It's a very common migraine drug, lots of people get them, and it often makes people stupid. But it was so bad, I couldn't string a sentence together. And we went back for a follow-up later, and I could not tell him what was wrong. And so my mom and my partner were there, like, *she's not dumb, and she can't say three-syllable words. This is a problem, she needs to stop taking this drug.* And he was like, *well if it cuts the pain down…* and they were like, *it's not cutting the pain down, she's still in pain every single day, and she's stupid now, this is no good.*

And my mom was trying to explain, *she's in law school, she needs to be able to think and write and talk.* And this man, without looking any of us in the eye, just shrugged [and said] *not everybody has to go to law school…* He had no respect for the intellect of me, my mom, or my partner. And I don't know, it was so clear to me afterwards, after I got off the stupid drugs, that because I was a woman, he did not think [that my] pain was as bad as it was. Which is very clear. And he also didn't think that I was actually smart.

[The drug] was Topamax, which is an anti-seizure medication that's commonly prescribed for migraines… I also had started having these seizures, I would just lose control of my body, and we told him that and he was like, *well, she seems fine.* And we were like, *well it's not happening* right now, *but it's happening all the time.* I couldn't walk half the time because I couldn't trust myself to stand up, because I was afraid that

I'd walk to the bathroom and hit my head. And he just didn't believe us. I think he thought I was drug-seeking, which is especially weird because I had been very clear [that] *there are addiction issues in my family, please don't put me on narcotics unless you have to.* So I don't know how that comes across as drug-seeking, but that seemed to be something…

We left that appointment, and my mom was like *you need a second opinion, this is not okay.* I was still brain foggy and was like, *no, he's the doctor, he knows what he's doing, he's so smart,* whatever. Fortunately my partner is a hugely social person… she makes friends everywhere she goes… she had informed her entire Atlanta network of that I was sick, and asking everyone for help and advice, and one of her friends was like, *oh I had bad migraines at one point, and I saw this neurologist at Emory, you should go see her, she's amazing.* So we lucked out, we called into the office and she had an availability the next day. Which is crazy, because now I see her regularly, and it's hard to get on the schedule. It was just, I don't know, fate smiled.

We got in the next day, and she strode in like my saving lesbian angel, in a burnt orange suit and cowboy boots. All this butch energy, and just sat down, looked at me, and was like, *I know the doctor you're seeing, he's very smart, why do you need a second opinion?* But then she looked me in the eye while I was talking, and I said I was in pain and none of the drugs were helping and she *believed* me.

I said I was having these weird seizures. And she was like, *okay you're not having one right now, let me see if I can do a little muscle test and trigger one.* And she did and she was like, *oh this is a problem, you might have a whole bunch of different, scary diseases. So let's make sure you're okay.* I think I might have cried a little bit when we left because it was just such a relief to be believed. And it was from that point on, everything just went so fast. She was worried at the time I had MS or some other really dramatic disease, so she sent me in for a bunch of tests. I remember I think the very next day she sent me in for a spinal tap.

A core facet of Emma’s experience is the distinction between being doubted and being believed. When the severity of her migraines was doubted by the male neurologist, it was not just a reflection of his bedside manners that was showing; fundamental misogyny led to the creation of assumptions about Emma that were unfounded, considering that the appointment with Emma was the first time he met her.

Unfortunately, the ordeal Emma described is not uncommon for women. In a sample of 162,576 individuals aged twelve or over, it was observed that of the 38.8% of participants who should be considered for preventive migraine treatment, only 12.4% were using a preventative (Lipton et al. 348). Considering that migraines are three times more common in women than in men (18% versus 6%, respectively), it can be inferred that a significant amount of female migraine sufferers are either undiagnosed and/or not receiving adequate treatment (Moloney and Johnson 282).

Chronic migraines are a severe public health problem in the United States for any genders that suffer from them. However, the high burden of chronic migraines, in conjunction with the fact that a majority of migraine sufferers are women, conveys a trend in U.S. biomedicine that, unfortunately, is no longer surprising at this point in the thesis: female pain is not taken seriously and often goes undiagnosed or untreated (if not both), to the detriment of female productivity, physical and mental health, and independence.

There is an exception to female undertreatment: if a fetus is, or potentially could, be involved, there is arguably too much concern from the provider’s perspective. In the upcoming pages, those circumstances are discussed in the context of Photo D.

Photo D: Reproductive Health, Birth, and M(other)hood

"I was a virgin… I was firm in my assertion that [the doctor had] better come up with another diagnosis, because unless I was a modern-day biblical parable, there was no way I was pregnant. Nor was my body consumed by syphilis or any other sexually transmitted disease."

– Abby Norman, *Ask Me About My Uterus: A Quest to Make Doctors Believe in Women's Pain*

Interview Response Keywords

Excitement

Female providers

Doula

Advocacy

Medicalization

Sterile

Fear

Panic

Disgusting

Vulnerable

Photo C was the first image in the photo-elicitation set that included a person. Photo D builds upon the introduction of people by painting a significantly more chaotic scene — a hospital childbirth. There are at least six people present in Photo D: the mother, the newborn, the two healthcare providers, the photographer, and an unidentified hand off to the side.

Photo D is very clinical; unlike in Photo C, the lighting is artificial in Photo D. The photo's perspective is directly behind the mother's head as she is laying on her back and looking at her newborn for the first time. Her legs are still open, but from what little can be seen of her body, she is relaxed. The two providers are in extensive medical protective gear, such as gloves, protective eye gear, and one of the providers is wearing a face mask.

Photo D was titled *labor – delivery*. The description of the photo describes the progression of eight hours of labor and identifies some of the individuals in the photo:

> that's my mom on the left sneaking in a shot with her phone. dr. Maria Castillo in front is delivering and Brittany Mumford to the right was the delivery nurse that pulled us through most of it.

When going through other photos on the account, it becomes clear that the photographer is the father of the baby being born. Thus, Photo D is a very personal photo to the photographer, who posted it with only some copyright restrictions: it can be shared and adapted, so long as the creator is attributed (Ruiz).

Based on this knowledge, it can be inferred that the photo was taken with an energy of love and excitement, with permission and awareness of the mother and others present in the photo. Responses to Photo D had differing levels of accuracy in reading the energy of the photo.

Only two of the responses accurately read the excitement of the photo. The remaining commented on various negative aspects of childbirth, from the medicalization of childbirth to the outright fear and panic associated with being pregnant and giving birth.

Photo D was one of the most striking photos of the photo-elicitation set, aside from Photo B. Through using Photo D, I was able to observe the subjects' opinions and beliefs about pregnancy, birth, and having children without asking questions that they had likely heard before from nosy relatives: "Do you want children?" "Do you think you would ever want to get pregnant?" And, most obtuse: "What do you think about the medicalization of childbirth?"

The subjects answered all of those questions without me having to ask them. From their responses, I was able to easily fit other experiences discussed outside of Photo D within a few core themes. Firstly, the medicalization of childbirth, such as the high sterility of hospital birth settings, birthing positions, and how female obstetricians and midwives have been affected by this medicalization. Next, the reduction of women's health to reproductive health. This refers to providers assuming that a female patient's health issue is due to pregnancy; forced pregnancy testing of female patients who are over 100% positive that they are not pregnant; as well as the marketing of products that regulate menstrual cycles and the well-being of reproductive organs as birth control (and the underlying assumption that a woman only wants birth control to prevent an unplanned pregnancy). Lastly, the cultural root of these experiences will be addressed: the othering of women who do not want to have children.

A majority of the responses saw negative aspects of childbirth in the photo. The most common theme among responses was the medicalization of childbirth. Mackenzie, who is the only subject who has given birth, directly noted the painful birthing position of the subject.

> I see this, and I think, why is she on her back? It's so uncomfortable to be on your back when you're in labor. I was literally on my back for two seconds while I was turning… And the two seconds I was on my back was excruciating. I didn't have any pain medication for my birth at all, I just used self-hypnosis and mindfulness. And that [laying on my back] snapped me out of it immediately. Being in the depth of my labor, pushing for two and a half hours, none of that phased me. But the two seconds I was on my back, I was like, *holy shit this is uncomfortable, why would anyone do this?*

Mackenzie continued to remark about some of the effects of childbirth medicalization, such as the intense cleanliness and sterility that has been normalized in medical settings.

> It also seems weird to me that they're already wrapping the baby in a blanket and messing with the baby, and that they didn't just immediately put the baby on the mom's chest. Her skin-to-skin. Cause all of the research indicates that that's best practice, and the best for baby's vitals and immediate bonding, and if the mother wants to breastfeed that's important for her body to start, to get that process started. So it's just weird… and the vernix the baby is covered in, it's really important to rub that in, it has lots of important nutrients and important things to help the health of the skin and protect against bacteria. So leaving that there instead of immediately washing it off is another thing that we know now is important that hasn't always been standard of care.

In contrast to many of the responses to Photo D, Anna notably said that it "makes me feel excited. I've never been through a birth, so I don't know the hard parts of it, but I think, *baby!* And the fact that they're [the healthcare professionals] women."

Subjects discussed negative experiences with both male and female physicians and providers. Yet, most at least mentioned that they would prefer to have a female provider as opposed to a male one, especially in the context of obstetrics and gynecology.

Within obstetrics and gynecology specifically, there is a significant trend of patients preferring to see female physicians. The preference is not difficult to understand, when considering routine practices in obstetrics and gynecology include pelvic exams and breast exams (Janssen and Janssen 222). Many subjects said that they preferred female physicians because of comfort and did not delve deeper in their reasoning. However, when one subject was asked if she would prefer to have a female physician over a male one, she answered that:

> I am more comfortable in general with female physicians, but particularly women's health issues. [In the past] I was sexually assaulted by a man. And so, having men that I don't know well and that I don't know in an intimate way performing those kinds of exams is triggering.

It is also important to consider other reasons for preference for a female physician. For obstetrics and gynecology as well as primary care in general, marked differences in provider communication based on gender create differential physician preferences for the gender of their provider. It has been observed that female physicians of multiple fields spend significantly more time and energy on psychosocial counseling, preventive services compared to male physicians, who were more likely to focus on technical practices such as obtaining medical history, conducting physical examinations, and planning treatment. In addition, patients of female physicians have been shown to be significantly more satisfied with their medical care than those of male physicians, even when patient characteristics and physician practice style were controlled for. It follows that physician gender and behavior both work together to influence patient satisfaction, rather than gender alone (Bertakis 357).

Considering that women were arguably the first physicians, it is not surprising that Western female gender norms lead to the development of characteristics that are beneficial for patient-physician interactions. In the United States, as gendered barriers to obtaining a career in medicine have diminished, women have steadily increased their presence in medicine. In 2019, females were the majority of medical students in the U.S. for the first time (Heiser).

As mentioned earlier, many subjects reported misogynistic and queerphobic experiences from female as well as male providers. Some of the most positive experiences discussed during interviews involved female physicians who were also queer.

Emma specifically mentioned her positive experiences with her queer female neurologist in the Photo C chapter. While the neurologist's visible queerness was comforting to Emma, she also had an experience in which the trials of being in a long-term relationship with a woman were shared in a welcoming space:

> [The PA performing my spinal tap] opened my chart and was like, *oh, well you're not pregnant if you were worried about that.* And I was like, *well my girlfriend would be pretty mad if I was.* And she laughed about it, and the whole time she was doing my spinal tap, she was telling me about all the times doctors had forced her to get a pregnancy test, like *yeah I've been with my wife for like 20 years and we have a kid, but I* bought *the semen to make that kid.* (laughs). It was just very cute and reassuring, and I remember feeling like I had just walked into this whole network of competent gay doctors. It was just like, all of sudden I was being listened to, and people were concerned with what was wrong with me. And I very much felt like it had to do — it made me very comfortable that both those doctors were gay, but I think it really made a difference that they were both women. And they listened and believed I was in a level of pain that was too much.

The tribulation that Emma and the PA discuss in the above excerpt is nearly a universal struggle for WSW, and also presents significant frustration for most women, regardless of their sexual lives: forced pregnancy testing.

Forced pregnancy testing sounds like something out of *The Handmaid's Tale*. However, it is something that most women are pressured, if not coerced, to do in even routine health exams. When asked how being a young woman influenced her healthcare experiences, Avery responded that:

> As a young female that is sexually active, a lot of the doctors — especially older ones — just completely don't believe me. Before I was sexually active, they were like, *ok, you say you're not, but we're gonna get your mom to leave for like two seconds, and then she's gonna step back in and you're gonna tell us the truth.* And when I say I'm still not sexually active, they're like, *well we're gonna have you take a pregnancy test just in case.* And I'm just like ok, I'm gonna pee in the cup, but I'm not pregnant.

Mackenzie discussed how she is also frequently pressured into taking pregnancy tests that she already knows the answer to. At this point, Mackenzie has been in a monogamous relationship with a woman:

> At my primary care office, [they will ask me when my last menstrual cycle was] and if, for whatever reason, it just happens to be late, and they're like, *okay we'll do a pregnancy test*. And I'm like, *no you don't understand. There's no physical way.* And they're like, *we're going to do the pregnancy test.* Because they don't believe you. How could you possibly only be having sex with women? How is it possible that there's no men involved whatsoever?
>
> The last time it happened at my primary care office, I had come in with concerns about hormonal imbalance because I was experiencing symptoms I had experienced in the past

> when I had way more estrogen than my body needed. And it was really inhibiting my daily functioning. And a lot of the symptoms were like pregnancy symptoms. So lots of nausea and vomiting, rapid weight gain. All of these things that are often associated with pregnancy. So I came to the office and said, *I'm having pregnancy-like symptoms, and I know 100% that I am not pregnant.* And the nurse was like, *so we need to do a pregnancy test.* And I was like, no we don't! I can tell you with 100% certainty that there is zero possibility that that is the case. Something else is causing my symptoms. So then when [my doctor] was like, *oh you were concerned you were pregnant?* and I was like—
>
> I specifically said I know that I am not, and then I told them that I did not need it. And [my doctor] was like, *oh my goodness, I'm so sorry, I'm gonna just cancel that test. That shouldn't have happened.* And she was really apologetic and just completely understood why it was so absurd. And was appalled that somebody in her office had responded that way. And then I was able to talk with her about what was actually going on, and what my concerns were. But it was one of those super frustrating things because I spent like twenty minutes trying to explain, *no, that's not what I'm saying. No.*[8]

Emma was also put in a position in which she felt she had no choice but to comply and complete a pregnancy test. Unfortunately, there was no systemic support for her like there was for Mackenzie. The following narrative occurred in the context of Emma being prepared to have her spinal tap done, and was right before her meeting with the lesbian PA discussed earlier this chapter:

> We were in the hospital, and my mom had come down from North Carolina, so it was me, my mom, and my partner, and I was filling out all the forms and they took me back to get some blood work done. And the phlebotomist was like, *okay I need you to pee in this cup.* And I was like, *oh, haha, for drugs or whatever? There's a ton in there, but none of them are illegal.* And she was like, *no, we have to do a pregnancy test because*

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[8] This conversation is continued in Appendix E: Extra Interview Snippets.

> *it's a spinal tap.* I was like, *you saw my girlfriend in the waiting room, right? I've been with her for a year, there's no chance, I also have an IUD, so we're double-double protected here. Literally using the abstinence method, we're fine unless the second coming is about to pop out of my vagina.* And she was like, *well, sorry, if you refuse the pregnancy test, you can't get the spinal tap.* Like, ok, I've been told I may have MS and this is the only way to find out, so I guess I will pee in this cup. But about a month later I got the bill, and the pregnancy test was $145. Which is absurd.
>
> So I tried to object to it, I called the hospital billing department — oh and my insurance wouldn't cover it, because they were like, *$145 is not reasonable for a pregnancy test, we would cover $10 because that's how much it should cost.* And I'm like, okay I agree, but why should I have to pay the rest of it?
>
> So I called the billing department, and they were like, *you had the option to refuse the test.* I was like, no I didn't! They said that I couldn't get the procedure if I refused to take the test! And she was like, *sorry, you should have pushed harder at the time.*

Patricia has successfully utilized a loophole to avoid the typical disjointed *are you sure you're not pregnant?* debacle. Instead of explaining to physicians that her husband is transgender and therefore cannot get her pregnant, Patricia simply says that her husband is sterile and that there is a 0% risk of pregnancy.

The normalization of pregnancy testing, to the point that providers feel entitled to deny patients from receiving care if they refuse to take it (even in Emma's case, in which she was "double-double protected"), reflects the societal fixation on the fertility of women. The obsession with female fertility has several themes that live within it: all women want to have children (if not now, someday); women are only on birth control to prevent unplanned pregnancy; and women are not to be trusted on reporting if they may or may not be pregnant.

Firstly, there is the assumption that all women want, or will eventually want, to get pregnant and/or have children. Avery described how the preoccupation that doctors had for her future reproductive ability negatively influenced her plan for pregnancy prevention:

> I wanted to get Paragard because it lasts twelve years, you don't have to worry about [accidental pregnancy] for twelve years. Other ones, like Mirena and Liletta, those last two to three years, maybe five. And the Nexplanon lasts three to four. So I'm like, that's twelve years I don't have to worry about this. I'm trying to think ahead. [The doctor] made it seem as though it's going to completely, no matter what happened, [make me] sterile after they take it out. I did research before I came in there, and I know Paragard, out of all of them, is the biggest one. So I know it was gonna be uncomfortable if I was able to get her to do it. But this was something I came in there knowing, and the fact that she was just like, *here's a speculum, stick it in there, don't move, and if you do, we're ending this right now.* You can do that, but I'm just like, *I'm ready to get something put in my uterus so I don't have kids* and you're like, *umm no.* It just doesn't make sense to me.

Fixation on the potential for pregnancy over every other concern of a female patient is also socially conveyed in how we discuss birth control. Firstly, we call a class of medications *birth control* when they provide services other than preventing pregnancy for patients. Many women suffer from menstrual migraines, in which they only suffer from severe migraines during menstruation; a device that could either lessen or completely stop one's menstrual cycle would therefore be incredibly helpful for that patient, regardless of her sexual activity. There are also many women who routinely endure incredibly painful periods and use medications or devices that regulate periods (such as "birth control" pills) to alleviate the monthly discomfort they face, again, regardless of sexual activity. Emma and I discussed this during our interview:

> R: I went on birth control when I was very young because my period just wasn't regular. I would have my period for two weeks, then off a week, and then another two weeks again. My parents were like, *we can't live with you like this, we'll put you on the pill.* So I feel like that's something people don't talk about. It's called birth control, but it's used for a lot of other things.
>
> E: Yeah. You don't go, *official medical contraceptives.* I know so many people who take it for endometriosis, or for, I know a girl who had Turner's syndrome and had to take birth control since she was 14, just to get the hormones she needed. Maybe if we just referred to it as just *taking hormones,* then it would normalize that, and maybe even normalize trans people taking hormones.

Anyone who grew up as a female recognizes the experiences shown in this chapter. From a young age, girls are assumed to be natural caregivers, to want children above all else, and to want a husband. In reality, many women stray from these societal assumptions. And even those who do want to have children face heteronormative influences such as the male medicalization of childbirth and the expectation that children retain the gender identity that they are given at birth. In the next, and last, photo chapter, the core aspects of being a queer female medical patient are examined, and an optimistic reality is explored.

Photo E: Clean Slate

> "There is a moral core to healing in all societies that I take to be the central purpose of medicine. That structure is luminously revealed by the experience of illness and by the demands made on the patient-doctor relationship."
>
> – Arthur Kleinman, *The Illness Narratives*

Interview Response Keywords

Open doors
Able to leave
Warmth/comfort
Modern
General
Sterile
False sense of security
Empty
Lonely
Overly medicalized

Photo D was arguably the most intense photo of the photo-elicitation set, due to its content as well as the large number of people within it. It follows that the photo following Photo D would be one of the most tranquil.

Photo E presents a stark calm compared to Photo D. Photo E is spacious in multiple senses; there are no people present, or even implied to be present, since the room appears ready to take in a new patient. The room is literally large, in that there is a good amount of distance between the bed and the door, as well as the fact that the room has its own bathroom. The lighting is artificial, yet less harsh than the illumination is Photos A and B.

Photo E is officially described as:

> An interior view of an inpatient room in Fort Belvoir Community Hospital Oaks Pavilion. The rooms are Americans with Disabilities Act-compliant and feature patient lifts to reduce a patient's fall risk. The lift also aims to minimize potential health care providers' injuries. (U.S. Navy photo by Mass Communication Specialist 2nd Class Todd Franthom/Released)

Fort Belvoir Community Hospital is a military treatment facility located just south of Washington, D.C. (Franthom). It makes sense that the room in Photo E is, as one respondent described, “pleasant.” Since Photo E depicts an inpatient room in a military hospital that is a spit away from D.C., it follows that it would contain a plethora of resources and comforts.

As implied by the title of this chapter, Photo E was meant to provide the subjects with the chance to convey any ideas or experiences that hadn’t previously been covered in other parts of the interview. I chose Photo E to be the last image in the photo-elicitation set because I wanted for subjects to have the opportunity to explore metaphorical and well as literal openness in a medical setting. Photo E is the most neutral photo in the set, due to its absence of anything incredibly out of the ordinary (aside from its large size). Aspects of Photo E that are not neutral are primarily positive, such as its large size, private bathroom, wide open doors, and warm colors. While some subjects did remark on parts of Photo E that they did not like, I was ultimately able to use the last image as an exercise in optimism.

Most responses contained participants' reactions to the large size of the room, the presence of a private bathroom, and the wide, open doors.

> Ooh, this one is … warm… This is pleasant. I don't know why. Maybe the bed. It's more color than the other rooms… if I want to leave, I can.
>
> It looks sterile. And I don't have an issue with that. They're clearly in between patients, also that seems like a giant room and bathroom. Most hospitals don't have rooms that big.

Not all participants viewed Photo E as a luxury hospital room. Many discussed how it appeared unnaturally nice based on their experiences.

> I like that the doors are open. It just looks really sterile, and like a fake sense of security, like they're trying to make it seem… the lighting's not awful. I noticed that the doors were open, that was nice.
>
> I feel like this is the kind of special room you get if you're a politician or something, when you're the elite.
>
> Jeez. It's very clean. It looks very lonely, though.

Responses to Photo E reveal some of the core themes of this project that have continually been discussed at length in preceding sections: comfort, medical authority, sterility, medicalization, and restrainment. As such, it was well-placed to be the last photo that subjects were asked to respond to. For this final photo-elicitation chapter, I take advantage of the broad nature of Photo E responses to provide a cohesive overview of the core themes that subjects discussed, given that the responses of most relevance to this project have already been described in earlier sections.

Photo E responses also create a starting point for discussing ideal interactions with providers. The key response words and transcript excerpts above show how, compared to the first four photos, Photo E had a positive impact on the subjects. While there was still trepidation of some subjects just based on the fact that it was a medical space, they nonetheless discussed the positive aspects of the photo as well, such as the open doors, private bathroom, and warm color scheme.

Responses to Photo E can be used to extrapolate ideals of medical experiences that were mentioned in other parts of the interviews. When asking subjects about the demographics of their ideal physician, their responses reveal how there is no model physician for the queer female patient. Likewise, when subjects describe their coming-out interactions with providers, they reveal what the provider did right and/or wrong.

Emma's narrative contained coming-out experiences in which the provider handled it well and also not very well. First, there is the therapist who was not culturally competent with queer patients:

> For the first appointment, you have to go through all your stuff. I was like, *I'm bisexual, my partner is a woman, blah blah blah.* And she was like *Okay*[9]. *So the word you use is*

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[9] Emma mimicked her therapist by making intense eye contact with me and speaking very slowly.

> *bisexual?* And I was like, *that's what I said.* And she was like, *okay, are there any other words you would like me to use?* And I was like, *why are you gonna need a word to use to talk to me? You don't need to be like, 'you, a bisexual.'* And I guess she meant for her notes or her knowledge or whatever, but she was like, she sat there and waited for me to answer, and I was like, *okay, well I guess I'm comfortable with queer, like my partner describes herself as gay, so I kinda use that one too sometimes.* Like, here's my relationship to just all of the words. And it took several minutes and I was kinda like, *you know, I know I only get like fifty minutes and you're using four.*

Emma also described one of the best reactions to her sexual orientation disclosure:

> I see my neurologist fairly often, and I go to see her with my partner, my mom, [and also with both] my partner *and* my mom. So I didn't have to out myself, my partner was there and it was obvious. She didn't bat an eye at my partner being there, or at the fact that, at that point, when I first got sick, we'd only been together for 6 months or so. Which is — we U-Haul'd pretty hard. But so a lot of people would not really want to talk to somebody's partner that they haven't been with that long. She never has — she's always treated my partner with a lot of respect, a lot of times when my partner comes in with me, the doctor will be asking me questions, and then she'll straight up turn to my partner and be like, *okay, what's your perception on what's been going on?* And just talk to her. And it's just a level of respect for that relationship that I don't encounter with every professional I've interacted with.

Emma's therapist most likely thought that she was being culturally sensitive by deliberately discussing terms of identity and asking Emma many questions, which in actuality detracted from the productivity of the sessions. The therapist's fixation on correct terminology revealed her discomfort and lack of familiarity with queer patients. The incessant questioning also perpetuated the idea that heterosexuality is normal, whereas queerness is something out of the ordinary that requires in-depth study.

In contrast, the neurologist "didn't bat an eye." She easily accepted that Emma had a female partner and only asked questions that were relevant to Emma's health. The neurologist also held a high "level of respect for that relationship" that did not meet heteronormative standards, since it involved an unmarried same-sex couple.

Both the neurologist and the therapist were women. As discussed in the previous chapter, almost all subjects described their ideal physician as being a woman or female-identifying. This trend supports the idea that androcentrism in medicine affects almost all female patients, regardless of sexuality. While female physicians have been described in these narratives as perpetuating the male-as-default paradigm, many subjects most likely hope that identifying as a woman would lessen the probability of a physician falling within that mindset.

It is also critical to note how race and ethnicity play into a patient's ideal physician. The default medical patient is a man, and he is also specifically white. Since the majority of subjects in this project are white, they did not note any preference for having a non-white physician. Yet, both Avery and Patricia described their ideal physician as being an African-American woman, as can be seen in Avery's quote below.

> My ideal primary care physician would be an older black woman that is queer, because my mom is a black woman that's queer… I feel a lot more comfortable talking to someone like my mom. Like a motherly figure. I know [that] my mom, no matter what, she might think I'm doing weird stuff, but she'll love me and she'll make sure I'm okay.

While a queer identity would be a bonus, they primarily identified their ideal provider provider based on race and gender. The lack of white subjects' consideration of physician race reveals how the U.S. healthcare system is inherently male and white.

Race and gender concordance between physicians and patients has been shown to be a critical factor in equitable quality of care. Although research focuses more on how a patient's race and gender may influence their quality of healthcare, it is equally, if not more, important to assess how physician demographics also influence the patient's quality of care. Physicians are undoubtedly influenced by nonmedical characteristics of their patients in their practices of diagnosis, therapy, and prevention across medical fields and for various conditions. It has been observed that physicians who were male and/or white tend to under-prescribe medications to ethnic minority and female patients. In addition, physicians who did belong to the same gender or race group as their patient did not practice the behavior of under-prescribing medications (Berger 100 – 101).

Given these realities, it is not surprising that Avery and Patricia described their ideal physician as being a black woman. Considering that only 5% of American physicians are black, and that roughly half of black physicians are female, it is likely a feat to find a provider who meets their ideal physician demographics ("Diversity in Medicine: Facts and Figures 2019").

Another critical aspect of physician demography is age. While few subjects mentioned anything specific about the age of providers, there were some inferences that they may prefer or feel more comfortable with younger physicians. When Emma was describing her frustrating experience in therapy, she commented that:

> If you happened upon her as a therapist in the 80s or something you would've been like, *wow, so accepting! So wonderful! This is pretty good!* But I was just like, no, I've had a therapist before who knew a lot.

Mackenzie described one positive interaction with a doctor potentially being due to her younger age:

> She [the doctor] is a resident and I think that that may have some to do with it, that she's like of a different generation, and she's more recently been in med school where they've updated some of their curriculum. Not nearly enough of it, but…

In the above quote, Mackenzie references another important characteristic of a provider: cultural competency with queer patients. While a queer identity can be comforting to patients, they do not necessarily expect for providers to disclose their sexuality along with their credentials. Rather, many subjects instead described the desire to have a provider who has attained some sort of certification as being a competent provider for queer patients.

Professional schooling for healthcare providers has not traditionally included LGBTQ-focused education in the curriculum. As such, it is not simply a matter of making medical training faculty teach these competencies; they most likely lack LGBTQ patient competencies as well. The fact that providers are not given LGBTQ patient care competencies in school and are not expected to follow a continuing education requirement once certified creates the negative circumstances that have been explored thus far in the queer female medical narratives (Singer 18–19).

However, heteronormativity is not a static idea that can be wiped out through changes in the formal curriculum[10] alone. Heteronormativity is reproduced in medical education in particular through a hidden curriculum of heteronormativity. The hidden curriculum is not found on any syllabi or course requirements but is instead transmitted to students through exposure to implicit cultural and educational norms (Robertson 161).

Even queer medical students are susceptible to the reproduction of heteronormativity. In a research article in which queer medical students were asked about the reproduction of heteronormativity in their education programs, distinct examples of its reproduction are shared. Many students discussed how case studies never identified patients as heterosexual, which enforced the behavior of assuming that the patient is always heterosexual. The only instance in which sexuality was made relevant in case studies was when the patient was a homosexual man with HIV/AIDS, which serves the purpose of supporting a harmful stereotype rather than deflating it (Robertson 164 – 167).

There are theories and data about what the ideal healthcare experience is for different people. For the queer female patient, I posit that the ideal provider is one that "doesn't bat an eye" at a patient's partner being female; someone who makes it as easy as possible for the patient to "get help or be understood right away"; and a provider who trusts the patient until proven otherwise, instead of the reverse.

The lower quality of care that many of the subjects faced in these medical narratives cannot be attributed solely onto heterosexist individuals. While it is tempting to blame individuals — and they are definitely responsible for their actions — there are larger networks at

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[10] Program requirements and course content.

play that make these events so unfortunately common. As discussed in the preceding pages, medical training curricula severely lack any lessons or procedures for culturally competent care. As students become professional providers, they work under and learn from senior advisors who are likely as uneducated in these skills, and the cycle continues.

There has been pushback for medical training programs to instill queer care techniques into their lesson plans. However, due to the long-standing structure of most programs, this concept poses many hindrances. Most significant is the fact that heteronormativity is a dynamic concept that bleeds into education in ways that non-queer students (and sometimes, even queer students) do not recognize.

Conclusion

“There’s no monolithic experience, no simple narrative, no easy way to lump and slice the incredible diversity that characterizes queer and trans identities, communities, and lives.”

– Zena Sharman, *The Remedy: Queer and Trans Voices on Health and Health Care*

This thesis reveals the interactions between queer female medical patients and their healthcare providers. Overall, “The Queer Female Medical Narratives” illustrates three critical themes: heteronormativity negatively impacts the health of queer patients in a variety of medical fields and settings and is especially prominent in counseling and psychiatry; women, and especially women who are queer, nonwhite, and/or low-income, are not listened to and are a medically vulnerable population; and more qualitative research should be done on the queer female population.

Heteronormativity is not an entity that can be dispelled overnight. It is easy to claim that the social circumstance of queer people has improved in the last hundred years, but that does not mean that no problems exist today, or that contemporary problems are not rooted in beliefs and practices from centuries past. The assumption that patients are heterosexual, and that any deviation is abnormal persists today, as seen in the Photo A and Photo D chapters. The perception of queerness as abnormal may appear subtle to the provider but is incredibly obvious to the subject. Prime examples include Heather’s physician, Emma’s therapist, Anna’s therapist, Avery’s therapist, and Mackenzie’s psychiatrist in the Photo A chapter, and the forced pregnancy testing of Emma, Mackenzie, and Avery in the Photo D chapter.

The abnormality of having a queer patient is also conveyed through the lack of trust that providers have for their queer female patients. Many interactions conveyed how society does not trust women regardless of sexual identity, which can be observed through the Photo B, Photo C, and Photo D chapters. Providers were specifically shown to not believe instances of female pain through Anna’s gynecology experience in Photo B and Emma’s chronic migraine narrative in Photo C.

The narratives in this work show how queer female patients are not listened to. While narratives of not being listened to appear throughout the thesis, an especially visceral instance includes the lack of preventive sexual health care afforded to WSW, as discussed by Heather in the Photo B chapter. In addition, a key example of not being heard can be observed through Mackenzie’s exhaustive efforts to have psychiatric providers correctly gender her transgender daughter, only for consistent misgendering to occur.

A core idea of this thesis is that these experiences are not unique. A contributing factor to the persistent heteronormativity of our society is that we are very selectively allowed to hear queer stories. Due to the paucity of queer narratives, in medicine and outside of it, these subjects’ narratives may be viewed as abnormal. If a reader is to take one idea away from this thesis, I hope that it is that nothing is abnormal about these narratives. Rather, the exhaustion, pain, and aggravation that comes along with being a queer female medical patient is symptomatic of the heteronormative system that we live in.

The negative attributes of the American healthcare system expressed in this thesis have strong institutional legacies that are not easily undone. Yet, there is potential for positive change. The fact that there are large populations of people who recognize when they are receiving lower versus higher quality medical treatment means that there is already a strong body of support for efforts to increase empathy and sensitivity in patient-provider interactions. Specifically, the optimistic experiences and ideas expressed in “The Queer Female Medical Narratives” embody the constructive breaking apart of the heteronormative lessons that we have been learning since birth.

As emphasized above, it is not easy to displace culturally insensitive behaviors and practices. Everyone, including queer people, are subject to heterosexist outlooks. It is only through consistent examination and reflection that our ideas about how gender and sexuality function in the world can change for the better.

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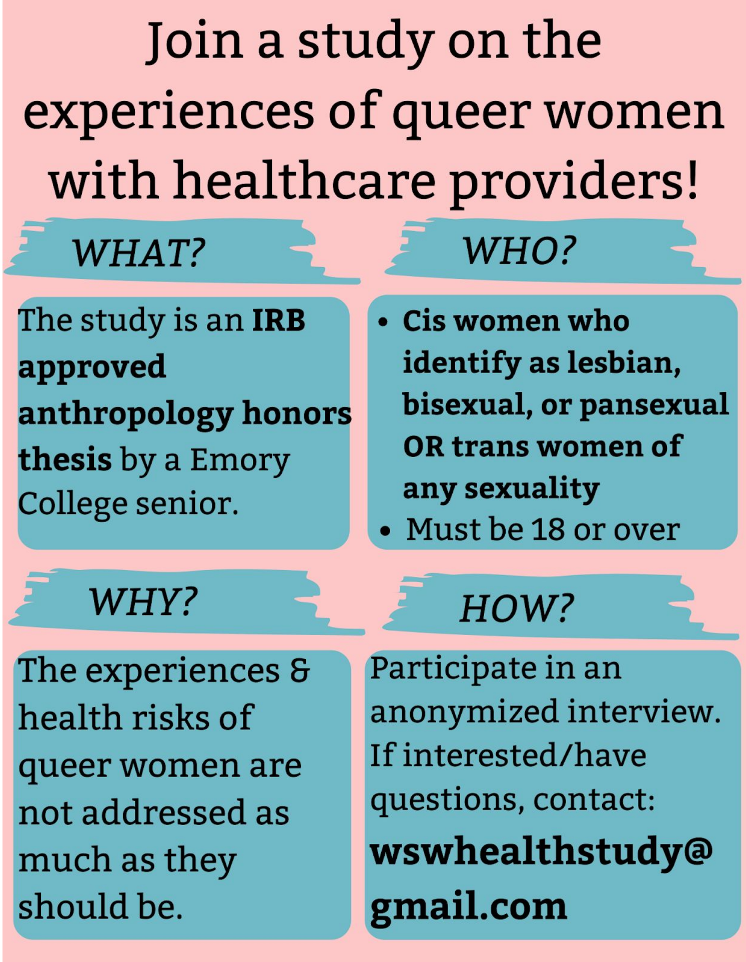
Appendices

Appendix A: Semi-Structured Interview Question Guide

1. What is your sexuality? Gender identity?
2. What is your age?
3. What is your race/ethnicity?
4. Have you always lived in Georgia/Atlanta?
5. Was your family religious at all?
6. Would you say that your family is more conservative or liberal-leaning?
7. Where do you typically receive healthcare (primary care physician office, walk-in clinic, emergency room, free clinic)?
8. Do you have an OB/GYN?
9. Have you ever disclosed your sexuality to a healthcare provider?
    a. Yes: please elaborate on the situation and provide details.
    b. No: is there a specific reason why you did not?
        i. Would you ever consider disclosing your sexuality to a provider/have you ever wanted to?
        ii. Has nondisclosure of your sexuality led to unnecessary tests/procedures/questions?
10. Do you believe that your sexuality has affected your relationship with healthcare providers?
11. Do you believe that sharing (or having shared) your sexuality with a healthcare provider could negatively affect your quality of care?
12. Would you prefer to have an openly queer woman as a healthcare provider? Why or why not?
13. Has disclosing your sexuality ever directly led to a lower quality of care/microaggressions/harassment/violence?
14. How has your form of gender identity (cis/trans) and gender performance (alliance with expected gender norms, i.e. butch/femme, masculine/feminine/non-binary presenting) influenced your experiences in healthcare, if at all? Why?
15. Is there anything that you believe could make you more comfortable as a medical patient?
    a. Would having a friend/advocate come with you help ameliorate discomfort/anxiety?
16. How do you decide where to receive health care?
17. [photo elicitation]: What experiences/feelings do the following photos bring up for you?

18. [The following is a question of personal sexual health/knowledge. Before asking the question, the subject will be told that they are more than free to decline answering this question.] Have you, in the past or currently, had sexual relations with a self-identified woman (cis or trans)?
    a. Yes: Did you use any form of protection? (dental dam, glove, condom)
    b. Do you think that HPV can be transmitted between women?

Appendix B: Recruitment Flyer



Join a study on the experiences of queer women with healthcare providers!

WHAT?

The study is an **IRB approved anthropology honors thesis** by a Emory College senior.

WHO?

- **Cis women who identify as lesbian, bisexual, or pansexual OR trans women of any sexuality**
- Must be 18 or over

WHY?

The experiences & health risks of queer women are not addressed as much as they should be.

HOW?

Participate in an anonymized interview. If interested/have questions, contact: **wswhealthstudy@gmail.com**

Fig 1: Recruitment flyer for this thesis; was posted in public spaces in Atlanta as well as through social media.

Appendix C: Clinical Reference Images

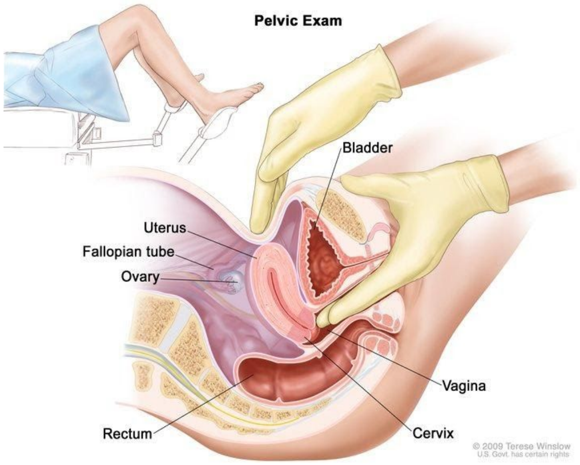


Fig 2. Medical illustration of a pelvic exam. For the National Cancer Institute © (2009) Terese Winslow LLC, U.S. Govt. has certain rights.

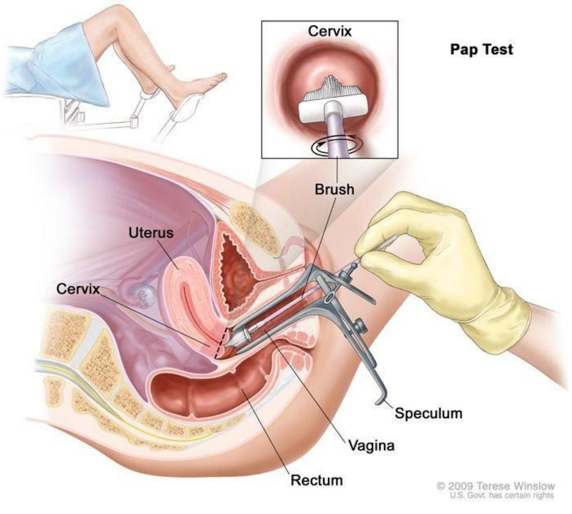


Fig. 3. Medical illustration of a pap test. For the National Cancer Institute © (2009) Terese Winslow LLC, U.S. Govt. has certain rights.

Appendix D: Photo-elicitation Images

Photo A

Photo B

Photo C

Photo D

Photo E

Appendix E: Extra Interview Snippets

Appendix E contains quotes from interviews that I found relevant and interesting to the project, but were also tangential to topics at hand. These transcript sections are less consolidated than those found in the result chapters in that the reader can see the give and take between myself, labeled R, and the subject. Before each quote, there will be a short heading that gives the context of the quote.

Emma

I. Continued quote from Photo A section on having a therapist who was not culturally competent with queer patients.

E: I just wanna talk about how to deal with the negative feelings that I will have when something like this is said, which will happen. And then I also would try to talk to her about cutting them off or going more low contact, and transitioning more to like extended family — my extended family is all very kind and accepting. And she was so clearly not comfortable or familiar with that kind of idea. I feel like she thought that she could therapize me into having a PFLAG family. That is not gonna happen, they are not ever gonna go to therapy. And that would happen too when I would talk about my relationship with my partner. I don't know if — I've only been in one straight relationship and that was when I was 18…

R: Yeah, it's not like dating as an adult.

E: Yeah. But I feel like anecdotally among queer people that I know, there seems to be a respect for partnerships that are not marriages, even if they are planning on following that path, they just haven't gotten there yet. I feel like a lot of queer people tend to be like, *this is my partner. We've been together for X years and we're not engaged, we're not whatever, but this is my life partner and we know that. And we act based on that.* Whereas a lot of my straight friends are like, *well, we're not engaged yet.*

R: *Yet.* Like, there's that inherent *yet.*

E: Yeah. Like they don't take it as seriously or don't respect it as much.

R: It's a given, probably.

E: Yeah, and maybe so. I doubt that that's a universal thing, it's just the people that I know. But this therapist, I felt like I couldn't get her to understand that that was how I saw my relationship. She wasn't rude about it, she was never recommending I would dump my partner and go sleep with other people or whatever. But she would just always question it when I was telling her about a decision I had to make in concert with my partner. Like, no, that's a decision about our finances and stuff, so that's a [decision we made] together. So I eventually did the patient thing and slowly ghosted her.

R: I feel like she should have seen that coming.

E: Yeah, but it was also finals and so I honestly forgot about an appointment one week.

R: At some point, if the experience with her was more exhausting than your usual therapy session — cause therapy is inherently exhausting, but that sounds like it was very much of having to fight for things you already know.

E: Yeah, I felt like I had to do a lot of teaching. And I frequently had to explain to her that my partner is visibly queer and I am not. And that colors our interactions with the world, and that colors what happens when we go out together, when the two of us walk somewhere together, this is my first time ever being read as queer and not straight, and that's new for me. And that leads to lots of things, and she was very clearly confused by that, so I spent like 5 minutes being like, *this is what my partner looks like. These are the reasons that people read her as queer and not straight.*

II. Emma explains her experience with sexual health, her family's viewpoint on HPV vaccines, and a unique example of female health advocacy.

E: I honestly have no idea where to buy a dental dam. I guess I could order a dental dam online. I feel like I remember that Planned Parenthood has them?

R: I guess it is different cause you know you can't get pregnant [when having same-sex intercourse]. But I think a lot of it is also just providers, and kind of society, don't really acknowledge that no matter which gender you're sleeping with, you should probably try to use protection.

E: Yeah. And I feel like there is still such a stigma attached to gay men having sex without protection, and the source of AIDS. It's not just a disease that happened, it's —

R: The gay disease.

E: Yeah. I sort of remember my dad telling me when I was in high school that AIDS is caused by 'butt-fucking' to use his term. And I remember being like, *well, there'd have to be a virus that starts somewhere…* with gay men unprotected sex is so stigmatized, and then with gay women it's just like, it's almost like that sex doesn't even really count. I've been lucky that I've never contracted anything or had a partner that had anything. I hope that, if I had not found a long-term partner soon after I had started dating women that I would have been like, *hmmm, I should start using dental dams or something.*

R: Do you think that HPV can be transmitted between women?

E: Yeah.

R: It's a big health issue, it's one of the main research questions in this project, just because it's a common [STD], and also women are equally likely to get it, even if they're having sex with women.

E: I think I was lucky in that department. Gardasil was in when I was in middle school, and my mom was all over it. Because her closest friend — at that time was still alive, but ended up dying of ovarian and cervical cancer as the result of having HPV at some point. And my mom was super clear — my dad was really opposed to it, he was like, *she doesn't need that, she just needs to be abstinent.* And my mom was like, *my daughter is not dying of HPV. Whatever percent of people who have HPV, my daughter is not going to be one of them who dies of HPV if I have anything to say about it.* And then a couple years later — I have a brother who is five years younger than me — they started saying boys should have it too. And my parents had a fight about it again. And my mom was like, *so you're okay with our daughter not being the one who dies, but you're okay with our son being the one who* causes *some woman to die? It's not gonna happen.*

E: I had one friend who got a strain of HPV from a dude who knew he had it and didn't say anything about it. And I had another friend who got — she didn't get cancer, but she got very scary cysts that had to be removed, and they were precancerous or something. I remember that that was when I was in college, and she came up and started crying about this, and we were like going through her sexual partners and she was like, *I know who gave it to me. And I talked to him about it, he knows he has it and didn't say anything.* And we were like, *well, we know who this guy is. We know that he's out there sleeping with other people. The public needs to know!* And she was like, *no, I don't want anybody to know that this happened to me.* And so, we were like, *okay, something has to be done.* And one of the girls who was in my sorority was like, *I'll take care of it, don't worry.* And she spread this rumor that he had a cone-shaped penis. It was amazing, no one wanted to sleep with him after that! Which is horrible, but also, it prevented more people from catching HPV.

Anna

This interview snippet gives further context on the religious foundations of Anna's family, and how they attributed her mental health concerns to her queer identity.

R: You mentioned that your family is conservative, and Baptist specifically. How do you think that affected things — besides the general queer experience of not being able to comfortably come out and not feel safe with your family. Maybe like how that specific Baptist religion may have played a part in it?

A: I had come out before I was hospitalized, and they [my parents] assumed I was hospitalized and my mental health issues — and because they knew about them, they'd been going on since I was at least 10 — they would very explicitly ask me, *maybe this comes from the fact that you're acting in sin, and you have consequences that come from that*. They blame things on either the fact that I'm sinning — or, my mom is really into weird medicine, like taking weird supplements that doctors haven't approved yet. She blames everything on mold. When she couldn't blame my sin on it anymore, she was like, *you must be living in so much mold, here are some supplements to help get the mold out of your body*, that type of thing. [It is] just a lot of denial. My dad has been prescribed antidepressants in the past couple months, and he refuses to take them. Just denial of what certain things actually mean.

Mackenzie

Continued from Photo C chapter in which she described being forced to take a pregnancy test.

M: I specifically said I know that I am not, and then I told them that I did not need it. And [my doctor] was like, *oh my goodness, I'm so sorry, I'm gonna just cancel that test. That shouldn't have happened.* And she was really apologetic and just completely understood why it was so absurd. And was appalled that somebody in her office had responded that way. And then I was able to talk with her about what was actually going on, and what my concerns were. But it was one of those super frustrating things because I spent like twenty minutes trying to explain, *no, that's not what I'm saying. No.*

R: Even if you weren't identifying as a lesbian or a bisexual woman having sex with a woman, there's so many women [who] just aren't having sex[11].

M: Right?!

R: So they know they're not pregnant, but then no one believes them anyway.

M: Right?! Clearly we're just all just…

R: Obsessed with the penis.

M: Yeah!

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[11] Implied: women who are either not sexually active with a penis, or are sexually active without a penis