Dedication

We dedicate volume 12 of *Dissenting Voices* to Pat Maxwell, BITS Project Manager, who has served as Managing Editor of *Dissenting Voices* since its inception in 2012. *Dissenting Voices* would not exist without Pat’s voluntary labor in collaborating with and assisting authors, and in editing, typesetting, and publishing each volume. It is a huge, tedious, time-intensive amount of work that Pat has taken on with kindness and grace. Thank you, Pat, for your many years of service to Women and Gender Studies in creating *Dissenting Voices*. We appreciate you and extend our gratitude for all you do.
Our Voices

Epistemic control of gender oppresses us. We challenge biology and the concept of nature and nurture in a way that sexuality can be a result of both, not just one or the other. We argue that violence and assault against Native women is an ongoing epidemic that plagues the indigenous community. We confront the toxic misrepresentation of queer identity in theatre. We expose the detrimental impacts of healthcare bias and highlight ways healthcare bias increases Black maternal death. We come together in strength and unity to dismantle oppressive systems around us.

Leana Colletti (she/her), Julie Kim (she/her), Kendra Mace (she/her), Alexis Rivera (she/her), Kylene Smith (she/her), Kay Timmons (they/them)

Dissenting Voices Cover Design

Cover Art by Alexis Rivera, conceptualized and created in collaboration with all WMS 421 class members.
Note from the Editor

I am thrilled to introduce volume twelve of *Dissenting Voices*, a student engineered e-Journal collaboratively designed, authored, and published by undergraduate Women and Gender Studies majors as an extension of their Women and Gender Studies Senior Seminar at SUNY Brockport.

*Dissenting Voices* grows out of a course learning structure where Women and Gender Studies students reflect upon their undergraduate experience in the discipline, and through engagement and synthesis of acquired knowledge, establish a theoretical foundation to inform future feminist practices. This work culminates in a meaningful capstone project grounded in contemporary and emerging feminist scholarship. *Dissenting Voices* volume twelve showcases six remarkable authors who research and write on a range of topics important to the Women and Gender Studies discipline.

“Opening Voices” introduces the volume where two authors pen powerful expositions of ways social constructions of identity intersect equality. The first essay uses autoethnography mixed with discourse analysis and phenomenology to examine epistemic oppression and gender essentialism from a transfeminist, transfeminine, and lesbian lens. The second essay blends social constructivist and feminist perspectives to investigate violence perpetrated against Indigenous women.

“More Voices” anchors the volume where two authors effectually disrupt pervasive gender binary conventions. Essay one uses case study couched in a literature review to explore sexual shifts in later life, arguing that sexuality is a result of both nature and nurture not just one or the other. The second essay analyzes several well-known plays and musicals to explain misrepresentations of queer folks in theatre.

“Closing Voices” bookends the volume where two authors provide compelling research on biases in healthcare practices. Essay one scrutinizes the harmful consequences of medical and healthcare inequalities based on race, gender, and weight. The closing essay
exposes racial disparities of maternal mortality experienced among Black and White pregnant women.

Six brilliant authors collaboratively designed and produced this substantive and important volume. Like the many authors who came before them, I am in awe of their perseverance and honored to serve as their faculty. They are skilled researchers and writers who raise their voices to reconcile still pervasive gender inequalities. Smart. Creative. Radical. Brave. Revolutionary. These are some of the words that capture the authors and their powerful agency in championing social justice causes.

The volume cover art, complied and illustrated by Alexis Rivera, portrays the hand of each author with words and images that convey each author’s essay topic. That these hands touch and meet in the center of the cover represents the interconnectedness and collaborative spirit of our class members. They supported and assisted each other in writing and shaping their Dissenting Voices contributions and in navigating life in and around academia. Stop. Listen. Follow their words. They imagine a gender justice path that we can and must follow.

Bridging theory with praxis, Dissenting Voices preserves the authenticity of student voice, sanctioning a wide range of ability and talent that students’ senior seminar coursework engenders. In my early role as Brockport’s Women and Gender Studies Director and faculty developing a new Women and Gender Studies senior capstone course, I had what seemed a pipedream in conceptualizing a student journal. Semesters of dynamic student activism and thought inspired me to imagine a women and gender studies publication that would bring to light undergraduate creative agency realized on the cusp of feminist knowledge. Dissenting Voices, as named and populated by its 2012 student founders, is this dream forward.

In closing, this 2023 Dissenting Voices volume is particularly special for me. I will retire in December 2023, so it is the last volume I will publish as Women and Gender Studies Senior Seminar faculty. As I look back over my shoulder, I am overcome with the
extraordinary breadth and depth of scholarship *Dissenting Voices* has enabled. Across a long and accomplished career, *Dissenting Voices* is the project that I am most proud of. At the close of the semester, the authors here gifted me a beautiful rambling rose bush. I am excited to watch it grow beyond the pages of this journal; its brilliance is commensurate to my students in all their splendor.


Barb LeSavoy, PhD
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Executive Editor, *Dissenting Voices*
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This essay explores the concepts of epistemic oppression and gender essentialism from a transfeminist, transfeminine, lesbian lens utilizing a mixed methods autoethnography which incorporates elements of discourse analysis and phenomenology. This topic is important because of the continued underrepresentation of trans, especially transfeminine, voices in the study of trans experiences. I hope that readers will examine their own relationship with gender essentialism.

Keywords: Epistemic Oppression, Gender Essentialism, Trans Studies, Compulsory Heterosexuality, Lesbianism

Come out of the closet or drink myself to death. These were the two options I permitted myself after admitting that I was transgender. I was afraid, confused, and desperately trying to go back into the closet. Coming out as transgender would disrupt my whole life and open me up to the possibility of being rejected for a core aspect of who I was. I tried desperately to integrate myself into manhood, because I saw my crisis as something fundamentally wrong with me. I went as far as trying to join the military, which I would later find is a common transfeminine experience. Pretending to be a man didn’t work for me. I never identified with boyhood or manhood. They were compulsory social prescriptions, a set of rules and expectations rather than a description and affirmation of myself. Living as a man was suffocating me. I was imprisoned within the structure of maleness, and this imprisonment was enforced by society with actual or threatened
violence and ridicule. Growing up in male spaces, the worst things that you could be were queer or a girl. I would eventually realize that I was both, but before I could begin the process of truly exploring who I was, I needed to recognize what I was not. So, I said those five simple words, “I am not a man,” in fall 2015, in the college dorm I shared with five young men. It took me twenty-two years to say it, and it was the most pivotal statement of my life.

Saying that I am not a man was just the beginning of my journey, and I knew from the start that it would be a difficult one. I would face discrimination and rejection due to my identity. These negative experiences stem from one singular concept: essentialism. The belief that there is an innate nature to the self upholds and replicates discrimination in all its forms, not least of which are transphobia and transmisogyny. I reject essentialism. There is no essential self. The self is constructed and given meaning socially and performed for the self and others. The essentialized self is enforced socially, and transgressing it is rife with consequences and danger. The mere threat of repercussions leads us to police ourselves (Foucault, 1995). This concept of the self upholds and normalizes social inequality by controlling the way that we think.

Culturally hegemonic powers control knowledge production, defining both themselves and others, a process called epistemic oppression (Dotson, 2014). The essentialized self is entirely socially constructed despite its insistence that it is natural, and society enforces it with threats of social consequences and physical violence. Essentialized gender is “a ritualized production … reiterated under and through constraint, under and through the force of prohibition and taboo, with the threat of ostracism and even death controlling and compelling the shape of the production …” (Butler, 2011, p. 60). Essentialism is reproduced and enforced not only by cisgender people, but also by transgender people. This essay will explore the epistemology of transfeminine lesbian identity as a challenge to the hegemonic gender system using my own experiences with existential crisis, essentialist thinking, social construction and compulsion.

Existence

I was raised as an atheist, albeit a Jewish one. I couldn’t believe that a benevolent God would allow its creations to suffer in the way that human beings do. We cannot blame God for our suffering, as the vast majority of human suffering is wrought by human hands. Transgender suffering is no different. In the absence
of God, I concluded that life had no inherent meaning. I did not choose to be born; I am simply along for the ride. Faced with a hollow existence or the promise of discrimination, I considered suicide. I looked death in the eye and decided that I could make life worth living by being myself. *The Myth of Sisyphus* (Camus, 1991) describes the existential crises I experienced using an analogy from Greek myth. Sisyphus cheated death and was sentenced to roll a boulder up a hill for all eternity. It is a meaningless, absurd punishment, but it is no more absurd and meaningless than any other possibility. Sisyphus could just have easily been sentenced to an eternity of modern commuting and office work. Our own lives are patently absurd when you consider the fact that they are lived under the constant threat of an apocalypse of our own making. Sisyphus, like any of us, has two options: suicide, or revolt against the absurdity of being. He can give up and let the boulder crush him or find a way to make it meaningful. Gender is my boulder, and I choose not to be crushed by the weight of it. We can simply choose what life means to us. Convincing others to accept that meaning is more difficult.

Transgender people live in a world that would frankly rather we not exist. This is because we represent a fundamental, existential threat to gender inequality. Transgender people are a relatively small population challenging an enormous societal cornerstone; that there is something fundamentally different between men and women, male and female, and that those are the only two options. Gender is a social system, and, according to Butler (2006) “all social systems are vulnerable at their margins, and . . . all margins are accordingly considered dangerous.” (p. 180)

Hatred and discrimination against transgender people are fundamentally a form of fear. The bigots fear the threat to the established social order, and there is no greater threat than that posed by transfemininity. Transfemininity is a diverse range of gender experiences with a slippery definition. For my purposes, transfemininity refers to people who are assigned male at birth (AMAB) who identify in some way with femininity, womanhood, or girlhood, who may or may not medically transition for any number of reasons, and whose social transition can take any number of forms. Transfemininity is not predicated on a feminine performance. Transfeminine people may be just as masculine or butch as cisgender women. What transfemininity is, however, is a direct
rejection of maleness, and society is determined to punish us for that.

*No Exit* (Sartre, 1989) gives us an analogy that is useful in describing the nature of trans exclusion and oppression. The play centers around three dead souls who are trapped together in hell, which takes the form of a hotel room that they cannot leave. Rather than the tortures they were promised in life, they find that they are there to torture each other. That “hell is other people” (Sartre, 1989, p. 47). Our hotel room is Earth. It is, in fact, every human being’s hotel room. We are confined to this planet, or at least its close vicinity. But real experiences of oppression differ from *No Exit* (Sartre, 1989) in two major ways. Firstly, unlike the play in which each character is equally powerless, cisgender people do have power over transgender people. The suffering of transgender people is entirely because of the way cisgender society treats us. We are denied legitimacy, safety, and opportunity. Secondly, we do have a way out. We can die. And cisgender society encourages transgender people to take that option. Forty percent of transgender Americans have attempted suicide in their lifetime, nine times the rate of the general population (James et al., 2016). When your only way out of hell on Earth is suicide, it doesn’t seem so absurd. Cisgender people aren’t trapped here with us, we are trapped here with them, and we are trapped because of essentialism. It is our meaningless, absurd punishment that we receive for merely existing, as it is our very existence that they hate. There is no inherent transness. There is no genetic marker or brain scan that can tell you a person is transgender, and if there were it would immediately be used for eugenics by the people who wish to eradicate us. If there were, it wouldn’t matter. What creates transness is simply our existence. Our “existence precedes [our] essence” (Sartre, 2007, p. 20).

**Essence**

I was rebuffed by my father the first time I wore one of my older sister’s skirts. I was young, preschool age, and had no concept of gender roles yet. He told me that boys don’t wear skirts, which I internalized. I would repress my feelings about gender for years. In my heart I found this new rule stupid and arbitrary, but I knew defying it would have repercussions. This was my first encounter with the collective self that society projected onto me. Rather than a completely internal process, the self is an ongoing collaborative process resulting from a complex interplay between
complementary individual and societal selves. It is malleable rather than static, and the development of identity necessarily requires the participation of people beyond the individual. Mead (1985) specifically separates identity into the “I” and “Me,” our individual and collective identities as subject and object, respectively, forming a feedback loop. Foucault (1978) describes identity as discursive. Rather than existing a priori, identity is created by the language that we use to describe action. Sex creates sexuality, and our gendered performances create gender. Trans womanhood embodies Simone de Beauvoir’s existential thesis, that “One is not born, but rather becomes, a woman” (1989, p. 273).

Gender is a dramaturgical construct in which all gendered behaviors are, consciously or not, a performance (Butler, 2006). For Butler (2006), gender is a combination of compulsory social construct and expression of the self. The social construct maintains a vested interest in reproducing itself and portraying itself as natural, whereas performative self-expression serves as liberatory. The self that we perform, however, changes based on the social situation in which we find ourselves. We “travel” between “worlds,” pieces of society large or small in which we project a different social self (Lugones, 1987). These selves that we present are dualistic; ontologically multiplicitous, but existentially singular (Ortega, 2016). The concept of truly disparate internal and external selves is merely an obfuscation of the reality in which we find ourselves (Butler, 2006; Ortega). This obfuscation can serve useful political roles, but there is no special metaphysical aspect of the self. Our existence is tethered to the physical world, as are our experiences. These experiences of being in that world are diverse, but we still occupy the same physical plane of being, even if our life experiences are disparate. Transgender identity is created in the act of being. We move between situations where we go in and out of the closet with various people who may affirm or disparage us. Our performances cannot be taken piecemeal, they are always a part of the same existential self. We seldom present the same self to others in all situations, whether that be for reasons as disparate as safety or apathy. Being trans isn’t about an essence, it’s about affinity.

The idea of a transgender (or specifically feminine) essence is not only

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1 That is, acted out like a play
inaccurate, but politically damaging. It is a form of self othering to insist that there is something fundamentally different with us at our core, rather than the difference being how we interact with the world. Even if there is something inherent to us that makes us more likely to experience the world as transgender people, we still wouldn’t be transgender in a vacuum. We are different, but we can be just as different from each other as we are from cisgender people. An essentialist view of trans identity is as facile as it is dangerous. It simply leaves many of us behind. To essentialists (Blanchard, 1985; Daly, 1978; and Raymond, 1979, as examples), me and people like me will never be woman enough. To them, we are nothing more than men chemically and surgically altering our bodies to appropriate womanhood (Raymond), or sexual deviants aroused by the very thought of ourselves as women (Blanchard). We will never be recognized playing by the rules of our oppressors. We need to organize around something different, and that something should be the oppression that we share. We need to deconstruct the compulsory aspects of gender and sexuality for everyone to truly be free.

Compulsion

Gender is enforced and defined hegemonically. Gramsci (2012) defines the process of cultural hegemony as one in which a dominant class utilizes their privileged position to redefine society around them. Foucault (1995) defines panopticism as the process through which we police our own behaviors due to our fear of being punished by society. This fear of reprisal leads to us policing our own identities as well as those of others, whether we share affinity with them or not. In effect, gender is enforced through unequal expectations and recruits both individuals and society as its police. Essentialized gender is a social imposition. It is an open-air prison in which we are all confined. As prisoners, we are organized in a hierarchy that privileges some of us over others. We are each other’s guards, but our own wardens.

People who are AMAB are expected to perform masculinity to certain standards. Connell (2005) defines the highest standard of masculinity as hegemonic masculinity. This variety of masculinity is the standard against which gender performances are judged. If you do not meet those standards, you are then considered to be less valuable as a human being. You’re a fag, a sissy, a tranny, or whatever expedient insult serves to designate you as inferior and
deviant. C. J. Pascoe (2007) gives an account of the way teen boys enforce maleness. Fag is not a static identity, rather, fagness serves as “a discourse with which boys discipline themselves and each other” (Pascoe, p. 54). This discourse extends to transgender and gender-nonconforming people; we are recognized as doing maleness wrongly and are accordingly punished for it by ridicule, violent and/or sexual assault, or even murder. The fag discourse also influences men who are attracted to transfemininity and contributes to violence against transfeminine people. Men who are attracted to us view their attraction as a threat against their masculinity, and they react the only way that men are taught to: with violence. In this way, contrary to popular trans 101 level pedagogy, gender can never be completely decoupled from sexuality.

Sexuality is also compulsory and hegemonically so. But sexuality is not a monolith. Gender and sexuality are a part of the same feedback loop. I am transfeminine and a lesbian, and the experiences of that identity are unique. My transfemininity is viewed as less legitimate due to my sexuality; it has historically been predicated on our sexual availability to men. This is true of all women but is especially formalized with trans women. My lesbianism is derided due to my transfemininity. In both cases, I am derided because of fundamental aspects of myself. I am asked how I am different from a gender nonconforming straight man. While most people who are AMAB are attracted to women, it is not a causative relationship. Who I love and who I am are not decided merely by the circumstances of my birth, but due to a complex of social experiences. My attraction to women was encouraged while I was living as a boy, and yet it always felt different. It felt wrong. I simply wasn’t into women in the way that a straight man is. For the longest time, I didn’t know that being a lesbian was an option.

Heterosexuality is the culturally hegemonic sexuality. Rich (1980) theorizes of heterosexuality as a compulsory force. It portrays itself as the normal, natural, and morally correct sexuality through a vast network of cultural forces. We are indoctrinated into heterosexuality from our childhood. Disney princesses and storybook romances not only privilege heterosexual couplings, but often portray a man as necessary to complete a woman’s life. Heterosexuality is compelled, and the way that compulsory heterosexuality compounds is especially poignant to the women whose sexuality
does not include men: lesbians (Rich). Lesbian intimacy serves as a foil to the cultural force of compulsory heterosexuality (Rich). When the entire world defines itself contrary to you, the process of making an identity becomes even more difficult. The expectation of heterosexuality forms an unwritten social contract, one that is not only about sexuality, but also gender (Wittig, 1980). The compulsory natures of gender and sexuality are inextricably linked in this way. By rejecting the heterosexual contract, lesbians are simultaneously rejecting compulsory womanhood such that “lesbians are not women” (Wittig, p.110). Patriarchy defines society around masculinity such that it is viewed as the default or neutral state rather than an affirmative identity (de Beauvoir; Wittig; Woolf, 1977).

My own forays into manhood and boyhood certainly fit the conception of it being a null state, but masculinity is not the “problem” in this equation. It is the essentialized and hegemonic notions of gender, as there are forms of femininity that mirror hegemonic masculinity (Hamilton et al., 2019). Transfemininity is no different, though it is important to recognize that trans women are not privileged by their attraction to men, merely granted a modicum of legitimacy. Transfeminine people’s femininity is judged like no others. Just like cisgender women, our value is judged by our attractiveness, body size and shape, skin color, and myriad other categories. Just like cisgender women, we judge ourselves and others, even going to the point of tearing each other down to build ourselves up. Our presentation is always under the microscope, and we are held up for the consumption of men. As someone who is both intensely masculine and feminine, I can’t seem to win. My androgyny delayed my transition, and I am still judged on it. I do not fit the cultural schema of a trans woman, and I don’t especially care to. My first exposure to transgender people was through disparagement and fetishization. Daytime talk shows and pornography. As objects for ridicule and the sexual pleasure of men. I didn’t know that I could be transgender without attraction to men. I didn’t know that, in its exclusion of men, lesbian womanhood is a very different creature than heterosexual womanhood. The reason I didn’t know is because of the suppression of stories like mine.

Epistemic oppression is “persistent epistemic exclusion that hinders one’s contribution to knowledge production” (Dotson, p. 115). Epistemic oppression is a specific form of epistemic power imbalance known as an epistemic
injustice (Fricker, 2007). Nowhere is the epistemic oppression of transfemininity more apparent than in the work of the men who “study” us. Transfeminine stories are rarely listened to, and when they are our testimony is often disregarded or misinterpreted. These “transsexual typologies” return to the fundamental patriarchal predication of women’s validity on their sexual availability to men, while simultaneously rejecting the existence of female sexuality (Benjamin, 1977; Blanchard). Blanchard is particularly heinous. His typology divides transfemininity into two archetypes; the “homosexual transsexual (HSTS)” and the “autogynephile (AGP)” (Blanchard). HSTS refers to solely heterosexual trans women who are misgendered by their characterization as hyper-feminine gay men who transition in order to sleep with heterosexual men. AGP, on the other hand, refers to homosexual, bisexual, and asexual transfeminine people. People who are a little more like me. We are characterized as fetishists whose sole reason to transition is that the thought of ourselves as women gets our rocks off. This is offensive, and quite frankly, fucking absurd. In a bad way. Blanchard’s research is filled with a myriad of methodological errors, which have biased his research from the very beginning in a way that places the entire theory firmly into the realm of pseudoscience (Serano, 2020). No sexuality is completely uncoupled from gender, but there are so many easier ways to get your jollies than to expose yourself to the dangers of existing as a transfeminine person in a world that hates us.

**Revolt**

My gender identity is complex and expansive. I am transfeminine and nonbinary as well as a lesbian. The lines of gender and sexuality are blurred for me; my gender is inextricably wound up in a lesbian identity to the point that it is often expedient to describe my gender as simply lesbian. I knew I wasn’t a man but didn’t know I wanted to be a woman until I knew I was a lesbian. While trans woman is a correct descriptor for me, my womanhood is in the Wittigian sense (Wittig). It is not a sense of internal self, at least not wholly. My womanhood is as much about political affinity as it is identity, and that identity is not the same as straight, bisexual, or asexual women’s, including trans women. Patriarchy has an interest in defining gender through exclusion, and people like me are denied the recognition of womanhood, the privilege of manhood, and often the simple dignity of personhood. Simply
put, I’m not quite a woman in society’s terms because I’m a dyke. I am fighting epistemic oppression by writing this essay, and I am fighting epistemic oppression by merely existing in opposition to the standards set for me by cisgender society. I am not a fetishist, but a complex human being exercising control of my fate. My story and the stories of people like me deserve to be told.

Existence is absurd, but that doesn’t mean that it is meaningless. We construct our own meaning even as we are tormented by other human beings. Identity does not develop in a vacuum. It is a complex and dialectical process, informed by our interactions with others and by our internalization of wider societal norms. Our identities are multiplicitous, even as our existences are unified. Gender is enforced through both public discourses and fear of punishment. Hegemons rewrite epistemology to position their own view (and dominance) as normal, natural, and morally correct. If the hegemon cements their power through epistemology, then it is necessary to develop alternative, contrary epistemologies to resist hegemony. We need to revolt. Don’t let the boulder crush you. Keep living your life, for you are rewriting oppressive epistemology by simply being. Do your best to inject a little bit of trans joy into the world. Those who hate us want nothing more than to see us miserable, so trans love and joy are trans revolution.

References


Stolen Sisters...
Violence against Indigenous Women

“Once our eyes are open, we cannot fall asleep again” (Raichō Hiratsuka, 1913).

This essay investigates the violence perpetrated against Indigenous women using a social constructivist and feminist perspective. This topic is important because it is often overlooked by society and the media. The violence and assault that Native women experience is an epidemic that has been an ongoing issue that has plagued the Indigenous community. I hope readers will understand the importance that all women regardless of race or class deserve to feel safe.

Keywords: Indigenous, colonization, patriarchy, violence, media, MMIW, REDress, intersectionality

The Story

I watch as the last puff of air escapes my breath into the cold night. My exposed chest surrounded by what remains of my shirt, ceasing to rise and fall. I know that we all await death in this life, but I didn’t realize this is how I would meet my maker in my twenty-second year on this earth. Twenty-two seems hardly long enough. My death was not the first and it certainly won’t be the last. No one cares about an Indigenous woman.
What started out as a simple act of walking to the local high school to see my little brother play in his debut basketball game would end with my demise. I didn’t think to pay attention to the headlights that illuminated my body from behind, anticipating it would pass by like all the others. Fuck, I wish I had paid attention! It all happened so quickly. The creaking hinged door didn’t even have enough time to allow sound to travel through the cold night air to my pierced ear. I felt the tug of arms embracing me in a sinister hug as I was hurled into the car, my 118-pound frame doing little to stave off my attacker. The driver speeding away from what remained the site of my innocence, while his accomplice restrained me, my punches and kicks bouncing off his body like that of a tantrum-throwing child. I knew it was over. I’d never see my mom, never see my little brother get his first shot on varsity, no… I would become another statistic, just another red dress lining the highway representing my physical form stolen. No one cares about an Indigenous woman.

As the weight of their bodies took what was left of me, their hands took what was left of my being. The pain in between my legs fell silent as the noose of their fingers encased my neck.

My last visual being the night sky clouded with the last of my breath. I remain there behind that bush on the embankment off of the roadside waiting for some passersby to stumble upon my bones, but that might be awhile. Law enforcement is not looking for me, only my blood searches and prays. I am just another of the forgotten. No one cares about an Indigenous woman.

**Before And Still**

According to the United States Department of Justice (2021), one in three Native American women will be raped and three out of four women will be physically assaulted. Nearly fifty percent of these women will or have experienced stalking, rape, physical violence, or murder (Hay, 2021). Although the above piece is a fictional story, it is a harsh reality as these sobering statistics reveal what Indigenous women face on a daily basis. Native Americans comprise about two percent of the population yet are the most victimized group of individuals (Lucchesi, 2018). According to Hay, federal data records that homicide is the third leading cause of death in Native women. This population of females are murdered at rates more than ten times the national average of that than any other racial group. The Urban Indian Health Institute (2018) reports that the youngest victim of Native female violence...
recorded has been a three-year old girl and the oldest victim was 83.

This essay analyzes violence against Native women that is often neglected by society and news outlets compared to women of other races. The intersections of race and gender, along with the patriarchal legacy of colonialism contributes to the levels of violence that Indigenous women face. Andrea Smith (2003) posits that “sexual violence is not only a tool of the patriarchy, but also a tool of colonialism and racism” (p. 71). Native women did not conform to European ethnocentric ideals of what was appropriate gender roles and dress. They were seen as uncivilized and unChristian and therefore unhuman (Agtuca, 2008). Sexual assault was not rape if the woman was not human and hence, in the European male’s eyes, permitted.

Native societies differed greatly from those of Europeans in that many of the former were egalitarian or matrilineal. Egalitarian refers to the power in a community being divided equally among all genders. Matrilineal is defined as women occupying culturally and structurally central roles in societies that trace descent through the mother’s line (Agtuca). The power that Indigenous women possessed threatened European patriarchal society as white women viewed them enjoying opportunities that they were denied. Because of Native women’s strong identities and important roles, Agtuca says, “they were perceived to be uncivilized and subsequently became targets of the federal efforts to civilize the Indian populations” (p. 8). This perceived lens of power dynamics became central to the violence that Native women would face.

A Synopsis of Historical Violence

The violence perpetrated against Native women has been a central feature of United States colonialism and imperialism. During this colonial and postcolonial era, European Americans not only claimed the right by Manifest Destiny in 1845 to the land, but also to the Native women that dwelled there. Rose Stremlau (2020) states, “Moreover, like their European forebears, Americans claimed sexual access to women, along with other forms of property, as a right of conquest. These beliefs were not limited to men of low status” (p.189). As colonizers began to dominate land, women’s safety became a concern. Before the arrival of the Europeans, Indigenous women were freely able to venture further than the confines of their community to gather food for their family and village. The presence of these European men put
Native women at an increased risk for being kidnapped and sexually assaulted. Many of these women no longer felt safe to maneuver beyond the visibility of their own men to secure food. In Sarah Winnemucca’s autobiography (1883), Stremlau states, “Sexual violence characterized many white men’s relations with the Native American women and girls whom they considered racially and culturally inferior and economically marginal” (p. 185). Winnemucca (2020) a northern Paiute woman herself, describes an event in April of 1860 involving two Northern Paiute women who were gathering roots and were seized by a group of white men. These men dragged them to a nearby barn where the girls were held captive and repeatedly gang raped. Stremlau explains, “Women were accustomed to spending a significant amount of their time gathering away from men’s supervision and protection. These women were independent workers unaccustomed to being sexually harassed” (p. 187). Indigenous women’s wellbeing and physical safety would be a constant challenge with the arrival of the male white colonizers.

The level of abuse continued as Indigenous women were forced to assimilate to the dominant white culture. Boarding schools were founded to “Kill the Indian, Save the Man” (Richard Henry Pratt, 1892) by teaching them to conform to the European American language, religion, gender roles, dress, and ideals. In her memoir, Inupiat native Florence Kenney (1995) discusses the sexual abuse she received at the age of sixteen by the head priest. She states, “I’d be sent to him for a talk. He would draw the shades in the girls’ building, he’d hug and kiss me and rub me and press me to his body” (Kenney, p. 38). In 1952, when Florence was eighteen years old, she went to work at a nearby army air base. Kenney recalls, “In the two years I was there, it seemed like I spent most of it hitting men with my purse just to get away. My girlfriend and I were walking to a show and all the way, there was this carful of servicemen who kept screaming at us- how they would take us off into the bushes, and what they would do to us- it was frightening” (p. 39). Acts of violence and threats of violence as evidenced in these narratives demonstrate the ongoing fear that Native women contended with as they maneuvered throughout their lives in the nineteenth and twentieth centuries.

From the 1950s through the 1970s many Native women were sterilized against their will or unknowingly. Simple procedures such as seeking medical care for a broken limb would result in the Indigenous
woman being administered anesthesia and waking up with a hysterectomy. Others who required care during labor would not only deliver their baby, but the doctor would extract their uterus. Ramirez (2004) writes, “Native women are also threatening because of their ability to reproduce the next generation of peoples who can resist colonization” (p. 78). The very natural right of a woman’s capability to give birth results in Native women being singled out and slaughtered at unprecedented rates to keep white patriarchy in control (Ramirez, 2004). Having control over reproductive faculties assists in destroying the Native race and maintaining white conquering mentality.

One victim of forced sterilization as documented by Agtuc states,

I was badly beaten by my husband and left on the street outside our apartment building. An ambulance took me to the hospital. When I woke up I felt my stomach and there were stitches. I asked the nurse, ‘Did my husband do this?’ She said, ‘No, the doctor did that.’ I asked why. The nurse said, ‘The doctor gave you a hysterectomy.’ I didn’t know the meaning of the word. No one in my family knew the meaning of the word (p. 18).

Later, the Indian Health Service reported that in 1976, some 3,406 hysterectomy procedures were performed on Native women in four cities alone without their consent (Agtuca). This is another example of the ways white settlers colonized and tried to eradicate Indigenous populations.

**Current Situation: Media Impacts**

The disappearance of Native women only started being documented in the 1960s, but since the 2000s the rate of occurrence of those missing has rapidly increased. Every year the number of Native women missing has been steadily on the rise (“The Tragedy,” 2019). The Urban Indian Health Institute (2018) documents that, “The National Crime Information Center reports that, in 2016 there were 5,712 reports of missing American Indian and Alaskan Native women and girls, though the U.S. Department of Justice’s federal missing person database, NamUs, only logged 116 cases” (para. 1). Victims of sexual assault indicated more often that the attacker was not of Indigenous descent. The National Institute of Justice reported that ninety six percent of Native American women report experiencing violence inflicted upon them by a Non-Indigenous person, particularly white males (Brewer, 2021). As an oppressed marginalized group covering multiple intersections of identity, the attacks imposed upon Native women by those in
power, who also happen to be white males, are continually denied justice for such crimes.

Many are unaware of the level of brutality that these women endure. Current justice systems and organizations do not sufficiently address the violence against Indigenous women (Kuokkanen, 2012). Media coverage is essential in finding missing women or identifying an attacker. Native women, however, are underrepresented by news outlets in locating their whereabouts. According to Andrew Hay (2021), only eighteen percent of Indigenous female homicide victims elicit media attention compared to fifty one percent of white female victims. This lack of representation showcases the inequality that Indigenous women face in being found safely or in a timely manner.

So why are more Caucasian females highlighted than any other race in the media? We have to ask ourselves who is reporting what makes news. Joy Mayer (2021) addresses the biases manifest in journalists’ reporting. As Mayer explains,

Journalists are also better educated than average, more middle to upper class and less likely to live in low-income areas. What we see in our own lives informs who we talk to, what we think is important, what we think is normal, what we ask questions about and ultimately, what our coverage includes (para. 9).

Diversity needs to be a priority in our newsrooms if all are to receive equality in media coverage.

Funding is essential in providing search and rescue efforts in missing cases. Unfortunately, Caucasian females receive more aid and attention than those of Indigenous women. Recently, Gabby Petito made headlines in her disappearance, however Native women in the same state were not granted the same publicity and financial support. Petito tragically lost her life, also as a result of male on-female violence. Her body was found in Wyoming, the same state where more than four hundred Indigenous women have been reported missing, yet received no publicity or funding (Hay). Jolene Holgate (cited in Hay), director for the Coalition to Stop Violence Against Indigenous Women states,

The national attention and resources that were put toward that case (Petito) when there’s such a high number of missing and murdered indigenous women cases in Wyoming and even the neighboring state of Montana, it did not feel good. I think there’s this practice of discounting indigenous bodies when it comes to folks who go missing or murdered (para. 5).
The term “missing white woman syndrome” coined by Gwen Ifill illuminates the white privilege in media and law enforcement funding that is granted to those atop the racial hierarchy that does not similarly benefit individuals of color in the same platform or context (Gonzalez-Ramirez, 2021).

The language that the media uses also contributes to the public’s empathy and assistance in these crimes. According to Hay, “Media coverage of homicides of Indigenous people was more likely to use violent language and portray the victim in negative light” (para. 9). Examples of these negative attributes include using mug shots from past arrests to serve as their missing photo or describing/portraying the victim as wearing provocative clothing to tarnish their image. Jaime Black (2019, as cited in Bolen, 2019) explains, “The justice system has repeatedly blamed the victim. The system is skewed toward the non-Indigenous” (para. 8). The result is lack of empathy among the viewing public and a prejudgment based upon what the media is showcasing. Attitudes such as victim blaming of “she was asking for it,” or “look at her lifestyle” feed the failure of assistance from those whom these women need help from the most, the public.

Measures of Addressing the Violence Epidemic

As the numbers of Native women missing and murdered continues to rise, local Indigenous groups are actively trying to generate the attention these women deserve. Organizations focused on confronting media attention have been established in an effort to locate these women and young girls. Missing and Murdered Indigenous Women (MMIW) was established in 2015 and its goal is raising awareness about the ongoing issue of violence and assault that Native women endure (Lucchesi, 2018). The foundation has social media accounts, a website, and other promotional endeavors to get images out with pertinent data on the last whereabouts of these women, what they were wearing, height and weight measurements, and other useful information vital in their safe return.

The Missing and Murdered Indigenous Women movement have also created a visual aid in the form of a logo. The red and black handprint over the mouth reiterates their slogan of “No More Stolen Sisters.” As a powerful metaphor, the handprint over the mouth symbolizes the silenced voice of another victim that has been taken. The color red is incorporated, as red is believed in Indigenous culture to
have a spiritual connection to the dead, while also associating the color of blood of a murder victim (Lucchesi, 2018). It is a powerful reminder of those lives that have been taken and the stain that ravages the Indigenous community.

Visual art can have an impactful meaning and is often difficult to ignore. Artist Jaime Black (2009) has created the REDress project in 2009 to bring awareness to our sensory faculties and magnify the issue of Native women violence. Black began to collect and display red dresses along the Winnipeg highway as a representation for each Indigenous woman who had their lives cut short due to murderous attacks. As reflected in the fictional story that I crafted to open this essay, our character acknowledges that she will simply be another red dress lining the highway. Black (cited in Bolen, 2019) states, “People notice there is a presence in the absence. This is a way to get the public’s attention on a tremendously unpleasant issue that otherwise they are not likely to want to be responsive to” (para. 3). To date Black has over four hundred dresses running up and down the roadway, among other public spaces, a solemn reminder of the vast number of victims who have been lost, and should not be forgotten (Bolen).

Where to Go from Here

The violence against Native women that is often neglected by society and news outlets compared to women of other races continues to be an epidemic that we must acknowledge. The intersections of racial and gender identities, compounded by the patriarchal power of colonialism contributes to the levels of violence that Indigenous women continue to face compared to other racial groups.

The level of danger that Indigenous women contend with is a disturbing reminder that the violent nature of colonization is still at work. The marginalization and racial stigmas surrounding Indigenous communities in today’s world need to be addressed if all women are to feel safe and secure in everyday life. Native women's lives are just as important as all women’s lives and deserve the attention and recognition by society, law enforcement, and the media. No woman should fear for her safety and maybe one day, hopefully soon, we will truly care about an Indigenous woman.

The Story Continued

…. I close my eyes as I hover above my lifeless body and imagine a new reality. My spirit longing for a new outcome, one that would involve opening my eyes as the illuminated headlights that outline my
body speeds past my small frame. I quickly pick up the pace as my sneakers scrape against the pebbles lining the shoulder of the road. As I entered the all too familiar high school entrance that I have outgrown, a kind, pale man would hold open the door allowing me to pass. I find an empty place on the bare wood bleachers as my brother looks up into the crowd, smiles and waves at me. I smile and reciprocate a wave back, but mine is in the form of goodbye.

References


ALEXIS RIVERA, State University of New York at Brockport

Nature and Nurture: The Changes in Sexuality Over Time Through Life Experiences

This essay explores the evidence of changes in sexuality that may occur throughout time during the course of many women's lives. The multiple theories proposed in this essay include ideas addressing variation in sexual attitudes and desires as different life experiences present themselves. This essay challenges biology and the concept of nature and nurture in a way that sexuality can be a result of both, not just one or the other. By having an understanding of how sexuality can change, we can begin to acknowledge the women who are struggling with these newfound inclinations and find ways to help them continue on with their lives as desired.

Keywords:
Sexualities; Divorce, Nature and Nuture, LGBTQI Identity in Later Life

Introduction

If you’ve ever heard some of the commonly talked about statistics of divorce, it can sometimes be disheartening when you think about your own future. Unlike many people, these statistics never scared me. Being a child of divorced parents, to this day I believe it was better for everyone. In 2016, at the age of 16, the day came when my parents sat me
and my sister down to give us the news. I felt a wide range of motions but the most surprising one was acceptance. Growing up in a household with the sound of constant arguing and awareness of your father’s alcoholic tendencies, I knew it was only a matter of time. It sounds bad, despite that my parents gave my sister and me anything we could ever want. Most importantly, we were loved and cherished, which is why I knew during that conversation they had tried their hardest.

Over the years, I began wondering if they would be interested in dating again when, on Christmas of 2022, my mother told my sister and me that she had been seeing someone for six months and that her name was Beth. I could tell from her face that my mother was nervous for our reactions, but she then displayed ease when she saw our tears of happiness. Later I asked my mother if she felt like some part of her had always felt attracted towards women as well as men. She told me no. Although, she noted that in her parents’ generation, homosexuality was not very well accepted. Growing up, I always had the mindset that you were born with your sexuality. Now my understanding is different. This is the inspiration for my research and why this topic is so important for me to learn more about. This essay explores sexuality changes occurring later in life, and I argue against the biological aspect of the debate and what, if any, life experiences factor into this change.

**Nature and Nurture**

The concept of nature and nurture has been an ongoing debate concerning sexuality for as long as people have been coming out. It begs the question of whether sexuality is biological or adaptive based on environmental factors. Fortunately, our current generation has become extremely accepting of members within the Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) community. Not only does the LGBTQ community have a lot more support, but they continuously gain allies that fight for their equal rights regardless of identifying as straight or not. Still, no matter how accepting society becomes, coming out continues to be very difficult for people to do. No matter how much happiness it will bring that person, the fear of whether everyone will accept them holds them back. This is especially challenging for people coming out as adults.

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1 Pseudonym
Miller (2019) helps us better understand how sexual desires of older women can convert over time. Many changes other than physical appearance go along with aging. Miller observes:

Research shows that role exits, transitions, and turning points cause people to re-evaluate their romantic and sexual goals, aspirations, and behaviors...women gain more control over their sexuality and experience more sexual pleasure in midlife. Further, aging offers people opportunities for self-reflection, which may help women better understand their sexual desires and what most pleases them (p. 374).

This makes sense why some women come out later in life as their romantic behaviors change with their age. For some, they have pushed aside these previous desires towards the same sex in the past. New opportunities of self-reflection allow these women to welcome the desires. Sexual changes among older women are more fluid than we are led to believe. For example, Ainsworth and Baumeister (2012) affirm,

That is, women display greater erotic plasticity than men. Erotic plasticity can be evidenced by changes in the object of desire... Women are more likely to adopt new activities and preferences at any point in her adult life (p. 1).

Given that women fluctuate more when it comes to their sexual preferences, it is easy to assume that as they get older the change in gender of their sexual partners is common as well. As previously mentioned, this change for some is not easy as they are in fear of rejection from friends and family as well as an identity shift that is new to them. Rickards and Wuest (2006) explain,

Women in this study described support as emotional and included being accepted, having continued love, knowing that important relationships are maintained, and having lesbian identity acknowledged. The extent to which women turned to family members for support in confronting the taken for granted depended on the quality of their past relationship, particularly with parents and siblings (p. 535).

For middle-aged women coming out in this generation, the chances for lack of support may be greater because of how homosexuality was viewed in their siblings and parents' childhoods and their views on LGBTQ rights in general. This brings me to the factor of how life experiences can affect when women
decide to come out and whether they acknowledge their difference in sexualities before and after.

**Life Experiences**

Elements like childhood, family views, past relationships, divorce, and children are all instances which can influence the decision to come out or not. Cultural and societal views have a big impact on determining whether the risk is worth the reward. Countries such as Iraq, India, or Pakistan are male-dominated cultures in which women aren't necessarily given the option to be openly gay and live with the acceptance from others. Moghasemi et al. (2018) write,

> Although the majority of middle-aged women considered sexual activity important in their life, in many cultures, sexuality for older women is less welcomed...in Iran with a male-dominant context, with priority of male sexual fulfillment, women limit sexuality to childbearing years and consider menopause as the time to say goodbye to the sex and feminine world (p. 47).

Although my study is not particularly on Iranian women, their culture's limitations is a good representation of how society's views can influence women's feelings toward sex in general. Many middle-aged women have internalized and carried the views that were embedded in them since childhood. For the majority growing up, there wasn't the option to express their sexuality as it was not accepted. Nowadays, coming out for middle-aged women is becoming more common as their sexuality is more likely to be embraced. Especially after a huge life change like divorce, more women are then able to express and experiment with their sexual desires. Recently Morrissey's (2018) study showed, “…the quality of the marriage impacted the experience of the divorce, and this was especially true with sexual expression. Less sexual pleasure in the marriage often meant that after the divorce, sexual learning was experienced as thrilling” (pg. 7). As it can be expected, having one sexual partner over an extended period can require more changes and trying new things. For most couples, when there is talk of the lengthy process of divorce, sex is off the table as they are adapting to becoming separate. In some instances, after the divorce is final, women may be looking for change and sexual expression, which isn't always with the same sex. Having the additional factor of children from the past marriage can make that exploration more difficult.
Morris et al. (2002) conducted a study on lesbian/bisexual mothers and observed, thus, mothers who had children before coming out were significantly older when they first questioned being LGB, when they had their first sexual experience with another woman, when they first thought of themselves as LGB, and when they first told someone that they were LGB (p. 4). The coming out process can be harder for women due to the thought of making their children confused or upset. These factors and more have shown to affect sexuality change and the process of women coming out later in life, which brings me back to the topic of nature and nurture. Life experiences and aging can cause changes in sexuality, not always making it biological.

Science and Society

Sexual identity is both sociocultural and biological. To argue that it is one or the other misses the point. The LGBTQ population is diverse and contains people with all different backgrounds and experiences. A large population of people who grew up in many different types of environments, families, and/or education systems fall within the LGBTQ community. There is not one single factor that every single one of those people have in common, also revealing that sexual orientation can be biological and cultural. There have been multiple studies trying to answer the scientific mystery to the question of whether sexuality is biological or not, including one done by a professor who identifies as gay himself.

Jenny Cornuelle (2010) documents, Pillard is quick to point out that much about how sexual orientation is determined remains a mystery. ‘It’s really hard to come up with any definite statement about the situation,’ he says. ‘I think some sort of genetic influence seems very likely, but beyond that, what really can we say? And the answer is: not a lot’ (p. 5).

Pillard’s study regarding twins was to determine whether sexuality is genetic. His hypothesis stated that if one is gay, it is more likely the other twin is too. Although his study does not have the twins raised in separate environments, it is understood that genetics regardless of separation does not have an influence on the outcome of sexualities.

When we think biologically about how the body uses the things we pick up through our senses to create our characteristics and personality traits, it's quite fascinating. Cues and behaviors that are picked up through childhood are eventually used in puberty, creating the
subconscious mechanisms that form sexual orientation. Salu (2011) writes,

The brain has auditory centers that process sound, and sex-control centers that control sexual activities. Certain auditory circuitries are innately tuned to distinguish between the voices of men and women. The specific innate connections between those circuitries and the sex-control centers determine the sexual orientation of the person at puberty (p. 2).

The explanation of how the brain works in regard to how we learn to speak, behave, and understand what's going on around us is something that was very interesting for me to read. This article gives a good understanding on what happens within innate auditory circuits and how that can be a factor into determining one's sexuality. The curiosity of how a person is determined to become straight or gay is something that scientists will always seek answers to. Jannini (2015) explores more of the genetic determination of sexuality and concludes,

The existing literature on human sexuality provides evidence that many sexuality-related behaviors previously considered to be the result of cultural influences (such as mating strategies, attractiveness and sex appeal, propensity to fidelity or infidelity, and sexual orientation) or dysfunctions (such as premature ejaculation or female sexual dysfunction) seem to have a genetic component (p. 8).

This can somewhat relate to how the brain works to subconsciously group these characteristics into ones that are attractive to the individual or not. Although the inner workings of the brain is a biological aspect, the people in which we come in contact with, the voices we hear, and the physical characteristics we see are all environmental. It is with this information and more that we recognize nature and nurture work in a corresponding relationship rather than a separate one.

**Future Awareness**

When I look back on my research, I feel validated by the potential and meaning I felt it would bring. The foundation of changing anything about our society or the way we view things is the knowledge and education we are given. As I have mentioned before, I can relate personally to this topic which is why I feel so passionately about bringing this information into light. My mother hasn't changed who she is or how much love she has for me after this realization, if anything I can see how all of those
amazing characteristics about her were heightened. It's incredible to see how not being ashamed and feeling as though you can be your true self across diverse and changing sexualities can do to a person, especially someone you so deeply care about. Since I believe there are other similar situations out there like mine between mother and daughter, I feel as though it's important to recognize how strong that bond really is. Davies (2008) says,

The stories told about change and adjustment but, most importantly, loyalty. Each daughter felt committed to honoring her mother's sexual orientation and all that comes with that. Every daughter spoke respectfully about her mother's role in her life, then and now (p. 2).

No matter how strong that relationship is, there is always doubt and fear when it comes to coming out to the persons you are afraid of losing most.

Reassuring them with loyalty is how they know that there was nothing to be worried about at all. Davies also states, “For women who were mothers, children had the potential to be their greatest source of support... Teenage and adult children, however, were developmentally better able to appreciate the significance of the transition their mothers were making” (p. 3). Giving the acceptance and support they deserve when the time comes is what will give them the security they need to finally live life the way they want.

Understanding how times have changed as opposed to when they grew up can create a sense of appreciation for how difficult it must be to share that part of their new selves. Since society has begun to change for the better when it comes to accepting different sexualities, we are able to better express how common it is to come out later in life.

My hope with my analysis throughout this essay is to bring awareness to the fact that people still are not allowing themselves to love who they want. That is an issue that desperately needs to change. The aspects about this society that continue to be heteronormative are the lingering effects of the past; let's make them disappear in the future.
References


The Misrepresentation of Queer Folks in Theatre

This essay uses content analysis to explain the misrepresentation of queer folks in theatre. This topic is important because a lack of proper representation can harm young queer people. I hope readers understand the information presented and advocate for proper representation.¹

Keywords: queer, cisgender, sexuality, gender, misrepresentation

Introduction

Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual (LGBTQIA+) pride is something that is meant to be celebrated in all spaces, including the spaces where pride is most cherished. Queer people have brought their community into theatre, where it is mostly celebrated by audiences but not by the industry itself. I want to note that throughout this

¹ I would like to acknowledge that, unfortunately, queer folks are not the only community lacking proper representation within the theatre industry. Many other communities face miscasting and stereotypes, but for this paper, I decided to narrow it down to the queer community.
paper, I will be using the word “queer” as an umbrella term for people who identify within the LBGTQIA+ community.

Theatre has been an enormous part of my life, especially during my tween/teen years. Being a part of the theatre gave me joy and a safe space where I could be who I was, regardless of my sexuality or gender identity. Theatre has given so many more young queer folks the same. Proper queer representation in theatre is essential, especially for queer youth, because a lack of representation could be harmful in many ways.

Stereotypes, stigmatization, miscasting, and harmful critic reviews are examples of the theatre industry actively participating in misrepresenting the queer community. Take, for example, the musical *Hedwig and the Angry Inch* (1998). The main character, Hedwig, is an openly gender-queer person, though they are often played by straight-cis males. The misrepresentation of queer folks in *Hedwig and the Angry Inch* (1998) is a classic example of miscasting, something that many producers and directors in theatre do not tend to care about and happen to do a lot. Not just with queer characters and queer people but with characters of color and people of color. This is just a tiny problem in a series of bigger problems. What we need is change, acceptance, and an expression of pride.

A Not So Warm ‘Welcome to Falsettoland’

*Falsettos* (Finn & Lapine, 1992) was ahead of its time. The show features a minimal cast, half identifying as gay or lesbian and the other half presumably straight. The plot follows Marvin in 1979, who left his wife and son to be with his lover, Whizzer. Marvin decides that he wants the best of both worlds and joins all of them together, kid, wife, and lover, under the same roof. The show’s first act ends with Trina (Marvin’s wife) marrying his therapist (named Mendel) and Whizzer leaving Marvin. They all regroup in the second act, which takes place in 1981. Whizzer and Marvin reconnect while Marvin and Trina try to plan their son’s Bar Mitzvah. We are also introduced to two new characters who are only referred to as the “lesbians from next door.” They do have names in the script, Dr. Charlotte and Cordelia, but their names are never stated in the actual content of the musical, something I discuss below.
With them remaining unnamed throughout the content of the musical, this, in turn, can be an erasure of their identity. Cordelia is a caterer, whom Marvin and Trina hire to cater their son’s Bar Mitzvah, and Charlotte is an internal medicine doctor. She becomes crucial in the show as Whizzer suddenly becomes sick and dies at the end of the musical. This mystery disease is never named, but in the song “Something Bad is Happening (Reprise),” the lyrics go as follows, “Something bad is happening; something very bad is happening; something that kills; something infectious; something that spreads from one man to another” (Finn & Lapine, 162). Though we never get direct clarification as to what disease this is, we can only assume from the words of this song.

Falsettos premiered on Broadway in 1992 (both acts of the show were written separately and were later combined to perform a full show) and had mixed reviews. The mixed reviews came from critics who needed help understanding the use of labels and taking back one’s identity (Smart, 1996). Both acts were written by openly gay writers James Lapine and William Finn, who used the labels gay and lesbian and other terms associated with the queer community. For example, as I referenced earlier, the characters of Dr. Charlotte and Cordelia in the second act are mostly referred to as the “lesbians from next door” (Finn & Lapine) whenever they appear or are introduced. The use of these words can be taken one of two ways. The first way is the route in which it was intended when this show was written, as a means for these characters in the show, half of which openly identify as gay or lesbian, to take back these words and use them not as derogatory but as a way of stating their identity. In a way, Finn and Lapine wrote it to be empowering. The play’s first act occurred in 1979, and the second act in 1981, when queer identities were not as accepted as they are today. Finn and Lapine encourage and empower the queer community through their characters and language, as this show intended.

Critics took that empowerment in the wrong way. Melanie Kirkpatrick (1990), who wrote for the Wall Street Journal, said Falsettos was “about homosexual life in a big city” (p.180). John Beaufort (1990) from the Christian Science Monitor saw the musical as “an instance of the
consequences of homosexual relationships in an age of so-called sexual liberation” (p.176). Critics dumbed the musical down to a simple show about gays living in New York City or saw it as a message about the faults of being gay in relationships. Smart said it best in his article about the show and the reviews, “The critics accept, categorize, and dismiss the characters based on the labels…given to them by Finn and fail to examine, interpret, or appreciate Falsettoland” (p.62). Yes, the characters express their identities using queer terminology, but their sexuality is not the only aspect of their identity. Critics could not look past the labeling and only saw queer, not the immense character development seen throughout the show by all characters, but just queer (Smart).

Falsettos is not the only musical that has generated this reaction. In an article titled, “It’s My Party and I’ll Die If I Want to!: Gay Men, AIDS, and the Circulation of Camp in the U.S. Theatre,” Roman (1992) sums it up best, “American theatres have less successfully expanded their interrogation of how the representations of gay men and AIDS have been perpetuated by such institutions of dominant culture as the media, biomedical science, and the state” (p.306). Musicals or plays with gay characters or characters who suffer from AIDS are often only referred to as such. The musical Rent (1996) is a great example of this. A musical meant to be about a group of friends struggling together through tough times ends up only being regarded as an AIDS musical. The characters’ personalities are completely thrown away because of queer labeling and an AIDS diagnosis. Interpreting musicals like this paved the way for people in the real world to think of being queer as a personality trait and not an identity. Critics and viewers did not allow them any real opportunity to showcase their true personalities, even if the show aims to do so. Sexuality is an identity, but it is not a personality trait. This is a total misrepresentation of the queer community. There is so much more to queer people than their sexualities and gender, but when it is showcased in theatre, the audiences see the label, not the actual person or the lived experiences within and around queer life.

Stereotypes are Misrepresenting

Sexual and gender stereotypes in theatre can lead to major misrepresentations of
the queer community. It can be a mistake and completely harmless, but sometimes stereotypes are used to perpetuate negative connotations of a certain community, especially the queer community. This has been a problem recently with musicals like *Legally Blonde: The Musical* (2007) and *Mean Girls the Musical* (2017) gaining popularity. These two musicals, and many others, perpetuate the negative gay stereotypes we should have left behind. For example, in *Legally Blonde: The Musical* (2007), there is a song in the musical called “There! Right There!” This entire song is about deciphering whether a witness on the stand during a trial is gay or European, and it gives us some problematic stereotypes, “Gay or just exotic? I still can’t crack the code. Yeah, his accent is hypnotic, but his shoes are pointy-toed” (Benjamin & O’Keefe, 2007). In the same song we also get the lyrics, “You are so gay, you big parfait. You flaming one-man cabaret” (Benjamin & O’Keefe). These are not necessarily hateful, but they do communicate stereotypes of gay men that some gay men may not agree with or participate in. This is why stereotypes can be harmful. They generalize and group people into categories that they might disagree with or that may not be their full identity. Instead of these musicals giving us early 2000s nostalgia, it gives us hate and misrepresentation by normalizing negative stereotypes (Slager, 2018). Shows like these give the queer community a bad rap and make it harder for young queer folks to come out and be honest about who they are.

As I said before, a lack of proper representation of the queer community can be harmful to queer youths. Theatre and the gay community are oftentimes grouped together because of a shared love for theatre throughout the gay community. Perpetuating negative stereotypes like this about a community that happens to be theatre’s number one supporter is almost like a slap in the face. How are we supposed to continue to support such an industry when for years, they have done nothing but mistreat us?

Another problem faced widely in theatre and briefly mentioned above is the constant practice of miscasting. Miscasting is the practice of putting an actor in a role that is not necessarily right for them. This happens a lot, especially in queer roles where straight actors are typically cast. Many argue that this is
done because the straight, cis counterpart may be considered more marketable (Rodrigues, 2019). It could be a situation where the queer performer is more talented and better qualified for the role than the straight cis counterpart, but that does not stop the latter from being cast.

Let us not get miscasting confused with the art of drag performance. We can trace drag all the way back to Shakespearean times when women were not allowed on the stage, so men had to fill the roles. Trends like this continued till the 1920s when vaudeville shows used drag performers. With prohibition being put into place from 1920-1933, along with drinking and partying, drag performers moved to underground venues, which quickly became a safe space for the queer community (Nasr, 2021). Sadly though, with the rise in drag popularity, police started to hunt for these venues and shut them down. This also led to a ban on “female impersonation” in New York. It was not until the 1970s when drag was re-popularized that it was brought back in New York (Nasr). There are certain instances within theatre where drag performance is essential to the show. An example is from the musical Hairspray (1988). Edna Turnblad, the main character’s mother, is always played by a person who identifies as a man, and this is what the creator wanted. He wanted this character to be in drag, so she is meant to be in drag. Instances like this, where this type of casting is intentional, are okay, but instances like Hedwig and the Angry Inch (1998), where casting agents are intentionally casting straight cisgender men into a gender-queer role, are not okay.

Another problem is the lack of queer representation in young adult theatre. You rarely see any queer characters in young adult theatre productions, and if you do, they typically are portrayed as “troubled” or “at risk” (Giannini, 2010). I will use Rent (1996) again as an example. The openly queer characters in the show either have a disease that will eventually kill them, or the characters are portrayed as a “bad type.” Maureen Johnson, a character in the show, is an openly bisexual woman. She is often shown to be very promiscuous and flirty with everyone around her. There is even an entire song (called “Tango Maureen”) where it is addressed that, inevitably, she will cheat on her current partner. As the
only openly bisexual character in the show, she is pushed into a negative narrative that people have always seemed to have about bisexual women. This is obviously an example of biphobia and an openly queer character being “a problem” and “troubled.” This quote says it best, “This negative discourse perpetuates the notion that ‘being gay’ puts youth at risk for a plethora of problems by suggesting that lesbian, gay, or queer youth will likely become either victims of self-hatred or victims of social hatred” (Giannini, p. 4). This is a great example of theatre being open and accepting of queer folks but, in the same breath, also misrepresenting what it means to be queer. In a way, this pushes for heteronormativity and could possibly make it harder for queer youths to come out. In biased environments like this, from an industry that preaches acceptance and diversity, many queer actors are starting to step away from the theatre industry and into better places.

We can use theatre to erase the stereotypes written in theatre. We must erase the stigma that some theatre writers have created for us. Even when queer characters are present, heteronormativity still reigns high due to how the queer characters are written, almost like a taboo, something that should not be openly talked about. Giannini puts it best, "Plays that reinforce heteronormativity support the idea that homosexuality is never desirable but that it is always already an affliction that leads to punishment, psychically and/or psychologically” (p.4). This underscores the argument about the problematic use of labeling, and in queer characters, labels take away from their personality.

**The Future**

Luckily, there is a future for theatre, and it looks brighter by the minute. Misrepresentation of all communities can be a thing of the past if we let go of our biases and treat everyone with respect and compassion. Sadly though, some people cannot do that, so instead, we must think of other ways to expand the inclusiveness of theatre and how to represent the queer community properly. There are ways this can be done. One is using theatre itself to spread information on queer communities to stop stereotypes and stigmatizations. With the use of theatre, the actors can express their emotions and ideas, which could lead to the
audience changing their perspective, especially regarding social issues (Iverson & Seher, 2014). At Great Lakes University, a community theatre group called Fringe Benefits “facilitated a five-day Theatre for Social Justice Institute to develop a play to educate about homophobia and chilly climate for gay, lesbian, bisexual, and transgender students on campus” (Iverson & Seher, p.41). At the end of this five-day event, a survey showed significant changes in attitudes toward queer people (Iverson & Seher). The survey proved that audiences better understood queer lives after the show and were more open to the community. If we educate on these topics, people will write about them factually without any assumption.

Though not all misrepresentation is intentional, it does not make it any less harmful. Understanding that this is a problem is the first step to trying to correct it. We need to raise questions like, why is that cis-male actor playing a genderqueer character? Why don’t we just cast queer people into queer roles? Why is there a displacement of queer people in theatre when queer people help the industry to thrive and survive?

If questions like these are not asked, no one will think that this is a problem. Things like stereotyping and stigmatization in theatre are harmful to the community, especially when showcased to a massive audience. Seeing a queer character on the stage who might not be portrayed in the best way could be harmful to queer youths and cause them not to want to come out.

In recent years, we have seen progress in the mainstream. The Tony Award is the highest award you can get on Broadway. At the 2022 Tony Awards, they made history by nominating L. Morgan Lee for Best Supporting Actress in a Musical. She was the first openly transgender performer to be nominated for a Tony. Though she lost to Patti LuPone for the role of Joanne in Company, she became a trailblazer with this landmark nomination. It does make one wonder, though. The 2022 Tony Awards preached diversity and inclusion within the nominations, but if you look at the winners’ list, that does not seem to be the case. It is not hard to accidentally misrepresent a community, but it is just as easy to be mindful, considerate, and not hateful.
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Healthcare Inferno: Exposing Medical Bias and Recounting Stories

“So early in my life, I had learned that if you want something, you had better make some noise.” (Malcolm X, The Autobiography of Malcolm X, 1965)

This essay explores medical/healthcare bias, its harms, and how it has personally impacted my health and been exacerbated by my social identities. This topic is important because healthcare bias is under-recognized and causes people to suffer and even die. My goal is to educate readers on healthcare bias and inspire healthcare professionals to work on their biases.

Keywords: stigma, healthcare, discrimination in medical care, endocrinology, health aspects, quality of care, discrimination against overweight persons, physical-appearance-based bias, prejudices, obesity, stereotyping.

Introduction

This essay seeks to present a comprehensive understanding of healthcare bias and highlight its harmful impacts. This paper will examine research surrounding the topic. The research I analyze will focus on biases that pertain to race/ethnicity, gender, and weight. I chose to focus on specific biases as they are representative of my personal
experiences with healthcare bias. Conceptual baggage I had during the research process was some of the words that authors used within their work when discussing weight bias in healthcare. Despite its medical origins, I find the word “obese” to be a little stigmatizing. Usually, this word has a lot of negative connotations around it like being lazy or gluttonous. The relationship I have with the research is that healthcare bias impacts me immensely. I have received poor treatment at the hands of healthcare bias. I decided to research healthcare bias because I want to contribute to combatting this issue. I argue that healthcare bias is harmful for marginalized people and communities.

Healthcare bias refers to the discriminatory beliefs and practices that healthcare professionals and institutions exhibit and implement in their practice. These biases can take several forms that include racial/ethnic bias, gender bias, weight bias, sexual orientation bias, socioeconomic bias, and geographic bias (where access to care is based on where one lives). This issue is particularly pressing for marginalized patients as they are disproportionately affected and thus face devastating consequences. Furthermore, when examining this issue through an intersectional lens, it appears that healthcare bias is even more dire for individuals with multiple oppressive identities.

The perpetration of biases in healthcare leads to serious consequences including misdiagnosis, inadequate or inappropriate treatment, decreased access to care, poor health outcomes, increased healthcare costs and most unjust, death (Sutin et al., 2015, p. 7). This is particularly true when examining the issue through an intersectional lens, as individuals with multiple oppressive identities face compounded effects due to the intersection of these biases. People dying at the hands of bias is unjust and highlights the urgency of addressing healthcare bias. On a societal level, healthcare biases contribute to systemic inequalities and reinforces social injustice. Dismantling healthcare bias requires increasing awareness and advocacy. For the well-being of all people, it is crucial that we advocate for an equitable and adequate healthcare system that benefits everyone.

**Healthcare Bias at a Glance**

In healthcare, the prevalence of bias and its harmful impacts has been documented in numerous studies. Fitzgerald and Hurst (2017) published a systematic review that examines implicit bias in healthcare professionals.
Fitzgerald and Hurst conducted this research to answer the question, “do trained healthcare professionals display implicit biases towards certain types of patients?” (p. 3). Fitzgerald and Hurst examined forty-two articles in this systematic review, with a majority of studies focusing on racial/ethnic biases. However, ten other biases including gender, age, and weight were also inspected in this systematic review. Fitzgerald and Hurst found that most studies examined in their systematic review provided evidence that healthcare professionals were holding biases. Three studies provided significant evidence that there is a connection between high levels of implicit bias against Black people and negative interactions with Black patients. Four studies found a significant connection between high levels of pro-white implicit bias and treatment responses that favored white patients (Fitzgerald and Hurst).

Overall, Fitzgerald and Hurst's systematic review suggest that implicit biases affect clinical judgement and behavior. For example, bias was manifested through diagnosis, treatment recommendations, number of questions asked of the patient, or number of tests ordered. Most of the studies used the Implicit Association Test (IAT) to measure implicit prejudice and implicit stereotypes. Nine IAT studies combined the IAT with a measure of physician behavior or treatment decision (Fitzgerald and Hurst). Limitations in the work included small sample sizes from certain studies, failure to report response rates, and failure to control for participant knowledge of the purpose of the study. Additionally, limitations of the field include the lack of established methodology and difficulty in comparing results due to varying methods and terminology used by different authors (Fitzgerald and Hurst). Including this systematic review to be a part of this essay is purposeful because it provides a comprehensive view on different types of healthcare bias and provides a quantity of evidence to support healthcare biases’ prevalence and impact.

Racial and Ethnic Bias in Healthcare

Racial and ethnic bias are one of the most prevalent forms of bias observed and experienced in healthcare. Maina et al. (2017) investigate this form of bias in healthcare by reviewing ten years’ worth of studies on the topic. Thirty-seven studies were used and the total number of participants among all included studies was 10,013. All studies assessed implicit bias among at least one type of
provider such as physicians, healthcare students, mental health counselors, nurses, genetic counselors, and occupational therapists. The majority of study participants were female (averaging 58%) and White or Asian. Bias related to race/ethnicity was assessed using ten types of Implicit Association Tests (IATs). The Race IAT, which compares bias against Black versus White adults, was used in 35 studies. Twenty-six studies reported that most healthcare providers have some level of pro-White/anti-Black bias. Results from the Ethnicity IAT, which compares bias against Hispanic versus White adults, showed slight pro-White/anti-Hispanic bias. Maina et al.’s work provides a sweeping collection of evidence to support the prevalence of racial/ethnic bias in healthcare. After reviewing the findings from their study, one can conclude that people of color are faced with adversity when it comes to their health.

**Weight Bias in Healthcare**

In recent years, weight bias in healthcare has become a hot button issue as more people speak on their experiences. Considering that people of diverse body size are marginalized in society, one can speculate that disparities in healthcare will be present. In efforts to provide a comprehensive look at weight bias in healthcare and its harmful impacts, I review several pieces of literature. Lawrence et al. (2021) published a systematic review and meta-analysis on weight bias among health care professionals. This systematic review is important as it highlights the validity of weight bias in healthcare by pointing out evidence from other studies. Previous studies about weight bias have produced mixed results, which is what prompted the authors of this article to conduct their research. Lawrence et al. reviewed forty-one studies ranging from 1989 to 2020. Evidence of both implicit and explicit weight bias among health care professionals such as medical doctors, nurses, dietitians, and others was found. Additionally, this review found that weight bias exhibited by healthcare professionals (HCP)s negatively affects the quality of care and may cause less use of health care services by clients who are overweight or obese (Lawrence et al., 2021). Individuals who are overweight or obese often face weight bias during their consultations with healthcare professionals, which can lead to internalized weight stigma and increase the risk of depression, anxiety, stress, and even suicidal thoughts. Fruh et al. (2016) add to this finding by providing readers with an overview of obesity...
stigma and bias. Fruh et al. focus on acknowledging that weight bias does exist and how it is a barrier for patients to receive the healthcare they need. For example, Puhl et al. (as cited in Fruh et al., 2016) report weight bias resulted in women gaining more weight by binge eating to cope. Another study highlighted by Fruh et al. was conducted with 358 nurse practitioners about their attitudes towards people who were overweight. Nurse practitioners reported holding negative attitudes towards overweight people such as them not being as successful as others, not fit for marriage, messy, and not healthy. Additionally, Fruh et al. highlight another study exploring the biases of 620 Primary Care Physicians (PCPs). The study indicated that half of PCPs found their patients to be awkward, unattractive, ugly and non-compliant.

Seymour et al. (2018) conducted original research that supports the findings from the systematic review by Lawrence et al. (2021). The purpose of the research study was to determine whether healthcare professionals in the U.S. exhibit weight bias towards patients with obesity and the effect it has on the quality of care they receive. Participants were healthcare professionals over the age of 18 in the Midwest. Open-ended responses to hypothetical patient scenarios and the Attitudes Towards Obese Persons scale were methods utilized to measure quality of care and weight bias among the participants (Seymour et al.). Multiple findings are addressed. First, findings indicated that healthcare professionals with higher levels of weight bias had lower quality of care towards patients with obesity compared to those with lower weight bias. When healthcare providers were presented with hypothetical scenarios involving patients with and without obesity, responses were similar however specific recommendations were made to patients with obesity. Healthcare professionals with high weight bias were found to offer less empathetic advice, such as prescribing pharmaceutical intervention over lifestyle modification. Seymour et al. suggest this could contribute to weaker practitioner-patient rapport and affect the quality of care delivered to patients with obesity. While the study had a large sample size and valid data collection methods, its limitations include a sample not representative of all healthcare professionals and the use of hypothetical data collection.

Abbott et al. (2023) highlight evidence that healthcare professionals are prone to weight bias. Specifically, the study examines implicit weight bias among
healthcare professionals who specialize in treating obesity and their views on alternative approaches that do not primarily focus on weight. Weight bias in obesity services is under-researched, which is why the authors undertook this research. The methods of this study included inviting obesity specialist healthcare professionals to a webinar about non-weight focused approaches in obesity services and then examine their bias using the BiasProof mobile device test (Abbott et al.). This test is based on the Implicit Association Test. Eighty-two out of 113 HCPs contributed their data to the study. Out of 82 HCPs, 51% held an implicit bias about people who are overweight. These research findings are important to highlight because even in specialties that are meant to help overweight people, bias is still prevalent.

**Mortality Risk and Weight Bias**

Weight bias has devastating effects, which on the extreme end can include risk of mortality. Sutin et al. (2015) examine weight discrimination and mortality risk in their work. The purpose of this research was to examine if there was a link between weight bias and risk of mortality similar to how there is a link between weight bias and declines in physical and mental health. The methods of this research included taking data from the Health and Retirement Study (HRS) and the Midlife in the United States (MIDUS) study. Participants were re-interviewed every two years in the HRS and completed a 30-minute telephone interview, self-administered questionnaire that included the discrimination measure in the MIDUS. Sutin et al. found that weight discrimination was associated with an increase in mortality risk of nearly 60 percent in both the HRS and MIDUS participants after controlling for demographic characteristics. The study also found that the risk of mortality was slightly stronger for Black participants than for White participants (Sutin et al.).

Of all the literature reviewed in this paper, Sutin et al.’s, research may be the most important to highlight. Their findings indicate an urgency to combat weight bias in healthcare.

**Gender Bias in Medical Research**

Gender bias is another form of bias that can be found in healthcare that also extends to medical research. Gender bias refers to the unequal attention and resources given to medical conditions that primarily affect women or are perceived as being related to women. Polycystic ovarian syndrome (PCOS) is considered a women’s disease and largely under-researched. Brakta et al.
Brakta et al. found that PCOS research may be underfunded when compared to funding awarded for research in similar diseases. During the 10-year funding from 2006-2015, PCOS research received $215.12 million compared to $454.39 million for rheumatoid arthritis (RA), $773.77 million for tuberculosis (TB), and $609.52 million for systemic lupus erythematosus (SLE) (Bratka et al.). Funding for PCOS was primarily provided by one NIH Institute/Center, whereas SLE and RA received funding from at least two Institutes/Centers. Additionally, more Research Project Grants were awarded for RA, SLE, and TB than for PCOS (Bratka et al.). Brakta et al. acknowledge that diseases that affect women are more likely to be underfunded. However, it is also noted that “PCOS is … a metabolic disorder, with substantial and well-documented metabolic origins and metabolic and cardiovascular morbidity, which are not areas of interest” to some institutes (Bratka et al., p. 4423).

Considering that bias in healthcare is becoming more discussed and researched, additional efforts and strategies have been suggested to combat it. Vela et al. (2022) published work that not only examines negative explicit and implicit biases held by healthcare providers but also how these biases affect patient-clinician communication, clinical decision-making, and institutionalized practices. Additionally, Vela et al. examine the strategies meant to combat healthcare bias and whether they are sufficient. Vela et al. found that current efforts to address healthcare bias include educating healthcare providers about the existence and impact of bias and teaching them skills to manage it. However, these interventions were found not to be effective as they did not lead to sustained changes in behavior or changing the clinical or educational environment (Vela et al., 2022). This may be due to the discriminatory practices prevalent in the healthcare work and learning environment that reinforce the biases being targeted.

My Experiences with Healthcare Bias

At the age of nineteen, I was thrust into a world of uncertainty and difficulty when I first learned about PCOS. It was during a routine check-up that I mustered the courage to confide in my doctor about the nagging symptoms that had plagued me for years: fatigue, thick facial hair, and rapid weight gain. They proposed it could be PCOS and ordered blood tests to investigate further. After a
month of waiting for results, I received a voicemail from my doctor's office asking me to call back urgently to discuss my results. It was then that I learned that I had elevated testosterone levels, a telltale sign of PCOS, and that I needed to see an endocrinologist for further evaluation. The news was bittersweet, to say the least. On one hand, it was daunting to learn that something was indeed wrong with me. On the other hand, it was a relief to finally have a name for the constellation of symptoms that had eluded me for so long. It was a ray of hope that I was one step closer to finding the treatment I needed and deserved.

As is often the case with medical specialists, getting an appointment with an endocrinologist was no easy feat. I had to endure months of uncertainty, wondering whether I had a disorder that could significantly impact my life. As I awaited my appointment with the endocrinologist, my nerves were frayed. My past experiences with doctors had been less than satisfactory, with many dismissing my concerns as nothing more than a result of my weight. I was worried that this visit would be no different. The appointment began with a medical student taking down my history and symptoms. Surprisingly, this part of the visit went smoothly, and I felt a glimmer of hope that I would finally get answers to my health struggles. My hope was short-lived as the endocrinologist entered the room. He was an older gentleman, short in stature, with a bald head and bulging blue eyes. His grin was pointy and revealed a set of gapped buck teeth. He started the conversation off on a positive note by complimenting my desire to become a social worker.

The true appointment began with the endocrinologist turning his attention to the medical student, asking her to recount my symptoms. She dutifully ran through the assessment she had conducted earlier, and the endocrinologist responded with an air of irritation and disgust, asking for her diagnosis. When she tentatively responded with "Cushing's," he scrunched up his face and rolled his eyes, clearly unimpressed. In a dismissive and disparaging tone, he sneered, "That's it? That's all you have to say. That's the only thing you could pull from your vast medicinal repertoire?" I was shell shocked; how could he degrade his student like that? The look of sadness and shame on the student's face was palpable as she struggled to come up with a response. But she was cut off before she could even utter two words, with the endocrinologist interrupting her mid-sentence. It was clear that anything
she said would be inherently wrong. After rudely silencing his own medical student, the endocrinologist turned back to me and asked why I was there. When I mentioned that my doctor thought I might have PCOS, he responded with a dismissive laugh and asked me why I thought that was the case. Despite my attempts to explain my pressing symptoms, he insisted that I simply needed to lose weight and reach a size 10. When I brought up my abnormally thick facial hair, he giddily dismissed it as a product of my Puerto Rican heritage, saying that "lots of women are hairy." As the appointment drew to a close, he asked if I snored in my sleep, and used my affirmative response as evidence that I did not have PCOS, but rather sleep apnea. In his eyes, the most important thing was for me to lose weight, and he seemed to believe that curing my sleep apnea would magically allow me to do so. I left that appointment feeling worse than when I came in. At the time, I lacked the language and understanding to recognize that what I had experienced was healthcare bias. All I knew was that I felt dismissed, defeated, and hopeless. It seemed as though I would never find the answers or the adequate treatment that I so desperately needed.

After my disappointing experience with the first endocrinologist, I spoke to my primary care physician, and they set me up with a new one. Unlike the previous doctor, this endocrinologist took one look at me and said that I most likely had PCOS. He asked me about my diet and exercise habits, and when I told him that I ate healthy and exercised regularly, he didn't believe me. He then recommended that I start with eating 1,200 calories a day, then drop to 800, and eventually down to 500 calories. Hearing this was hard, and I felt a sense of shame and unworthiness. At this point, I just wanted to leave the appointment as soon as possible. Everything he said went in one ear and out the other. I left feeling frustrated and overwhelmed. Awaiting me were more calls, more waiting, and more difficulties. It has now been two and a half years since that appointment, and I have yet to return to an endocrinologist because of what I have experienced.

Healthcare bias has left me feeling alienated from the treatment I need and deserve. I fear the future dismissal I will face on my journey for treatment. After researching this issue, I realize just how prominent it is as many patients face similar situations. In the medical field, there is still much work to be done to ensure that patients are heard and treated with the respect and dignity they deserve.
Bibliography


The Reality of Maternal Mortality

“A Black woman having a baby is like a Black man at a traffic stop with the police.”
(Felicia Ellis, Aftershock, 2022)

This paper explores the racial disparities of maternal mortality, with a focus on the disparities between Black and White women. This topic is important because it is not gaining enough attention on a national scale and it highlights the fact that institutional racism is still very well prevalent in the medical world (e.g., Tuskegee syphilis study, sterilization of Puerto Rican women or the exploitation of Henrietta Lacks’ (HeLa) cells). I hope to bring knowledge on how racism and medical implicit bias can affect people’s quality of life specifically women of color.

Keywords: Black maternal healthcare; Racial bias in maternal care; Race and Maternal Mortality; Eugenics

Introduction

Imagine being 35 weeks pregnant, excited to meet your little one, your partner talking about who the baby will look like more, until you start experiencing chest pains. You visit the Emergency Room explaining your concerns, but the doctors dismiss you because it may be from the pressure of the growing uterus and a minor heartburn. Still worried but reassured by medical professionals telling you are alright to go home, you leave the
hospital with your partner also trying to reassure you. Then, the pain becomes sharp for the next couple of hours, and you knew something was very wrong this time. You visit the hospital again later that night, but rather than receiving help, you get questioned if you take drugs because “you fit the profile” of someone who takes drugs. Highly offended by the comment, you try to stay calm and still complain about your chest pains. Doctors simply prescribed you medication and tell you to come back if you still feel the pain. No medical history background asked, no diagnostics testing done. You and your baby die from pulmonary embolism.\textsuperscript{1} If they had just believed your concerns, checked your oxygen or respiration rate, you might be alive with your baby.

This scenario was fictionally created to show how common it is for Black women to experience situations where implicit bias exists while seeking healthcare. Implicit bias is the unconscious/unintentional practice of bias judgements that affect decisions.\textsuperscript{2} For example, the aftermath of the War on Drugs created an image for society to believe Black people are dangerous and are drug addicts\textsuperscript{3} or the stereotype of Black people having higher pain tolerance because of a medical myth that Black people “have thicker skin.”\textsuperscript{4} These stereotypes/ideologies allow implicit bias to continue to be practiced in healthcare settings and Black women’s concerns to be repeatedly ignored from professionals, putting Black women’s holistic health at risk. In this essay, I discuss why we are seeing an increasing trend of Black maternal death, as well as different policies that place Black women at a disadvantage when accessing healthcare needs and the history of Black childbearing in the United States. By explaining why we are seeing such trends, I will also speak to possible policies that can be implemented to decrease Black maternal mortality.

As an Asian woman, I will never understand what it is like to be a Black

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\textsuperscript{1} When a blood clot gets stuck in an artery in the lung causing blood flow disruption of the lung.

\textsuperscript{2} See The National Institute of Health for additional information:

https://diversity.nih.gov/sociocultural-factors/implicit-bias

\textsuperscript{3} This was discussed in the film “13\textsuperscript{th}” by Ava DuVernay.

\textsuperscript{4} This was discussed in the film “Race: The Power of an Illusion” (Adelman, 2003).
woman, nor will I ever know the struggles Black women face across different intersections of intersectionality. As an ally of the Black community, I and other members of society have a duty to educate ourselves on how the effects of racism can impact one’s life and help advocate for policy changes.

**Coverage Gap**

Over the years, the United States has been seeing an increasing trend in maternal mortality, specifically Black maternal mortality. Black women are three times more likely to die from pregnancy-related causes compared to White women (Centers for Disease Control and Prevention, 2022). Judith Solomon (2021) the author of *Closing the Coverage Gap Would Improve Black Maternal Health*, introduces the idea of what the coverage gap is and how this negatively affects pregnant Black women. She stated,

But the Medicaid coverage gap – in which adults with low incomes have no pathway to affordable coverage because their state is one of 12 that has refused to expand Medicaid - puts continuous health coverage out of reach for over 800,000 women of reproductive age (Solomon, p.1).

Those who are not insured in the twelve states that have decided to not expand Medicaid will have a difficult time finding healthcare at an affordable cost. The privilege to have health insurance is a classism issue because, depending on socioeconomic status, there are different levels to accessible healthcare and health insurance. For example, those who earn a higher income are more likely to have access to employer provided health insurance whereas those who earn a lower income may not offer employer provided health insurance or cannot afford a private health insurance. Not only is this a classism issue but when we factor in race/ethnicity, many people of color experience discrimination when accessing healthcare. This leads to disparities in health outcomes between different race/ethnic and socioeconomic groups. This may cause Black pregnant mothers to seek care in other states, placing a huge inconvenience and financial burden to seek constant care outside of the state in which they may live.
For the 12 states\(^5\) that have not expanded Medicaid, living below the poverty line or those making less than $17,800 a year per person puts more women of reproductive age at risk of being uninsured compared to the expansion states. In 2019, of 810,000 women of reproductive age with incomes below the poverty line, 29 percent were Black women and 33 percent Latinas who had no affordable healthcare (Solomon). Expectant Black mothers who reside in those twelve states are at risk of receiving less care, which eventually puts their fetus and their own lives at stake. Moreover, states that have not expanded Medicaid puts those 65 percent of Black pregnant mothers in huge medical debt for receiving the absolute minimal to no prenatal and intra/postpartum care. Solomon mentions Medicaid pays for more than 65 percent of births to Black mothers; therefore, expanding Medicaid will help address the Black maternal health problem. Removing Medicaid can put more women - not just uninsured Black women - at risk because of the burden of the cost to receive care. According to Solomon, if people in the coverage gap were to get pregnant, they become eligible for Medicaid but may not get the necessary preconception care. Uninsured people may delay their prenatal care until they apply for and enroll in Medicaid.

Prenatal care is crucial for a healthy delivery as it addresses any potential concerns related to pregnancy, possible birth complications, and risk factors. These have been interconnected with negative pregnant outcomes and higher pregnancy-related risk factors especially for Black women (Kendall, 2021). Unaffordable healthcare causes higher potential negative outcomes and financial burden on Black women who are seeking to become pregnant.

**The Disparities**

Various research has examined social disparities in maternal mortality for decades by race/ethnicity, socioeconomic status, nativity, immigrant status, marital status, area deprivation, urbanization level, and cause of death.

\(^5\) According to Holahan et al. (2021), the 12 states that have not expanded Medicaid are: Alabama, Florida, Georgia, Kansas, Wisconsin, and Wyoming.
Singh (2020) collected national vital statistics data from 1969 to 2018 and results showed “with the rate increasing from 9.9 deaths/100,000 live births in 1999 to 17.4 in 2018…Black women in 2018 have 2.4 times higher maternal mortality than White women” (p. 1). This demonstrates to the public that not only is the United States seeing an increasing trend in maternal mortality in general, but Black women are more likely to die from childbirth. Singh continues to report that women who are unmarried, have U.S.-born status, have lower education, and have rural residence were associated with 50-144 percent higher mortality risks. Black pregnant women who are unmarried, of U.S.-born status, with lower education, and living in rural areas have also largely faced additional marginalization due to the institutionalized racism and sexism embedded into our society. This can lead to further complications in maternal health outcomes. To further explain, Kendall states, Social and environmental risk factors that influence poor maternal health outcomes disproportionately impact marginalized communities. Poverty-based risk factors, from housing instability to increased exposure to toxins because of subpar housing to increased exposure of violence, contribute to higher stress levels and lower access to quality healthcare, including comprehensive mental health services (p.231-232).

It is important to note that in many cases social and environmental risk factors are deeply connected to institutionalized racism entrenched in policies that segregate communities. For example, institutionalized racism has constructed policies such as segregation and redlining, which result in members of the Black community, especially Black women, to have less education or live in rural areas where education and healthcare access is difficult. Kendall’s (2021) statement of social and environmental risk factors to lack of housing further illustrates how these policies have affected the Black community negatively causing resource scarcity. Redlining is one example where it was difficult for Black families to purchase homes in “affluent” areas because of racial prejudices. This resulted in lower financial status among Black populations, causing them to live
in low-income areas with limited access to healthcare.

The issue of maternal mortality is more racially rooted than any other social disparities. Walker and Boling (2023) showed Black women are more likely to die during childbirth than Hispanic, Asian/Pacific Islanders, American Indian/Alaska Native women in the U.S. as well as women in Mexico, where nearly half its residents live in poverty: “A Black woman with a college degree is more likely to die during childbirth than a teenage White woman” (p. 2). If a well-educated Black woman is more likely to die from childbirth than a teenage White woman, then society needs to see maternal mortality as a race disparity issue as much as a socioeconomic issue. Macdorman et al. (2021) analyzed the 2016-2017 National Vital Statistics System’s mortality data, examining the cause of death literals (actual cause of death written on the death certificate) with racial/ethnic differences. Macdorman et al. found several results in that the mortality rate for non-Hispanic Black women was 3.55 times higher than for non-Hispanic White women. They also found the leading cause of death was preeclampsia, eclampsia, and postpartum cardiomyopathy with rates five times higher than those for non-Hispanic Black women (Macdorman et al.). Black maternal mortality rates from obstetric embolism and obstetric hemorrhage were 2.3 to 2.6 times greater than those who are non-Hispanic White women, accounting for 59 percent of the non-Hispanic Black non-Hispanic White women disparity. The results show a substantial rate of Black mothers dying from cardiovascular-related deaths compared to White mothers. The healthcare system needs to increase its attention to this issue, as preeclampsia and eclampsia are easily preventable diseases with the right care and monitoring. Black women are all too often ignored or overlooked by healthcare professionals when reporting a symptom such as pain, causing the Black community to be hesitant when seeking care.

The Unspoken History

It is evident in U.S. history that Black women have been denied autonomy in the deeply personal process of reproduction and childbearing. Owens and Fett, authors of *Black Maternal and*
Infant Health: Historical Legacies of Slavery (2019), speak on the history of enslaved women and childbearing:

Continuing up through the Civil war, White women’s childbearing built free patriarchal lineages while southern laws forced enslaved Black women to bear children who would build capital for enslavers (p. 2).

It is clear enough to say Black women during slavery had no autonomy when it came to childbearing. Oftentimes, after enslaved mothers gave birth, their children (who were often a product of rape) were immediately taken away from their biological mothers for financial profit. Enslaved Black women frequently had to take care of their master’s children by breastfeeding, cleaning, cooking, and changing, rather than taking care of their own children. This allowed society to continue a cycle where Black women are exploited physically, emotionally, sexually, and financially.

One cannot say race does not play a role in our healthcare system today without discussing the significant history of racial inequalities in childbearing for Black women. We must understand how the relationship between the medicine we know today and slavery interconnect. To give a few examples, Francois Marie Prevost, a slaveholding surgeon, performed countless cesarean section surgeries on enslaved women. James Marion Sims, a gynecologist who created Vesicovaginal Fistula Repair, experimentated on enslaved women in Alabama (Owens & Fett). Surgical techniques were developed even though Black women were unwilling subjects to these painful experiments. During the slavery period, we did not have the advanced pain medication that is used in surgeries today. Black women endured an immense amount of pain so that white physicians could acquire new medical knowledge for future generations of medical students. Owens and Fett also highlighted an important point: the advanced medicine of gynecology we know today is due to many Black women sacrificing their bodies unwillingly. Black women like Henrietta Lacks contributed immensely

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6 Vesicovaginal Fistula Repair is a surgery that closes the opening of the vagina.

7 Henrietta Lacks is a Black woman whose cells (HeLa cells) were taken without informing her or her family and used for
to the medicine we know today due to the exploitation of her cells. We continue to witness a higher maternal death rate for Black women compared to any other racial group.

**Hood Feminism**

Mikki Kendall, author of *Hood Feminism*, dedicates a chapter in her book to Black maternal mortality, reproductive justice, and eugenics. She writes,

Higher abortion rates in low-income communities are sometimes connected by anti-choice groups to eugenics as well. Because of environmental racism, limited access to prenatal care, and subpar nutrition and housing for many in marginalized communities, the risk factors for having a child with a serious disability are higher than average (p.226).

Kendall argues a correlation with higher abortion rates because there is limited access to resources that help carry a fetus to term. Having good prenatal care is the foundation to a healthy term pregnancy. If this foundation is not laid, the risk of fetal death and possible maternal death will only be apparent. Kendall’s argument of lack of resources tremendously impacts how a woman will do throughout the pregnancy and continues to state how lack of resources is what we should address about reproductive justice.

Kendall points to tennis athlete Serena Williams’ story as an example that wealth “does not protect Black mothers” (p.220). Serena Williams had the means to access top quality healthcare because of her financial status as a world star tennis player, but she still faced a near-death experience because her pain and concerns were overlooked by medical staff. This further proves my argument that this is a racial issue more than socioeconomic issue. Kendall also says,

For Black communities in the United States, even when factors such as physical health, access to prenatal care, income level, education, and socioeconomic status are controlled for, Black women are still far more likely to experience maternal mortality rates that hark back to the days when Black motherhood was seen as a medical research purposes and financial profit. See *The Immortal Life of Henrietta Lacks* by R. Skloot.
problem to be solved with sterilization (p.231).

The writer makes a connection that because Black women lack access to resources, we are seeing higher rates of Black maternal mortality; that is the sterilization issue of today. The history of forced sterilization in the United States is another form of discriminatory practice that has existed since the 1940s, beginning with Puerto Rican women and then Black women in the 1950s. The infamous eugenics movement triggered women to be sterilized involuntary by threatening Black women’s welfare benefits if not sterilized. The eugenics movement’s goal was to decrease the reproduction of groups that were deemed to be “undesirable”. Such groups were largely people of color. Black women were mainly targeted to be sterilized to permanently prevent them from giving birth. Both these issues highlight the systemic racism and sexism in our healthcare system and how this prolongs health disparities in communities that are still racially marginalized.

For a Better Future

The national conversation and efforts to correct inequalities in maternal mortality in the United States have not been communicated enough. Walker and Boling showed the challenges journalists faced when reporting health disparities as the result of social inequalities. Journalists felt they could not adequately cover the topics from a racial perspective because of tight deadlines, limited staffing, training, and time. Researchers and health professionals such as surgeons, doctors, nurses, and more have come together to discuss ways to decrease the disproportionate rate of maternal death. Lister et al., researchers of *Black Maternal Mortality – The Elephant in the Room* (2019), argue there are three central issues to the unbalanced death rates: First, Black women are more likely to have pre-existing cardiovascular morbidity that increases the risk of maternal mortality; second, Black women are more likely to experience adverse pregnancy outcomes putting them at risk for long term cardiovascular disease; and third, the racial bias and perceived racial discrimination of healthcare professionals reduces the essential health care Black women receive. Lister et al. offer several
recommendations: Women with a heart condition should be cared for by a team of “cardio-obstetrics” during their pregnancy; Black women who experience pregnancy complications should have a primary provider in the immediate postpartum care; hospitals that serve Black women should have extra resources available. Lister et al. propose expanding coverage outside of the immediate postpartum period to ensure that those at greatest risk for a cardiovascular event are immediately connected to the healthcare system. Lister et al. point out that many reproductive age women have OBGYNs as their primary care provider, which gives them the unique position to join with skilled physicians who specialize in cardiovascular disease to prevent or manage postpartum complications. Most postpartum follow-up visits are six to eight weeks after giving birth. Immediate coverage after postpartum can significantly decrease the risk of complications.

Many healthcare providers are trained and educated on how to therapeutically communicate with patients. It is part of their duty as healthcare professionals and their ethical responsibility to provide autonomy and more. We are seeing healthcare providers forget to practice their therapeutic communication skills. Serena Williams’ story is an example of how crucial it is to have effective and continuous communication with providers and patients. Lister et al. reference two studies illustrating how effective communication between healthcare providers and patients can allow the patient to feel more trusted with medical staff. In the first study, 204 African American pregnant patients and their 21 ethnically diverse providers demonstrated that patient-provider communication had a positive effect on trust in provider and on prenatal care satisfaction (Dahlem et al. (2015), as cited in Lister et al., pp. 4-5).

The second study, a qualitative study of 22 African American Women, [identified] the qualities important to effective communication were (a) demonstrating quality patient-provider communication, (b) providing continuity of care, (c) treating the women with respect, and (d) delivering compassionate care (Lori et al. (2011), as cited in Lister et al., p. 5).
Not only do these studies show that effective communication can build a positive healthcare experience, where patients will feel more trusted and inclined to seek care, but they mention qualities that make communication between healthcare providers and patients successful.

The Association of Black Cardiologists (ABC) published a position paper stating more than half of Black maternal death cases were from preventable causes with cardiovascular disease being the leading one (Bond et al., 2021). The ABC addressed many topics, including pre-conception counseling to provide health education, risk assessment, and intervention before pregnancy. Their goal is to help reduce adverse outcomes by expanding community outreach programs, using media to expose the issue of Black maternal mortality to the public, building a faith-based partnership between professionals and patients, acknowledging Black mother’s concerns, and improving overall quality care during the antepartum\(^8\) and postpartum periods. In 2020, SELF, a popular media/magazine company, published an eleven-part editorial to provide Black mothers-to-be information about their pregnancy journey (Bond et al.). We have also seen Black public figures who have given birth like Serena Williams, Beyonce, and Michelle Obama to name a few, share their experiences on their pregnancy journey to the public. This can raise awareness to other Black women who look up to them. The use of media is an excellent way to implement change by informing women of color on a global scale and diversifying what is being put out on media.

Another idea Bond et al. reported is to have insurance companies hold hospitals accountable for collecting and reviewing patients’ morbidity and death outcomes, including the physicians’ race/ethnicity. If hospitals reported the physician’s race/ethnicity, they could then provide a list of physicians the patient may want to seek care from. Bond et al. argue this is important as,

Research has shown that patient-physician racial concordance has led to improved quality of care with greater interpersonal trust, satisfaction with

\(^8\) Antepartum is referred to a time period right before childbirth.
care, loyalty and satisfaction with the physician, self-reported health improvement, and willingness to give the physician control in the relationship (p.5).

Having a patient-physician racial concordance can also help reduce implicit bias because implicit bias only occurs when two or more people of different backgrounds come together. When a patient and physician share the same racial/ethnic background, the physician may exhibit less bias toward the patient because of the shared bond.

Healthcare systems need to hire more people of color so that patients have a team of providers they might identify with.

Bond et al. cite that the U.S. spends about $111 billion on maternal, prenatal, and newborn care per year, but I think the budget should be greater. According to USAspending.gov, the military received an annual budget of almost two trillion dollars in 2023. Allocating just five percent of that budget, about $100 billion, would increase the annual maternal healthcare budget to about $200 billion per year. This can allow more community-based outpatient clinics to be built, hire more Black doulas and healthcare professionals, and advocate for WIC program funding to research more on prevention of postpartum cardiovascular events and more.

**Conclusion**

This essay examines the racial disparities seen in maternal mortality, why we are seeing those racial disparities, the history of Black women’s childbearing, and the experiences of pregnant Black women/mothers and how that impacts their families. The essay also examines possible solutions to decrease the rate of Black maternal mortality such as increasing funding and hiring more people of color. In doing so, I have argued that Black maternal mortality is a racial issue rather than a socioeconomic status issue, as articulated by Kendall’s chapter on “Reproductive Justice, Eugenics, and Maternal Mortality” in her book, *Hood Feminism.*

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9 Doulas are trained professionals that help support/guide mothers-to-be through childbirth, they do not provide medical assistance.

10 WIC program stands for Women, Infants, and Children program, government assisted program to help with nutrition needs.
As an ally to Black women, I want to spread knowledge to others and have open discussions on Black maternal mortality issues, especially to those who are not Black. I also want to increase awareness that maternal death is one of the many societal issues Black women face every day. We must make it a priority to acknowledge the pain these women have felt and find solutions together. You and I need to fight back against systemic racism. You and I need to fight back against implicit bias. You and I need to fight for more resources. You and I must listen to the cries of Black women. You and I need to protect Black women.

Imagine we are 200 years in the future where people live harmoniously across all intersections with unlimited access to resources needed to survive, and policies like the Affordable Care Act, and Women, Infants, and Children (WIC). Programs do not exist because everything is free of cost. Black women can come seek care without the fear of dying because systemic racism was addressed and corrected with new policies. Medical debt is nonexistent because society cares for a human’s wellbeing rather than money. Funerals for grieving partners is long past because the gap between maternal mortality is gone. Imagine.

References


