“I’LL LOOK INTO THIS ON MY OWN”: KNOWLEDGE AND RESISTANCE IN NARRATIVES OF CONTRACEPTION AMONG COLLEGE-EDUCATED AMERICAN WOMEN

by

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A THESIS

Presented to the Folklore Program
and the Graduate School of the University of Oregon
in partial fulfillment of the requirements
for the degree of
Master of Arts

June 2018

THESIS APPROVAL PAGE

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Title: “I’ll Look into This on My Own”: Knowledge and Resistance in Narratives of Contraception among College-educated American Women

This thesis has been accepted and approved in partial fulfillment of the requirements for the Master of Arts degree in the Folklore Program by:

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Original approval signatures are on file with the University of Oregon Graduate School.

Degree awarded June 2018

THESIS ABSTRACT

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Master of Arts Degree

Folklore Program

June 2018

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For every method, there's a story - the IUD that almost killed her, the male birth control that almost happened, the weight gained and the moods changed. Whether a narrative of personal experience or one heard through the grapevine, stories about contraception illuminate critical issues in reproductive health today.

Using ethnographic data deeply colored by ongoing partisan rhetoric around reproductive rights and the body, I discuss the dynamics of power at play in patient experience, the performance of social complaint and institutional critique, and vernacular conceptualizations of health and embodiment in the contraceptive regimen.

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ACKNOWLEDGMENTS

I wish to thank my advisors Carol Silverman and Riki Saltzman for their ongoing encouragement, insight, and support. Working with each of them has been the highlight of my studies at the U of O.

I also want to thank the participants who gave their stories and ideas for this project. They have been instrumental in not only the completion of this thesis, but in my own growth as an ethnographer, social critic, and feminist.

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INTRODUCTION

> That day, he put this local anesthetic in my arm… [When] he came in, I said, ‘What is this like?’ He said it’s similar to how you microchip a dog… it was this little machine, and he said [the implant] was the size of a pen cap. He injected it into my arm, and it was just numb. He told me, ‘don’t mess with it too much for the rest of the day, ‘cause if you mess with it too much your body will try to reject it.’ So I left it alone. I had a lot of bruising around the site, and it was really sensitive for a while. I couldn’t sleep on that side [of my body], and it would get really hot. But once it sort of settled into my skin, I guess it was a month and a half after I had it in, I got super depressed, I gained probably about 15 pounds really quickly, and I had super sore breasts. I was a different person completely. And I thought that maybe it was something to do with the birth control… [but] I thought, well, maybe I’m pregnant… My husband would go get pregnancy tests in the middle of the night, and it would be negative… [but] I had nipple discharge. It was really really scary… I called my doctor, and he said [to] just give it a few months and it’ll level out, your body’s just getting used to it. So I gave it a little while. I ended up staying on it for 6 months. I know this sounds crazy, but I’m not the only person who’s ever had this experience [on the implant]: I had a flutter movement in my stomach, and I looked online and they call it phantom baby kicks. After that happened I was just like, I have to have this out of my arm. So I called the office, and he told me that he couldn’t get me in for another 2 months to have it removed. I told him, I said, look, if you don’t take this out of my arm, I’m going to take it out myself.

Over the last year, I have been collecting stories like these about women’s experiences with contraception. In the above story, April, a 27-year-old river guide and college student, relates her experience with a contraceptive implant. This was a semi-permanent device that her doctor placed beneath the skin of her upper arm. Her experience of the device’s insertion, side effects, and removal represents an ongoing process of decision-making as well as complex interactions with biomedical authority. On her doctor’s advice she left the insertion wound alone, and when her doctor told her to leave it in longer than she preferred, she complied. Yet she acted according to her own medical judgment when she suspected a pregnancy, and made contingency plans to have the device removed if this were the case.

Describing her unexpected side effects, April defended the validity of her experience by bringing to bear the wider community of anonymous implant-users who had reported similar symptoms in online fora. In the end, she asserted her own authority over the doctor's protocol by threatening extreme consequences if her doctor did not address her concerns. Negotiations of power like those April described, especially as they are informed by both biomedical and vernacular constructs of illness, health, and the body, are at the heart of contraceptive decision-making and use.

One way women explore this space is through narrative. Narratives help us articulate knowledge in terms of action and experience, and in this way they both create and disseminate knowledge within social groups (Goldstein 2015, 127). In the field of reproductive health, narrative is both understudied and underappreciated: although qualitative biomedical research is being conducted on the topic of contraception, it tends to focus on users' misunderstandings and reasons for method underutilization with the purpose of discovering how to correct users' beliefs or behaviors, often in the context of unintended teen pregnancy or widespread reliance on traditional methods of contraception in the Global South.[1]

Filmmakers Ricki Lake and Abby Epstein, who created "The Business of Being Born," are currently fundraising to explore women's experiences with contraceptive

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[1] See, for example, "A qualitative study of contraceptive understanding among young adults," (M. Carter, 2012); "Limits to modern contraceptive use among young women in developing countries," (L. Williamson, 2009); or "A Qualitative Study of Factors That Influence Contraceptive Choice among Adolescent School-Based Health Center Patients" (A. Hoopes, 2015).

technology, basing their work on the book *Sweetening the Pill: How We Got Hooked on Hormonal Birth Control*, by Holly Grigg-Spall. In a 2015 promo video posted to *The Guardian,* Epstein and Grigg-Spall question whether "some birth control methods could kill you." While scientists and medical professionals are obliged to correct misperceptions to improve benefits to contraceptive users, they should also investigate why and how such critiques of birth control find purchase within a community.

In my research I have been guided by the following questions: What do narratives about birth control reveal about users' conceptualizations of their body and their health? How do these narratives reveal alternative values and ideals not currently reflected in pharmaceutical development, provider training, or health education and counseling? And in what ways might the institutional critique inherent in users' narratives be not only heard, but heeded?

Fertility management can involve a high degree of contact with biomedical authority, often requiring visits to the doctor, pharmaceutical regimens, and sometimes hospital procedures. In most cases, clients seek medical care *not* in order to treat or even prevent disease, but in order to manage a normal and healthy state such as menstruation, fertility, pregnancy, childbirth, and menopause (Palley and Palley 2014, 8). A patient may use prescription contraceptives not just for years but for decades at a time, often under the direction of a health professional (Guttmacher Institute). As patients try new methods and abandon old ones, adapt to new life stages, and manage their life goals, they interact with biomedicine in multiple, highly dynamic contexts. I am interested in this space where people who are healthy need medicine, where intimacy requires the oversight of a professional, and where the goal, most of the time, is for nothing to happen at all.

Scholarly Framework

My discussion integrates a wide array of literature from fields such as science and medicine, folklore, feminist studies, and medical anthropology. In the field of folklore, researchers have worked extensively on the topics of health and medicine, but have rarely focused on contraception. Biologist Mariamne Whatley's and folklorist Elissa Henken's *Did you Hear about the Girl who…? Contemporary Legends, Folklore, and Human Sexuality* (2000) extensively discuss the folklore of contraception, positioning folk belief about sexuality as a tool for improving the efficacy of teen sexual health education. At East Tennessee State, interdisciplinary masters student Emily Dale completed her 2006 thesis on "*Folk Medical Beliefs and Practices Concerning Women's Health and the Female Body in Southern Appalachia."* Her work explores Appalachian women's beliefs regarding menstruation and contraception through ethnographic methods. Dale's informants, ranging in age from 19 to 99, named contraceptive methods such as the Pill, placing vinegar-soaked moss inside the vagina, and drinking turpentine. Dale reports that she consistently found that "the topic of the female body has proven to be unmentionable, not only in public but also in private family settings" (Dale 2006, 8). This taboo may account for the relative silence of the humanities on this topic.[2]

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[2] Indeed, when I gave a presentation on my research at a recent academic conference, one audience member was discomfited enough by the mention of abortion that she verbalized several distracting and clearly personal comments about the procedure. Issues surrounding women's health remain a sensitive area in American society.

Folklorists specializing in reproductive health, such as Robbie Davis Floyd, have focused largely on childbirth. Their work, along with that of feminist medical anthropologists, has provided theory and language for the problematics of authoritative medical knowledge and the female body. Folklorists such as Diane Goldstein and Sandra Dolby-Stahl have informed my interpretation and use of narrative, and Katherine Young's concept of bodylore has provided a framework for analyzing the role of the body in participants' stories.

Theoretical discussion of the body ranges widely across disciplines. While many scholars have credited Marx, Foucault, and Bourdieu with historicizing, theorizing, and politicizing the body, anthropologist Rayna Rapp argues that feminists' work on bodily experiences of fertility, aging, and illness has formed the cornerstone of this scholarship (Rapp 1991). While feminist work on widely researched topics such as AIDS narratives, new reproductive technologies, and midwifery only touch on the topic of contraception, they do provide frameworks for integrating feminist theory, personal narratives, and health belief systems.

In my discussion of reproductive technologies, I use a Foucaultian lense to understand the historically naturalized hierarchies of the medical model within a more dynamic model of power and resistance. While both the biomedical system and the individual actors within it may operate under normative ideologies that render the body of the patient as a space of control, within this space there are also multiple and ever-changing sites of resistance. I also use critical theorist Donna Haraway's cyborg theory to analyze how biotechnologies both embody and enforce social relations for women (2004). Advances in contraceptive technology have continued to blur the difference between machine and organism, as gynecologic care, sub-dermal and intra-uterine contraceptive implants, and the increasingly successful manufacture of human hormones exemplify the ways that biomedicine transforms women's bodies and renders their boundaries newly permeable (Haraway 2004, 28).

Anthropologist Tine Gammeltoft, who researched contraceptive narratives among Vietnamese women, uses Haraway's cyborg theory to analyze the uses and meanings of contraceptive technology. This technology mediates and transforms social relationships, bodies, and subjectivities by shaping new modes of agency and new forms of social relations. At the same time, contraception is often deeply embedded in ongoing issues of power and control (Gammeltoft 1999). Like Gammeltoft, I look to the social, economic, and political conditions under which participants choose and use birth control. I examine how these technologies act upon the women's bodies, and how these technologies are used by the women themselves to affect their surroundings.

In considering hegemonic ideas about the body, and especially the female body, I turn to feminist analysis of Western scientific discourse. Medical anthropologist Emily Martin argues that the language of biomedicine is historically "infused by cultural assumptions" that devalue female reproductive processes and, ultimately, devalue women (1987, 27). Feminist scholar Susan Bordo adds, using concepts from Foucault, that these views of the body enforce "docility and obedience to cultural demands" (1993, 27). Martin's analysis of medical metaphors and Bordo's analysis of embodied resistance are important for my discussion of both individuals and systems.

Research Activities

From February to August 2017 I conducted interviews with 21 college-educated American women who related their current and past experiences with birth control. I also interviewed a University health provider who had been working in reproductive health for 28 years. In addition, I examined posts on two online public fora, “CureZone” and “Susan’s Table,” which feature community discussions of women’s experiences with several intrauterine birth control methods. I received IRB approval for this project in July 2017 (Protocol #05242017.030). In this thesis and in my records I have assigned pseudonyms to all participants to protect their privacy. The majority of interview participants were students at the University of Oregon, where I had provided my contact information on flyers and handouts around campus as well as a sign-up sheet in an undergraduate Anthropology class. Other participants, who lived elsewhere in the United States, responded to online announcements I made within my own social circles. Interviews lasted from 28 minutes to 57 minutes with an average length of 45 minutes. I conducted interviews in person with participants who lived in Eugene, and conducted them over the phone with the out-of-state participants. I interviewed local participants in the UO Folklore graduate student lounge, elsewhere on campus, at coffee shops, and in homes. In total, I recorded 892 minutes of interview audio.

All of the participants identified as heterosexual cisgender women, and ranged in age from 18 to 41 years. Of the 21 participants, three identified as Hispanic or Latino, thirteen as White, one as Asian, three as Black, and one as Other/Mixed. The ratio of racial and ethnic minorities in this sample fell short of my goals, as I was unable to connect with more participants before beginning the process of coding and analysis. As

Gwendolyn Etter-Lewis writes in “Black Women’s Life Stories,” many scholarly projects focusing on women fail to represent women of color (1991, 43). Doing research exclusively with white people promotes white normativity. I spent time doing outreach to connect with more women of color who would be willing to discuss birth control, but these contacts stalled over time. After I began to focus on coding, analysis, and writing, I could no longer spend time pursuing potential interviewees.

I began interviewing women about their experiences with birth control as a part of my coursework for UO’s Folklore Fieldwork class. For this initial project I first interviewed a friend of a friend, Jennifer, and then a women’s health nurse practitioner at the UO student health center. I used the initial interview to refine my questions and interest areas. The local health provider, Elizabeth, works directly with my desired study population. Elizabeth provided her perspective on the kinds of medical experiences and health services UO students were receiving. I then made contact with 17 undergraduates through a study sign-up sheet that a friend circulated in her anthropology class. Ten of these seventeen students followed through with communications and meeting for interviews. These undergraduates from the Anthropology class formed a relatively homogenous group, with all ten identifying as women and almost all as white or Caucasian.

My main line of inquiry throughout interviews was: How do participants think about their health in the context of birth control? How are they willing (or unwilling) to alter their bodies for the sake of preventing pregnancy? How do they express agency across the contexts of reproductive health, and who or what figures in reproductive decision-making? Although my specific interview questions evolved over time, these questions always provided a guidepost for my inquiries.

Guiding questions for interviews included the following:

- What birth control method are you currently using?
- How do you feel about it?
- What has been your experience with side effects?
- How/why did you choose this method?
- What others have you used?
- How/why did you decide to stop using/not to use?
- What have you heard about other methods?
- What would be your ideal method of birth control?
- What is it like seeing doctors about birth control?
- What have you shared with other women about your experience with birth control methods?
- What have you shared with your partners?
- Why do you share your experience?

Because I elicited stories about these topics in interview format, rather than gathering them through participant observation, the narratives are likely different from how they may be told to a partner, family member, provider, or friend. Indeed, a few participants told me they did not often express the level of detail and explanation elicited in our interviews. These participants did note, however, that they enjoyed having the opportunity to do so. Folklorist Patricia Sawin notes that her interviews with singer and storyteller Bessie Eldreth circled naturally around shared experience as a gendered subject, although Bessie did not usually reflect on this topic among family and friends (2004, 15). Similarly, I felt that my interviews with participants evoked a sense of intimate camaraderie in which participants “took advantage of the particular discursive space created by my questioning… to explore facets of [their] experience that [they] had not often been given an opportunity to talk about” (Sawin 2004, 15).

Positionality

I am college-educated, identify as a woman, do not have children, and am young and white. I noticed that I especially enjoyed speaking with participants who were, like me, from the South. For my own contraception I use a hormonal IUD, called the Skyla, which was placed in 2016 and lasts for three years. I have not experienced any negative effects from my IUD and appreciated the counseling of my provider in Florida who recommended and inserted it.

I originally became interested in narratives of reproductive health because I had noticed the way that information about this topic spreads informally from person to person through stories, rumors, and cautionary tales. I’m especially interested in the way this process can sometimes inform a patient’s decision-making more than their own doctor’s advice. I had noticed this both in my personal life, as a woman using contraception who often discusses the topic with friends, and in my past jobs as a health educator working in women’s health. Across these contexts, narratives about birth control seemed to be an important part of medical decision-making and experience, but no folklorist had yet explored them in depth.

As a “folklorist” conducting such research, my identity evoked concerns among participants that I was looking for “things that aren't true,” and that I wished to represent them as uneducated and anachronistic. While the ‘folk’ of folklore are often popularly understood as “‘others’ viewed at a distance,” folklorists understand folklore as a part of every individual’s life, and often work within their own cultural group (Whatley and Henken 2000, 5). Many participants’ stories and beliefs paralleled my own feelings and experiences. I was not looking for the quaint worldview of an exotic ‘other’ to be analyzed from the outside, but for the same patterns I had always noticed as I chatted and commiserated with my own friends and clients.

My questions about pharmaceuticals also led participants to presume that my research was concerned with factual accuracy rather than personal narrative or beliefs. For example, after listing every prescription method she had ever used, Amber said, “I’m nervous that I might be reaching the end of my memory here… I don’t want to miss [anything].” Subjective commentary and stories of personal experience often surfaced later in interviews, after a relatively formal and often impersonal recounting of prescription brand names and durations of use.

Trans-Exclusionary Language and Polyvocality in “Women’s Health”

As I analyze women’s experiences with birth control, I acknowledge that my attention to patterns tends to erase difference and mute polyvocality (Haraway 2004). No category in this project is monolithic, from individual experience to institutions as a whole. Where I generalize about “women,” I am totalizing a diverse range of people, bodies, and experiences. When asked what my thesis is about, I often say “women’s health," but it is both heteronormative and cisnormative to frame the topic in these terms. Many people who need and use birth control are not women; conversely, many women do not need or use birth control.

In my discussion of contraceptives in this introduction, I use inclusive language that frames users in non-binary terms. In my discussion of my own research, I have used language reflecting the interviewees as a group: all participants identified as women, and spoke only of men as sexual partners.

Participant Quick-Facts

Pseudonym	*Race/Ethnicity*	*Age*
Elena	Mexican-American	25
Serena	White	25
Vanessa	Black	30
Kimberly	Filipino/Asian	28
Jennifer	White	37
Miranda	White	34
Brianna	White	23
Ava	Mixed/Other	25
Madi	White	20
Lana	White	42
Mia	White	28
Gina	White	18
April	White	27
Amber	White	20
Thea	White	33
Haley	White	19
Rachelle	Black	29
Lucia	White	19
Andrea	Latino/Black	27
Natalia	Mexican-American	18

Birth Control Policy in the United States

I began this project in October 2016, when any insured woman in America was eligible to receive free birth control coverage. Following the election of Donald Trump in November of 2016, the landscape of women's reproductive health began to shift dramatically. In October 2017, for example, the federal government released a new rule allowing employers to deny contraceptive services to their employees on the grounds of "conscience".[3] The document defended the move with a reminder that affected women could still access contraception by paying for it out of pocket. It also claimed that access to birth control is not known to decrease rates of unintended pregnancy, and that "contraception's association with positive health effects might also be partially offset by an association with negative health effects."[4] The document even questioned whether fertility should be considered a qualifying "health condition" at all, but deemed the matter too "sensitive" to be decided.[5] These semantics attempt to separate family planning from health, and to normalize paying for medication out of pocket as "access." In another semantic twist, the rule also minimizes the relationship between access to birth control and unintended pregnancy by exploiting the fact that correlation *might not* mean causation.

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[3] Employee Benefits Security Administration. "Coverage of Certain Preventive Services Under the Affordable Care Act." Confidential draft released by the *New York Times*, 1 June 2017. <https://www.nytimes.com/interactive/2017/06/01/us/politics/document-Read-the-Draft-Rule-That-Could-Limit-Access-to.html>

[4] Edney, Anna. "Trump Officials Dispute Birth Control Benefits to Justify Rules." *Bloomberg*, 6 October 2017. <https://www.bloomberg.com/news/articles/2017-10-06/trump-officials-dispute-birth-control-benefits-to-justify-rules>

[5] Employee Benefits Security Administration. See above.

During the course of my research, the management of fertility became increasingly subject to state policy, employer interests, and debates about public morality.[6] My participants' concerns about their access to healthcare and reproductive rights have increasingly colored my research. Many participants explicitly framed their personal contraceptive decisions in terms of ongoing presidential rhetoric and current events in health policy.

At the time of our interviews, reproductive health was often in the national spotlight (e.g., Republican bids to defund Planned Parenthood), but no changes had yet been put into effect. Participants who relied on Planned Parenthood not only for access to birth control but for reproductive healthcare in general were especially worried about partisan action against the organization. But many participants were worried that infringement on women's healthcare would go beyond merely defunding Planned Parenthood. Madi, who had recently decided not to have biological children, said she was worried about her ability to see this goal through in the changing political climate, and felt pressured to find a provider who would perform a sterilization procedure as soon as possible: "My goal is to hopefully have it within the year, before Trump messes up all of our reproductive rights." Madi was grimly facing the unspoken and very real threat of compulsory pregnancy. Many women's fears of this rhetoric manifested as a sense of urgency to receive care while they still could. As Gina put it, she needed to plan ahead

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[6] The historical transition of contraception from the realm of female discretion to that of proscription and of prescription has served as both a symptom and a method of compounding patriarchal control over the female body. Powerful social forces such as gender norms, eugenic principles, Western imperialism, Malthusianism, feminism, and biomedical science have all claimed a stake in the control of women's fertility in addition to state-level policy (Hartmann, 1995; Ginsberg and Rapp, 1991). Tracing this fascinating and infuriating history is, however, outside the scope of this project.

for her reproductive health, as she was "not exactly sure what resources are going to be available in the near future."

In addition to political threats to Planned Parenthood or abortion rights, participants also worried about changes to the Affordable Care Act that could affect their insurance coverage of contraception. Serena, for example, shared a story about the time her insurance company dropped coverage of her prescription birth control, leaving her with a $400 charge at the pharmacy. At the time, she was able to have her provider switch the prescription to one that her insurer would cover, but this experience showed her "how expensive [birth control] could be if it wasn't covered by insurance." After the election, she said, "I made the decision to switch my birth control [from the Pill to the IUD]….when I realized that birth control might not even be free." Despite the fact that she "wasn't thrilled about having something shoved up my vagina," she was so worried by the prospect of paying $400 a month for Pills that she switched to a method that could outlast the current administration.

Elena described the situation by saying,

> The way that I see it… it's just a way to oppress certain groups of people…. I foresee a lot of women struggling with birth control in the near future… [and] that could potentially lead to some serious harm. … It's really scary to think that we could all potentially be in turmoil because of administrative decisions. And that's the scariest part of it, is that you're seriously inflicting pain on the rights of half the population.

Participants' accounts of their decision-making in this context represented a critical vernacular response to the repressive rhetoric and platforms of state power. Many participants responded with plans for insertions and ingestions of new contraceptive measures as they physically and mentally prepared to lose their reproductive rights. In this way, participants expressed disapproval and fear of negative changes to reproductive health policy through not only their narratives but their bodies as well.

Birth Control as Biotechnology

As the stories above reveal, reproductive biotechnologies are never neutral. These technologies necessarily reflect the interests and values of those who develop, provide, use, and debate them. Prenatal screening for Downs or spina bifida, for example, may be seen as an affront to disability rights, as the results of genetic testing leads to discrimination against people with disabilities in the form of selective abortion. At the same time, the costs of supporting a disabled child in a publicly funded medical system may account for the general accessibility of these screenings for patients covered by Medicaid (Burden of Knowledge 1994). Birth control is similarly subject to the forces of economics, social norms, moral values, and national policy. At every level of reproduction, local and larger systems of power come to bear. Access to birth control determines who may or may not reproduce, and when they may do so. The production of birth control determines who will and will not funnel their time and money into using it. Moral debates around birth control purport to determine whether and when people are entitled to sexual pleasure, to life goals, and to privacy.

My most recent job in public health services included encouraging “at-risk” women to use prescription birth control methods to delay subsequent pregnancies by at least two years. “At-risk” meant that the women and their children were statistically more likely to suffer from heath disparities based on zip code, educational attainment, insurance coverage, and other social factors. My services were meant to promote positive outcomes for both pregnancy and infant health. Because birth spacing is correlated with positive child health outcomes, I had to counter clients' complaints about their experiences with birth control, and even their preferences in planning when their next child would be born, with exactly what was "recommended." I now realize that I was participating in a fraught history of insensitivity to women's preferences, insights, and autonomy in reproduction.

Margaret Sanger, who fought from 1916 to 1945 to legalize contraception and increase access to information about its use, began her campaign as part of a radical bid to separate female sexuality from reproduction (Hartmann 1995, 97). Over time, she sought new alliances to increase the movement's power and respectability (Hartmann 1995, 97). Medical professionals became involved in Sanger's movement, gaining full control of contraception as a prescribed medication (Hartmann 1995, 98). Sanger also promoted birth control as a tool for eugenics (Hartmann 1995, 101). Indeed, modern contraceptive measures have often been abused in poor, black, and brown communities, as well as among individuals with disabilities and the imprisoned (Hartmann 1995). These histories of contraceptive technologies deserve more in-depth treatment, but are outside the scope of this particular project.

Overview of Contraceptive Methods

Birth control is used primarily to determine whether and when pregnancy occurs. In the past, contraception was comprised of the discrete restriction of births, whereas today we see a broader principle of "family planning" (Aries 1972, 110). Available methods of contraception include hormonal and non-hormonal options. Non-hormonal options include barrier methods, sterilization, withdrawal, and fertility awareness methods. Hormonal options include the Pill, shot, ring, patch, and implant. The IUD is available in both non-hormonal and hormonal forms. Hormonal birth control methods are used not only to prevent pregnancy but also to control acne, regulate periods, minimize painful cramping, and in some cases to improve mild depressive symptoms.

Barrier methods include condoms, the cervical cap, diaphragm, sponge, and other spermicidal suppositories. Condoms are available for both internal and external use in the vagina or anus and on the penis, and contain ejaculate as well as prevent the spread of STIs. Rates of failure range from 18% for the external condom to 21% for the internal condom with typical use. Condoms are the third most commonly used method of contraception in the U.S.[7]

Sterilization can be achieved through tubal ligation, the Essure tubal implant, and vasectomy. Tubal ligation is far more common than vasectomy, although the latter is safer, simpler, cheaper, and more effective (Jayaraman and Mann 2012). Rates of failure range from .15% for vasectomy to .5% for tubal ligation. Tubal ligation is the second most commonly used method of contraception in the U.S.[8]

Withdrawal, also known as “pulling out,” relies on the couple’s ability to prevent ejaculation within the vagina. Rate of failure ranges from 4% with perfect use to 22% with typical use.[9]

Fertility awareness methods depend on tracking the ovulation cycle to determine changing levels of fertility. Some users simply count the days from menstruation, while

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[7] Hatcher RA et al., eds., Contraceptive Technology, New York: Ardent Media, 2011.

[8] Ibid.

[9] Ibid.

others document changes in the texture of cervical mucus and daily body temperature. On fertile days, the couple uses a barrier method or abstains. Individuals often track these changes through apps that use algorithms to predict fertile windows. There are many such apps available, with varying prices, reputations, and rates of efficacy. The “Natural Cycles” smartphone app, for example, is “certified in Europe to be used as a contraceptive device” and has a reported rate of 93% effectiveness.[10] Rates of failure for fertility awareness methods range widely from .4% to 24%.[11]

The Pill is the most commonly used method in the United States. The Pill and the mini-pill introduce hormones that affect fertility. There are many varieties of the Pill and mini-pill available. Users must take their pill every day for this method to remain effective. Rate of failure is 9% with typical use.[12]

The shot, often called by its brand name Depo, is a hormonal injection effective for up to 3 months. Rate of failure ranges from .2% with perfect use, to 6% with typical use.[13]

The ring, usually called by its brand name NuvaRing, is a device that the user places in the vagina. The warmth of the surrounding vaginal canal causes it to release hormones at the site of the reproductive system. This method, like the Pill, has a 9% rate of failure with typical use.[14]

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[10] https://www.naturalcycles.com/en

[11] Hatcher RA et al., eds., Contraceptive Technology, 20th ed., New York: Ardent Media, 2011.

[12] Ibid.

[13] Ibid.

[14] Ibid.

The patch distributes hormones through the skin. Users must place a new patch on the body once per week to maintain effectiveness. Rates of failure range from .3% with perfect use to 9% with typical use.[15]

The implant, also called by its brand name Implanon or Nexplanon, is a hormone-releasing plastic rod placed under the skin of the arm. It remains effective for up to three years. Because this method is entirely provider-controlled, rates of failure for perfect use and typical use are identical, and very low, at .05%.[16]

The IUD comes in several versions and is placed by a health provider into the uterus. The Mirena lasts for five years and operates by releasing hormones. The Skyla is also hormonal, but is smaller and lasts for three years. The Paraguard uses copper instead of hormones and lasts for ten years. For all IUD models, there is an added contraceptive effectiveness in the reaction of the uterus to a foreign object. With perfect use, rates of failure for the IUD range from .2% for hormonal versions, to .6% for the copper version.[17]

IUDs and implants are known as long-acting reversible contraceptives or LARCs. With these methods, a doctor inserts the device one time and removes it upon expiration.[18] LARCs have grown in popularity in the last decade, from 2% of contraceptive users in 2002 and 6% in 2007, to 9% in 2009 and 12% in 2012.[19]

For hormonal methods such as the Pill or patch, users usually must see a doctor and be given a prescription. Public policy in Oregon changed recently, allowing users to

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[15] Ibid.

[16] Hatcher RA et al., eds., Contraceptive Technology, 20th ed., New York: Ardent Media, 2011.

[17] Ibid.

[18] womenshealth.gov

[19] Ibid.

receive prescriptions and immediately obtain hormonal contraceptives at their pharmacy, bypassing the inconvenience of an added doctor's visit (Belluck 2016). This policy may be enacted elsewhere in the U.S. in the coming years. User-controlled methods such as withdrawal and fertility awareness are entirely at the user's discretion, requiring no prescription and no visit to the doctor.

Overview of Thesis

My argument travels from micro to macro, beginning with individuals and groups, and ending with the institutions surrounding them. I begin by tracing notions of embodiment in participants' narratives about birth control. Next, I explore participants' shared health beliefs and practices, with an eye to how they interact with medical authority. Finally, I discuss threads of institutional critique found across participant narratives. With this critique I include counterpoints from feminist healthcare and from participants themselves who have shared their vision for improving doctor-patient interactions, pharmaceutical research, and other social systems related to reproductive healthcare.

CHAPTER II

BODYLORE

All birth control narratives that I documented involved specific reference to the body. Participants' stories articulated experiences of being a body and of having a body, as well as categories of health, illness, and other concepts related to the body. Across participants' narratives, the body served as a site of contestation and control as well as a site of self-determination.

Kathy Neustadt writes that folklorists and anthropologists have historically tended to distance themselves from the body, both their own and those of their subjects (1994). It was not until the early 1990s that folklorists, informed by the burgeoning role of body studies across academic disciplines, began to devote attention to the body and its roles in vernacular culture. Beginning with conference panels and culminating in a book by Katherine Young, "bodylore" became an important new analytical lense for the field. Folklorists worked to expose the social construction of the body by exploring how it is shaped by discourse, by culture, and by worldviews. This scholarship focused around physical inscriptions on the body and taboos on bodily processes, which folklorists used to show how culture shapes the ways we experience ourselves. I adopt a similar framework in tracing how the bodily phenomena of birth control are constituted in cultural lore through stories, beliefs, and behaviors.

In this chapter I begin by examining the ways participants described their experience of embodiment. I close by analyzing the ways participants discussed the body as a concept beyond individual experience. Sociologist Deborah Lupton writes that embodiment, the sense of "both having a body and being a body," is applied through daily life to human perception, knowledge, and identity (2003, 50). Participants' narratives about medical care, sexuality, and self-determination showed how the body and bodily processes are personified, mystified, dissociated, gendered, sacrificed, and otherwise experienced in their daily lives.

Dualism: Body and Self

Experience of the body as an entity separate from the self was one common theme in the narratives. Participants sometimes portrayed their bodies as "doing" things that could be "crazy" or "scary" as they themselves experienced them. The body was also said to like or not like things, and to reject what it didn't like. In many narratives it seems to have its own preferences, priorities, or sense of justice. The body takes its time getting accustomed to new prescriptions, or requires the aid of its owner to "do what it was meant to do," either by being left alone and protected from medical intervention, or by being given a "kick-start" with pharmaceutical or alternative medicine. Miranda used her birth control for both pregnancy prevention and acne control, which she framed as "helping [her] body do what it's supposed to do."

In still other cases, the body figures in the narrative as a sort of object over which the woman presides in her decision-making about fertility or medical care. Participants referred to the body or body parts with quips like "I don't know if it's her uterus that rejects [the IUD] or just her body entirely rejects it, but she had pretty intensive bleeding" (Gina), and "I feel like lately my vagina's not been liking condoms" (Andrea). Miranda, going off the Pill after a divorce, said, "okay body, you get a break now."

This language presented the body as a personified if not sentient entity with some degree of agency or even negative intention towards the person herself. The body is sometimes as an actor and sometimes a prop, but in every case it figures as a separate entity from the woman herself. Susan Bordo has shown how Western philosophy has long framed the body as “not ‘me’ yet inescapably ‘with’ me,” and how this ideology of mind/body dualism has formed a “practical metaphysics” internalized by law, medicine, art, and by women and girls in their construction of the self (1993, 12). Dualistic separation of the body from the self — the sense of having a body as opposed to being one — has been a historic and recurring theme of Western embodied experience.

April, who began taking birth control as a teenager to manage heavy bleeding and cramping, exemplified this sense of separation in a story about her first experience with the Pill. While using it as an effective medication for her menstrual discomfort, she also suffered from the Pill’s side effects. Discussing her thoughts at the time, she recalled,

> My mom always said [that] this is why girls have periods, because it’s Eve’s punishment for the original sin, and for her bringing Adam into it. And I wonder if that [idea of punishment] was in the back of my head too, like, I’m taking this medicine to alleviate my suffering, and now my body *knows* [that I’ve evaded the punishment]… it’s this whole, you know, retaliation kind of thing.

After experiencing the Pill’s negative side effects, April went off the medication. When she later became sexually active, she felt she had no remaining options to prevent pregnancy, saying, “I was young, and I’d never had these conversations, and I thought, well, I don’t get to use birth control, because my body doesn’t like it. So I’m just kind of on my own to figure it out.” While April would have liked to enjoy the protection birth control could have afforded her, she believed this choice was not available to her.

This story illustrates the power of dualistic thinking in the context of women's reproductive health. Because April perceived that her body had an immaterial aversion to the birth control that she herself needed, she went without. She later suffered from an ectopic pregnancy. I often heard stories of the body and the self doing, feeling, or desiring things differently, as they do in April's story.

Lucia exemplified this sense of dissociation in a different way when she expressed to a health professional her discomfort with the number of IUDs she'd had inserted and removed. Describing her worried exchange with a health provider, she said,

> I was just like, I feel terrible for my body, because I've had one inserted and then I had it removed, and then I had another one inserted, and then I had that removed, and the same day inserted another one. And I'm just like, my poor little body! I [must be] hurting [it]. And she was like, 'No, it's fine. It might tear a little bit, but your body's fine. You know, it's not this terrible thing you do to it, and your body's going to deal with so much more in life that [this is] the last thing it's really concerned about.'

While the body doesn't act as a character in the same way that it does in April's story, Lucia's pitying exclamation of "my poor little body!" sounds like the exclamation of an onlooker or outsider to the body. The health provider in this story, incidentally, also portrays the woman's body as a separate entity. The body is ascribed a built-in ethic of endurance (presumably looking towards future labor) that is not ascribed to the woman herself. While the idea that there might be things the body is or isn't concerned about is a stylistic trope, it is telling that a health professional used this trope in her explanation. Anthropologist Robbie Davis-Floyd has similarly written about the ways that obstetrical procedures work to alter women's perceptions of their birth experience by separating individuals from their laboring bodies (2004).

The Body Mystified

Many women expressed a need to "keep my body guessing" when using birth control for reasons other than or in addition to contraception. Because they felt that their body became less receptive to the desired effects of any given method over time, they felt they needed to switch prescriptions often to maintain their management of menstrual cramping, flow, or acne. These women articulated a sense of their bodies as being fickle or poorly behaved, ascribing the body a level of sentience and separation from the self. Nevertheless, they were speaking confidently about what their body was and wasn't doing – which was not the case for all participants.

Susan Bordo has shown that the medical model casts the body as a "purely mechanical, biologically programmed system" that can then be naturally "quantified and controlled" (1993, 66). This dualistic view of the body allows for a level of description and classification that renders the body "transparent and accessible to the qualified specialist" yet "opaque to the patient herself" (Bordo 1993, 66). This notion of opacity was a common theme during interviews, such as when women referred to a sense of confusion about their fertility cycle. When Mia was prescribed a version of the Pill called Seasonique, which spaces menstruation to once every 3 months, she was uncomfortable with the idea of going so long without a period, saying, "I don't know what happens to any of that in your body – it just sits there? It just seems natural to have that expelled every month."

April, who also took Seasonique for some time, felt that

> [The blood] was something that was always there, that just needed to come out every once in a while, because it was a bad thing that would make me cramp and make me sick… And so to think, oh god, well what's going to happen if it stays in there forever?… I had no idea how it worked, and didn't, until I was over 21.

At the time of our interview, April was in the process of trying to conceive, and had begun charting her basal temperature and cervical mucus as well as using ovulation strips, which she said had given her a greater understanding of her own reproductive processes and allowed her, as a result, to feel “more relaxed.” Reflecting Bordo’s claim that biomedicine enforces a monopoly on understanding the body, April called her use of basal temperature and ovulation strips “putting all this science into it,” showing that scientific knowledge provided the ultimate access-point to her own body. Nonetheless, April contrasted her new sense of knowing her body with “boxes that come with instructions” that are “standardized.” This suggests that she perceived institutionalized ways of understanding the body—the diagrams that come in the tampon box or the posters on the wall at the doctor’s office—as obscure. She differentiated this provider-controlled, universal knowledge from her own individualized, self-controlled cooptation of scientific knowledge.

Madi, too, seemed to confirm this sense that a medical approach to the body can make it more difficult to know or understand one’s own embodied experience. After being diagnosed with diabetes, Madi felt she couldn’t or shouldn’t try to determine what side effects she might have from her new form of birth control, as it would be impossible to accurately say whether it was the disease or the device that was the source of her discomfort. The medical impulse to pinpoint and to standardize—to determine what is the singular effect of a singular source—left Madi, at the intersection of her individualized health conditions and needs, unable to assess her own bodily experience.

For many participants, there was also a sense of not knowing what one's own body was "really" like because its true nature had been obscured by medical intervention from an early age. Women often described first periods that were irregular, heavy, or painful. It frequently happened, then, that their mothers were so concerned that they sought a doctor's opinion. Providers almost always responded to women's complaints of irregular, heavy, or painful early periods by giving them a prescription for birth control as a treatment to regulate their period duration, cramps, and flow. Most stories then ended up like this one from Ava, who said,

> Well, I have been on contraceptives since I was thirteen years old. I went to see a gynecologist about that time because I started my period, and it lasted for about fifteen to seventeen days, and my mom was concerned. So, because of that, and then the sporadic periods that I had afterwards, that were just as lengthy, they were concerned that I might have polycystic ovarian syndrome. So they put me on birth control to regulate my periods, and I was on the pill from thirteen to, oh gosh, probably twenty-one?

Ava remained diagnosed and treated for polycystic ovarian syndrome (PCOS) for nearly a decade before switching providers and finding that she did not, in fact, have PCOS. While being on the Pill was important when she became sexually active, this diagnosis and treatment also served to obscure her body and the status of her health for many years.

When listening to these stories, it often occurred to me that my own period was irregular when it first began but settled into a mostly predictable pattern after the first year. Had I revealed my initial irregularities to an adult (being parented by a single father, I never would have), would I, too, have been medicated for something that eventually resolved without medical intervention? To that point, a local women's health provider, whose commentary I will later provide in greater depth, noted that birth control has been increasingly prescribed for young girls with irregular menses. While irregularity is widely understood to be common in the years after menarche, providers are aware that young patients sometimes do not think ahead before becoming sexually active. Hoping to provide access to contraception before that point, some providers may prescribe birth control to young girls for irregularity, regardless of whether this may resolve on its own.

While it would be impossible to know whether the participants who went on birth control at 12 or 13 to manage their periods might have found that their irregularities were only temporary, many women expressed a sense of unfamiliarity with their bodies after so many years of being medically managed. Having begun a prescription regimen at menarche, women expressed sentiments like wanting to experience "a real period" or "want[ing] to see what [their] body was like without hormones." Drawing ties to medications that treat the symptoms instead of the disease, April said she has "sought intervention for so long" that she doesn't know what's normal or natural for her cycle or her body.

Lucia reported being distressed not only by the ways her birth control had so mysteriously affected and obscured her body, but by the lack of explanation from her doctor when she brought up these concerns. "It's just concerning not to know exactly what is going on inside my body for it to [do this]. Because, I like to have reasons… and [to] know why this is happening, and if it's okay…[because] I've had [birth control] for so long that I don't really know the difference."

This tendency of medical care to obscure the body and its workings was just one of many ways the body was portrayed as hidden or mystified. Many of the women reported that family members avoided discussing women’s health and the body, or that the topic was dismissed as gross. When asked about sexual health education in school settings, nearly every participant reported that they were taught almost nothing of substance during sex or health ed.

Fragmentation

At the same time that the nature of the body and embodied experience may be obscured for the woman herself, she may also engage in some degree of what Susan Bordo calls “dissociated self-surveillance.” Bordo writes that women’s internalized dualistic cultural ideologies and assumptions are often expressed through a detached, appraising experience of the body. This then leads to a “fragmentation and alienation in women’s general conceptions of body and self.” Bordo writes that this fragmented experience applies to many of the physical events associated with the female body, such as labor, menopause, or menstruation (1993, 89).

Serena exemplified this fragmentation in her feelings towards menstruation. “I want to get [a method of birth control] that will stop my period. Because I’m starting grad school and this is just something annoying that happens to me every month, and it would be kind of nice if I could eliminate this expense of tampons, and just, you know, everything else gross that happens to me.”

Kimberly, however, had a different view about losing her period due to hormonal birth control. She noted that after being accustomed to menstruating “like a normal body, like a woman’s body,” she felt that losing her period “distorted” her body and made her feel as though she were “not a woman or something.” In this case, Kimberly felt alienated from her identity by these changes to the body. For both Serena and Kimberly, the physical events of the body failed to correspond to their own self-concept and internalized values.

Body Horror

Many of the women's narratives communicated a sense of detached helplessness as the body was invaded or harmfully altered by their method of birth control. At its most mild, this sense is described in terms of things happening to the body that 'freak out' or 'weird out' the participant herself. For example, when April shared the story of her Implant's insertion (see Introduction), she exhibited a tone of detached fascination, her eyes wide as she described her feelings after the insertion.

> It's such a strange feeling to have had something injected into my body. And they told me, don't break it in[side] your arm, 'cause then it could release. They gave me a card that had the number of my Implant. And they said, if you ever need it, this is the number of your specific Implant. And this is the factory that makes it, if they ever need to go back and collect anything from you. I kept it in my wallet. It was just the strangest thing.

Reminiscent of Donna Haraway's discussion of the cyborg, April's story shows how she experienced her body being fundamentally changed by contraceptive technology. While April's only explicit commentary on the life-altering experience was that it was 'strange,' her narrative reflects the unspoken and deeply troubling possibility of the device malfunctioning within her flesh, or being entirely lost within her own body.[20]

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[20] This is a documented possibility described in commercials for the device, which warn that removal of the device from the body, in these cases, would become "impossible."

Many of the women seemed to linger in this way on the grotesque or frightening aspects of their tales. To describe this range of narratives, I take the term 'body horror' from my colleague Kirk Peterson, who, after hearing about some of my findings in the initial stages of fieldwork, said he was reminded of the body horror film genre. Exemplary films of the genre include *Teeth, Body Melt, Under the Skin,* and *Akira*, all of which are characterized by themes of bodily dissociation and mutilation.[21] Often, body horror storylines feature a parasite visibly growing within the body, or the body beginning to rot while still alive.

In the context of my own work, I use body horror to refer to a sense of contraceptive technologies invading, altering, or harming the body from within. This may be identified with the side effects of birth control or with the physical birth control device itself. At the same time, I use body horror to describe a sense of powerlessness to stop this process, as well as a dissociated experience of side effects and pain. Stories of body horror are marked by grotesque details about the ways the body was altered and harmed. Sometimes these stories are told about a person at several removes from the narrator herself. In these cases, the stories may be likened to contemporary legends, which relate bizarre or unnatural events and circulate within social groups. Melissa Henken and Mariamne Whatley write that such stories "reflect with particular clarity the current fears and anxieties of a group and serve as warnings about potentially dangerous situations, behaviors, and assumptions" (2000, 2). Such storytelling not only entertains, but conveys a particular set of messages about pharmaceuticals, health, and medical care.

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[21] The term was first coined in the "Body Horror" theme issue of the University of Glasgow film journal *Screen* in 1986.

Body Invasions

Many of the woman expressed a fear of IUDs and Implants because of their internal placement. Haley, who did not have an IUD, said she was even “freaked out” by the idea that her *roommate* had an IUD. She said that whenever she was with her roommate, she would reflect with dismay that “there's something inside you right now.” Many of the women expressed this sense of invasion when discussing the IUD. As Andrea put it, “I really don’t like the idea of having a thing inside of my cervix.” In this case, “thing” seems to suggest the otherness of the IUD – foreign to the cervix, to the body, and to herself.

Thea gave more detail about why the “idea” of having something inside the body was so alarming. She said that when she had her Mirena IUD placed, “it just made me anxious having it in there. It’s not something I can see or feel like every day. It’s just this piece of plastic in my body… It was kind of like paranoia I guess.” She described the IUD like a body part of which she could have no bodily awareness. The IUD had physical form, but she could only conceptualize it intellectually, rather than through sight or touch.

April, who ended up keeping her Implant for far longer than she preferred, experienced increasingly extreme side effects over time, describing a sense of invasion by the device. As she said,

> It was just this foreign object that I didn’t know anything about. I could stop taking the Pills [if I were using the Pill instead of the Implant], but [the Implant] was just a whole other thing. It felt like I was invaded – I wanted it out, and I couldn’t [get it out]… It felt like an alien. I know that sounds crazy, but it’s like, in my head… this medicine is bad for me, and it’s doing awful things to my body, and it’s making me feel pregnant… I’m not saying I felt like I was pregnant by a alien, but… if this medicine’s making me feel that way, then what’s in my stomach?

Because her provider was not willing to remove the device, her sense of being invaded was compounded by a feeling of helplessness to avert the increasingly negative effects to her health.

The Grotesque Body

Amber explained her contraceptive decision-making process by saying, “Even to get an IUD, you have to be dilated and things like that, so they have to change your body to even place it.” As for the Implant, which she currently uses, she said, “It’s like if you’re getting your ears pierced, and they slide it, so that it surgically goes under your skin, and you can feel it, and I have a little tiny scar here from it.” Many of the participant’s narratives seemed to linger on the grotesque in this way, with abstracted attention to detail about the pain and bodily harm associated with birth control. The sense of physical vulnerability to bodily invasion is a well-documented aspect of American cultural disgust, which may account for participants’ tendency to link stories of invasion with grotesque details of its effects (Lupton 2013, 9).

Participants’ narratives described persistent and chunky bleeding, diarrhea, digestive problems, migraines, hemorrhaging, cramps, chest pains, heart palpitations, weight gain, depression, breasts so sore they could never remove their bra*,* strange discharge, cystic acne, loss of libido, and more. Another participant warned that the copper IUD could “implant itself further into your uterus, kind of like burrowing into the organ.” Haley told a story about a girl in her dorm whose birth control “made her hair really greasy, and her skin just broke out, she was gaining weight, she was just going crazy about it… I think her *hair* was turning a different color. It was gnarly. I think – oh yeah! – She had a lot of break-outs on her back, so she broke out on her face *and* on her back." Participants' narratives presented a fantastical and sometimes bizarre array of danger and suffering. Such symptoms in many ways represent the body at its most grotesque: the vulnerable, physical, decaying animal body, the body breached by bodily products, and the irrational, uncontrollable, and anomalous body (Lupton 2013, 11).

Storytellers usually treated the horrifying details of an experience with the utmost drama and awe, and characters in their stories often faced down death itself. In one story about a friend of a friend's IUD, for example, "it ended up going into her cervix, and her cervix grew around it, and she had to go to the hospital. She's not able to have kids anymore. She's never had any kids. And it almost killed her." In one story, a friend's IUD was "heading towards the uterine wall" where it was bound to rupture and cause infertility or, as she "presumed," death. When IUDs weren't almost killing people, they were at the very least causing unspeakable pain. Lucia said that in the minutes after her IUD insertion, she "couldn't breathe, couldn't see, and [she] was dizzy with pain."

Body Dissociation and Powerlessness

Participants sometimes created distance between experience and event when discussing the negative effects of birth control. For example, April described a sense of dissociation when having her Implant removed, saying,

> I went in and he deadened my arm, and it took three different people to get it out of my arm, 'cause it had gotten underneath some tissue, and they were having to pick the scar tissue off around it. I could hear popping noises, and it was numb, so he just told me, don't look over here, and I was like, okay. And so he just kept digging, and I could feel the pressure of him digging, but it was numb, and he finally pulled it out, and it sounded like a rubber band popping… I still have a little bit of a scar, and

> for probably the first month [after the removal], there was a pocket, that I could feel in there where my skin was still separate.

April's sensory experience of what was happening to her arm was so removed from her sense of self that the procedure, though apparently going horribly wrong, became nothing more than popping noises.

Miranda, discussing her preference of the NuvaRing over other birth control options, said this of the Implant:

> I get weirded out, because in the commercial it says 'it should be above your muscle and underneath the skin; if you can't feel it, go to the doctor.' I'm like, 'I don't need anything moving around [gestures 'inside'].' I don't really want a foreign thing in my body, like, permanently. If I start feeling uncomfortable or start feeling like something's wrong, I can take the Nuvaring out easily. Where with an Implant, there's a doctor's appointment and stuff.

For Miranda, provider-controlled devices such as the implant allow the patient less power to act quickly when, through bodily experience or even through instinct, she becomes aware that there is "something wrong" happening in her body. With the time it may take to procure an appointment for removal of an implant or IUD, the patient may at times end up functionally stuck with them. This was the case for more than one participant whose providers were resistant to removing the devices despite their request. This aspect of their experience added a sense of powerlessness to narratives of body horror when participants experienced negative side effects from a device they were unable to remove.

Narrative Functions

From personal stories of body horror to third-hand stories of near-death and pain, many of the women's narratives seem to function as cautionary tales. Some women acknowledged that what worked or didn't work for their own bodies had no bearing on the possibilities for someone else's, but many of the women included an explicit directive for *me* to avoid a method myself. I can think of many times this has occurred naturally among women in my personal life. A cousin at Christmas once overheard I'd gotten an IUD and launched into a story about her own experience with the Mirena, concluding with a warning that "I wouldn't have it if I were you." A stranger in the parking lot once implored me to never get the Essure, and described her health complications and her lawsuit against the Essure company at length.

Beyond their function as cautionary tales, I believe participants' stories articulate a larger group belief related to the disproportionate physical burden of contraception on women in American society. Tine Gammeltoft, who worked with rural Vietnamese women to understand the social, economic, and political conditions that contextualize their negative physiological reactions to birth control, has shown that women's experiences with the IUD are in many ways experiences of gender (1999). For her participants, their gender was associated with physical overwork and social submission. Gammeltoft argues that pain, discomfort, and other health problems as women experience them with the IUD are socially and culturally shaped. In a society where expressing negative feelings brings unwanted social tension, experiencing and discussing birth control side effects are a 'safe' way to perform distress. Using the work of James Scott, Gammeltoft writes that being physically weak from the side effects of birth control becomes, for the women, a form of power. IUDs are inserted into their bodies in a deeply layered context of oppression, and the health problems associated with this practice may provide a way for the women to quietly object to their larger burdens (1999, 106).

While women in the context of my own study were not operating under a state-sponsored family planning initiative, many expressed a sense that they had no choice but to use some form contraception, usually in the form of prescription drugs that they may or may not consider to be healthy. Society seems to expect and accept that women hold primary responsibility for preventing pregnancy, although they are not responsible for any greater measure of sexuality and fertility than other individuals (Fennell 2011). As Nancy Scheper-Hughes and Margaret Lock write, “Illness somatization has become a dominant metaphor for expressing individual and social complaint” (1987, 27). Perhaps the women who emphasize their distrust of hormones or their painful experiences are working to critique this norm. While still accepting the responsibility of birth control, the women can also express their discontentment with the existing system by describing its negative effects in distressing detail.

The dissociative nature of some of the women’s narratives also suggests a sense of powerlessness that causes them to protectively withdraw. This aspect of their storytelling might be related to a sense of forces at odds, as the young, healthy body, in ongoing sexual relationship with male partners, is likely to conceive. The woman, meanwhile, pursuing self-actualization by managing her fertility, may feel pitted against the “natural” processes of her own body. The sense of detachment from reproductive processes suggests this dynamic of opposing purpose between person and body.

As Sandra Dolby-Stahl writes, the personal narrative itself also serves to create intimacy with a listener by revealing the “inner life” of the storyteller (1985, 47). Women who share stories about birth control, perhaps lingering on the grotesque details of their bodily experience, create intimacy by revealing an inner life that is both psychological and physical, as side effects can cause both physical discomfort and psychological distress. With around 99% of American women using or having used contraception at least once, the experience of birth control is often a shared one, making it a compelling subject for private conversation and commentary (Guttmacher Institute). From intimate connections to critiques of the social order, stories of body horror and other narratives about birth control are doing much more than relating individual experience.

Being a Body

I turn now from narratives that separate the body and self to narratives where the body and bodily processes are closely identified with the participant. There are taboos on women's bodies in cultures across the world, including in the US where menstruation and sexuality are kept hidden, while standards of beauty are kept highly visible.[22] As critical theorist Judith Butler writes, "The body is… always a phenomenon in the world…. The body which one 'is' is a body materialized—determined, labelled, understood, sexed—by the gazes of those outside (Butler 2014)." Being identified with a body, then, means that this body-self may be gendered, compromised, or controlled, even as it serves as the participants' site of self and self-determination.

While participants often framed the body as 'not self' in their narratives, many also said they felt comfortable with their body and knew it well. Their narratives suggested a sense of 'being' a body in contrast with merely 'having' one. For example, Andrea valued the Fertility Awareness method she had been using not only as contraception but as a way of "understanding [her] body." For Andrea, this function of

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[22] See See Blood Magic: The Anthropology of Menstruation, by Thomas Buckley and Alma Gottlieb (1988).

her birth control method was important because “a lot of women don’t understand their bodies. And we grow up and we’re not taught about how our bodies work. Our reproductive systems and our sexuality, a lot of people go through life not really understanding it, and [not knowing what is] normal and not normal in their bodies.” Andrea suggested that being aware of small changes, such as in mood or vaginal mucus, was an important yet neglected aspect of identity.

Participants who used the NuvaRing were also vocal about being connected with their bodies. Miranda contrasted the provider-controlled insertion of a LARC with her self-administered insertion of the NuvaRing. For Miranda, using the NuvaRing expressed her comfort with her own body. The ability to place a NuvaRing entails knowing where one’s cervix is, being comfortable inserting both an object and a finger deep into the vagina, and having confidence that the Ring cannot and will not become lost or stuck in the vagina. The same could be said of the diaphragm and cervical cap, although no participants mentioned trying these barrier methods.[23]

The NuvaRing did not evoke stories of body horror as LARC methods so often did. Participants’ experiences of NuvaRing insertion seemed to belong to another category of “sticking something in the body” than the Implant or IUD. Brianna said she wasn’t interested in the IUD because “I don’t need to stick something in my body,” but at the same time was using the NuvaRing. She had no problems wearing the Ring internally or inserting it weekly. Brianna shared that her best friend, who does not use the

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[23] Several participants reported interest in but difficulty procuring barrier methods outside of the condom. April said that when she requested a diaphragm she “got laughs.” Gina said that at her doctor’s office “information about diaphragms and cervical caps is really limited… if you ask them about that you usually just receive a pamphlet, which is what’s [already] on [the product] website, and then you don’t get anything else.”

NuvaRing, is “completely weirded out” by the idea of inserting the Ring and by the idea of leaving it inside the vagina. Elizabeth, the local health provider whom I also interviewed, confirmed that methods requiring self-administration high in the vagina tend not to be popular with the populations she serves at the U of O Health Center.

When discussing NuvaRing, Brianna also shared that her boyfriend “had heard rumors” that it was “dangerous to have something up there all the time.” Showing another aspect of both knowing and being comfortable with oneself as a body, she said she “debunked that myth,” contradicting her boyfriend with her own proprietary knowledge of what was and wasn’t dangerous for her. Lucia expressed a similar sentiment when she said, “I know what’s best for my body over a doctor any day.”

While some participants expressed unfamiliarity or discomfort with their reproductive processes and cycles, many also discussed their body and bodily processes with a sense of both intimacy and respect. When Gina described her experience tracking her cycle, she said it sometimes “skipped and shifted” but was always “doing exactly what it needs to do.” Gina also liked to examine her cervical mucus as a way of checking in on her overall health. An important consideration she brought to decision-making about birth control was how her vaginal discharge might be affected as a side effect. She said she valued this “indicator” of her health and well-being to such an extent that she was not open to considering any hormonal contraceptive options, having read online that they may alter the cervical mucus.

Outsiders and the Body

Participants who felt they knew and understood their bodies sometimes extended this into a sentiment that outsiders to the group, namely male providers and partners, were fundamentally unable to understand their bodies, bodily experiences, and bodily needs. Several of the women asserted the inability of men to relate to their concerns about contraceptive side effects because the men lacked lived experience with uterine cramping, sore breasts, and mood swings. April perceived a gendered disconnect in her doctor's lack of concern about her increasingly serious side effects from the Implant, reflecting, "[For him] to be a male and to say those things was really irritating to me…. When I would complain, [saying] 'oh it hurts,' and I would have all these problems, he would just dismiss them like, oh, that's nothing. And I was like, you've never, ever, *ever* felt this way before."

Male doctors were commonly understood to lack a basic level of knowledge about the body that the participants believed could be shared by only a fellow woman. Lucia shared a story about her conversation with a friend who had become pregnant, saying,

> [My friend] was saying, 'they're trying to give me a male doctor, and I don't like the idea of a male doctor because I'm self conscious about my body.' And I was like 'no-no-no-no-no-no-no-no [clucking with disapproval] – you shouldn't want a male doctor because a male doctor has no idea how a female body works, because he doesn't live with one. He's never had the experience of pushing out a human and dealing with contraceptives and cramps and all of these natural things that happen to women.

When participants discussed their partners, similar themes emerged. Amber said that as she has dealt with an ongoing period that started with the insertion of her Implant 4 months ago, her boyfriend has been "very sympathetic… [He is] as close as he can [be] to understanding. [But] you really can't understand an experience that you can't bodily-experience."

Self-Determination

In the preceding sections, I have shown the wide spectrum of experience women articulated in relation to embodiment, whether conceptualized as "having" a body or "being" a body. I will now trace the ways participants discussed the body as a concept separate from experience, generalized in terms of how the body should interact with medical technologies and treatment. For example, a sense of the body 'doing what it's supposed to do,' of being able to trust the body to do what is needed to maintain health, was a common theme in participants' narratives. Belief in the body's ability to heal itself is widely popular in alternative medicines from around the world (Torri 2017).

Sentiments of the self-healing body often served to articulate a sense of self-determination as well as resistance to the official medical solution. Ava, for example, took herbs to avoid an invasive medical procedure and to act on her belief in the power of her own body, of herbs, and of her own positive thinking. In her narrative, she effectively averted biomedical protocol when there appeared to be tissue leftover from her recent abortion:

> [The doctor] explained to me that she wanted me to go into surgery for a dilation and curettage, which is where they take a tool and they wipe down the sides of the uterus to remove any of that excess tissue. And I didn't feel comfortable with that. I had [just] had a medical abortion so I guess I was feeling kind of vulnerable. I [hadn't told] my mom that I['d] had a medical abortion, but I called her because, since I was on her health insurance, I wanted to talk to her about me potentially having surgery. And [my mom] told me to trust my body—so I did. I drank a lot of parsley tea, and I had vitamin C, which are things that are supposed to irritate the walls of your uterus. I luckily started bleeding before I was supposed to be in for surgery… When I came in [later] for the Implanon [to be inserted], [my

> doctor] said that I was one of the lucky ones, that their body just took care of it, rather than getting an infection… But she didn't know that I had this in my mind that I should just trust that *I* could get it to come out.[24]

Ava used her own online research to find folk remedies that allowed her to take control of her body as a site of self-determination, rather than submitting to an unwanted and apparently unnecessary surgery (Bordo 1993, 21).

Control over the Body

Many of the participants expressed discomfort with the idea of outside forces exerting control over their body. Gina said she was averse to methods like the Pill and Implant because of the way they distribute hormones, making her feel "I [wouldn't] have a lot of control" over their effects. Gina said she would feel more in control with devices like the self-inserted NuvaRing that distribute hormones locally and are and less provider-dependent. Similarly, April said that with "any sort of implant or patch or ring, I don't know the dosage, and it's not by my own hand. So it feels like I'm less in control." Methods without a tactile component decreased April's and Gina's sense of agency. Recurring narrative themes of control over what goes into the body represent the most intimate negotiations of authority. Participants' desire to be in control—to personally handle and administer their birth control—was an important part of their decision-making.

Social norms around female sexuality have also further complicated women's access and approach to contraceptive options and decision-making. Amber shared that

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[24] Sociologist Rhian Parker, exploring dynamics of power in the context of cosmetic surgery, discusses the abdication of agency once one submits the body to a surgeon (2009).

when she was a minor her mother viewed the medically unique Implant as a symbol of sexual freedom, and therefore disallowed its use. Amber’s mother preferred her to use the Pill and the Depo shot, because their similarity to other medicine and to vaccines minimized their associations with sexuality. These decisions were made regardless of which method would best meet Amber’s needs and treat her painful period.

In another example of the ways that repressive social expectations can interact with contraceptive choices, Mia described wearing the Patch as “a branding” that broadcasts the private matter of sexual activity to the world. These examples show how normative beliefs about the female body and female sexuality can mediate biomedical experience, siphoning off options for medication or treatment on the basis of what is considered appropriate for a young girl or for a woman. This ultimately serves to preclude possibilities for self-directed choice and sexual freedom.

Normativity and control over the body necessarily suggest Foucault’s theories of regulatory power, which operates by rendering bodies docile and useful within the matrix of reproduction and power (2017). Socially constructed feminine roles make the normative body useful through standards of beauty, child-bearing and child-rearing, and the care of others’ bodies (Bordo 1993, 17). The feminine body is meanwhile subjected to rules and hierarchies expressed in automatic daily rituals such as healthy eating, smart dressing, table manners, toilet habits, and, perhaps, one’s daily contraceptive regimen (Bordo 1993, 165). These regulatory norms construct the ‘embodied subject’ as an instrument of power, and the material body as a site of political control (Bordo 1993, 73). Discussion of power and the body, however, must account not only for hegemony but for ongoing dynamics of subversion, contestation, and agency. I will discuss these dynamics in greater detail in the final chapter of this thesis.

Sacrificing the Body

At the same time that many women expressed concerns about the effects of birth control, many articulated the need to use these products regardless of their perceived health effects. Participants explicitly framed their decision to use birth control as a compromise or sacrifice. Using methods that they considered not ideal, they willingly altered their bodies as the unavoidable cost of preventing pregnancy. Some simply didn't like "the idea" of using a particular method. Others endured a spectrum of side effects negatively affecting life, school, and work. As Thea said, "There's not a perfect method, so you just have to outweigh the pros and cons: better to be safe from getting pregnant, [and] deal with the side effects."

At the same time that they held clear beliefs and values about their bodies and their health, they willingly denied or ignored these values in order to prevent pregnancy. Gina, who expressed that she was opposed to "hormonal interference" with her body's "natural state," discussed her decision-making process with birth control as "just a back-and-forth between finding the lesser evil."

Many participants, although less opposed to birth control in practice, still framed their use of hormonal birth control as an uncomfortable "compromise." Madi, although currently using the Implant, said she wished she could use plants or other natural substances instead of hormonal birth control:

> I personally don't like putting like extra hormones and stuff into my body, but it's the only way birth control can be effective… I keep hearing all of the side effects

> that can happen like the long term cancer or toxic shock syndrome or stuff like that, but it's a necessary evil… [however,] I'm not sure whether or not to actually believe it… I t tend to ignore stuff like that because it seems a lot of it's really unfounded in facts… It all seems like hearsay.

This very sentiment appears in a leading gynecology textbook when discussing long-term effects: "The possibility of adverse effects from [birth control pills] has received so much attention for so long that clinicians as well as the public are frequently confused by the often conflicting reports" (Schorge et al. 2008, 110). Even as Madi's provider and she herself would assert that there is little documented risk involved in hormonal contraception, she nonetheless reports a sense of uncomfortable compromise in "putting stuff in my body," regardless of the risk it may or may not present to her health.

As Mia put it,

> It's like you have to have something in your body or have to be consuming something in your body, and both of those things have certain – I don't want to say sacrifices or consequences necessarily, but you accept that you have to do these things to protect yourself from pregnancy… You make the sacrifice that you know you have to do this thing to achieve this other thing and so you're like, oh, pumping hormones in my body to not get pregnant? Sure. I guess. I don't know.

Kimberly framed this sense of sacrifice in terms of having no other choice from the subordinate position of being a woman:

> I'm sure it's true that all this contraception somehow affect[s] your body and the hormones, the pills, the IUD, but what's our choice? I mean, you're the woman, what's your choice? You have to decide. You don't want to get pregnant, and then of course you have to take the pill. So what else? I don't want to take the pills, I don't want to take any contraception at all, but my boyfriend don't want to [use condoms], so of course I kind of [air quotes] 'sacrifice' myself, you know.

Lucia further elaborated on the idea of compromise or sacrifice by relating it to the idea of control over oneself, one's choices, and one's body:

> It’s weird because it’s a compromise for me in my life right now… I made this choice to use hormones that will keep me from becoming pregnant because I’m not ready for a child at this point in my life… I’m kind of making a little bit of a sacrifice, or whatever. Not a sacrifice, that’s not the right word, but just the idea of something controlling my body and controlling the process of my natural hormones. I don’t know how to put it into words… I don’t like the idea, but I’ve always kind of compromised it, because I know that I would prefer hormones in my body than an abortion, or a really invasive procedure.

The fact that so many participants used words like “compromise” and “sacrifice” shows there was a clear pattern of social complaint. As they voiced concern over interfering with their bodies, they faced an ongoing dilemma: they could either use contraception, have frequent abortions, or have children. There was no ideal option, and they had no choice but to choose one. As they described this distressing reality, I thought of the research I had done into the birth control of the past, and of the future—of ancient silphium,[25] of the many male contraceptive options being researched around the world. Hormonal birth control for women is not the *only* way to achieve family planning goals. Participants’ performance of distress in their decision-making highlights the hegemonic nature of our narrowly defined options for contraception today.

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[25] In his history of contraception and abortion in the West, John Riddle describes silphium as a plant in the fennel family highly favored as contraception in the ancient world. When it was overharvested to the point of extinction, the ancients substituted with asafetida, which was proven effective as a contraceptive for humans in 1963 (1997, 45-46).

CHAPTER III

VERNACULAR BELIEF AND PRACTICE IN REPRODUCTIVE HEALTH

Folk medicine as a term and concept is an etic, academic construct, generally associated with health-related practices that fall outside the “mainstream,” and defined in opposition to “official” medicine (O’Connor & Hufford 2001, 13). In the US, “official” health systems are those rooted in standardized and scientific knowledge. Folk medicine represents unofficial or lay values and meanings such as alternative ways of knowing about the body, evaluating treatment and care, and defining health and illness (O’Connor & Hufford, 2001; 16). Often, reputations for health efficacy within these systems are based on the observation and experience of the group. This can be seen in the body of stories women shared about friends’ and strangers’ experiences with contraception, which the women then used in their own contraceptive decision-making (O’Connor & Hufford, 2001,16).

Folk medical systems usually involve “a complex interconnectedness of body, mind and spirit,” and a definition of health that “incorporates all of these aspects” (O’Connor & Hufford 2001, 19). Many of the women discussed the effects of medications as not only physical but also mental and spiritual. They discussed side effects of physical pain and poor mental health as well as their psychic distress at these unwelcome changes. Many of the women also expressed a belief that herbs and other “natural” treatments were more healthy and strongly favored them over pharmaceutical medications. This is another common tenet of folk medical systems (O’Connor & Hufford 2001, 23).

Researchers have found that the increasing number of Western patients who seek alternative medical treatment and care do so because they are dissatisfied with the health outcomes of biomedicine (Torri 2017). They may feel that biomedical health professionals are untrustworthy and that conventional pharmaceuticals are health hazards (Torri 2017). Patients may also be motivated by dissatisfaction with the dynamics of patient-provider relationships, including a perceived lack of autonomy and control over their health (Torri 2017).

The history of women's health care, specifically, reveals tensions between official and unofficial belief and practice. For example, medical and anthropological researchers in the 20th century worked to dispel, explain, and document the folk medical practice of using lactation as contraception. Numerous women across the U.S. told folklorist Wayland Hand that prolonged nursing prevents subsequent pregnancy, but the apparent polygenesis, ubiquity, and persistence of this belief did not serve to validate the practice among the scientific community (Friedman 1982, 204). Not until the early 1980s did orthodox medicine did accept that lactation could be an effective method of contraception if used in the first 6 months and without supplemental feeding. Folklorist Albert Friedman argues that the close association of the practice with much-maligned folk beliefs such as "troubled blood" likely contributed to the confusion around its effectiveness (1982, 204).

Story-Telling and Networks of Knowledge

Throughout my ethnographic study, the ways women communicated their reproductive health experiences correlated with expressive forms identified by folklorists as memorates, personal experience narratives, contemporary legends, and other genres of verbal art. These forms are understood to convey vernacular knowledge, values, and beliefs within the social group.

Participants often described the stories and knowledge of their friends, family, and online communities as an important part of their contraceptive decision-making. They used this information alongside and sometimes against more official medical information. Because the medical model attributes credibility to the scientific method and clinical trial, medical authorities may question or downplay the authority of lay perspectives and subjective experience (Goldstein 2015, 134). However, stories of subjective experience provided my participants with a way to navigate and conceptualize each method's risks for negative health effects, pain, and pregnancy.[26]

Natalia said explicitly that she would not use any method that wasn't familiar within her own social circles. "Doctors obviously know what's good for you and what's not, but… [I'm still] precautious [sic]… I think it's definitely comforting to know that I have a lot of friends who use it… And they have been using it for a long time… I probably wouldn't take it [if] I haven't heard of anyone [else taking it first]." Andrea reflected a similar sentiment when she said "I thought about the IUD for a while, because I… know of people who have gotten it." At the same time, she added, while the fact that they had used the method was encouraging, the quality of their experiences was equally important: "A lot of the stories I heard from people also kinda turned me off from that [the IUD]."

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[26] Cf: IUD insertion as described by the Mirena website: "Some women may experience some discomfort while Mirena is being placed." Cosmopolitan article from January 2016: "What Getting an IUD Really Feels Like, According to 13 Women."

The negative opinions of friends, especially when framed as horror stories, did seem, at times, to entirely dissuade a participant's choice of a given method. As Rachelle said, "I just don't want to do the birth control thing, because I've heard too many horror stories." Elaborating on the kinds of horror stories she had heard, Rachelle shared a friend's experience with the IUD, which was "lodged in too deep [so] that it caused some bleeding." Rachelle said that this story "scared [her] like crazy." Another horror story Rachelle shared was the experience of a former co-worker who had an IUD. The former coworker, she said, went months without returning Rachelle's calls. Finally, she said, "I remember she told me… it was affecting her brain.. She was feeling really low… [and] when she had talked to her OB, they decided to remove it just because she had too much hormones flying around." After hearing about her co-worker's experience, Rachelle concluded, "I was like, you know what, I don't even need birth control."

Gina, too, said that these kinds of stories were ones she heard often, and that the majority of people she knew had had bad experiences with birth control. Moreover, she said, these stories provided information "above and beyond what is usually presented to you [by health professionals]." She felt that the information about side effects and other risks that were shared through stories were more helpful and more complete than the information her doctors had presented.

Other participants, despite hearing horror stories about various methods, said they took these with a grain of salt. As Miranda said, "I've heard horror stories about IUDs either not working or coming unattached and being painful, but not anything that would push me to not [use the method myself]… I think that you have to understand that nothing is perfect, and people are going to have weird things [happen to them]. That's why they put all the [prescription label] warnings on everything."

While Miranda implied that what befalls one user won't necessarily befall another, many of the participants did not feel this way. These participants discussed making a difficult decision to use a contraceptive method in spite of the negative experiences of others, which they feared could happen to them as well. As Kimberly said, "Before [getting] the IUD… I was really hesitating… because my friend said she had her IUD, and she said it came off… And she said she tried to put it on by herself, and I guess it can't go back in… So I was worried that it [might] come off, and I won't notice it, and… then I [would] get pregnant." She finally decided to have it inserted, on the advice of her provider, despite misgivings based on her friend's experience.

Many participants indicated their awareness of a widely circulated body of stories about the various methods of birth control. As Ava said, "I feel like I do a lot of research, and I should be able to share that knowledge with people, and when people ask [about birth control], I'm like, 'Glad you asked, here's all my knowledge!'… I have [a story] for almost every method. Like, NuvaRing, [I] know somebody that got pregnant 'cause dude accidentally pulled out the NuvaRing with his penis… just weird stuff." Sharing stories and other information unlikely to be discussed in a professional medical setting provided several participants a sense of pleasure, competence, and ownership in their reproductive health.

Andrea also enjoyed sharing her knowledge, and was politically motivated to empower others by doing so. "I like people asking me [about reproductive health topics], because I love being able to help people… But also, what I know is basic. Things that I know, everyone should know. [Everyone] should have access to that information, and even [have access] to the knowledge that it's something they *should* know." Sharing information between friends, outside of the patient-provider relationship, served as a source of power.

Many participants noted that when they spoke with a provider, they were acutely aware of power differentials, and sometimes felt dismissed, rushed, or disrespected in that space. When talking with other women, however, participants noted that they felt empowered, likely as a reflection of a more egalitarian relationship and more collaborative dialogue. Gina described this style of communication among equals as a "dialogue with any woman that I can get to talk about it…. My sister and I are constantly talking about the birth control dilemma that we both feel." Their "dilemma" is rooted in their anticipation of reduced access to abortions under the Trump-Pence administration. Up to the time of our interview, Gina and her sister had been using withdrawal. When a friend told Gina's sister about using withdrawal successfully for several years, Gina's sister began to use the method herself. After a period of successful use, she discussed the method with Gina, who also adopted the method. Now they are engaged in an ongoing discussion of possible alternatives to withdrawal, feeling that they may have no recourse if the method fails. Together they have been discussing each method and whether they feel it will be good for them and their health, although they prefer withdrawal as their ideal method.

Vanessa shared a story about a friend "who was so ready to get off birth control" and was looking for alternatives to the prescriptions she had been using. Because Vanessa had successfully used fertility awareness in the past, the friend asked Vanessa for advice about this method.

> I was like, let me get with you so that we can really talk things out … [but] she never got back with me. I think she just kind of researched it on her own, and I don't really know what she researched. But then, she got pregnant with twins [laughing]. I felt guilty, because, you know, we never got back together and talked about it. I was like, oh man, and it wasn't just one, it was two.

Vanessa's story showed how confident she was in her own expertise, and how much she felt this method depended on dialogue between friends rather than impersonal research. To Vanessa, the method's failure was not a matter of efficacy, but of insider knowledge. Among friends, sharing knowledge about unofficial methods allows for the performance of competence by women who are accustomed to playing a reversed role in their interactions with providers.

It was often the case that a more experienced friend or family member mediated a participants' experience with reproductive health resources, whether navigating fertility awareness, enduring a first gynecological appointment, or figuring out which method to use. As Madi said, "My friend… went with me to get my Implant [because she] had a ton of information, 'cause she's older and had tried a ton of different stuff." From horror stories to dialogue, participants showed that choosing and using a birth control method is dependent not only on the counseling of their health provider or other official sources, but on the stories and knowledge of others in their social circles who have shared values and experience.

Medical Knowledge Online: Participants' Health Research

According to a 2002 study, fully 80% of Americans with access to the internet were using it to find health information (Goldstein 2008, 28). According to a 2003 study, this behavior is more prevalent in women than in men, and also correlates with education (Goldstein 2008, 28). The internet has blurred the lines of medical expertise as many women go online to self-diagnose, to seek health-related communities of support, to research preventive health practices, and to pass on warnings and other information (Goldstein 2008, 26). Patients are no longer the passive receptors of their doctor's exclusive medical knowledge. Lay people now have a variety of sources of medical information, both official and alternative. This allows for unprecedented levels of proactive medical consumerism and research supplementing their doctor's diagnoses and advice (Goldstein 2008, 25).

In my study, online research was a prominent aspect of participants' interface with reproductive health and medicine. Women described visiting official pages such as WebMD, the Planned Parenthood website, and pharmaceutical manufacturer websites. Other participants mentioned ordering the Pill "online from Canada," and using an app to track fertility cycles. Women also described researching contraceptive methods and side effects through online fora in addition to the more official websites listed above. They described these communities as a source of collective knowledge and experience. Lana said that within her own online communities, "Women ask, 'Who's had an IUD?' or whatever, and then I say, 'Oh, I had a good experience with it.'… I usually check in on those discussions… and usually there are a couple other people who say good things about the copper one [IUD] too. But then some people say that they hurt, so it's kind of a mixed bag."

Participants often sought out these narratives of individual experience in online communities and health fora. While doctors and other official sources may not always describe the common or typical experience a patient can expect from medication usage or illness, online communities give primacy to experience and subjective expertise (Goldstein 2008, 37). Some medical organizations have issued warnings against these sites, as they present alternative forms of knowledge that do not rely on a scientific approach (Goldstein 2008, 32). However, stories of subjective experience are the most popular form of information sought by lay people in online health research (Goldstein 2008, 32).[27]

Folklorist Diane Goldstein writes that medical professionals' warnings against these alternative sources of information construct a deficit model of an "imagined lay person" who is ignorant and unable to identify biased or unsubstantiated health information. The lay community, she argues, also constructs an "imagined expert" who cannot be relied upon to provide the full spectrum of information that a patient needs. This is attributed to the provider being biased by pharmaceutical interests, too busy to take the time to answer all of a patient's questions, or uninterested in providing information on alternative modes of healing, treatment, support, or somatization. Thus,

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[27] This concern is not unfounded. In one forum about the Mirena IUD, a user attributed a wide range of negative health effects to her IUD, but later posted that she had been diagnosed with multiple sclerosis. Although many of the symptoms she attributed to her IUD might have been related to her disease rather than to the device, her original post, rather than her update, remained the one most widely read.

lay people use the internet as a way to fulfil needs that they feel their provider cannot or will not meet (Goldstein 2008, 37).

Most of the women seemed to assume that doing online research was as necessary to their reproductive health as seeing a provider. For example, when Madi became sexually active and decided to start using birth control, she began talking to friends and going on the Planned Parenthood website, "which was super helpful [to] look at all of the options there." After completing this research, she selected a method and then went to the doctor for a specific prescription, illustrating an informed, consumerist approach. Rachelle, too, acknowledged that she would need to invest her time into this kind of research if she were to begin using a prescription birth control method. As she juggled raising her one year old, working full-time, and going to school, she decided to continue using withdrawal until she could do more research.

Elena's experience exemplified the substantial amount of energy that can go into this process. When she was interested in getting the Implant, she said,

> I really did my research, I did about two months of research just asking questions to my doctor and really looking into all the things that were a concern to me. … WebMD is always something you have to keep in the back of your mind. But I don't know how evidence-based it is, so I did go onto the manufacturer website and I got information. I made sure to read through all the side effects.

Regardless of how much research a participant said she was able to do, all of the women framed their birth control choices in terms of doing or needing to do their own research online. Several of the women specified that this research was necessary precisely because the information provided in the doctor's office was not satisfactory. Gina said that "if you're at the doctor and you ask them about [less commonly used barrier methods], you usually just receive a pamphlet… you don't get anything else, and so there's not a lot of information." And as Elena said,

> I noticed that my doctor, even though she was relatively younger… really didn't give me as much information as I was hoping for. So it was helpful for me to come loaded with questions, and they answered every single question that I had, but as far as going into depth about things that I didn't know, they didn't really do that… I think it's because of time constraints… so they're kind of like, 'come in for a certain treatment, we address the treatment, and then you're on your way.'

Yet some participants did acknowledge the value of a doctor's advice amidst the barrage of information available online. When Mia shared about the time she was diagnosed with human papillomavirus (HPV), she said, "I had to do the scary internet research, which just is awful. It's much better to talk to a professional about it, because it's a scary world out there online. I just went through the rigmarole with it, trying to figure out what the hell it was, and I finally got a good doctor here in town who really laid it out for me."

When they weren't looking at particular pages such as WebMd or reddit, participants used keyword searches to find other online health information. Ava told me that she "looked up ememogues [emmenagogues], which are herbs and different things that you can take that might induce a period or cause your uterine lining to be irritated enough to bleed… I just google, like, 'what will make me bleed' or like, 'what can start a menstrual cycle.'" Ava connected her use of the internet for self-treatment with a long history of home treatment for women's health. "Before I had the medical abortion, I was like, [dramatic voice] 'I can probably abort this myself…' [laughs]… 'cause I was like, 'people been aborting babies since before medicine came around,' so I looked up 'natural abortion.'" Ava identified herself as "the girl who spends too much time on the internet researching her reproduction."

While Ava represented perhaps a unique level of engagement with online health information, many other participants voiced similar confidence in their online research abilities. Participants' self-guided exploration yielded information far beyond lists of a method's side effects and ingredients. This sometimes included information outside of what their doctors might have accepted or approved. Thea found that "you can keep [the Mirena] in for seven years," which was two years longer than officially indicated. April found information on an obscure contraceptive side effect that she didn't initially know how to describe: "I had a flutter movement in my stomach, and I looked online and they call it phantom baby kicks." While April's doctor did not believe that this was related to her Implant, she found statements from other women who attributed their own flutter feelings to this method.

Participants also found online DIY information that instructed lay people in procedures usually reserved for medical professionals. Both April and Amber found WikiHow pages on self-removal of the Implant. Both women had turned to online research as their side effects from the Implant worsened, and their providers put off scheduling appointments for removal. April used the idea to coerce her provider into finally scheduling her Implant's removal.

Whether women are seeking out stories of personal experience, finding DIY info that circumvents medical authority, doing their own research, or asking their doctor directed questions, they are exerting control over their medical care and their health through their uses of the internet. Patients' online research presents opportunities for empowerment that are not always present within the conventional medical model. Using the internet to access a wide range of medical information, both official and unofficial, provides participants a sense of ownership in decision-making and a sense of comfort in finding shared experiences online.

This sense of autonomy, however, can present tensions in a medical model based in binaries of expertise. It is understandable that April's provider was "put off" when she told him she had found the WikiHow for removing her implant herself, as this could be dangerous. But why was he unwilling to concede to her request for removal in the first place? Vanessa said that "[doctors] kind of have the idea that when you go in, you're not going to be informed. And so, when I have gone in informed, I think sometimes that's threatening. … I know that some of the doctors have looked at me like, okay, what are you talking about?" While many medical professionals make space for patient authority, some participants have not experienced this in their reproductive healthcare. Even when patients feel their doctors treat them like they're "crazy," they do express confidence in their ability to use the internet to achieve their reproductive health goals on their own terms.

Conceptualizing What's "Natural"

Vernacular concepts of health and illness were another important part of participants' decision-making about their method of contraception. Many participants expressed a concern with what might be "natural" or "unnatural" in their reproductive health, although the medical establishment might not necessarily share such values. For example, many women expressed a sense that it is not natural to have decreased or irregular menstrual flow, or to lose the menstrual cycle entirely. Both of these are common side effects of prescription birth control, and medical authorities agree that period suppression does not represent any negative impact on health. But the idea of the natural, as it seems to function across participant narratives, stands for the range of bodily states, medical treatments, and practices that participants—not their doctors—considered to be normal, right, or healthy for the body.

Often, the idea of the natural was not just a medical principle but rather an aspect of identity. Madi thought of herself as an all-natural and holistic person, reasoning that "we don't always understand the side effects" of medications, and that they should be used, then, with caution. She specified that even natural remedies are "still messing with your body." In this sense, she expressed skepticism for anything meant to treat or to medicate (that is, anything meant to alter the body at all). She conceptualized birth control specifically as a way to disrupt her natural rhythm of fertility in order to prevent pregnancy. While she chose to use birth control for this reason, she also expressed that it was best for the body to remain undisturbed by medical intervention and outside control.

Vanessa used the same phrase as Madi to describe her identity when she listed her reasons for discontinuing the pill:

> I felt like I was gaining weight on the pill. Weight gain, skin changes. I'm really a natural, holistic person. Whenever I get sick I won't buy medicine. I look in my little pantry to see what herbs I have, what teas I can make, that sort of thing. So I think just me taking something orally—it could have just been mental—but I just felt strange taking it. It wasn't really something I could explain to my doctor.

Vanessa's motivation to quit her birth control was based more in her identity as a "natural person" than in any discrete side effects. While she *could* clearly explain why the idea of taking the pill felt contradictory to her identity, she knew that this reasoning would not be corroborated by her health provider. Indeed, her provider might have emphasized, contrary to her feelings, the near-complete safety of her birth control.[28]

Brianna introduced the idea of the natural when we were discussing male birth control. Her male partner, she said, was “kind of a naturalist, he doesn’t like taking Tylenol.” Her partner believed anything ingested or placed into the body should be “natural.” While she sometimes agreed with this view, she was “not as conscious” of her health as he was. She felt she was not as health-conscious because she was open to medications for “relieving [pain] symptoms,” which her boyfriend considered to be neither natural nor healthy. Brianna was also using the NuvaRing for contraception. While her male partner was able to bring this level of discernment to his own use of pharmaceuticals, it was up to Brianna to absorb the contraceptive requirements for their shared sexual activity.

Lucia also noted that she prefers to use things in her body that “come from the earth,” although she was not opposed to taking pharmaceutical medications when necessary. Like Brianna’s boyfriend and several other participants, she described herself as someone who avoids taking over-the-counter pain-relievers whenever possible. For many participants, their willingness to take such medications served as the benchmark to describe their overall philosophy about conventional medication. Within this matrix of medical decision-making, birth control occupies a unique space, as it does not primarily

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[28] “No [method of regulating fertility] is completely without side effects or categorically without danger - for example, latex condoms can cause anaphylactic reactions. That said, contraception poses less risk than does pregnancy. In fact, for most women it is safer to use contraception than it is to drive a car.” (*Williams Gynecology* 2008, 105).

treat illness but only prevents transition from one bodily state to another. It is perhaps more difficult to think of birth control as healthy when it is not a medication meant to make one well.

In fact, participants sometimes framed birth control as patently unhealthy insofar as it intervened in the body's cycle. Gina used withdrawal and avoided prescription birth control entirely because, as she said, "I don't want any sort of hormonal interference with my natural cycle." Likewise, even though Haley was using birth control at the time of our interview, she still expressed an aversion to birth control as unnatural and therefore undesirable. Such ambivalence was common to many other participants' narratives. As Haley said, "[Birth control is] kind of artificial and, like, natural is good. Which makes me kind of not want to be on the pill… [because] I don't want gross, artificial [stuff]… [but] like I said, birth control is like second nature to me now, so it's weird to say that."

Serena, who expressed this same ambivalence about pharmaceuticals, nonetheless accepted birth control as a necessary intervention in the normal functioning of the body.

> I mean, [birth control is] not natural. So I'm conscious [that] you're altering your body's natural chemistry. But I also have a science background, so I understand that sometimes intentionally altering your body's chemistry is beneficial, like for people that have depression, taking anti-depressants really helps their symptoms. I personally have somewhat of an aversion and bias towards trying to not take medication and trying not to interrupt my body's natural state, but I do have the background that I should be more open to it.

The ambivalence that participants exhibited shows that they understood their use of birth control as a kind of compromise. While they valued leading a natural lifestyle free of pharmaceuticals, they also felt compelled to use the most effective forms of birth control and accept their unnatural effects. These trade-offs reflect what was discussed previously in chapter one: that participants who discuss their dislike of birth control are performing their distress as a form of larger social complaint.

Plant-Based and Natural Treatments

Many women used the internet to find herbal treatments for their reproductive health needs. These were used to help them supplement or avoid official medical treatment and care. In some cases, participants also learned about herbal remedies through books or personal contacts. Participants used a wide variety of herbs, teas, foods, and vitamins to support their reproductive health. These treatments symbolized their self-reliance and their belief that natural substances were better than pharmaceuticals. Health professionals often discourage this kind of self-treatment because certain herbs may interact with prescription medications or harm the patient if incorrectly used (Jones 2015).

Several participants said they learned of black cohosh by researching natural alternatives to medications for reproductive health. Miranda said black cohosh was "supposed to be good for women going through menopause as well as women who have really severe menstruation." Vanessa said black cohosh was used to improve fertility, and Thea said she took black cohosh for "really bad PMS." Participants also mentioned learning about parsley, neem, and pineapple when researching contraceptives and abortifacients, and some mentioned maca and vitex for PMS. For administering herbal treatments, participants mentioned using teas, tinctures, suppositories, and vaginal steaming.[29]

Many of the women voiced the tension that although the natural treatments may not work, they still felt drawn toward using them. As Madi said about herbal treatments, "I've never known if they actually work, or if they're just old wives' tales and stuff… [but] normally old wives' tales have some foundation in truth. Whether or not it actually works I don't know, but it would be cool if it did, because I know that I personally don't like putting like extra hormones and stuff into my body." Ava expressed a similar ambivalence about the positive results she got from drinking parsley tea after a delayed period, saying, "I don't know if it's really doing something… [because] if I didn't drink it my period might still have come. But I do think that herbs have power."

Ava discussed this power of herbs in terms of the problems caused by conventional medicine: "I think that if maybe medicine looked more towards natural things that help with menstruation, we might not have as many hormonal disruptions from medical, hormonal birth controls." In fact, for some of the women, natural remedies occasionally replaced official treatment. Thea considered taking prescription birth control to manage her PMS, but decided otherwise after finding that maca and black cohosh "really helped." The participants who were using fertility awareness methods were doing so without an additional prescription method, which it was their express goal to avoid. Most often, women discussed using natural treatments in addition to conventional

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[29] According to Vanessa, "vaginal steaming is [when] you take certain herbs… maybe I'm having a certain issue that I want to try to help with… I have a little packet of herbs that my cousin gave me… so you just boil some water and you sit over the steam that it creates… Some people put it in the toilet. I think that's gross… But you sit over the pot and you just basically steam your labia and your vagina, your vaginal canal, all that."

medical care and pharmaceutical products. The use of self-treatment and natural methods was nearly always embedded within the participants' ongoing use of official medical resources. Their assembly of both official and unofficial beliefs and practices constituted their own vernacular health systems that presented an implicit commentary on what they considered to be good, bad, healthy, and unhealthy within dominant systems of reproductive health.

Internalized Hierarchies and Critique

While many of the women used stories, online resources, and herbal remedies as expressions of agency, some also articulated an internalized submission to medical authority. This was expressed through moralizing and self-deprecating language about their reproductive health habits. Most often, they were "bad" for forgetting to take the Pill at the same time every day or "irresponsible" for missing days in their regimen. Such language also emerged in discussions with participants who had explicitly chosen not to use prescription birth control methods, representing the women's ambivalence between values of self-reliance and of medical compliance.

Indeed, the whole thorny question of whether and in what way to use contraception seemed to inspire a spectrum of tensions between what women wanted or preferred to do and what they felt they should or had to do. Participants described women who forgot to take their Pill or chose methods less preferred by medical professionals as inconsistent, irresponsible, not good, not compliant, not reliable, and bad. This applied not only to other women but to themselves as well. They commonly used absolutes that did not reflect reality, saying, for example, that they "always forget" to take their pills every day, or to take them on time.

Elizabeth, a local provider from the University health clinic, emphasized repeatedly that the Pill does not need to be taken at the same time every day. Elizabeth described this idea of time-sensitivity as a "scare tactic" providers use to ensure women will take their pill every day. They assume that women who are in the habit of taking a pill at the same time every day will better maintain the habit of taking it at all. Elizabeth expressed that when providers withhold this information, it can cause patients more anxiety than is necessary. It can even lead some patients to discontinue use of a birth control that works perfectly well for them but that they think they can't maintain because they struggle with the timetable. Indeed, researchers have shown that many health authorities believe provoking fear is a legitimate and effective way to ensure clients will adhere to a desired health habit (Lupton 2013, 2). On the contrary, Elizabeth believes such tactics are unhelpful and even harmful in some cases. At the very least, they create a sense of incompetence, as almost no one can reliably maintain such an exact routine.

Participants' inability to take pills on schedule—which many of the women explicitly framed as failure—was often a major part of their decision to switch to a LARC. As Lucia said, "I've stuck with the Mirena… because I don't trust myself with other birth control. I originally started the Pill my freshman year of high school, [but]… I didn't like the Pill, [because] I always forgot to take it. … The big reason I am on the Mirena is because I'm really bad at using condoms. I hate admitting it, but I am. I'm terrible at it, and that's why I like the Mirena so much."

Thea chided herself for failing to stick with a method “long enough” when she discontinued use after experiencing negative side effects. “I know a lot of people who don’t mind the side effects… I think it’s just me being a little fussy.” She felt she was being unusually and perhaps irrationally sensitive to something that other patients are somehow better able to bear. This reminded me of how I myself felt after a doctor flatly told me that my own disconcerting side effects from the mini-pill were “common” and nothing to worry about.

It can be difficult to assert a medical concern with confidence when it seems to go against what most other women are doing or what health professionals recommend. Rachelle expressed the moral tensions she felt when she decided, against the counsel of her provider, not to use birth control after the birth of her first child. “Sometimes when I think about it, I’m like, am I being irresponsible for not taking birth control pills? Because, you know, what if I get pregnant tomorrow? … You can’t be just having kids like that… I’m like, that’s the responsible thing to do, to get on birth control. But who made that up, you know? Who say that birth control *is* the right thing to do?” While Rachelle worried about the possible repercussions of going against her doctor’s advice and social expectations for women to use contraception, she also identified that normative notions of what should or should not be done are, in reality, constructed: as she put it, who made that up?

Questioning Medical Authority

I often found a current of questioning, resisting, critiquing, and circumventing in participants’ lay perspectives on the injunctions of official medicine. Participants’ beliefs and practices in reproductive health often worked to reject the oppressive, the normative, and the institutional. Reflecting the same ethos of critical consumption that women brought to their online research, women questioned the knowledge and authority of experts in whom they perceived a conflict of interest. Several explicitly questioned the safety of a product for which the industry researching its risks has an interest in maintaining sales. Rachelle expressed a distrust in the transparency of contraceptive labelling and production. "They already put steroids in our food, so I don't know what's in birth control." Vanessa also expressed this sentiment, saying, "I can't really account for all the ingredients [in birth control]. That's one of the things that I've always been concerned about in my food and my medicine, is not really knowing what everything is, and how it affects you in the long term."

Several women mentioned their belief that their providers were connected with this industry and had a financial stake in increasing prescription drug use. Some believed this motivated their providers' censure of non-prescription methods. Gina suspected this because no provider had ever provided her with education on methods such as withdrawal or fertility awareness, but had always stressed the inefficacy of these methods in comparison to prescription contraceptives. To explain providers' undue interest in prescribing certain methods, she said that "one of my really good friends had a doctor who said that if she could, she would have every young woman that's sexually active have an IUD." Gina found this "scary" because it represents a lack of concern for individualized preferences and needs.

April, after being prescribed the Implant, later questioned her provider's interests by referring to the 2006 documentary *Big Pharma, Big Bucks*:

> He had absolutely no doubts about it. He said, you know, ‘I would put this in my own wife’s arm…’ I wondered; I’d watched documentaries like Big Pharma, you know, where certain groups go out and they try to get doctors just to sell stuff. I wondered about that. But then… he was so laid back, and he even said ‘shit’ or ‘damn’ in our appointments – so I thought, he’s cool, he’s not that older doctor that I grew up with that’s institutionalized… But I did wonder: are they buying you lunch? Because he was so sure of it.

April tried to navigate her ambivalence by trusting that her provider’s unprofessional language dissociated him from “big pharma” and other institutional interests.

Vanessa expressed similar worries about her provider’s motivations for prescribing certain forms of birth control. She said that when she requested a less commonly prescribed method of prescription birth control, her provider

> looked at me like, okay… what do you know about this? …why would you request this? It was very defensive. Like, *we* prescribe [the more commonly prescribed Pill] to all our patients. Well, you know they had that option… but she didn’t want to prescribe it. She didn’t even want to talk about it. So, I don’t know if maybe providers get some kind of kick-back for the birth control they do prescribe and recommend to their patients, I don’t know. … I think the system of care that we have in the United States, prescription medicine is big business, and most doctors have some kind of relationship with a pharmaceutical rep.

Amber also hypothesized about her provider’s motivations when she was unable to have her LARC removed upon request, saying,

> I wondered if they make more money if it stays in longer, or I wonder if they want people to keep it in as long as they possibly can convince you to, so that then you’ll report your symptoms, because they really don’t know what kind of reactions people are going to have. But if I’m forced to leave it for 6 months… [and] I have to tell them what my symptoms are [to finally have it removed], they have, I don’t know, possibly free research? I mean, I don’t know if that can ethically be used in research, but I know that maybe if one doctor has a lot of patients who are reporting the same things, maybe they stop recommending it, or they’ll keep recommending it. So that’s my theory.

Subverting Medical Authority: Non-Compliance and Non-Prescribed Use

Women often shared stories of circumventing medical authority to follow through on their own values. Off-label use of contraceptives was fairly common, and many of the women adapted their regimen to non-standard use. Most commonly, they took extra pills when they realized they had gotten off schedule. The official recommendation is to take no more than 2 pills in one day; if more than one pill has been missed, users are advised to dispose of the rest and adapt the whole month's schedule in ways specific to the prescription and number of pills skipped. Ava said of her Pill regimen, "I would forget frequently, and pop pills that I had missed for three days, and hope that it worked…. if I missed a pill maybe two or three days in a row I'd chuck—I'd take like, you know, four in one day, because I was like, [blithely] 'this will make it better!'" Ava made clear from her tone that she knew this was not the proper protocol for missed pills, but she preferred to manage the mistake in her own way. Haley, too, said she knew that taking extra pills after getting off schedule was "obviously a no-no." However, she always did so in the hopes of preventing the onset of menstruation, which she preferred to skip.

Women also worked to circumvent individual providers who failed to respond appropriately to their concerns. Often they accomplished this by finding another provider or by discontinuing their gynecologic care in general. April shared a story about being mistreated by a male provider and then switching to a female. At the end of her story, she illustrated how strongly she felt about avoiding this particular provider with a sort of gut reaction to seeing him in public. "In fact, we saw the [old] doctor [in] town over here, one night. I was with my husband, and [the doctor] was in there with his family. My husband was like, that's him? And I was like [to my husband], '*Stay away from him!*'"

Participants also discussed how to navigate the spectrum of good and bad providers with recommendations about different kinds of specialists. Several participants said they preferred other kinds of providers over general physicians. Thea said that “Nurse practitioners are more receptive to listening to what I have to say, where the doctor [is] like, okay, there’s side effects, deal with them, or try something else.” Mia said she found that seeing a gynecologist was “a lot more helpful than seeing a practitioner who was just sort of throwing medications at me.”

Aside from switching providers or choosing particular kinds of practitioners, avoiding reproductive healthcare altogether was another way for participants to circumvent negative doctor-patient dynamics. Andrea said that when she requested information about barrier methods that she might use along with her fertility awareness, her provider “was just kind of dismissive about my question.” Andrea said she “immediately dropped it” and decided, “I’ll look into this on my own later.” Lacking insurance and busy with waitressing, Andrea’s gynecologic appointments were disproportionately burdensome for how much she was getting out of them. Finding these appointments unhelpful, Andrea ultimately stopped attending appointments altogether.

What does it mean when women find ways to avoid providers whose care they dislike, or when they combine statistics with stories, and their own lay research with their doctor’s expertise? Participants’ systems of vernacular health belief and practice articulate tensions between compliance and defiance of the medical model. As always with folk medicine, creating and adhering to alternative modes of knowledge and value necessarily comment on the knowledge and values of the dominant system. In the next chapter, I will discuss the institutional critique and social complaint inherent in stories, beliefs, and practices at the local level.

CHAPTER IV

INSTITUTIONAL CRITIQUE

Sherry Ortner has developed an anthropology of resistance that focuses on inequality, social action, and the rethinking of world orders (2016). According to Ortner, resistance is never monolithic, as the same person may alternately both resist power and collaborate with it. In the past, scholars have understood resistance as an uncomplicated binary to power—for example, James Scott's "weapons of the weak" presented a monolithic conception of peasant rebellion (1995). However, Ortner argues that resistance operates on strategy and negotiation, on discrete incidents of resistance and changing goals over time.

This complexity in resistance is represented well by Kimberly's insistence that "you trust the doctor because they're the expert" even as she questioned biomedical expertise. This is also illustrated in the tensions between participants' desire for a method that allows them the greatest amount of personal control at the same time as having the greatest effectiveness for preventing pregnancy. In all such cases, participants expressed a tension between discounting the authority of institutions and professionals, and fearing the consequences. This reflected a spectrum of resistance, where participants alternately collaborated with and complained about the normative systems of gender, biomedicine, and other institutions that come to bear in reproductive health. Where my previous chapters have focused on individuals and groups, this final chapter concerns the larger structures that surround them, and expands the picture of contraceptive experience.

Interrogating Scientific Knowledge: LARCs

It is understandable that health professionals rely on statistics about effectiveness and user error to understand which methods are most appropriate for a given patient. However, from the lay perspective, patients identify their own priorities and values that may differ from those of their provider. While a doctor may feel that a young patient should use the Implant because she may not be reliable with a pill regimen, the patient must also consider the threshold at which ongoing spotting, weight gain, or other side effects become unacceptable. This disconnect between patient and provider priority is at the root of the alternative forms of communication so common to participants' experiences: the sharing of stories and rumors, the use of unofficial online resources, and the exchange of information about fertility awareness methods, withdrawal, and other ways of circumventing pharmaceuticals and conventional reproductive healthcare.

Emily Martin and other feminists have shown that scientific knowledge is never free of cultural norms and assumptions (Martin 1999). Martin shows how medical textbooks presented the egg as feminine and the sperm as masculine: the passive egg drifts along the fallopian tube to receive the sperm, while the sperm propels itself to penetrate the egg. This reflects how cultural norms and biases can interact with scientific discoveries to construct modes of knowledge reflective of existing social structures more than of biological fact.

These cultural values, interests, and biases are reflected in contemporary research on contraceptive methods. In a 2015 study of the IUD and Implant, researchers found that 83-88% of users continued the method for a year or more, and concluded that both methods are “well tolerated among women of all ages” (Berenson et al.). In another 2015 study on the positive effects of the Implant, researchers defined the device’s “favorable” effects on bleeding as amenorrhoea, infrequent, or normal bleeding (Constantino et al.). Yet these studies operated under rather narrow definitions of patient experience and preference, rather than the full spectrum of patients’ experience. It is possible that participants in the first study continued use of their LARC in spite of misgivings, discomfort, or personal preference. Regardless of these possibilities, the study deemed the methods “well tolerated.” In the second study, researchers did not investigate the individualized responses of users to the side effects that they considered to be “favorable.” What if participants found these changes in bleeding to be, on the contrary, unfavorable experiences? In these ways, biomedical knowledge continues to be informed by the norms and assumptions of researchers and practitioners in the field.

As a result of studies like the ones described above, LARCs have now been endorsed by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the American Academy of Pediatrics as the preferred contraceptive method for the majority of women, and health professionals are broadly supportive of their use across patient populations (Quinn 2016). LARC methods are highly effective, long-term, and entirely provider-controlled, eliminating the variables of patient compliance, such as forgetting to take pills (Quinn 2016). Some medical professionals see LARCs as a solution to what they consider to be a disproportionate, if not “disturbing,” rate of unintended pregnancy in the U.S (Bloomenthal et al. 2011). These interests may account for participants’ perceptions that providers prescribe LARCs over other methods, even against the participant’s initial preferences. They may also account for participants’ sense that providers are reluctant to remove their implants and IUDs upon request.

While it is understandable that the biomedical community is concerned with patient non-compliance and unintended pregnancy, such perspectives tend to pathologize patient belief and behavior. The women I interviewed complained of feeling pressured by providers to use LARCs and to keep them in when they wanted them removed; they complained of providers’ insensitivity to their concerns, and of the negative health effects of prescription birth control. Where providers may see only the potential benefits of LARCs, patients may see a symbol of their own struggle for autonomy in reproductive health. Participants described their difficulties in balancing the perspectives of their provider with their own conclusions drawn from lived experience.

Navigating Risk

An example of this disconnect between the lay and medical communities is the way participants described and understood their birth control’s risks for failure and side effects. According to feminist standpoint theory, “knowledge is situated and perspectival, and there are multiple standpoints from which knowledge is produced" (Hekman 342). This reality was reflected in participants’ narratives as they sought to understand and navigate medically constructed notions of risk. To Vanessa, scientific measures of the Pill’s risk of failure were high, and she believed that “people get pregnant all the time on the Pill, even when they’re taking it correctly.” Already disinclined to use prescription drugs in general, she decided that she would “do this naturally.” While she understood her risk of pregnancy increased from ~5% on the Pill to ~15% with fertility awareness, she balanced this increased risk with the Pill's negative effects on her weight and her mood. This process of decision-making shows how Vanessa's alternative values interact with conventional medical notions of effectiveness.

Where Vanessa seemed to compress numbers, counting risks of 5 and 15% as comparable, Serena seemed to inflate statistical differences. She said that she was "really grateful" for the high level of effectiveness of the IUD, since pregnancy was "literally [her] worst fear." At the same time, however, she expressed concern about its effectiveness: "I'm kind of a worrier; I do hope that I'm not the 1% that it doesn't protect from pregnancy." Serena's concerns illustrate how difficult it can be to conceptualize a numerical level of risk, even if it is only 1%. Rachelle put it well when she spoke of her own concerns about the risk of side effects from birth control: "Doctors may say it's not possible. But what if something happens? It becomes my reality."

In their work on patient narratives about cancer in an Appalachian medical setting, Joseph Sobol et al. found that their patients preferred not to make decisions about their care based on percentage rates of survival or other numerical probabilities (2007). This work is being used to inform the training of health professionals in providing more effective communication with their patients. Official medicine maintains that "many women have misperceptions about the risks of contraception use," but participants' narratives reflected that it takes more than knowing a percentage point for risk of failure or side effects to conceptualize and to accept the possible outcomes of their contraception (Schorge et al. 2008, 106). Patients' decision-making involves belief, values, fears, and other subjective measures, which can sometimes be negatively understood in biomedical practice as patient "misperception" or intolerance. On the contrary, participants' decision-making illustrated the complexities of constructing their own system of belief and practice based in both subjective experience and scientific measures.

Providers Dismissing Patient Concerns

Conventional biomedicine tends to devalue the patient's subjective interpretations of reality in favor of empirical constructions of biological fact (Goldstein 2008, 37). Empirical notions of risk, tolerance, and acceptability rely on a particular set of values and assumptions that may not be shared by the patient. This can create tension within their relationship as patients struggle to assert their alternative understandings within this normative system. Amber noted that when she voiced concern about her Implant causing an unpredictable cycle, her provider responded, "'But does that really matter, though… Do you really need that [predictability], if it'll work for you [to prevent pregnancy]?'" According to sociologist Deborah Lupton, there is a "widespread, unexamined agreement" among health professionals that public health issues such as unintended pregnancy merit "confronting tactics" to ensure patients will conform to desired health behaviors (2013, 9). Yet dismissing rather than addressing patients' concerns neither creates trust nor leads to compliance.

In some cases, participants shared narratives that featured providers who not only dismissed their concerns but also belittled them. When April's provider prescribed her Seasonique, she expressed concern about the drug's safety because she had a history of bad reactions to hormonal birth control. Her doctor told her that she shouldn't worry about any possible effects from the drug because he "would let his wife go on this stuff." He also told her that her problems were more likely caused by her teenage anxiety than by the medication. April’s provider used trivializing stereotypes about young girls to undermine the validity of April’s knowledge about her body. By communicating his trust in the drug from his position as a husband, he also exerted his patriarchal authority to invalidate April’s concerns.

Many other participants’ narratives featured providers who dismissed or did not address their concerns. Kimberly, who experienced vaginal dryness with the Mirena, related, “I ask my doctor about it, and said, ‘I don’t have this wetness anymore, you know; if we have our intercourse it hurts.’ And so I guess [the provider] just said, ‘Use the lubricant, the KY jelly or whatever.’” Kimberly’s ambivalent language, such as ‘I guess’ and ‘whatever,’ seems to indicate her dislike of the lubricant: “I really don’t like it, I guess the brand I use is not good.” Outside of the appointment with her provider, she reflected, “I said to my husband, does this mean that I don’t get excited or what?” Kimberly was concerned about this dryness because she worried it meant that her libido had been negatively affected, affecting her sense of identity in turn. Because her provider was unconcerned with what was for her a deeply pressing issue, Kimberly’s narrative exemplifies the tensions between biomedical fact and patient interpretation.

Beliefs and Values in Dispute

Participants’ narratives exemplified an overall critique of medical practice that was larger than their specific complaints and experiences. Diane Goldstein notes that medical experience stories “often focus heavily on the inadequacies of treatment and articulate cultural criticism of the hegemonic discourses of medicine” (2015, 133). In this vein, participants’ accounts of the negative side effects of IUDs or Implants and the struggle to have them removed are stories about the larger social and political context and the dynamics of power at play.

Amber was "miserable" for the first three months after she got her Implanon, but when she went in to have it removed, she was told she had to wait another 3 months "before they would even consider [removing] it." Amber explained "all the different symptoms I was having," but the provider told her that "you really have to let yourself have five to six months before your body will adjust." At the time of our interview, which was during her sixth month of use, Amber was still experiencing negative side effects (including a never-ending period) and still trying to have it removed. "I have a second appointment to hopefully get a step further towards getting it taken out [in three weeks]."

Amber's provider was obviously optimistic that her negative symptoms would diminish with time. Amber, meanwhile, was suffering from side effects that, from her perspective, were unacceptable. This included a "loss of motivation" that negatively affected her school performance, which she felt must be "related to the Implant, because I've never felt like that before." Amber likened her doctor's control over removal services to the control of abortion services. "If it's not provided to you, people will find ways to do it, if that's what they really want." While Amber described her provider as "sympathetic," she nonetheless used the example of abortion to relate her experience to larger systems of power and control over women's bodies.

As participants' narratives articulated problems with the authoritative medical model, their clearest critique was of the presumption of health professionals to know more about the patient's body than the patient herself. Thea related that when she complained of weight gain from her contraceptive, her provider told her that the change must have been caused by overeating during the holidays, even though she had not overeaten during the holidays. Miranda said that when she turned 34 her provider told her she no longer needed annual gynecologic exams because she was no longer in the "at-risk age group." Miranda responded to her provider's assumptions by asserting, "You don't know me."

When Gina was using withdrawal as her only method of birth control, she was well aware that it was "risky." Because of this, she had put an enormous amount of energy into deciding on and researching this method. When she told her provider that her primary birth control method was withdrawal, she said, "I swear to god her level of care dropped when she found out I wasn't using [prescription] birth control." Gina said that because providers "don't hide how they feel" about the use of withdrawal as a primary method, there has been no opportunity for her to discuss the method with her doctor. Because of this, her provider can have no way of understanding her reasons for choosing this method, or of providing education on how to use withdrawal effectively or combine it with a supplementary method. The Guttmacher Institute reports that "If the male partner withdraws before ejaculation every time a couple has vaginal intercourse, about 4% of couples will become pregnant over the course of a year. More realistic estimates of typical use indicate that about 18% of couples will become pregnant in a year using withdrawal," which is "only slightly less effective than male condoms, which have perfect- and typical-use failure rates of 2% and 17%, respectively" (Jones 2009). If this method is only slightly less effective than condoms in both perfect and typical use, then why did Gina's provider behave in this way?

Dynamics of Power and Resistance

Amber shared a narrative about a provider who brought her biases to Amber's process of looking for a new method of contraception. "I tried to explain the different methods I'd be willing to choose, and she was very pro-IUD and did not want to consider what my opinions were." With their opinions at odds, it was Amber who ultimately claimed authority over the decision. "I was able to request seeing a specialist in contraceptives… instead of letting this [first] doctor decide for me. [The specialist] gave me a chart that had all different kinds of pills you could take, and implants, IUDs, everything. And so I got to read a pro and con list for what's great about taking this pill versus this pill, and then what side effects will you have." Amber subverted the authority of the first provider by replacing her with a more egalitarian specialist.

April also successfully took control over her own situation when a provider was unwilling to observe her interests and concerns.[30]

> I called the office [to schedule a removal] and he told me that he couldn't get me in for another two months to have it removed, and I told him, I said, look, if you don't take this out of my arm, I'm going to take it out myself. I can't do this anymore… I told him, I said, I went online and I found there's wikihow pages of how to remove your Implanon, you know, or your IUD…. I wanted it out, [but] he was like, no, I can't get you in for a while, and I was just like, 'you're going to take this out of my arm, [or] somebody's going to [take this out of my arm]'…. And he was really dismissive about all of my symptoms, and was kind of put off that I was so urgent to have it taken out.

Threatening to remove one's own implant, a contraceptive method normally controlled entirely by the provider, exemplifies the dynamics of resistance. While the provider had told April that there was no room in his schedule for her to have the

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[30] See "Listening For A Life: A Dialogic Ethnography of Bessie Eldreth through Her Songs and Stories," by Patricia Sawin, for the construction of an empowered self through reported speech.

removal, April was sure this was only his way of preventing her from having the device removed. “And once he knew I was serious,” she said, “he told me that he would squeeze me in.” After she had felt disempowered by her doctor’s belittling language and lack of concern for her side effects, April ultimately found an effective way to override his decision.

The bodies of patients always serve as the “terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle” (Scheper-Hughes and Lock 1987, 31). April’s narrative identifies the contradictory nature of authoritative medicine as it intervenes in the lived experience of the patient. When she told her doctor that she had nipple discharge, he didn’t believe her, and deferred removal of the device. April embodied her struggle for autonomy in this decision as she suffered from ongoing side effects and threatened violence to achieve her goals.

Politicizing Individual Complaints

Like April, many participants’ stories commented implicitly on the contradictions of medical expertise where it becomes manipulative or hegemonic. Many also commented explicitly on the gendered imbalances inherent in their reproductive healthcare. When participants shared horror stories about IUDs or chose to use herbs instead of pharmaceuticals, they were voicing not only individual but also social complaint in critique of larger systems of power. Their stories, beliefs, and practices illustrated their distrust and dissatisfaction with contemporary options for birth control, with social expectations for women, and with the medical model.

Normative systems of both medical authority and gender roles benefit from the "filtering of human unrest, dissatisfaction, longing, and protest into the idiom of sickness" (Scheper-Hughes and Lock 1987, 27). As Diane Goldstein explains, "the medical gaze is… a controlling gaze, through which active (although furtive) forms of protest" become passive, individualized complaints, concerns, and illnesses (2008). Whenever illness, symptoms, and side effects are individualized and pathologized, the larger social problems at their roots are often obscured.[31] For many of my participants, their performance of distress in protest of larger social systems was translated into "the idiom" of method intolerance. Their rejection of a device or pharmaceutical was flattened into an individual complaint about its side effects. However, many participants' stories of their experiences with birth control articulated important social commentary and critique. Patients' reports should be understood as part of a broader cultural narrative about reproductive healthcare and the social realities it reflects.[32]

Where there are patterns of discomfort and complaint, public expression (as opposed to the privacy of the doctor-patient relationship) can contribute not only to individual well-being and empowerment but also to positive social change (Cohen 1988). Participants illustrated this by discussing birth control problems with friends and with strangers online. I looked at a few medical fora where users share their symptoms and offer encouragement and advice for others. One member of the CureZone birth control forum, after describing her negative experience with the Mirena, reflected,

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[31] See, for example, S. Lochlann Jain's "Cancer Butch" or Jana Sawicki's "Disciplining Mothers: Feminism and the New Reproductive Technologies."

[32] According to a leading gynecology textbook, "a causal link has not been demonstrated" for many of the side effects popularly attributed to birth control (Schorge 2008; 114).

> Why is it almost always women who draw the short straw? I bet you they could have produced an effective male contraceptive pill. Kill off their swimmers and let our complex hormone system be! This has been going on for years… could you imagine if a man suffered in this way from contraceptives, they would be taken off the markets directly, here thousands of women are screaming out in agony and doctors are still recommending this shit to us??! I want to advise against this method of birth control, even if it turns out it isn't the reason for all of my symtoms [sic].[33]

Reflecting on one's experiences with birth control in social spaces such as online fora or among friends can expand shared personal concerns into political ones. Most importantly, through the public sharing of individual experiences and concerns, private health problems become part of a collective experience that ultimately comes to shape social movements and advocacy (Conrad et al. 2016).

Feminist Healthcare

Feminist praxis presents another possibility for addressing participants' critiques of reproductive health and care. Feminist healthcare exhibits a long history of reclaiming body knowledge while resisting institutional control. This is exemplified by the ground-breaking publication of *Our Bodies, Ourselves* in 1973, which emphasized the social contexts that come to bear on women's health, including gender roles, stress, and personal empowerment (Ruzek et al. 1997, 20). The feminist healthcare movement also achieved the implementation of the Family and Medical Leave Act, which allowed all workers up to twelve weeks a year for the care of children, other family members, or themselves (Ruzek et al. 1997, 80). Second wave feminists have also worked to uncover the hegemonies of the medical model, including the white, patriarchal cultural values of

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[33] Permission for use granted by CureZone webmaster on 6/15/17. <https://www.curezone.org/forums/f.asp?f=817>

biomedical science. Feminists have worked to 'desexigrate' medical professionalism, to demystify medical knowledge, and to re-integrate caring with curing (Heide 1978).

I interviewed a local health provider, Elizabeth, who reflected the values of feminist healthcare. According to Elizabeth, who has 28 years of experience in the field, the most common model of care doesn’t allow enough time for educating clients about their options for birth control. She ultimately attributed providers’ lack of time for patient care to the volume of paperwork required by insurance companies. She said that she “learned a very long time ago to go deeper” with patients who say they are happy with their method of contraception. Upon further questioning about their moods, periods, or any other negative effect, she said she often learns that clients are unhappy with their method, but don’t pursue an alternative because they think it’s normal to be “bloated or bitchy.” In fact, she said, with so many formulations of the Pill and other methods available, patients should be able to find a method that doesn’t have any concerning side effects: “I expect you to feel fine.”

Elizabeth said that other providers often do not go deeper into clients’ experiences because simply refilling their prescription makes for an easy and efficient visit. This incentive to work quickly can also, she noted, lead providers to force a painful IUD insertion rather than taking the extra time to numb the cervix. She said that while asking questions about her clients’ motivations and experiences is central to her practice, other providers either don’t have the time or don’t make the time to do so.

When patients come to her with complaints about side effects that are not indicated for the method they are using, Elizabeth said that she “give[s] credence to it” because clinical trials don’t always account for individual responses. She recommends her clients take a break from any method they feel is having a negative effect, even if the relationship between the method and the reported side effect "doesn't necessarily make sense [to her]." If the symptoms go away after they discontinue use, the client can find a different method. If the symptoms continue, Elizabeth often recommends clients try vitamins, minerals, and botanicals to help with the symptoms they describe.

Elizabeth's practice represents a willingness to share authority with her patients according to their own lived experience. She uses her expertise to support patients in their decision-making and makes time to ensure patients are happy with their method of birth control. Many of the participants in my study complained of providers who did not reflect the level of care seen in Elizabeth's practice. Feminist praxis in healthcare characterized by shared decision-making offers a compelling alternative to the problematic models of care that participants described.

Gender and Birth Control

I now return to the participants' narratives to explore the solutions they themselves present within their critiques. I focus on participants' complaints of the ongoing failure of the pharmaceutical industry to develop a birth control method for men. As Serena said, indicating the inadequacy of the status quo in light of scientific advancements, "I definitely think it's crazy that we're in 2017 and there's not something like a pill [for men, and] the only male option for birth control right now is condoms or vasectomy. [It] seems very archaic to me. It seems like we have the technology… something should have been created for males forever ago."

Rachelle also critiqued the status quo by identifying its relationship to entrenched gender roles and the demands on women for their labor:

> Why do I have to take birth control? Why can't my husband take birth control? As a woman, we always have to do this, we have to do that, so, I'm like, ugh, you know what, just put on a condom. And sometimes, you know men, they don't want to put on the condom… But when I read through [the methods of birth control available to women], it's just adding work for us… Who makes birth control? Now I need to go research that. Why haven't you guys made any birth control for guys?

Like Serena and Rachelle, many participants expressed negative feelings about the imbalance of contraceptive responsibility in their sexual relationships. They realized that they bore the risks not only of pregnancy but also of possible contraceptive side effects and associated health risks. Andrea complained, "it's annoying to me that… it's just on women… [and that] we're the ones that have to deal with all of the consequences, all of the time…. Women are only fertile for a couple of days out of the month, but we're the ones who have to deal with side effects." According to a 2011 study, even the most conscientious and invested male partners attribute contraceptive responsibility to their female partner (Fennell 2011). In this study, men who claimed to have equal interest in preventing pregnancy always included some kind of qualifying statement like "'… but ultimately it's her body, so it's up to her'" (Fennell 2011, 510).

Of the two methods currently available to men, the condom is associated with decreased pleasure, and the vasectomy with the possibility of pain. This further contributes to the imbalance of contraceptive responsibility, as some male partners are unwilling to abide these possible effects. Mia shared, "I feel like a lot of women are told that you don't use protection because it feels better for them. And that's a really sad thing. I hear that really often from men too, that there's this refusal to use protection, or there's this complaint that you hear, like, 'well I won't enjoy this if I have to do this for you.' Kimberly also reported that her male partner refused to use a condom, even when she framed her request in terms of her own problems with the IUD.

> I said that I'm tired of me taking this pill or I have this IUD that I get dry [vaginal dryness] or I get cranky or whatever going on with my body adjusting, you know, and I said, "why you can't just take the condom?" I mean, I even told him, I said, "you can just have the condom." And he said, "it doesn't feel good." And I said, "Why? It still feel good. Even with the condom it still feel good. Why." And he just don't want it. He just don't want to wear the condom. So that's why [I still have the IUD].

Cultural narratives around condoms sometimes lead men to refuse even occasional use, leaving their partners, to quote Andrea again, to "deal with all of the consequences, all of the time."

When I asked Gina whether her boyfriend would agree to take a hormonal contraceptive if it were developed and made available, she responded, "I've definitely asked him that many times. And he always says yes really quickly, but I always counter that with, 'well, you don't really know, because it's not available to you.'… Maybe he would feel differently if any kind of contraceptive *was* available to him." Gina's response reflects her belief that her partner could not fully consider the decision to use birth control until it actually reached the market. His response, then, was only hypothetical or symbolic—and, thus, was questionable. Gina's belief reflected an underlying critique of gendered social realities, where she was burdened with researching, obtaining, and using a method, while her partner was left entirely unconcerned.

Ava articulated an important question about our society's stalemate in male birth control, saying,

> [Our current contraceptive options] are heavily female focused. I go back and forth on whether or not it's because we have an oppressive patriarchy, or if it's easier to reign in a woman's cycle… I don't know if it's biology or if it's societal, that we have more things that disrupt the female reproductive cycle than male."

Many participants discussed rumors of male birth control in various stages of supposed research and development. Of course, many substances and procedures have been found to be effective for controlling male fertility, and their success is often reported through news outlets and social media. Within social groups, stories about these prospects circulate widely, often without full details on the procedures, data, location, and timeline of the clinical trials. These stories retain only their most salient details, often those that touch a nerve of hope, fear, or anger within the cultural group. The stories and details that find purchase in this vein not only spread information but reveal the group's underlying assumptions and beliefs about themselves and the world (Turner & Fine 2001).

Participants often shared stories, for example, about a particular set of clinical trials in which male research subjects effectively halted the study with their complaints of side effects. As Elena described it, "from what I know about the research… the male research participants have been horrible. They've just dropped out, they're like 'ah, I'm aching here, this and that is happening, I don't want to do it anymore.'" Andrea said, presumably about the same clinical trials circulating through the grapevine, "I know that they were working on [male birth control]… and then they stopped it because it was *hard* for the men or something, which was dumb." Lucia apparently referenced the same trials when she said, "I know actually that… there was one [male contraceptive] that was supposed to come out… and the men complained too much about it…. I was so incredibly upset that [the pharmaceutical company] would do that, and that they didn't at least give it as an option for men to deal with.” Male complaints of side effects in this rumored clinical trial seemed to perfectly capture the women’s sense of inertia in a society so bent to the service of male comfort. They used the story to express their anger at the continuing obligation of women to use contraception and accept any side effects, while men carried on without any parallel discomfort.

Other participants shared rumors of impending male birth control not with anger, but with hope. As April said, “My husband looks into it quite a bit, he’s like, ‘they’re making strides’… He’s like, ‘they do it in other countries.’ … There’s some sort of gel that they put in, and it’s like a numbing injection and it traps sperm from being able to get through it or something, negatively charges it. He’s like, ‘we might have to go do some medical tourism.’” Amber, too, referred to the proactive research of her male partner with a sense of hope for imminent change: “We’re both reddit users… There’s a lot of threads on there you can read about different trials that have happened with male birth control, and they have a lot of their personal anecdotes with things that have happened… so it’s interesting to read about it. He’d try it. It’ll never be an even trade off, it’ll always be uneven, but if he could try one for my six or seven, then it would be nice.” Ava also shared rumors of research and development in male birth control with a tone of hope, apparently discussing the same gel-based product that April’s partner had discovered.

> [My partner and I] did talk about Vasalgel, which is something I think I’ve seen on Facebook and the internet and stuff, and that was something that appealed to us because it was something that could just block the sperm from getting out… I feel like I see rumors that it’s going to start up, and then I see they need crowd-sourcing or something. It just seems like a lot of mixed evidence, and I haven’t looked into it formally, you know, I just hear stuff on Facebook, and then every once in a while I go, ‘hey, what’s the status of vasalgel,’ and I google it… I don’t

> know the status of it, but I hope it’s soon. I’d get [my] copper IUD pulled out the next day.[34]

Rumors about the failures of male birth control research served to confirm participants’ belief that men are unwilling to share the burden of contraceptive responsibility. Rumors about its successes confirmed participants’ hopes that they would soon be relieved of their one-sided burden. Either way, these stories articulate a critique of the undue burden of contraception on women today. As Gillian Bennett writes, these rumors both evince and explore the limits of knowledge and power, ultimately contesting the authority of official medicine and its current approach to reproductive health (2005).

The Ideal Birth Control

When asked, some participants said that male birth control for their partner was their ideal method of contraception. Miranda, however, qualified that probably “not all men would participate.” Indeed, a few participants were sure their partners would not take male contraception if it were made available. Some said this was because their partners would want to maintain their masculinity, which could be threatened by a drug so strongly associated with women. Others said their partners would consider such a drug dangerous to their health or their libido.

When asked what would be their ideal form of birth control, other participants responded to my question more literally, choosing from the spectrum of options that are currently available rather than dreaming of male options or other alternatives. Lucia said

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[34] For more information about Vasalgel, visit <https://www.parsemus.org/projects/vasalgel/>. The page requests funding from its viewers, stating, “even $5 or $10 each will really help.”

she hates condoms, but that they are nonetheless her ideal form of birth control, as they "interact" with her body the least. She said she wished she could use the non-hormonal IUD, but she experienced extreme cramps and bleeding when she tried it. Reflecting on the drawbacks of even her "ideal" forms of birth control, Lucia said, "It's hard—there's no way to stop your fertility without being invad[ed] somehow, with hormones, or patches, or by inserting a NuvaRing, or a shot; it's really hard to find a method that's not going to mess with my hormones and is not going to direct my body down a different path."

Other participants, when asked about their ideal form of birth control, dreamed of an entirely new form of contraception. April said she would invent a method that was ingestible and patient-controlled, like the Pill, only non-hormonal. Like April, many participants identified non-hormonal forms of contraception as their ideal method, whether a real method like the copper IUD or an imagined one. Still more participants did not mention hormones specifically, but said their ideal method would be "non-invasive." As Gina put it, her ideal method would "not pose any threat" to her health.

At present, the vast majority of contraceptive options are hormonal. Pharmaceutical companies have developed many ways to introduce hormones into the female reproductive system, from the shot to the patch to the pill to implants, but research and development of non-hormonal options is far smaller in scope and scale. Nevertheless, the possibility of a prescription non-hormonal method is not unreasonable. In Sweden, for example, researchers are currently developing a contraceptive "technique" without the use of hormones (KTH Royal Institute of Technology 2018). This method has no side effects, is entirely "bio-based," and operates locally to the cervix. The technique uses “chitosan, [which]… develops in the hard outer shells of crustaceans such as shrimp and crayfish.” For participants resistant to the use of hormones or who prefer to use natural substances, this may present a viable alternative, although it is possible there may remain a sense of “invasion” or “threat” in the introduction of a foreign substance to the body.

Other participants who envisioned an alternative form of birth control said their ideal method would be “100% effective,” “easy to take in and out,” or would prevent the transmission of STIs. Amber imagined a form of the Patch that would be “not so visible,” and specified that any new method ought to be “really really heavily researched before it’s out on the market.” The fact that participants discussed the effectiveness, convenience, and safety of their “ideal” method reflects their concerns with current methods’ rates of failure, inconvenience, and painful insertions or unexpected side effects. Moreover, the fact that so many participants envisioned new non-hormonal methods as their ideal suggests that pharmaceutical research should focus on developing a more diverse range of methods than currently available.

In many cases, participants imagining an ideal form of birth control tended to remain within the realm of what already exists. Sometimes they even rejected the possibility of an “ideal” at all. This illustrates how participants’ resistance relies on negotiation rather than monolithic rebellion against the medical model. Their stories and insights suggest that they are dissatisfied with the established methods, yet willing to accept a similar alternative if only it were more effective, safer, easier, or even just less visible.

CHAPTER V

CONCLUSION

As contraceptive users seek to control their fertility, they interact with biomedicine not because they are ill, but because they are seeking to plan their lives. Inherent in the vernacular beliefs and practices they use to navigate this space is a critique of the status quo in family planning. Although they accept their prescribed insertions, dosages, and regimens, they also offer social complaint in coded worries about their health and rumors of long-awaited alternatives. In their story-telling, decision-making, research, and beliefs, participants envision a world where their choices will be less constrained by medical authority, gender norms, and other forces surrounding their reproductive healthcare and well-being.

From the individual to the systemic level, women's stories about their experiences with birth control confront not only the hierarchies of the medical model, but the injustice of reproductive health policies and gender norms, as well as the threatening new prospects of life under a repressive political administration. Participants expressed their sense of tension as they work to protect their health and yet prevent pregnancy at any cost. Their stories of invasion, pain, and bizarre side effects articulate a commentary on their medical experience and illuminate the ways they negotiate both their own and their doctor's health knowledge and beliefs. Understanding their local knowledge, alternative values, and vernacular categories of health and risk provides much-needed nuance for understanding patient compliance and providing appropriate contraceptives and care.

Through the interrogation of biases, the exploration of patients' lived experience, and the politicization of reproductive health-related complaints, we discover positive alternatives to the status quo. Ethnographic data and feminist methods can be used to improve pharmaceutical research and development, provider training, and care. Vernacular conceptions of the “ideal” birth control, for example, can inform new pharmaceutical research by illuminating users’ relationship to the larger system of contraception and the social order in which it operates.

David Hufford advocates for the use of folklore fieldwork to solve practical problems in doctor-patient relations and patient care by “help[ing] official medicine to recognize its cultural location within the community” (Hufford 1994, 129). It is important that medical professionals remain aware of dynamic vernacular response to treatment and care, which ethnographic studies can both document and interpret. For example, Michael Owen Jones’ recent ethnographic study of Latinx knowledge about diabetes documents local explanatory models for the disease and herbal treatments for symptoms (2015). Jones’ work explores the layers of identity and symbolism that make recommended changes in diet difficult for diabetic patients to maintain. He concludes that there is a need for more responsive, patient-centered, empowering health education and programming, as well as a need for increased cultural and communication training among medical professionals (Jones 2015).

Likewise, reproductive treatment and care should be informed not only by clinical trials but by continued attention to the knowledge and insights of the patients who use these products and services. The ways that patients combine official and unofficial medicine or construct cultural notions of risk and of health are not divergences from scientific truth but important articulations of the values, beliefs, and priorities that patients bring to their reproductive health. Further research is needed into the vast body of stories, rumors, beliefs, and local practices in contraception, which have as yet been little explored by both academics and by medical researchers.

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