

**RACIAL INJUSTICES: THE MENSTRUAL HEALTH  
EXPERIENCES OF AFRICAN AMERICAN AND LATINA  
WOMEN**

**Honors Thesis**

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By

L. Virginia Martinez

Sara B. Moore, PhD  
Faculty Advisor  
Department of Sociology

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## Abstract

The goal of this research is to examine racial disparities among college-age African American and Latina women with a focus on menstrual health issues and their experiences with health care. This research includes a literature review that explores the existence of institutionalized racism and sexism in medicine, giving attention to reproductive justice and ultimately menstrual justice for women of color. It also entails four semi-structured, in-depth interviews with African American and Latina women, through which I identified four common themes: 1) the normalization of pain, symptoms, and experiences, 2) feelings of not being taken seriously by medical providers, 3) the disruption of daily activities and self-image, and 4) feelings of frustration that treatments are not working. Previous research supports the findings that women of color are disproportionately disadvantaged compared to their White counterparts in terms of birth outcomes and infant mortality, quality of medical care, and their relationship with medical professionals. Although the area of menstrual justice is particularly understudied, this research sheds light on the experiences of women of color who have sought medical care for menstrual health conditions in the hopes that their health care experiences will not go unnoticed or be dismissed. Medical professionals can draw on this study to address the problem of racial disparities in medical treatment, menstrual health, and health care in general to provide a meaningful and effective path for women of color.

*Keywords: menstrual health, racial disparities, health care, institutionalized racism, medical care*

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## Introduction

Menstrual health is an understudied topic composed of complex intersections between race, gender, medicine, and health care. I begin this thesis with a literature review describing how institutionalized racism and sexism intersect to shape women's experiences within the institution of medicine. Specifically, I describe the history of medical racism and reproductive injustice in the United States and its impact on women of color. I also describe some of the issues related to menstrual health, specifically how menstrual health issues and racialized menstrual injustices reflect institutionalized racism and sexism.

I then describe the methods used to collect data around women of color's experiences when seeking medical care for menstrual conditions. Through four semi-structured, in-depth interviews with African American and Latina women, I identified four common themes: 1) the normalization of pain, symptoms, and experiences, 2) feelings of not being taken seriously by medical providers, 3) the disruption of daily activities and self-image, and 4) feelings of frustration that treatments are not working.

Previous research supports the findings that women of color are disproportionately disadvantaged compared to their White counterparts in terms of birth outcomes and infant mortality, quality of medical care, and their relationship with medical professionals. Although the area of menstrual justice is particularly understudied, this research sheds light on the experiences of women of color who have sought medical care for menstrual health conditions in the hopes that their health care experiences will not go unnoticed or be dismissed.

## Literature Review

### Institutionalized Racism and Sexism

Institutionalized racism exists within and between social and political institutions, and is defined as “the discriminatory treatment, unfair policies and inequitable opportunities and impact based on race” (Lawrence & Keleher, 2004). Discriminatory policies and practices exist within organizations and institutions that are intentionally designed to marginalize people of color. Because of institutionalized racism, people of color often experience poor health outcomes (Bailey et al., 2007). Problems stemming from institutionalized racism include a lack of diversity in the medical profession, the high cost and poor quality of care, language barriers between patients and providers, a lack of culturally responsive and evidence-based treatment, and limited access to health insurance (Brown et al., 2000; Smedley, Stith, & Nelson, 2003; Greil et al., 2011).

These issues are particularly problematic for women of color in the United States. Sexism is a form of discrimination or prejudice against a person’s biological sex and/or gender, which particularly disadvantages women. According to Sensoy & DiAngelo (2017) “sexism encompasses economic, political, social, and institutional actions and beliefs that perpetuate an unequal distribution of privileges, resources, and power between men and women.” (p. 228). Like institutionalized racism, institutionalized sexism entails discriminatory policies that marginalize women. However, they are also a principal means of justifying the perpetuation of a racist social structure (Roberts, 1997).

Women of color suffer double discrimination, meaning institutionalized racism and sexism intersect and overlap, thus creating the experience of multiple oppressions at the same time (Collins, 1998). Women of color face racial discrimination because they

are not White, and they face gender discrimination because they are not men (Collins, 1998), with whiteness and maleness being privileged identities in the United States. Essentially, these two socially constructed identities have become detrimental in the lives of those who are minoritized in the United States. The intersection of racism and sexism has disproportionately disadvantaged women of color's life experiences in the United States and has affected African American and Latina women in particular (Lillie-Blanton, Martinez, Taylor, and Robinson, 1993). With systems that were designed to underserve or erase them, marginalized groups suffer in terms of health outcomes, education, housing, employment, and other social inequities (Lillie-Blanton, Martinez, Taylor, and Robinson, 1993). Intersectionality, a term coined by Kimberlé Crenshaw, helps us understand the multiple and intersecting social positions people occupy (Crenshaw, 1991). There is not just one identity women of color identify with or belong to. Race, gender, sexuality, religion, and class are all identities used to make sense of how individuals are both privileged and oppressed.

For most of America's history, women of color were denied bodily autonomy. This legacy has consequences for how women of color experience the world today. Throughout the era of slavery, the bodies of Black women were used for profit, considered undignified, and treated as commodities (Davis, 1981; Roberts, 1997). Society held no regard for enslaved people because they were seen as goods. They were their enslaver's property, and their unborn children, known as "slave children" (Roberts, 1997), were also considered enslaved. When children were fathered by an enslaver, they were not seen as the enslaved woman's biological children. Institutionalized racism and sexism led to decades of suffering, pregnancy complications, infant mortality, unethical

experimentation, and more. Discriminatory policies in the health care profession, from slavery through the post-Civil Rights era, reflect racist historical underpinnings that have negatively shaped the health outcomes of African American women today (Prather et al., 2018).

For decades, African American and Latina women have been structurally disadvantaged, and issues of reproductive and menstrual justice have been ignored, which has negatively impacted their health outcomes (Rosenthal & Lobel, 2018). The roots of this issue stem from the institutions and systems built to serve White people, and they explain why social inequities like a lack of affordable housing, quality education, employment, and health care persist. The U.S. health care system should not decide whom to help or how to treat an individual; its function and purpose is to provide individuals with quality care that is favorable, affordable, and accommodating to the individual's needs (Tweedy, 2016). Unfortunately, this is neither the outcome nor the experience many African American and Latina women receive. Their experiences involve mistreatment and dismissiveness from medical professionals through ignored and disregarded fear, anger, and pain.

### **Medical Racism and Reproductive Justice**

To understand the struggle for reproductive justice for women of color, we must consider this issue through a historical lens, beginning with the institution for slavery. For women, slavery relied more on routine sexual abuse than physical abuse (Davis, 1981). Violations of reproduction rights were "sanctioned by law" (Roberts, 1997), and White male enslavers had considerable control over enslaved women's procreation. The law failed to recognize the rape of an enslaved woman as a crime (Roberts, 1997). Some

enslavers practiced “slave breeding” (Roberts, 1997) as a means of financial gain, and some enslaved women were even "guaranteed freedom" (Roberts, 1997) if they gave birth to many children.

Enslaved women endured decades of sexual violence, unwanted pregnancies, and mistreatment from their enslavers and other social institutions. Their voices were silenced and remained so for decades after the abolishment of slavery. Before the abortion-rights movement, enslaved women aborted their own pregnancies as “acts of desperation motivated not by the biological birth process but by the oppressive conditions of slavery” (Davis, 1981). Terminating was a form of desperation, but could also be interpreted as liberating. Enslaved women asserted what little agency they had by refusing to bring a child into the world to suffer the same conditions. While many enslaved mothers were accused of killing their unborn children either deliberately or carelessly, infant death was more often due to "poor prenatal care" (Bowen, 1987). Black children died at a significantly higher rate than White children because of their mothers' laborious work, malnutrition, and the physical and sexual abuse their mothers endured during pregnancy (Roberts, 1997). The absolute domination of enslaved women's procreation paved the way for centuries of reproductive regulation, which continues to this day (Roberts, 1997).

While slavery was abolished more than a century ago, reproductive control took on the form of forcible or coercive sterilization. In the early 20<sup>th</sup> century, a racist form of mass birth control called sterilization was conducted on women of color, specifically Black, Puerto Rican, Chicana, and Native American women (Davis, 1981). This “alternative” to abortion damaged the lives of thousands of women of color who underwent this procedure without their informed consent. Not only did this invasive,

unethical, and racist procedure ruin these women's lives, it stripped them of their reproductive rights.

Forced sterilization was guided by notions of white supremacy and was implemented to "improve the [human] race" through any means necessary (Roberts, 1997). Guy Irving Birch, director of the American Eugenics Society, advocated for sterilization as a weapon to "prevent the American people from being replaced by alien or Negro stock, whether it be by immigration or by overly high birth rates among others in this country" (Davis, 1981). Even progressive activist Margaret Sanger wrote to her colleague that "We do not want to get the word out that we want to exterminate the Negro population..." (Davis, 1981). As someone who is often put on a pedestal for being the "mother of birth control," her legacy is more complex than we think. Such practices and comments are clear examples of medical racism, and though we think of them as historical in nature, they reverberate throughout our contemporary society and political climate. Indeed, racism and sexism are woven throughout American history.

Unfortunately, forced sterilization still occurs today on incarcerated women, racial and ethnic minorities, women with disabilities, and poor women (Patel, 2017). For example, from 2006 to 2010, about 150 female inmates in two California women's prisons were sterilized "without the state's approval" (Chappell, 2013). At least 100 more took place between 1997 to 2010 (Chappell, 2013). Doctors in these facilities were paid "a total of nearly \$150,000 for conducting the [tubal ligation] procedure" (Chappell, 2013). Some indications suggest a history of forced sterilization, unethical experimentation, and reproductive control have been a cause of medical distrust among women of color (Ehrenreich, & English, 2005; Skloot, 2010).

Given the decades of oppression and marginalization they have suffered, many African American and Latina women simply fear or distrust medical practitioners. The so-called father of modern gynecology, Dr. J. Marion Sims, performed a series of experimental surgeries on enslaved women who were powerless and could not provide meaningful consent (Wall, 2006). These women endured unethical experimentations without the use of anesthesia. In fact, a racist belief that Black people can tolerate more pain than White people is a false idea that continues to shape their treatment within the health care system (Hoffman et al., 2016).

Care providers' dismissive attitudes and negative beliefs about women of color persist through implicit bias. Implicit biases are unconscious stereotypes and negative attitudes affecting a person's understanding and actions (Blair et al., 2013). Biases are inevitable and expected in any culture, but implicit biases create barriers that inhibit access to health care, medical treatment, education, employment, and more. Race remains a determining factor in the type of treatment a person receives. A study conducted by Blair et al. (2013) found 60% of primary care providers express substantial implicit biases against African Americans and Latinx people. What does this mean for reproductive justice? Racism is prevalent and permits sexual and reproductive health disparities among African American women to still exist (Prather et al., 2018). Decades of mistreatment cannot be erased; instead, it needs to be acknowledged and called out. Medical mistreatment is a multi-generational, intersectional crisis that has persisted throughout our history.

Imagine suffering from an ambiguous health condition, being unable to afford treatment, not having proper access to health care, and having medical professionals

dismiss your pain and your concerns. This is an experience many women of color in the United States face. Dominguez (2011) and others found African American women have the most significant infant mortality rate that exists among all other racial and ethnic groups in the United States (Howell, 2008; Hauck, Tanabe, & Moon, 2011; MacDorman & Mathews, 2011). White, McQuillan, and Greil (2005) found women of color often avoid medical care for infertility for a variety of reasons that may be culturally bound. In addition to the possibility of general distrust of the medical establishment, they may fear being rejected for treatment. They may also be disinclined to accept technological solutions for holistic health concerns and may feel stigmatized by the labels associated with infertility. African American and Latina women are less likely to undergo medical tests or receive treatment (Greil et al., 2011), and are said to be more distrusting of physicians (Armstrong et al., 2007) than their White counterparts. Taken together, this evidence suggests women of color often suffer in silence and are afraid to seek medical help for fear that they will not be heard, believed, or have their pain taken seriously.

### **Menstrual Justice**

Menstrual health is a topic both understudied and stigmatized, something I am personally very aware of. My own challenges seeking and receiving health care for menstrual issues deeply affected my adolescence and early adulthood, thus these experiences inspired me to pursue research on this topic so other women facing menstrual health challenges feel heard and empowered.

Menstrual health is an important component of most women's lives. It allows women to menstruate, prepare for pregnancy, and release and produce various types of hormones. However, women's experiences with menstruation are highly variable, and

without proper medical assistance, hygiene, or health care, a woman who struggles with menstruation may not receive adequate treatment. For African American and Latina women, the literature suggests that their reproductive experiences are more challenging than their White counterparts. African American infants are dying at a more rapid rate than others, and African American and Latina women are more distrustful of medical professionals. To understand the many dimensions of reproductive health, we need to first examine menstrual health. Why are some women's periods irregular? Why are periods painful or heavy? And how is this issue related to racial disparities and outcomes?

From the beginning of our country's history to the post-reproductive rights era, women of color continue to struggle within our social institutions. From higher rates of infant mortality (Dominguez, 2011) to high levels of physician distrust (Armstrong et al., 2007), it should come as no surprise that institutionalized racism and sexism remains an underlying cause. The existence of gender bias in the medical field has been well documented. For example, women's pain is often ignored, dismissed, or undertreated (Hoffman, Trawalter, Axt, & Oliver, 2016; Dusenbery, 2019). Doctors often doubt the severity of African American women's pain; as a result, African American women are more distrustful of their doctors (Armstrong et al., 2007), thus less likely to speak candidly with them.

Women's menstrual health concerns have historically been cast in gendered terms and served as tools of oppression. For example, hysteria was considered a psychiatric disorder until its removal by the Diagnostic and Statistical Manual of Mental Disorders (3<sup>rd</sup> ed.; DSM-III; American Psychiatric Association, 1980). Many of the symptoms

associated with women's reproductive and menstrual cycles were considered evidence that women were "physically abnormal and inferior," (Dusenbery, 2019). and in some cases, the symptoms were not considered "real at all" (Dusenbery, 2019). Menstrual health disorders like Premenstrual Syndrome (PMS), Premenstrual Dysphoric Disorder (PMDD), and menopause were once considered psychological disorders (Dusenbery, 2019).

Although many women consider menstrual pain to be "normal," women of color who are disproportionately underserved and undertreated often find their reports of pain dismissed. The term secondary dysmenorrhea describes menstrual pain caused by an underlying issue such as endometriosis, fibroids, or ovarian cysts (Dusenbery, 2019). However, primary dysmenorrhea is not due to any "evident pathology" (Dusenbery, 2019). The notion that these disorders are merely psychological is absurd, sexist, and offensive. Hysteria, which comes from the Greek word *uterus*, is considered a woman's condition and typically connotes femininity (Tasca, Rapetti, Carta, & Fadda, 2012). The term reflects a historical disregard for women's health.

All the women I interviewed had at least one female relative with menstrual health problems during their adolescence. I was surprised to find generational similarities in menstrual health. This might suggest that doctors were unable to catch, diagnose, or discover these issues. As I describe more fully below, participants in my study also reported that medical professionals normalized their menstrual pain and showed dismissive attitudes. I was not surprised that the normalization of pain was a reoccurring theme, given research suggesting women's higher likelihood of reporting and higher sensitivity to pain due to stigma of not having their pain taken seriously and inadequately

treated when they sought for help (Dusenbery, 2019). When the participants in my study sought for menstruation treatment, their doctors often did not believe them and proceeded to tell them that what symptoms are “normal.” Hoffman and Tarzian (2001) found that women are at a higher risk of having reports of pain disregarded before the origin of their pain was even found, which ultimately resulted in inadequate treatment and care.

For women of color, institutionalized racism and sexism intersect to shape their experiences with health care in the United States. As this review of the literature suggests, many scholars have written about the history of reproductive (in)justice in the United States, but few have focused on menstrual justice specifically. The findings that follow begin to shed light on the menstrual health care experiences of women of color in the hopes that their health care experiences will not go unnoticed or be dismissed.

## **Methods**

### **Participants**

For this study, I aimed to speak with college-aged African American/Black and Hispanic/Latina women who have sought treatment for menstrual health issues. I used a snowball sampling method to recruit participants. With the approval of Salem State University’s Institutional Review Board, I published a recruitment statement on various platforms. I recruited participants via social media platforms including Facebook, Twitter, Snapchat, and Instagram, and through faculty from the Sociology, Psychology, and Criminal Justice Departments in one regional university. People reposted or reshared the social media advertisement to their followers and friends. When the participants reached out to me, they were exclusively screened for the following: 1) identify as

African American/Black or Hispanic/Latina, 2) over the age of 18, and 3) sought treatment for menstrual-related health conditions such as Polycystic Ovary Syndrome (PCOS), PMDD, uterine fibroids, Endometriosis, or other conditions. Note that I self-identified as an Afro-Latina woman, which may have led to some participants' willingness to share their experiences.

I sent each screened participant an informed consent form indicating the purpose of the study; the details of their participation, including risks and benefits; confidentiality information; and mental health resources should they need support after the interview. Four college students in the Northeastern region participated in the study. Of the four participants, two self-identified as Black and two identified as Hispanic/Latina. The age range of the participants was between 18 and 26. Appendix A includes each participant's pseudonym and demographic characteristics.

### **Procedure**

I conducted an in-depth, semi-structured interview with each participant. The interviews lasted from 25 minutes to 2 hours. I conducted two interviews in a private study room on a university campus, and two via FaceTime or phone call. I recorded all interviews using an electronic device. Within 24 hours of each interview, I stored the audio files in a password-protected file on my personal computer and assigned each participant a pseudonym. Once the file was uploaded to the computer, I deleted the recording from the device immediately, and the device was locked in a secure drawer. The interviews were later transcribed using SONIX, an online transcription software. I then reviewed each transcript to capture any discrepancies.

I started each interview with a brief statement thanking the participants for taking the time to speak with me. I stated, “I like to start by saying that I know it can be difficult to speak about issues that are very personal and that may be sensitive to you, especially given the stigma that is often attached to discussing menstruation with others. To ease into our conversation about menstrual health problems and diagnoses, I would like to ask you a couple of general about your experience with menstruation. Is that okay with you?” After easing into the conversation about how their menstruation experience started, I asked participants specific open-ended questions pertaining to their menstrual health experiences and challenges. These areas of inquiry included challenges participants faced in terms of their menstrual health, when and how they sought help from medical practitioners; what diagnosis and treatment they received, if any; and how they felt about their health care experiences. Appendix B includes the list of guided questions on menstruation.

Although the interviews were semi-structured and situated around menstrual health, participants also talked about their relationships with partners, having children, infertility, racial and ethnic discrimination, mental health, intersectionality, and doctors of color. When necessary, I asked participants to elaborate on their specific experiences and posed clarifying questions. Only two of the participants had received a medical diagnosis (PCOS and Endometriosis). No specific conditions were associated with the other two participants.

### **Grounded Theory Approach to Analysis**

I used a grounded theory approach to analyze my data. Grounded theory is “derived from data, systematically gathered and analyzed through the research process”

(Strauss & Corbin, 1998). This involves examining qualitative data such as transcripts, from which concepts and themes emerge and are coded into categories (Strauss & Corbin, 1998). Through the process of notation and color-coding, I identified four recurring themes: 1) the normalization of pain, symptoms, and experiences, 2) feelings of not being taken seriously by medical providers, 3) the disruption of daily activities and self-image, and 4) feelings of frustration that treatments are not working. It is worth noting that participants had similar experiences, some of which overlapped more than others. However, the goal of this research is to open possibilities for future research and call attention to an issue that is understudied: the menstrual health experiences of African American and Latina women.

### **Findings**

Four common themes emerged from the interviews I conducted. The first is the normalization of pain, symptoms, and experiences. This theme emerged from questions regarding women's experiences with medical practitioners and overlaps somewhat with the second theme, feelings of not being taken seriously by medical providers. I separated these two themes to illuminate on specific accounts that were not centered on the normalization of pain. This second theme focuses specifically on participants' reports of harsh and arguably racist disregard for their symptoms and reveals how women *thought* and *felt* about their health care experience. The third theme, the disruption of daily activities and self-image, emerged from the symptoms women reported and the associated challenges they faced. The fourth theme, feelings of frustration that treatments are not working, emerged from participants describing treatment options and effectiveness. Below I describe each theme in turn.

### **The Normalization of Pain, Symptoms, and Experiences**

Participants often described how their menstrual pain was typically regarded by doctors as normal. When this “normal” persisted, some participants were left in excruciating pain and wanting to know the underlying problem of their condition. Uncomforted by the doctor's response, some were left to fend for themselves and “sucking up [the pain].” Two participants openly expressed distrust of the medical field and fear that their experiences may be misinterpreted as “overdramatic,” and three expressed that the medical field lacks empathy for women of color. The fear of being perceived as “overdramatic,” “exaggerated,” or even “emotional” is often regarded as a women's issue, which reflects gendered bias and potential gender difference when seeking for pain treatment and being taken seriously.

Krishna, an 18-year-old African American student, mentioned that when she got an ultrasound at 13 years old after having excruciating menstrual cramps. She said, “Every time [I go to the doctor], they say, ‘It's a normal period.’ No, it's not a fucking normal period. All my friends don't go through this. I'm the only one that's going through this...I don't enjoy going to doctors. If I'm going, it's because something is wrong.” Like many women who seek medical help and treatment, Krishna was tired of getting the same answers for something she knew was wrong. Cramps are a symptom of menstruation; however, the pain a woman feels should not be minimized because it is part of menstruation, especially when they seek help numerous times like Krishna did.

Alexandria, a Latina 26-year-old college student, and mother stated, “It's all ‘everything is always normal’ here. So, I would tell my mom and my grandmother, and they have had the same issues before as well.” Alexandria was frustrated and annoyed

with how discomfort is normalized and that finding answers is a difficult process. It was interesting that her menstruation-related problems seemed to suggest generational problems. This may speak to the more significant issue of doctors not catching how patients tell their stories, how they live their lives through their intersectional identities, and how genetic and environmental factors can be passed on to children. Medical professionals need to continue to work on effective communication with their patients as we continue to call attention to racial disparities in seeking medical treatment (Becker and Tsui 2008).

The normalization of pain shaped my own experience as well, and in this case, was attributed to a lack of knowledge of menstrual-related symptoms. When I was twenty years old, I had a heavy and painful period that lasted 47 days. I saw three different medical practitioners for this issue. I was experiencing the worst abdominal pain and constipation due to an unprecedented menstrual cycle. I was in excruciating pain while sobbing to the nurse practitioner. When I asked her what I could do for the pain, she said I could start using an oral contraceptive. When I asked her about other options, she said that I could either take the birth control pill or continue to bleed. I was in so much pain that I did not call out her unsympathetic words. For the past two years, this experience stuck with me, specifically the nurse's disregard for my pain, dismissive attitude, and inability to put me at ease. Unfortunately, when I started taking an oral contraceptive, it did not help regulate my menstrual cycle. Like most of the women I interviewed, I was constantly told that the cramps, mood instability, heavy and painful cycles, and lumps in my breast were normal and that it will get better, but it has not. When it comes to

disorders that affect women's reproductive and sexual health, an old bias persists:

“medicine's tendency to treat women's illness as perfectly normal” (Dusenbery, 2019).

Lena, a 21-year-old African American woman, said that when she was 11 years old, she had irregular cycles that lasted a month, and she skipped a month within the first six months of her cycles. She said it was an odd experience that came out of nowhere, but her cycle became regular after that. However, menstrual pain persisted, and when she sought treatment six years later, she stated, “[My doctor] told me, ‘It was normal. It'll get easier, but if you want to change something you can always do this, you can always do that. But it's normal, every woman goes through this.’ ”

That pain was addressed several times by different women is important to acknowledge. Pain affects a woman's physical and mental health, and if it is not addressed with urgency, it may cause severe, underlying complications and, in some cases, may be life-threatening (Tabibian et al., 2017). Women should not have to live through excruciating pain, nor should their experiences be minimized because it is simply part of their menstruation. This is especially true for women of color, as racial disparities affect how pain is perceived by doctors, and recommended treatment is associated with the false “beliefs about biological differences between black and white people” (Hoffman et al., 2016). The normalization of pain also speaks to the larger issue of institutionalized racism, specifically how African American and Latinx people in the United States are medically underserved and undertreated (Lee et al., 2019). For these women, the normalization of their pain may reflect and reproduce racial injustice in the healthcare system.

### **Feelings of Not Being Taken Seriously by Medical Providers**

Three participants recounted a time when they felt their medical practitioner was either dismissive towards them or did not take them seriously. The issue of pain was overwhelmingly minimized and normalized, and even when they were willing to go the extra mile to get answers and advocate for themselves, they still experienced a dismissiveness that is typical of when women of color attempt to seek medical care (Blair et al., 2013).

Before coming to the United States, Krisha lived in Haiti. When she started experiencing heavy periods and intense cramping at the age of 11, she sought treatment in the Dominican Republic, where she was told everything was “normal.” Two years later, when she arrived in the United States, she continued to seek other medical opinions and was told the same thing, “It’s normal.” When I asked her how her doctors responded to her reports of pain and discomfort, she answered very seriously:

I feel like doctors are pretty nonchalant. They don't care. I didn't have good experience in health centers at all. I mean, I feel like [the staff] are every rude, first of all. So, like, I don't feel comfortable just talking about it, but I always did because I'm suffering. But I feel they don't take it seriously. I think because they think, like, cramps is just this normal thing. But they don't understand. I don't know. I feel like doctors should understand like there's actual [women] you know, there's more extensive than others. They said, “You're supposed to get [cramps]. As time goes by, it will go away.” But like I can't just wait 'til it goes away. (Krisha)

Krisha was explicit, angry, and candid about her experiences with doctors in the United States and overseas. In the past five years, she has visited “five different doctors” for menstrual cramping, which was not only debilitating to her physically but greatly affected her mental health as well. As a result of these experiences, Krisha expressed considerable medical distrust (Armstrong et al., 2007), specifically of White medical professionals. Krisha was told to “suck up” the pain that “got worse every month.”

Lena comes from a different culture but had a better experience with her doctors. She said, “[Doctors] don't make a big deal out of it. I feel like they should take it more seriously. They just think it's normal. I know, I understand it's normal, but sometimes people actually go through hard pain.” Lena's last words before the interview ended suggest the medical profession's inability to take women seriously when they express concerns about their health conditions. Particularly for women of color, this seems to be a persistent issue that stems from the prevalence of racism and sexism (Prather et al., 2018).

During the last six years, Denise has seen various medical practitioners and had the unfortunate experience of not being taken seriously by any of them. She described two experiences in particular. The first was during her last visit to the emergency room that she made twice in one year for the same issue. Denise's emergency room visits suggest she not only felt bad, but also that her pain was far from normal. “According to the Endometriosis Association's research registry, 61% of women and girls were eventually diagnosed with endometriosis had been told by health care providers that nothing was wrong with them” (Dusenbery, 2019). While experiencing a lack of sleep, dehydration, and vomiting associated with a painful menstrual cycle, Denise checked into the emergency room. She stated:

It [got] very bad. The last time that I ended up in the ER last year, I told the nurse, who was seeing me, and she called [the doctor] and said, “What are you doing to help this girl? Like, you're not doing anything.” And [the doctor] was like, “Oh, yeah. Tell her to stop by, and we'll see her.” And then they call me, and they're like, “This time is inconvenient for us. Can you come back like later?” And I was like, you know, just forget it. And on top of that, I get a bill for \$25 because I was a “no-show.” (Denise)

Denise sought medical care for extreme pain, encountered a doctor who was unresponsive to her needs, was told to come back later because it was “inconvenient” for them, and was sent a bill because of a service she did not receive. While this may not be the reality for all women of color, there is evidence to suggest an implicit racial bias in how doctors treat their patients of color (Blair et al., 2013; Hall et al., 2015). Because women feel discouraged or hopeless after these kinds of experiences, they often do not share what happened to them.

Denise’s second experience when she was 19 years old centered on a fertility test, which revealed she had endometriosis. Endometriosis occurs “when tissue similar to the lining of the uterus (womb) grows outside of the uterus” (Office of Women’s Health, 2019). Infertility is associated with endometriosis, and while research is currently limited about this relationship, there is evidence to suggest about at least 25-50% of women with endometriosis may experience infertility (Verkauf, 1987). When Denise arrived at the doctor’s office in search of a fertility test, she recounted talking to the nurse practitioner:

I want to know if everything seems normal for somebody my age because I want to have kids one day. And I feel like, if possible, I would like to have kids when I’m in my early 30s, which is not that far from now. Like we’re talking about ten years. So if there’s anything that I can start doing now that would prepare me for that, then I would love to know. The nurse practitioner laughs. And she goes, “Oh, honey, you have a long way to go. Don’t worry about that right now.” I would like to know because, hell, maybe I want to start saving for whatever treatment I’m going to need when I do have kids. So for her to be so dismissive about it at a point in my life where I was just like so emotional, because right now I’m not even thinking about it anymore. (Denise)

Wanting to be a mother some day and not knowing whether it is a possibility is a terrible feeling. In this situation, Denise was denied a service because she was too “young,” and it was nothing to “worry” about. Yet the prevalence of infertility in women who have

endometriosis is overwhelmingly high, as previous research suggests. Denise expressed that during this process, she felt like she did not get the help and resources she needed. Infertility and being a mother were brought up in two other interviews and is a much larger issue for women of color. Women of color are overrepresented among women who suffer from infertility, but are also “less likely to receive services than other women” (Greil et al., 2011), which suggests that the racial disparities persist in all aspects of health care. The discriminatory policies implemented during slavery continue to negatively shape the outcomes of women of color (Prather et al., 2018; Rosenthal & Lobel, 2018). Women of color continue to suffer in silence, sometimes afraid to share their stories or seek help afterward.

Finally, Denise’s endometriosis and related pain had continuously been dismissed by her doctors. She mentioned that her vaginal opening hurts when she is on her period:

This is something that I guess a lot of people haven’t heard about before, and I don’t understand why it happens to me. But I remember saying to my mom, and she was like, “What the hell?” She laughed. She’s like, “You’re confused. It’s your abdomen.” And I’m like, no. I know exactly where it hurts. When I mentioned it to the doctors, and they were like, “No, no, no.” So, I just feel like I got so dismissed so many times from people that think I don’t know what I’m talking about, but I do. (Denise)

Denise’s experience reflects both the problem of not being trusted or taken seriously and the inability of doctors to find a cause of her pain.

### **The Disruption of Daily Activities and Self-Image**

It matters how we see ourselves, how we feel about ourselves, and how our conditions affect us. All four participants described incidents when their menstrual health condition greatly impacted their daily routine, lifestyle, or self-image. No matter how many times one visits the doctor, takes pain relief medication, exercises, or diets, the pain

persists. That pain affects one's ability to go to work, sit in class, be intimate, hang out with friends, and more. This theme describes the many times each participant was affected by their condition, menstrual cycle, or pain. Note that this theme overlaps with related themes like the normalization of pain and the sense that treatments are not working.

Alexandria was diagnosed with a pituitary tumor after she gave birth to her son six years ago. "A pituitary tumor is an abnormal growth in the pituitary gland" (Johns Hopkins Medicine, n.d.). Located in the brain, the pituitary gland is responsible for making "hormones that affect many other glands and many functions in your body" (Johns Hopkins Medicine, n.d.). Although most pituitary tumors are benign, they can cause the pituitary gland to produce either too few or too many hormones resulting in critical problems in a person's body (Johns Hopkins Medicine, n.d.). After Alexandria gave birth, she did not resume her period. When her doctor ran a few blood tests, they found that her prolactin levels were high. They continued to run more blood tests and an MRI, after which she was diagnosed with the tumor. High prolactin levels in women can irregulate menstrual periods or stop it altogether (Johns Hopkins Medicine, n.d.), which is consistent with the findings from Alexandria's test results.

Alexandria was also diagnosed with Polycystic Ovary Syndrome (PCOS), which is a reproductive hormone imbalance (Office on Women's Health, 2019). Alexandria's menstrual health conditions have affected her body-image and lifestyle; she recounted:

I would say like the gaining weight and everything—all that. I wouldn't say it depresses me, but it puts me down sometimes and being worried about my period all the time like if I walk by a mirror, I'm checking my pants just in case, you know. I have this random feeling that I'm wet or something. And then I go check and there's nothing there. So, it has affected my lifestyle a little bit." (Alexandria)

Alexandria's symptoms, mentioned in Table 1, also affect her mental health. She explained that due to PCOS, she has facial hair, gained over 120 pounds, and is always anxious about when her period is going to come. PCOS can also affect a woman's fertility. She did not explicitly mention that she is infertile, but she did recount a specific time when she was not getting a period, and the doctor mentioned that she was still ovulating. When Alexandria asked how that was possible, it turned out she had unknowingly suffered a miscarriage when she was just ten weeks pregnant. I asked if her doctors ever mentioned whether she would have trouble conceiving because of her condition, but she said, "No, they did not. They said, well, first they want me to try to lose weight. They said, "it would help. And that I can get pregnant. It will just be really hard, and I would probably have to use metformin and see a fertility specialist."

Metformin is a medication used to treat Type 2 diabetes and may help some women with PCOS symptoms. However, metformin is not FDA-approved to treat PCOS symptoms (Johns Hopkins Medicine, 2019), which is concerning.

For Krisha, her menstrual cramps have affected her academic performance, her job, and her mental health. At one point during our interview, she started crying:

I can't eat. I don't know. I can't eat during my period. So, I lose a lot of weight. After my last period, it was almost a whole week without eating anything. I couldn't even drink water. Because everything I eat, I just threw up. And then even if I don't eat, I just threw up. If I gain a little bit [of weight], I lose it fast. And like that's one thing I'm very self-conscious about. And like that affects you. I try to say like I don't care, you know, I'm confident. But in reality, it's like, oh shit... and also just seeing all of this social media, while I'm trying to gain weight...It's just like, you know, it takes a lot of you. You're trying to make all this effort to try to be this healthy person, to better yourself and stuff... just for it to be taken away because of this stupid stuff. (Krisha)

Krishna often felt she had to mask her pain and pretend everything it was alright, though it was not. Menstrual health not only affects the reproductive system, but it also affects how women view themselves (i.e., self-objectification) and their mental health. The invisibility of women of color's experiences throughout social institutions is not uncommon; it is as if their stories never existed. Not only is the invisibility of women of color's experiences a function of institutional racism, but it also continues to mask their intersectional identity.

For Denise, her condition has also influenced her inability to attend school and work. She stated:

I know that it is affecting my everyday life. Like there's times where I have to miss school, there's times where I have to miss work, and not everyone understands it. Like, how can I call my boss every month?... I was missing work every month. I was missing school every single month. How can I call someone and say, hey, I can't go to work because of my period and have them understand how much it really hurts? And not have them be like, "Oh, you're just being a big baby." (Denise)

Armor et al. (2019) discuss the disruption of period pain (dysmenorrhea) and its impact on women's productivity (e.g., in school, at work, etc.). Of the 21,573 young women who participated in this global study, 20% reported absences in school or university due to menstrual-related symptoms, and 41% stated that their condition affected their performance (Armor et al., 2019). They also found that women also missed other activities due to their symptoms. Extreme period pain is not always normal and may be attributed to underlying conditions that may have yet received a diagnosis. Like Denise and Krishna, Lena also mentioned that at one point, she was not able to go to school and participate in activities she normally would. "It would be hard for me to get up and go out with my friends," she said.

There is little research on the disruption caused by periods that is specific to women of color. Although none of the participants mentioned fibroids as a diagnosis, it is important to discuss this specific condition and its effect on women's health and their ability to be productive. "Uterine fibroids are muscular tumors that grow in the wall of the uterus" (Office of Women's Health, 2019). Not all women show symptoms, but those who do find that they are hard to live with, and some experience pain and heavy menstrual bleeding (Office of Women's Health, 2019). African American women have a greater risk of developing uterine fibroids, have more severe symptoms, and face more adverse outcomes than their White counterparts (Stewart, Nicholson, Bradley, & Borah, 2013; Eltoukhi et al., 2013). This may reflect racial bias in medicine, and how African American women have had to deal with suffering in pain because of medical distrust, the normalization of pain, and not being taken seriously. Heavy bleeding, endometriosis, tumors, infertility, and fibroids do not just affect women's physical health. As the literature and my interviews suggest, these conditions impact many parts of a woman's life.

### **Feelings of Frustration That Treatments Are Not Working**

This fourth theme refers to three experiences: inadequate or ineffective treatment, the refusal of treatment, and outrageous treatment suggestions. Ineffective treatment is not uncommon for a woman of color, as the above literature review suggests. Feeling exhausted by seeking treatment options and not knowing what else they could do, each participant recounted a story of emotional pain and frustration. The intersections of the participants' identities highlight the underpinnings of medical racism in this country and its adverse effect on women of color. These findings reflect persistent racial disparities in

treatment and outcomes that are associated with racial bias and institutionalized racism and sexism.

As the literature review suggests, unethical experiments and illegal surgeries have been performed on women of color throughout American history and have caused generational pain and trauma. While this may not be happening at such a high rate today, doctors continue to normalize and disregard women's issues because of the racist and sexist practices already embedded in our institutions. For example, Denise was told that her options to deal with her endometriosis were limited. She could continue taking a high dose of (ineffective) birth control, a high dose of ibuprofen, or induce early menopause. Denise's doctor mentioned the possibility of a laparoscopy but discouraged it, and Denise was presented with what she felt was an outrageous option of inducing early menopause. After trying traditional pain medications and four different types of oral contraceptives, Denise found nothing worked for her. When she visited her gynecologist last year after her birth control dose was upped, she stated,

[When] I go back again, I see the actual OB-GYN, she's with a student, and I'm talking to her, and I say, "Listen, like, I am not doing ok. I'm really not. Every time I get my period, I just get into a mentality that I don't want to be in. I'm in so much pain. This is, like, affecting my life so much right now. Like, I just can't do it anymore. I really need some help." First of all, she laughed in my face, and she goes, "Well, you know, it's a whole procedure and surgery, it's a non-invasive one, but it still has risks. You know that there's anesthesia, and you would have to go under. There's so many things, like, and there's still risks, there's risks with every procedure," like trying to scare me from doing the [laparoscopy] in order to, you know, better myself, in order to get better. So, she's trying to scare me off when she talks about the anesthesia. I tell her I had my wisdom teeth taken out years ago. And I went under, and I was completely fine. So, I don't think I would have a bad reaction to the anesthesia. And she's just like laughing again and saying, "Yeah, but like, this is very you know, there's still a risk. There's just like a lot. And you would have to go through a recovery process. And this and there's some factions." So, she's really trying to scare me off. And I say to her, "Well, I want to do it

anyway, because, you know, I can't live like this anymore." So, she tells me that my options are either to keep trying birth control and continuously take ibuprofen 800...or induce early menopause...And, I just looked at her, and I said, "I'm 20 years old. Like, I'm not doing early menopause. Like there's nothing in the world that would convince me to do something like that. Like, women dread getting to that point in their lives. Why would I do that shit on purpose? (Denise)

As a woman of color who wants to have children someday, who is constantly advocating for her medical needs and researching her condition, Denise found this to be a "humiliating experience" for her. To be discouraged or refused services are not uncommon experiences for women of color (Bailey et al., 2007; Ramos et al., 2010; Prather et al., 2018).

Doctors often prescribed conventional pain medication to help with participants' menstrual pain, but this was often ineffective. Krisha had to stop taking Tylenol because it was not working for her, and she felt that her body got used to it. When she temporarily went on birth control, after having reservations about it, she decided to stop it because "nothing changed." Although she was grateful that she was prescribed something after years of seeking medical treatment, the treatments were ultimately ineffective. Before Lena found effective treatment with her current oral contraceptive, she stated that "there wasn't any medication that actually stopped [the pain] even when I took Tylenol. It is only for a few hours, and then it goes back to normal." Over-the-counter (OTC) medicine such as Advil, Tylenol, Aleve, Motrin, and other OTC are used to alleviate menstrual pain. OTC medicine are "nonsteroidal anti-inflammatory drugs" (Medline Plus, 2020) that are less potent than what a doctor would prescribe. However, these temporary reliefs only last so long and excessive use can pose dangerous risks like internal bleeding and even death.

When I asked Alexandria how her medical practitioners responded to her pain, she stated, “I felt like they weren't really experienced with the type of problem and, like, they couldn't really help to be honest. Like everybody’s just like, oh ‘go on birth control or take this pill.’ Everything is a pill, and it doesn't really fix the problem.” Even after Alexandria saw various specialists who she felt were experienced with her condition, yet she was still given inadequate medication, which resulted in very low success. Each participant exhausted their options on how to seek treatment. Overwhelmed, frustrated, and angry, each participant felt like “giving up” at some point or had to “suck up” the pain because their doctors were not listening or helping. They felt doctors continued to minimize and normalize their pain, refuse particular treatment options, or prescribe ineffective pain management and/or birth control pills as a way to treat them.

### **Discussion**

I identified many similarities among the women I interviewed. All four participants had a female relative with menstrual problems. Mothers were most common, but participants also spoke of aunts and grandmothers. While participants did not mention whether their relatives sought treatment or were diagnosed, this was a common experience each participant discussed. Three participants mentioned that their female relative who suffered similar experiences mentioned that it was “normal.” This suggests a generational normalization of pain and may reflect medical practitioners’ racialized perceptions of pain in people of color (Blair et al., 2013). Each participant recounted numerous times her pain was normalized or not taken seriously by doctors. Even when participants sought multiple medical opinions, doctors either did not know how to treat these women or did little to help them. Alexandria stated, “I saw four different

endocrinologists. And I've seen a few different OB's and honestly, I've given up because they all give the same answer. And it's like there's nothing you can really do about it like there's no cure."

Another issue that came up in my interviews is cultural and language barriers within the healthcare system. Krisha, a Haitian native, came to the United States when she was just 13 years old. Her lack of confidence in speaking English was an additional barrier for her, and she felt scared trying to learn and navigate her way through a foreign system. She stated, "There is more options for people, you know? Options, translation, basic rights, you know? Not having a 13-year-old try to translate when she obviously doesn't know what the fuck she is talking about." When I asked her if there were translators available to her, she said she did not know if she could ask for translation or how to even advocate for herself. This suggests that the medical field needs to be more inclusive of diverse needs, and we need to meaningfully bridge cultural and language gaps.

Two participants said their diagnosis led to a sense of comfort knowing they had a name for the condition, yet both expressed some level of ambiguity and suspicion regarding their condition. For instance, when I asked Denise how she felt about her diagnosis, she stated, "I am here telling you I have endometriosis. But then again, do I? I might. I feel like I do. They 'think' I do, but I don't have anything official to prove to you that I do have endometriosis." The doctors said they were not sure if Denise actually had endometriosis, so she responded, "How can we be sure, and how can we fix this?" Her doctor suggested that would require an "invasive" procedure to find out, and that it would be "a lot of work."

Alexandria mentioned that right after she gave birth, she was diagnosed with PCOS, so she “did not really have to experience the symptoms before they diagnosed [her].” Her doctor performed a pelvic ultrasound to check for cysts, ovary size, and other abnormalities. When her results came back normal and without cysts, Alexandria experienced confusion about her diagnosis. She was told, “it’s not like a real diagnosis,” but rather a collection of symptoms. Since there is some ambiguity surrounding PCOS, effective treatment options, and how to diagnose it, patients like Alexandria may be left feeling confused.

Another interesting finding across all participants was reservations about the use of oral contraceptives. Birth control may be seen by some as unnatural, morally problematic, or even debilitating. Lena did not go on birth control because she felt “it kind of changes [the] body.” Denise felt the same way, stating that she “never agreed with putting hormones in [my body] ... [birth control] doesn’t seem natural to me.” Alexandria had similar beliefs but added that although they do seem to work for her, she feels like “it’s more of a fake period. It’s not a real one when you use birth control.” Krisha said she does not like birth control because of the “negative side effects” and was unwilling to “put [hormones] in [her] body at the moment,” especially because she is “not sexually active” and did not want to “fuck up [her] body even more.”

These findings may reflect participants’ cultural beliefs, but they also suggest medical distrust. As the literature suggests, White et al. (2005) found women of color often avoid medical care for infertility for several factors that may be culturally related, such as the general distrust of the medical establishment, they may fear being rejected for treatment, and may also be disinclined to accept technological solutions for holistic health

concerns. Armstrong et al. (2007) found that African American and Latinx people reported higher levels of medical distrust than their White counterparts and across different demographics (e.g., SES, education, wealth, gender). They also found that discrimination that produces medical distrust in African American communities may be applicable to other minoritized groups such as the Latinx community (Armstrong et al. 2007). My findings suggest a few things: 1) women lack knowledge about different birth controls pills (e.g., brands, levels of hormones, etc.); 2) doctors may not be properly explaining the use, effectiveness, and side effects of oral contraceptives; 3) cultural attitudes that come up against American medical practices, especially regarding foreign objects in the body (e.g., IUD, ring, etc.) or medications that are considered unnatural.

Participants also brought up womanhood, motherhood, and infertility in their interviews, reflecting the intersectional challenges the women faced. Krisha shared,

I would like to have the opportunity to give birth and feel like a woman, because you know, like even though sometimes I hate being a woman, things like [having a period], they identify who I am. You know what I mean? Being able to have your period, is something that's in your identity, you know? And it sucks because I'm going through all this. But I just love being a woman, you know? And I just hope that things like this would not be taken away from me just because of like, you know, I can't just be like "I am going to suspend my period" because I want to have a child. I can't just dismiss my period. I want to experience things like this that just makes me a woman. (Krisha)

Denise also mentioned, "I feel like my whole I've just been preparing to the point where I have children because I feel like I am meant to be a mom, and it's my number one goal in life." Throughout her interview, Denise emphasized her goal of being a mother one day but was concerned about the possibility of being infertile. She has actively advocated for herself but was dismissed when she asked for an infertility test. Infertility is not a small issue and should be taken seriously regardless of a person's age.

From this discussion, it is clear the women I interviewed expressed similar concerns around pain, diagnosis, treatment, and accessing quality medical care. Yet the resilience women of color demonstrate continues to challenge deeply rooted racist and sexist systems. Black and Latina womanhood and motherhood need to be discussed, as do issues like high infant mortality and infertility rates and the issues I describe here. Women of color must not continue to be marginalized by racist and sexist institutions. They should be free to redefine their identity, reclaiming their self-worth, acknowledge their contributions, and advocate for themselves.

### **Limitations and Directions for Future Research**

This study presents a series of limitations that are important to address and suggests areas of inquiry for future research. The first limitation is the sample size. As with much qualitative research, the sample is relatively small (N=4), therefore these findings cannot be generalizable to the larger population. Given the small sample size, there were minimal opportunities to capture the full diversity of women's experiences. For example, one participant had a relatively positive experience with her medical practitioner, while three others did not. This study does not include sufficient data to compare and contrast positive and negative experiences without seeming biased. This study also does not examine the experiences of women of color who have never sought medical treatment because their discomfort was so normalized, which may be an area for future study. Future research might also compare the experiences of younger and older women who sought treatment for menstrual conditions to see how treatment may look different across age groups.

Another limitation of this study has to do with recruiting participants. Although snowball sampling has its advantages, it also has its disadvantages, which include relying on participants to share the study advertisement with others. Snowball sampling sometimes takes a while to uncover willing participants. I had limited time to share my recruitment statement, screen for eligibility, interview participants, and complete the transcriptions. More time would have likely yielded richer results.

A third limitation has to do with the demographics of my participants, specifically, a lack of diverse racial and ethnic backgrounds. Two participants self-identified as Black (Haitian) and two identified as Hispanic/Latina (Dominican). Since the sample size was so small, it is impossible to make meaningful comparisons across racial and ethnic groups. Future studies might include a larger sample that include other racial and ethnic groups including White women. This would allow the researcher to consider the extent to which race, gender, age, and other demographic characteristics might shape women's experiences. Moreover, all four participants are local to the Boston area, which may mean there is bias in terms of location. This makes sense given the limited scope of this thesis project, but future researchers could think about more diverse ways to recruit participants, including reaching out to medical offices, clinics, and women's health organizations.

A few issues came up through these interviews that may be areas to explore more fully in the future. For example, a few participants brought up the lack of diversity in the medical field, and one woman shared that she prefers to see doctors of color. Interestingly, two participants said they would rather see a male doctor, which may speak to an internalized sense that men are more knowledgeable than women. Becker and Tsui

(2008) found that English and Spanish-speaking Latinas were more likely to prefer a female clinician than White women, contrary to what I heard from the Latina participants in this study. Future research might reveal how women of color engage differently with male and female providers or White and non-White providers when it comes to menstrual health.

Some participants touched on other issues related to the issue at hand. Two participants suggested that menstrual products should be free everywhere, especially because they are expensive, taxed, and “women do not ask for their periods.” They also mentioned how menstrual products are often left out of discussions about reproductive health, yet condoms and other contraceptives are free in many places. The differences in availability between women’s hygiene products and men’s condoms suggest sexist attitudes. Finally, participants observed how menstrual health discussions are often considered “taboo.” Each participant said they were not prepared for their first period, and some said they never had the “period talk” in school or at home. This is an issue that should be addressed at home and in school to effectively prepare young girls for their periods, including what to expect and how to manage their menstrual health.

Additional directions for future research involve exploring the deep complexities of age, doctor-patient communication, gender identity, and a lack of funding for menstrual health related research. First, age may have played a role in participants’ experiences. Women aged 18-26 participated in the study, with an average age of 21.5 years old. It is difficult to determine whether doctors simply do not take young women’s concerns seriously. For example, one participant who was concerned about infertility was dismissed because she was “too young” to be thinking about having children. Menstrual

research often deals with older women's concerns like menopause. I would argue that young women deserve more attention when it comes to menstrual pain and conditions and treatment experiences. Future studies might also explore whether younger women are either underreporting or not seeking treatment for menstrual pain due to their age.

Poor communication between doctors and patients may lead to misunderstanding as well. Medicine is clearly a complex field, and some women's conditions are comorbid, complicated, or simply poorly understood by doctors at this time. Doctors who do not communicate clearly and with cultural competence may be giving patients incorrect impressions of their conditions and treatment options. It may be that doctors' implicit biases are shaping their interactions with patients, but it may also be that doctors are not well trained to communicate with patients clearly. Future research might try to capture effective and ineffective communication between doctors and patients in ways that allow both parties to reach a better understanding of their menstrual health.

All of the women I interviewed identify as cis-gender, meaning their gender identity matches their sex assigned at birth. Transgender men as well as non-binary, gender non-conforming, and other folx who were assigned female at birth may still menstruate or have problems with menstruation. Research shows that transgender men, for example, struggle to find adequate medical care when it comes to reproductive issues, including menstruation. Implicit bias and gender identity might therefore be another area for future research. Are transgender men's menstrual concerns taken seriously by doctors? What barriers to quality care and treatment do they experience? Like women of color, transgender folx often fall through the cracks of our institutions. How can we be

more inclusive in the future by address how gender identity expression may shape people's menstrual health care experiences.

Finally, the challenges doctors face in diagnosing patients' menstrual issues may be tied to a lack of funding to study specific menstrual disorders or conditions. Doctors may genuinely lack knowledge about their patients' conditions, and patients may perceive that as dismissiveness. For example, regarding endometriosis, "minimal investment in this area has significantly limited our understanding of the disease and slowed the progress in treatment." (Mostafavi, 2019). Without adequate research and clinical funds, the opportunities to advance our understanding about menstrual conditions and women's treatment and care are limited. Research on other conditions like PCOS, uterine fibroids, and PMDD is also underfunded, which affects both medical providers' knowledge and, by extension, women's health care experiences and health outcomes.

### **Conclusion**

One of the reasons I wanted to do this research was to provide an opportunity for young women to talk about something that is often stigmatized: menstruation and menstrual health. Participants really did want to talk about these issues, which was a validating feeling for me as a researcher and as someone who has shared some of these same experiences. Some participants became emotional during their interview, even crying as they shared their experiences. The interviews were semi-structured to allow for the emergence of issues participants needed to get off their chest, and I assured participants that this was a space to talk openly, and safely about their experiences. They were all grateful for the chance to speak. Krisha said, "I feel like awareness is so great

because more people are talking about it. And more people are opening up, and I feel like that's how we create change.”

During the interviews, I also had a chance to talk with participants about things like intersectionality, the history of forced sterilization in the United States, and reproductive health in general. Most participants were not familiar with these things, which made me realize that societal awareness regarding historic and current reproductive injustices is potentially limited. Their lack of knowledge provides yet another reason why we should continue to learn about the ongoing effects of historically racist and sexist policies and practices. More women of color need to know they are not alone and that their experiences are microcosms of institutionalized racism and sexism embedded in our country.

We also need to call more attention to menstrual health specifically. This is a developing area of research, but it remains understudied and rarely approached from an intersectional perspective. There may also be some stigma attached to women of color coming forward with their stories. I suspect cultural values may influence their lack of response, as might experiences that were too painful and traumatic to recount. I hope women who have suffered in silence, been dismissed or ignored, or received inadequate care find value and comfort in this research as well as the courage to share their stories. I am not sure where this research will lead, but I hope that someday it reaches the attention of medical professionals so that they can offer better alternatives to patients in addition to providing a listening ear and a helping hand.

Although this study includes the experiences of only four women of color, by examining their experiences through an intersectional lens, I hope it provides useful

information to an understudied field. Participants' detailed, painful, and frustrating accounts creates an opportunity for reflection and illuminates medical disparities that are difficult to discuss. This study will not solve the problem of institutionalized racism and sexism or medical racism, but it acknowledges the persistence and prevalence of reproductive injustice throughout American history and now. We, as a society, need to hear and address the historic normalization of women's pain; the systemic oppression that continues to endanger their lives; and revise outdated, gendered, and racist health policies. Lastly, by thoroughly examining the systems that have hidden the links between historic injustice and the experiences of women today, we can begin to change the culture and attitudes that have minimized oppressed groups like the ones in this study.

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## Appendix A

*Participant's Characteristics*

Pseudonym	Age	Racial and/or Ethnic Identity	Diagnosis	Symptoms	Treatment
Denise	21	Hispanic/Latina	Endometriosis***	Intense cramps Sweating Hot flashes Lack of sleep Loss of consciousness** Heavy flow Vaginal pain Headaches Constipation Back pain Painful sex Skin discoloration Anxiety*** Depression***	BC pills Advil* Ibuprofen 800mg**** Painkillers
Krishna	18	Black	Anemia*** No menstrual disorder/diagnosis	Diarrhea Cramps Headaches Loss of appetite Weight loss Fainting Vomiting	*BC pills Ibuprofen**** Herbal tea
Lena	21	Black	No menstrual disorder/diagnosis	Cramps Fever***** Vomiting*****	BC Tylenol
Alexandria	26	Hispanic/Latina	PCOS*** Pituitary tumor***	+Diarrhea +Vomiting +Fever ++Irregular, heavy, and prolonged periods ++Headaches ++Facial hair ++Amenorrhea ++Stress ++Darkening of skin ++Frequently changing pads/tampons	Progesterone***** BC pills Patch IUD (Mirena) Depo shot Metformin Paragard*****

Note. \*=tried Birth Control for two weeks. \*\* =during periods. \*\*\*= diagnosed. \*\*\*\*=Recommended by a doctor. \*\*\*\*\*=before birth control. \*\*\*\*\*= in order to get a period or stop it. \*\*\*\*\*=body rejected it twice. Amenorrhea= absence of period. += Associated with first period. ++=After giving birth. Metformin is given to control blood sugar levels. PCOS= Polycystic Ovary Syndrome. IUD=Intrauterine Dev. BC= Birth Control.

## Appendix B

### *Guided Questions on Menstruation*

- Were you prepared for when your period came, in if so, in what way were you prepared? How did you feel when it came?
- What challenges have you faced in terms of your menstrual health? Have you ever experienced intense cramps, constipation, heavy bleeding, nausea, depression, anxiety, or any other symptoms associated with menstrual health issues?
- How long did you experience these symptoms before you sought medical help?
- How did your medical practitioner respond to your experience(s)? How did that make you feel?
- If you feel comfortable sharing, were you diagnosed with any menstrual health-related disorders (e.g. PMDD, PMS, PCOS, endometriosis, uterine fibroids, etc.)? If so, how did you feel about that diagnosis?
- Did you ever seek another medical opinion about your issue? If so, why?
- What kind of treatments did you receive, if any (e.g. birth control)? How did you feel about this treatment? How many treatment options were provided to you, and how were they explained?