



2018

Queer People Navigating Experiences with Health Care Providers and Contraception

Dana Lavergne
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_theses



Part of the [Gender and Sexuality Commons](#)

Recommended Citation

Lavergne, Dana, "Queer People Navigating Experiences with Health Care Providers and Contraception" (2018). *Master's Theses*. 3748.

https://ecommons.luc.edu/luc_theses/3748

This Thesis is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Master's Theses by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License](#).
Copyright © 2018 Dana Lavergne

LOYOLA UNIVERSITY CHICAGO

QUEER PEOPLE NAVIGATING EXPERIENCES WITH HEALTH CARE PROVIDERS
AND CONTRACEPTION

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

PROGRAM IN SOCIOLOGY

BY

DANA ROSE LAVERGNE

CHICAGO, IL

AUGUST 2018

Copyright by Dana Rose LaVergne, 2018
All rights reserved.

ACKNOWLEDGEMENTS

I would like to express my gratitude to the Gannon Center for Women and Leadership for providing the necessary funding for this project. I am also thankful to Dr. Anne Figert and Dr. Dana Garbarski for giving their guidance in the thesis process. A huge thank you to Hope Levy and Hannah Youngblood for their ongoing friendship and support. I am also grateful to Melissa Kinsella for sharing tacit knowledge in the thesis process. Thank you to my parents, Donna and Paul LaVergne, as well as my siblings Christina, John, and Grace for their love and laughter. Lastly, I am endlessly grateful to the sixteen people who gave their time to participate in this study. Without their valuable insights, this thesis would not have been possible.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iii
LIST OF TABLES	vi
ABSTRACT	vii
CHAPTER I: INTRODUCTION	1
CHAPTER II: LITERATURE REVIEW	3
Queer Health Care Inequalities	3
Birth Control	4
Queer Birth Control	6
Current Literature	8
CHAPTER III: METHODS	9
Analysis	11
Participant Demographics	12
‘...’But, you get it’: Researcher Positionality	14
Limitations	16
CHAPTER IV: RESULTS	17
How Queer People Obtain Contraception	17
Where Queer People Obtain Contraception	17
Access and Choice in Contraception Obtainment	21
Mother’s Emotional Support in Obtaining Contraception	22
Mother’s Instrumental Support in Obtaining Contraception	24
Father’s Role in Contraception Obtainment	27
Disclosure of Sexual Orientation and Gender Identity	28
Why Queer People Obtain Contraception: Similarities to Heterosexual Women	34
Pregnancy Prevention	34
Medical Conditions	36
Why Queer People Obtain Contraception: Differences from Heterosexual Women	38
Menstruation Related Dysphoria	38
Pregnancy Related Dysphoria	41
Politics and Political Climate	43
Fear of Sexual Assault	45
CHAPTER V: DISCUSSION	48
Dysphoria	48
Expectations vs Data	50
CHAPTER VI: CONCLUSION	52
Broader Implication	52

Recommendations.....	55
APPENDIX A: INTERVIEW PROTOCOL	57
APPENDIX B: RECRUITMENT FLYER.....	61
REFERENCES	63
VITA.....	66

LIST OF TABLES

Table 1. Respondents' Self-Identified Demographic Characteristics15

ABSTRACT

Contemporary views of contraception have intrinsically linked birth control to heterosexual sex and pregnancy prevention. As such, contraception is culturally understood to be exclusively for heterosexual women. Despite this, the little work that has been done on queer people¹ and contraception use demonstrates they are also accessing birth control (Chrisler, Gorman, Manion, Murgo, Adams-Clark, Newton and McGrath 2015). This schism between the cultural understanding of contraception as a manifestation of heterosexual womanhood and the everyday use of contraception by both queer and heterosexual people takes root in the medical system. Based in heteronormative ideologies, the medical system fails to take into account the needs of queer people (Lim, Brown and Kim 2014). Given both the incongruity in the cultural perception of contraception, as well as heterosexism in the healthcare system, I have chosen to study the intricate relationship between queer women and contraception obtainment. Using face-to-face interviews with sixteen self-identified queer people, this study investigates how queer people obtain contraception, as well as why they obtain contraception. This Study finds that queer people have a myriad of different reasons for obtaining contraception, including pregnancy prevention and relief of dysphoria.

CHAPTER I

INTRODUCTION

Contemporary views of contraception have intrinsically linked birth control to heterosexual sex and pregnancy prevention. As such, contraception is culturally understood to be exclusively for heterosexual women. Despite this, the little work that has been done on queer people and contraception use demonstrates they are also accessing birth control (Chrisler, Gorman, Manion, Murgo, Adams-Clark, Newton, and McGrath 2015). This schism between the cultural understanding of contraception as a manifestation of heterosexual womanhood and the everyday use of contraception by both queer and heterosexual people takes root in the medical system. Based in heteronormative ideologies, the medical system fails to take into account the needs of queer people (Lim, Brown and Kim 2014). Given both the incongruity in the cultural perception of contraception, as well as heterosexism in the healthcare system, I have chosen to study how and why queer people obtain contraception. Using face-to-face interviews with sixteen self-identified queer people, this study investigates how queer people obtain contraception, as well as why they obtain contraception. In doing so, I highlight both the similarities queer people and heterosexual women have when obtaining contraception, as well as the unique experiences queer people have in the medical system. This study concludes with a broader analysis of the choice rhetoric queer people use when obtaining contraception, as well as the implications contraception obtainment has on the perception of sexual orientation and gender identity.

For the purposes of this study, queer will be used as an umbrella label to describe people who identify as non-heterosexual, non-cisgender, or both. This term can comprise of sexual identities, such as lesbian and bisexual. Queer can also be used as an identifying term on its own. The term queer will also be used to describe people who encompass a myriad of gender identities, including transgender, genderqueer, and gender nonconforming. Within this study, not all participants identify as cisgender, and not all participants use she/her pronouns. Participants who do not identify as cisgender use either they/them or ze/zer pronouns in order to refer to themselves. This paper honors participants' choice of pronouns. Although the word "They" has traditionally been plural, within this paper the word "They" is singular when being used to refer to an interview participant. Furthermore, this paper will use the term "queer people" in place of "queer women" in order to refer to participants who were identified female at birth, but do not personally identify that way.

CHAPTER II

LITERATURE REVIEW

Queer Health Care Inequalities

Despite the existence of unique health care needs for lesbian and bisexual women, “they are known to underutilize health care services and to present for care later than heterosexual women” (Weisz 2009). Lack of health insurance and previous negative interactions with medical care providers are the most commonly cited reasons for the disparate utilization of health care services among queer women (Weisz 2009). Furthermore, queer women are reluctant to disclose their sexual identities when interacting with health care providers, as “episodes of hostility, sexist and demeaning comments, withholding information, and inappropriate mental health referrals” are common occurrences (Platzer and James 2000).

This reluctance to interact with the health care system has severe impacts on the health of queer women. Queer women are more likely to miss annual breast examination, pap smears, and mammograms than their heterosexual counterparts (Rosser 1993). Furthermore, queer women report having a higher rate of alcohol consumption, illicit drug use, and cigarette use than straight women (Bernhard and Applegate 1999). These risky behaviors combined with an underutilization of preventative health care measures, places queer women at a heightened risk of breast and ovarian cancers (DHHS 2000). Furthermore, there is ample evidence suggesting that queer women may underreport instances of domestic violence, as well as mental health issues to their health care providers (Bernhard and Applegate 1999). This demonstrates that both physical

and emotional health needs of queer women are not being met by the health care system (Harbin, Beagan and Goldberg 2012).

These health care inequalities, paired with a reluctance on the part of queer women to disclose their sexual orientation to their health care providers raises the question of how queer women navigate their relationship with health care providers. Within the body of literature on sexual orientation and institutions, it has been demonstrated that queer individuals use passing techniques in order to conceal their sexual identities in workplace and educational settings (Fuller, Chang and Rubin 2009). Passing refers to the deliberate process by which one hides their sexual orientation in order to appear heterosexual (Pfeffer 2014). This passing occurs in both subvert and overt ways. In subvert passing, questions on relationships and dating may be answered in vague terms, not lending any clues to the gender of a partner. Moreover, this passing may be overt, deliberately lying when questioned on their sexual orientation (Fuller et al. 2009). While literature addressing queer women passing in the health care system is not readily apparent, using this scholarly lens it could be theorized that queer women utilize these same passing techniques when interacting with health care professionals.

Birth Control

In the fight to obtain birth control, supporters of the women's health movement historically have employed deliberate rhetoric in order to further their agenda. Specifically, the use of narrative frames allowed for supporters to construct images of those who would most benefit from the use of contraception (Liao and Dollin 2012). In doing so, contraception was intrinsically linked to heterosexual sex and pregnancy prevention, despite there being a myriad of health reasons why women would choose to use it (Planned Parenthood 2017).

In 1928, Margaret Sanger furthered her crusade to bring birth control to the masses by publishing letters she received in her book “Motherhood in Bondage.” Within these letters were pleas from young, poor mothers, desperate to prevent another pregnancy (Sanger 1928).

Although this activism eventually allowed for the use of contraceptives (such as the diaphragm and condoms) among married women, these letters also helped to create a cultural narrative on whom birth control was for and who it was not for. (May 2011). When the FDA approved the first birth control pill in 1960, it was narrowly prescribed to married, heteronormative couples (Allyn 2016). Within cultural rhetoric, it was understood that contraception was intended to aid in family planning and to prevent dangerous and illegal abortion procedures (Liao and Dollin 2012). As such, many health care providers refused to prescribe contraception to unwed women (May 2011). Although critics of birth control argued that contraception would lead to promiscuity, the presented narrative of birth control users as poor, married mothers allowed for contraception to continually be prescribed in the United States (Sanger 1928).

As part of both the Women’s Health Movement and the Sexual Revolution in the late 1960s, 1970s, and 1980s activists advocated for a more widespread use of the recently introduced birth control pill. Activists singled out young, white, liberal women as being the ones who would benefit most from using the pill. The pill, they stated, would allow women to be liberated both in terms of their sexuality and their career (Goldin and Katz 2002). This liberation, paired with legal rulings which brought greater availability of the pill to women, changed the cultural narrative of birth control yet again. No longer was contraception use limited to married mothers. Rather, cultural views of birth control shifted so that young women of all marital and relationship status were able to take the pill (May 2011). Although critics of the birth control

movement still linked contraception with promiscuity and moral deviance, women were obtaining the pill in record numbers (Goldin and Katz 2002). Furthermore, in the early 1980s, a greater understanding of the health benefits of taking contraception allowed for the acceptance of individuals taking birth control for non-contraceptive reasons (Ory 1982). In the early 2000s this narrative on contraception shifted once again, with the introduction of menstrual suppression birth control drugs, such as Seasonale. In the creation and marketing of these drugs, birth control pills were no longer framed as a preventative medication. Rather, they now belong to a class of “lifestyle drugs” designed to allow women to manipulate their bodies using pharmaceuticals (Nordqvist 2008).

As the cultural understanding of birth control shifted from family planning to liberation, healthcare, and lifestyle, so did the notion of who birth control was supposed to help. No longer was birth control only targeted towards married mothers. Now, birth control could be used by women regardless of their marital or relationship status. Seemingly, all women were included under this cultural narrative. However, this is not the case. Queer women are still excluded from current cultural conceptions of birth control (Roberts 2000). This exclusion from the birth control narrative problematizes not only how these women experience birth control, but the birth control narrative as a whole.

Queer Birth Control

The incongruities experienced while obtaining birth control extend beyond race, negatively impacting queer women as well. Within the narrative on birth control, queer women are still excluded. There have been few studies examining the ways in which queer women utilize birth control. The work that has been done suggests while sixty percent of lesbian women

engage in heterosexual sex at some point during their lives, only thirty-two percent of those women report using birth control (Klitzman and Greenberg 2002). This is particularly harmful, as birth control is not only linked to pregnancy prevention, but has health benefits as well. Birth control use has been linked with a decreased risk of ovarian, uterine, and breast cancers, and can be used to treat PMS, acne, dysmenorrhea and amenorrhea (Planned Parenthood 2017). Although these health issues impact both queer and heterosexual women, due to the aforementioned inequalities within the health care system, queer women are undertreated for these health issues, perpetuating health care inequalities between heterosexual and queer women (Weisz 2009).

Despite there being little academic work on the ways in which queer women obtain contraception, there have been colloquial pieces written on the impact birth control has had for the queer community. For non-binary and gender non-conforming queer individuals, the use of hormonal birth control is linked to their gender and sexual identities. In some instances, these individuals will use birth control prescribed to them or their cis-female friends in lieu of traditional hormone replacement (Smith 2011). This subversion of traditional use of birth control directly contrasts work that has been published on birth control and sexual identity. Woods (2013) argues drugs that suppress menstruation serve to maintain a heterosexual ideal, as it leaves women available for “clean” sexual intercourse at any time. However, writings on the lived experiences of queer women describe how menstrual suppression may actually affirm a queer identity (Olson-Kennedy, Rosenthal, Hastings and Wesp 2016). By not having a period, some queer women feel as if they are able to escape restricting gender and body norms (Chrisler et al. 2016). In this way, queer women are able to use birth control to fit their own needs despite being excluded from the normative birth control narrative.

Current Literature

Despite there being an emerging literature on queer people using contraception in order to manipulate their bodies, there are still a myriad of lived experiences that are not included in the birth control narratives. Within the narrative on birth control, there is an over-emphasis on individual choice in contraception obtainment. Morgan and Throne (2010) and Crosby, Collins, and Stradtman (2017) write on positive parental influence in their young adult and adolescent children's decision to obtain contraception. However, these studies do not take into consideration the unique experiences and familial dynamics that queer young adults and adolescents may experience. A study by Newcomb and colleagues (2018) found that parents struggle to discuss sexual health and wellbeing with their queer children, despite parents wanting to have these conversations. Without understanding the multitude of factors that queer people consider before obtaining contraception, it is difficult to contextually understand the interactions queer people have in their subsequent health care appointments. In 2017, Baldwin, Dodge, Schick, Sanders and Fortenberry conducted a study on satisfaction queer women have with their health care providers. Baldwin et al. found that in states with supportive and inclusive legislation in regards to queer rights, queer patients are more satisfied with their health care. While this study is among one of the most contemporary studies on the healthcare needs of queer women, Baldwin et al. do not specifically write on contraception and reproductive health care. Within academia, there is little understanding of how and why queer people obtain contraception. This study strives to both answer these important questions on the lived experiences of queer women, as well as call for more research into the experiences of queer people within the medical system.

CHAPTER III

METHODS

In order to gain more insights into the experiences queer people have when obtaining contraception, I conducted both semi-structured and cognitive interviews with research participants. To be eligible to participate in this study, my interview subjects had to meet four separate criteria. The first requirement was that participants must self-identify as queer. My participants ranged in their sexual orientation identity labels, as some identified as lesbian while others identified as bisexual and pansexual. Furthermore, my participants ranged in their experiences of their gender identities, as six out of sixteen participants did not self-identify as Cis-Gender or woman. These participants identified as Gender Queer and Gender Non-Binary, while others used terms like Femme and Gender Fucked to describe their embodiments of gender. Despite my participants encompassing a diverse range of sexual orientation identities and gender identities, they all shared the commonality of not identifying as heterosexual while having bodies that were assigned female at birth. The second criteria was that participants must have obtained contraception while simultaneously identifying as queer. While participants ranged in their disclosure of their sexual orientations to others at the time they obtained contraception, all of my participants were “out” to themselves. The third criteria for participation was that participants must speak English. This is because I, as an interviewer, do not have the language skills needed to complete an interview in another language. Lastly, all of my

participants were over the age of eighteen. This was done in order to ensure participants were not a member of a protected group under IRB protocol.

Participants were recruited through social media platforms made for queer people. Flyers were posted in online communities like Facebook's Chicago Queer Exchange, Chicago Intersectional Queer Exchange, and Chicago Queer Friendship. Furthermore, a recruitment flyer was posted on a bulletin board at Chicago's Center on Halsted. Recruitment for this study was voluntary, and I as the researcher did not solicit participation by contacting potential participants directly. Rather, on the recruitment flyer participants were given access to my email address and phone number, and were told to call or email if they wanted to participate. In order to incentivize participation, the people who were interviewed were given a \$30 Amazon electronic gift card at the conclusion of the interview.

This study utilizes both semi-structured and cognitive interviews. During the semi-structured interviews, queer people were asked questions on how they obtained contraception, who influenced their decisions, and if this contraception use changed the perception of their sexual or gender identity. In the cognitive interviews, participants were read a series of survey questions measuring sexual orientation and gender identity. During this portion of the interview, participants were asked to both verbally respond to the questions as posed, as well as give insights on what they were thinking when they answered these questions. Interviews lasted between forty-five minutes to an hour and a half. These interviews were conducted in semi-public locations of the participant's choice. Fourteen of the sixteen interviews were conducted in person. Interview locations ranged from offices on Loyola University Chicago's Lakeshore

Campus, to coffee shops and cafes in Chicago. Two interviews were conducted via Skype with participants who had seen my recruitment flyers but were no longer living in the Chicago area.

Analysis

After my interviews were completed, I saved the audio files on my password protected computer. Using an audio playback application, I transcribed my interviews into a Word document. Once the interview was completely transcribed, I then began coding my interview data using an Excel spreadsheet. Using Excel, each question and subsequent response was placed into a single cell. This allowed all questions (both those from the protocol and those I asked as follow-up) and their answers to have their own interview cell. After the interview questions and answers were broken down into individual cells, I then went through these cells noting the interview themes that emerged.

Although I begin my coding process using open coding, the interview data began showing specific result patterns, and the coding process became more refined to account for these patterns. After this first round of coding, I took the codes I had originally created and refined them. Using these codes, I then analyzed the data a second time, placing these new codes in a third column in the excel spreadsheet. After creating this third column, I then went through the codes in order to see what themes were most salient. Both when writing my interview protocol and in coding my data, I had no research hypothesis in mind. My interview protocol was written as broadly as possible, as to allow for a wide range of narratives to be shared during the interview. Furthermore, in not having a hypothesis, I was able to find what narratives were most salient and spoke most towards the experiences of queer people obtaining contraception.

Participant Demographics

The participants interviewed for this project were not demographically homogenous. Of the sixteen participants I interviewed, six used the term queer to describe the embodiment of their sexual orientation, while another four used the word queer in tandem with other sexual orientation identity labels like lesbian or bisexual. Two participants exclusively used the term bisexual, while another two exclusively used the term pansexual. Furthermore, two participants in the study exclusively used the term lesbian. Ten participants in the study either used the term Cis, Cis-Women, or Women to refer to their embodiments of gender identity. Three participants identified as Gender Queer, while one participant used the term Gender Non-Binary and another used the term Gender Fucked.

When recruiting for this thesis, the flyer that was posted online and at Center on Halsted encouraged queer people who were taking contraception to contact me if they would like to take part in this study (See Appendix B). In keeping the language of the recruitment flyer purposefully non-descriptive, it allowed participants who had a myriad of different conceptions of queerness to participate in this study. For some, “queer” was connected to their sexual orientations. Those who were non-heterosexual and who were taking birth control were able to self-identify as eligible for participation in this study. Other participants connected their queerness to their gender identities. Those who identified as not being cisgender were also able to self-identify as eligible for this study. As part of the criteria of this study, participants must have been ‘out’ to at least themselves at the time they obtained contraception. However, the degree to which participants were ‘out’ to others varied greatly. For some participants, at the time they obtained contraception they did yet have the ability to define their sexual orientation

and gender identity in specific terms, only that they were not heterosexual or cisgender. For these participants, not having a specific label impeded their ability to come out to others. On the other hand, there were participants who had been both out to themselves and others for a while before deciding to obtain contraception. Furthermore, through the course of these interviews, participants revealed that the ways in which they conceptualized their sexual orientation and gender identity had changed over their lifetime. Participants discussed how when first obtaining contraception they identified with one identity label, only to subsequently identify with other labels during follow-up appointments.

In terms of contraception use, six of the sixteen participants had an IUD at the time of the interview. The IUD, or Intrauterine Device, is a small T-shaped coil placed in the uterus by a medical professional. IUDs can either be hormonal, meaning it releases doses of progestin in order to prevent pregnancy, or they can be copper, which acts as a spermicide. Another five of the participants used oral contraception at the time of the interview. Three participants were using Nexplanon. Nexplanon is the most well-known birth control implant. The matchstick sized device is inserted under the bicep, and releases hormones to prevent pregnancy. One participant used Nuva Ring, which is a flexible ring that is self-inserted in the vagina for three weeks at a time in order to prevent pregnancy (Planned Parenthood 2017). At the time of the interview, one participant was not using contraception, although had previously obtained contraception while ‘out.’ Twelve participants self-identified as either white or Caucasian, while two identified as mixed race and another two as either African American or Black. The participants were most similar in terms of their educational status. Of my participants, all completed high school, and fourteen of the sixteen participants completed college. Furthermore, of those who completed

college, another three had either completed or were on track to complete a graduate degree. A complete chart of participant demographics can be found in Appendix A.

‘...But, you get it’: Researcher Positionality

Like all social science researchers, my positionality has influenced the way in which I approach my work, as well as the types of data I am able to collect. As a queer woman, I am privy to social and digital communities on the basis of my sexual orientation. In recruiting participants for this project, my own queerness was vetted by moderators of these Facebook groups before I was allowed to post recruitment flyers. This process of vetting made it so participants could trust that I would be a worthy confidant. Before and after multiple interviews, participants disclosed that they felt comfortable being interviewed by me, as I would “get it”.

Much of my ability to ‘get it’ was predicated on my physical appearance. As seen in Table 1, the majority of my participants were white and in their twenties. As a queer white woman in my early twenties, my participants and I shared social and cultural capital that made it easier to establish a rapport. For instance, upon noticing my dyed hair and tattoo before the interview began, Rachel told me I had a “queer look” that made her feel at ease. Through both my queerness and the vetting of my queerness by moderators of these Facebook message boards, I was able to obtain information and research populations I would not have otherwise been privy to.

My own positionality as a queer researcher places me in a position in which I can speak towards the experiences of my research participants without othering or further marginalizing their identities and experiences. However, with this positionality also brought up challenges of reflexivity when conducting interviews and analyzing the interview data. Due to my own

closeness with the subject matter, I had to ensure I could remove my personal biases and interpretations of the subject matter from the respondents' answers. Through both personal conduct during the interview process and objective coding during analysis, I attempted to alleviate any biases I may have brought into the data collection process.

Table 1. Respondents' Self-Identified Demographic Characteristics

Pseudonym	Sexual Orientation	Self-Identified Gender Identity	Current Contraception Used	Age	Self-Identified Race	Preferred Pronouns
Siobhan	Bisexual	Cis Female	The Pill	29	African American	She/Her/ Hers
Rachel	Queer	Cis Female	IUD	25	Caucasian	She/Her/ Hers
Alison	Pansexual	Female	Nexplanon	23	Caucasian and Israeli	She/Her/ Hers
Cosima	Queer and Lesbian	Cis Gender and Gender Queer	The Pill	35	White	She/Her/ Hers
Charlotte	Lesbian	Cis Women	IUD	24	White	She/Her/ Hers
Elle	Queer	Femme	IUD	25	White	She/Her/ Hers
Felix	Queer	Gender Queer	None	25	White	Ze/ Zir/ Zirs
Frankie	Pansexual	Gender Fucked	IUD	23	White and Native American	They/Them/ Theirs
Natalie	Queer and Bisexual	Cis Women	Nexplanon	22	White	She/Her/ Hers
Harper	Queer and Bisexual	Cis Women	Nexplanon	24	Black	She/Her/ Hers
Nora	Lesbian	Cis	The Pill	19	White	She/Her/ Hers
Molly	Bisexual	Woman	The Pill	23	White	She/Her/ Hers
Tyler	Queer	Gender Queer	IUD	26	White	Ze/ Zir/ Zirs
Rose	Queer	Female/Cis Gender	The Pill	24	Caucasian	She/Her/ Hers
Colin	Queer	Gender Non-Binary	IUD	25	White	They/Them/ Theirs
Beth	Bisexual and Queer	Cis-Female/ Women	Nuva Ring	24	White	She/Her/ Hers

Limitations

As is the case with most research, my study has limitations. In recruiting through Chicago-based Facebook groups, all of my participants either live or have lived in highly urban environments. As such, their experiences do not reflect respondents living in rural areas. Furthermore, because government support for contraception access varies state to state, the experiences captured within these interviews largely reflects politics in Illinois. Moreover, my interview participants have all received a high degree of education. This high level of educational attainment varies from the known statistical information on queer people and education, which states queer women are less likely to complete college than their heterosexual counterparts (Sears 2005). Lastly, fourteen of my sixteen participants identify as white. While this is congruent with data on self-selection for participation in medical studies, contraception attainment among queer people of color needs to be further studied (Scalici et al. 2015).

CHAPTER IV

RESULTS

How Queer People Obtain Contraception

One of the key questions this thesis strives to answer is how queer people obtain contraception. This section opens with a discussion of which medical care providers queer people utilize in order to obtain contraception, and how they make these health care decisions. Next, this section will demonstrate who queer people consult when making decisions on obtaining contraception. While previous literature has showed that LGBT teenagers and adolescents have difficulty communicating their sexual health needs with their parents, my data shows that motherly emotional and instrumental support is pivotal for many queer people to obtain contraception. Lastly, this section delves into the experiences queer people have in their health care interactions. While disclosure of sexual orientation and gender identity during health care appointments varied among participants, in some way, every participant grappled with the choice to out themselves to their health care providers.

Where Queer People Obtain Contraception

All sixteen interview participants indicated they obtained contraception using the medical system. In doing so, participants used a multitude of different medical care providers. Five participants indicated that they exclusively used publicly available health providers, such as Planned Parenthood and Howard Brown Health Center in order to obtain contraception, while eight participants exclusively used private health care providers. Three participants indicated

they use a combination of public and private health care providers. Surprisingly, despite the interview participants all having been enrolled in some sort of higher education, only one participant discussed getting contraception through their university's health center.

Among the participants who exclusively used Planned Parenthood in order to obtain contraception, they cited multiple reasons for doing so. For Elle, a white queer femme identifying person, the ability to access a multitude of health services made Planned Parenthood the obvious choice for where to obtain contraception. When asked why Elle chose to use Planned Parenthood to obtain contraception, she told me:

um, it's... access to everything is easier. Hormones, birth control, like we (partner) go to the Near North Planned Parenthood. I love them, they're fantastic. It doesn't seem like much of a struggle to do anything related to hormones or birth control, or up here (points to chest). You walk in and they're like, 'hey, sure'.

When discussing her reproductive health care needs, Elle views her choice to obtain contraception in tandem with her potential choice to use testosterone in the future. As such, in using Planned Parenthood Elle is able to ensure she can establish rapport with a health care institution that can get both her present and future health care needs met. When thinking about where to access contraception, Elle stated that Planned Parenthood seemed like the obvious choice. Other participants shared this sentiment as well. Nora, a lesbian cis woman described how Planned Parenthood was colloquially known for contraception. When asked how she chose Planned Parenthood over other health care providers, Nora stated: "It's like when you think about 'Where do I get contraception from?' It's from Planned Parenthood." When discussing where they obtained contraception, Nora and Elle cited both the ubiquity and availability of Planned Parenthood, as well as the services they provide as reasons for using Planned Parenthood. In making their choices, neither Nora nor Elle discussed the insurance or

affordability as reasons for using Planned Parenthood. For them, their choice was not restricted by finances. This was not true for all participants. In the next section, restriction to access and choice when obtaining contraception will be discussed further.

Much like those who used Planned Parenthood to obtain contraception, those who utilized private insurance had a myriad of reasons for doing so. Harper, a queer and bisexual Black woman discussed how her occupation as a health educator prevented her from accessing public health centers. When asked why Harper utilizes private healthcare providers, she stated:

Honestly I tend not to get my medical, you know, procedures done at (one of the publically available health centers) because I know so many people who work there. Like a lot of people know me on a very personal first name basis.

Harper prefers to use private health care providers due to the line of work she has entered into.

Other participants have cited personal preference as reasons for seeing a private health care provider. Felix, a white genderqueer participant described zir's preference for a private provider.

When asked what kind of doctors Felix used to obtain contraception, zir and I shared this exchange:

DL: So when you were obtaining contraception, did you use services like Planned Parenthood, or was it through primary care providers?

Felix: I went through um, with my insurance for all the contraception.

DL: Can you tell me a little bit more about why you haven't gone to Planned Parenthood?

Felix: Well I am a little picky when it comes to gynecologists. Like I really need my gynecologist to be the same person every time. And I need them to be a doctor and not a nurse practitioner. And I feel like at places like Planned Parenthood and Howard Brown you might end up with a different provider.

Interestingly, while Elle prefers to use Planned Parenthood due to the continuity and ubiquity of the care she can receive, Felix cites these factors as the very reason ze choses a private care provider.

Although there are participants who clearly state they prefer one form of healthcare provider over another, there are participants who have utilized both private and public health care institutions. Siobhan has utilized a combination of public health care providers like Planned Parenthood, as well as private health care providers. When recalling the way in which she first obtained contraception, Siobhan told me:

I went to Planned Parenthood... I had, wasn't really sure what to expect. I went-I'd only really known about Planned Parenthood through word of mouth and from what I could find on their website. And I didn't know what to expect when I went in, but the services were great through.

However, after the Affordable Care Act passed in 2010, Siobhan was able to obtain health insurance. Siobhan told me: "Occasionally I'll go through my insurance, cause now I have insurance through the ACA. I still prefer to get my reproductive health care at Planned Parenthood." For Siobhan, the ACA provides her the opportunity to obtain contraception through a private health care provider. However, Siobhan discusses how she prefers to utilize Planned Parenthood, as things go more "smoothly" with them than with the providers her insurance recommends. For participants like Siobhan and Felix, the ability to choose one health care provider over another is indicative that they do not experience a great deal of constraint in their health care decisions. In this next section, the ways in which participants navigated their constraints in making health care decisions is explored further.

Access and Choice in Contraception Obtainment

Where participants ultimately decided to obtain contraception was contingent on both their ability to access health care providers, as well as their ability to choose between health care providers. For some participants, like Felix and Nora robust insurance plans mean they both have access to health care, as well as choice in the types of providers they are able to utilize. As discussed above, Felix's ability to be "picky" when choosing health care providers is contingent on zir's access to insurance. When asked to elaborate more on this use of health care providers through insurance, Felix stated: "I really feel like if I can afford to see a doctor, I want to see a doctor." Felix links zir's ability to see a doctor rather than a nurse practitioner with having insurance that would allow zir to have preference on the types of care providers ze sees. Nora, a white lesbian also described how having good insurance influenced her decision to obtain contraception. After moving out of her parents' house to attend college, Nora decided to obtain contraception. When walking me through this process, Nora stated:

I started school really early, so I moved out of my parent's house pretty quickly. And I'm still on their insurance but I really didn't want them involved in the process at all, so I was avoiding doctors who would talk to them, that sort of thing. And Planned Parenthood seemed to be the easiest, it seemed safe. There was one near where I was living, and getting an appointment online was really easy.

Although later in the interview Nora indicated that she could have sought a primary care provider using her parents' insurance, her geographic location and knowledge of Planned Parenthood as a cultural institution made both her ability to access contraception and her choice in doctor a straight-forward choice.

Both Nora and Felix were able to access health care, as well as enact their ability to choose which health care institutions they obtain contraception. However, not all participants

were able to have this degree of freedom in making health care choices. For Alison, her ability to obtain contraception was limited due to the health care institutions she could access. Alison describes how she used Planned Parenthood in order to obtain the Nexplanon implant during her junior year of college. When describing the way she made the choice to go to Planned Parenthood, Alison stated: “The school I went to was a very small liberal arts college, and their health center was not the best. In fact, they would refer people to Planned Parenthood, as I recall.” Until Alison made the choice to switch from the pill to the Nexplanon implant, Alison would get her birth control prescription from her campus health center. When asked why Alison didn’t go through her campus health center to obtain the Nexplanon implant, Alison told me:

Going through the health center at my school would have cost more and was frankly less realistic. If I had gone through the school I would have had to continue taking the pill, because I do not believe the school I went to provided other birth control services, and you had to pay for a prescription.

Alison theoretically had the ability to obtain contraception from her campus health clinic and her local Planned Parenthood. However, both the cost of contraception through her campus health center and the limitations to the types of contraception the health center could provide made it so Alison was limited in the types of institution she could utilize when obtaining contraception.

Mother’s Emotional Support in Obtaining Contraception

In making the choice to obtain contraception, eleven of sixteen participants made reference to the emotional support their mothers provided. However, among participants, the amount of emotional support varied. When asked about her parents’ support in obtaining contraception, Rose, a queer white woman, stated that her mother knew she was obtaining contraception, and did not have any concerns. However, Rose did not mention her mother’s influence further. Harper had a similar experience. After graduating from college, Harper stated:

My mom, she just made a very funny joke, she was like, ‘Now that you have your Bachelor’s degree you can start having grandkids,’ and I was like ‘Nope, you just reminded me I need to get on birth control like yesterday.’

Much like Rose, Harper did not mention her mother providing more emotional support when obtaining contraception; although Harper stated she felt comfortable discussing her sexual orientation and romantic experiences with her mother. Elle felt equally able to discuss her sexual orientation and health needs with her mother. Due to a medical condition, Elle was unable to take a hormonal birth control pill and instead had to use an IUD. Elle described how her mother helped her both choose to go on an IUD, and pick a doctor. Elle describes:

...but it was a gyno that my mom went to, that I’d seen a couple of times. And my mom had one (IUD) and was like, ‘If you can’t take birth control, you need something. I’m not just going to let you out into the world with nothing.’ So she like advocated for that to happen. And it’s wonderful. I love it. I feel like I don’t have to worry about anything. So it was easy getting it because of my mom.

Even though Elle felt comfortable speaking to her mother about her sexual orientation and sexual health, other participants reported having more bounded relationships with their parents. Rachel discusses how although her mother made herself available to discuss matters of sexual health, she personally does not feel comfortable doing so. Rachel, a queer white woman told me:

My mom’s very open and honest and um, was always like, although I would never talk to her about sex or did I want to, she was always okay with me coming to her about that stuff. She’s always. She’d rather me talk to her about it and like, go see a doctor, and like, take steps to me being healthy and to hide it and end up with an STD because I didn’t know better.

Participants reported varying comfort levels in utilizing their mothers’ emotional support both when obtaining contraception and when discussing sexual health more broadly. However, sixty-seven percent of participants reported having some degree of positive emotional support from

their mother. This finding varies from current literature on parental comfort in discussing sexual health needs with their LGBTQ children. Newcomb, Feinstein, Matson, Macapagal and Mustanski (2018) reported that parents of LGBTQ children often felt uncomfortable and ill prepared to discuss sexual health with their children. Furthermore, Newcomb et al. also found that LGBTQ children and adolescents felt uncomfortable bringing up issues on their sexual health and wellbeing with their parents. This discomfort was not present among the queer people interviewed as part of this study, suggesting the need to further investigate motherly emotional support for their female-bodied queer children.

Mother's Instrumental Support in Obtaining Contraception

Not only did participants report having positive experiences with their mother's emotional support in obtaining contraception, eight out of sixteen participants also stated their mothers provided instrumental support in obtaining contraception. This instrumental support took two forms, the first being through the utilization of their mother's insurance to make healthcare appointments and the second being through mothers setting up and bringing their children to health care appointments. In obtaining contraception, Charlotte, a white lesbian, did not directly utilize her mother for emotional support. However, Charlotte said she purposefully went to a doctor covered under her mother's insurance rather than go to Planned Parenthood when she obtained contraception for the first time. For participants Frankie and Natalie, their mother's employment in the health care industry was pivotal in their ability to obtain contraception. Natalie, a queer and bisexual white woman, told me, "My mom's a dentist, and she knows a lot of doctors and stuff. She definitely expedited the process." Natalie perceived her mother's occupation as a way to bypass perceived systemic barriers that would make the process

to obtain contraception take longer. When describing their choice to obtain contraception due to menstrual cramps, Frankie, a white, pansexual, “gender fucked” participant said:

...My mom’s a doctor so she had really good insurance through her hospital. And I was able to use it because I was getting sick...and I got it. My mom has good insurance and I’m still under her insurance because I’ve got some time.

For Frankie, their ability to easily get contraception was contingent on their mother’s occupation. Furthermore, Frankie’s continued use of birth control is dependent on being young enough to still be under their mother’s insurance. This is true for Harper as well. When discussing her transition from the pill to Nexplanon, Harper said:

Okay, so um, I actually went to the medical district to get my Nexplanon installed since I am still a baby, I am 24, I am still on my mom’s insurance and I was able to get it through her.

Charlotte, Natalie, Frankie, and Harper all relied on their mother’s insurance to help them obtain contraception, with Harper and Frankie making explicit mention of this ability being bounded by age.

For some of the people interviewed in the study, their mothers played a direct role in the facilitation of health care appoints. However, of the four participants interviewed, three noted they felt the need to lie to their parents about their sexual behavior in order to obtain contraception. For Rachel, her age when she first obtained contraception made it so she would have to seek her mother’s help in doing so. Rachel described how she first obtained contraception in her mid-teens, by using her menstrual cramps as a reason for doing so. Rachel stated:

I was with a child care doctor um, and so uh, my mom set me up with an appointment with her obgyn... my mom brought me to get the pill and on a side note I was also sleeping with someone she didn’t know about but I was like okay, this will be easier.

Felix had similar experiences, ze used zir's menstrual cramps in order to get zir's mother to make an appointment. Felix said, "When I was 15 and I got birth control pills for the first time I went to see my mom's gynecologist. And it was like my mom and my sisters' gynecologist, like our families' gynecologist." Much like Rachel, Felix was able to use an established connection with the doctor of zir's mother in order to facilitate obtaining contraception. Both Rachel and Felix were sexually active in their teenage years, yet wanted to obscure this knowledge from their mothers. In doing so, they prioritized their menstrual cramps over sexual activity with people who could lead to pregnancy. Colin, a white, queer, gender non-binary person, told me:

I think my mom helped me out some. I kind of felt like at the age that I was - I was in my early 20's, but I like I still had to be like 'I'm doing it for the health part not the sex part' ... I guess we didn't talk too much about it, I was just kind of like... I've had cramps for a long time, um I said I felt like they were getting worse, so she helped me set up an appointment with a doctor in my home town. I think that's mostly it.

Like Felix, Colin used their experiences with menstrual cramps as a way to create a dialogue with their mother in order to gain her help facilitating an appointment with a contraception care provider. However, unlike Rachel and Felix, Colin was over eighteen and in college when they obtained contraception. For Colin, their age did not prevent them from obtaining contraception from a Planned Parenthood or a campus health care provider. This shows that like other participants, Colin had established a comfortable enough rapport with their mother that they felt comfortable enough bringing up concerns about reproductive health, while at the same time felt uncomfortable discussing overt aspects of their own sexuality. While this varies slightly from those who solely had their mothers emotional support in obtaining contraception, Morgan and Thorne (2010) show that the age at which children engage in conversations with their parents has

influence over their comfort level, with older adolescents and young adults experiencing more comfort discussing their sexual behavior.

Father's Role in Contraception Obtainment

Although eleven of sixteen participants mentioned their mother had provided them emotional or instrumental support in some capacity, only two participants discussed their fathers. Both Rachel and Felix discussed how their fathers had either no influence or negative influence in obtaining contraception. When asked if anyone had either positively or negatively influenced their choice to obtain contraception, Rachel responded, "Umm, I don't think so. I know I didn't tell my dad, 'cause that's just weird. I think eventually he found out and was like, 'Oh, okay'. No one really cared." Even though Rachel's father was not privy to her choice to obtain contraception, Rachel views his inaction as a benefit. Because Rachel had both emotional and instrumental support from her mother and her father posed no opposition to her obtaining contraception, Rachel went on to say, "I got really lucky with my parents." It is important to note that when discussing her father's role in obtaining contraception, Rachel considered it "weird" to discuss contraception obtainment with her father. This is consistent with Crosby et al. (2017) who discuss the perception of fathers as sexual educators among college age women. In their article, Crosby et al. show how young women often felt uncomfortable or embarrassed by their father's attempt to discuss sexual health. Much like the participants in the study conducted by Crosby et al., Rachel felt more comfortable discussing contraception with her mother.

While Rachel's father was neutral in her decision to obtain contraception, Felix had an overtly negative experience discussing contraception with his father. Both because Felix had started having sexual encounters with people who could get him pregnant, and because he

experienced painful periods, Felix's mother and therapist recommended ze start birth control. Like Rachel, Felix had both emotional and instrumental support from his mother. However, Felix's father had contention with zir being on birth control. Felix stated: "My dad was absolutely like 'Never, that's not going to happen'." Felix expressed that zir father was uncomfortable with many aspects of zir embodiment of gender identity. However, because Felix has an understanding mother and sister, Ze was able to obtain contraception. Furthermore, because of geographic distance between Felix and zir's father, Felix did not have to take the opinion of zir's father into consideration. This finding is incongruent with Crosby et al. (2017), who showed that fathers in bi-nuclear households are more inclined to speak with their daughters about contraception and sexual health. Although Felix is gender queer, and not a daughter per se, zir's biological experience align with those in Crosby et al. While the overt lack of fatherly support was not detrimental to Felix being able to obtain contraception, zir's experience shows the need for more insights into parental support for trans and gender non-conforming people when making medical choices.

Disclosure of Sexual Orientation and Gender Identity

One of the pivotal questions this project set out to examine is the ways in which queer people disclose their sexual orientation and gender identity when obtaining contraception. Of the sixteen participants, fourteen indicated that they had disclosed their sexual orientation or gender identity at least once to a medical provider when obtaining contraception. When asked about why they chose to do so, a majority of participants cited the health care intake forms, as well as the institutions they obtained contraception from. When asked if they disclosed their sexual orientation when obtaining contraception, both Harper and Rose cited the inclusive health care

intake form their providers used as reason for doing so. Harper, who used a private health care provider to obtain contraception explained to me, “I don’t think – I think in the process I may have said it once, but I did uh, always put it written form.” Although Harper doesn’t specifically remember disclosing her sexual orientation verbally, she makes it a point to always disclose her sexual orientation to providers whenever possible.

Rose, who also obtained contraception from a private health care provider also shared this sentiment. Rose explained, “Normally whenever I have a new gynecologist and I do a new intake form, the providers I see have tended to indicate on those intake forms for um, sexual identity or who your sexual partners are.” Rose views the intake form her doctors have her fill out as a place for her to disclose her sexual orientation. However, Rose expressed frustration with these forms. Rose told me:

I think even though I’ve filled out those intake forms and at some points even had verbal disclosure to my providers, anytime I go to like follow-ups or anything like that later on I think people go on my chart and look what kind of birth control that I’m on and assume that I’m like heterosexual or that its specially for that reason.

Rose expressed frustration that her contraception use was intrinsically linked to heterosexuality by her medical providers. Furthermore, Rose’s frustration also indicates that health care intake forms alone may not be enough in order to ensure that one’s identity is known and respected in the medical system.

For many participants, using health care institutions like Planned Parenthood helped assuage the fear that they would not be able to obtain contraception. Nora who used Planned Parenthood to obtain the pill explained to me that she was nervous about disclosing her sexual orientation during her appointment. When asked to explain further, Nora told me,

I guess I sort of knew that of course they would give it to me. Like that's not, they would do that. But I couldn't stop worrying about it I guess? Like it seemed so weird. Lesbians aren't supposed to need contraception.

However, both from talking to a friend, and from meeting her health care provider at the Planned Parenthood, Nora felt comfortable disclosing her sexual orientation. She told me, "The people here (Planned Parenthood) are awesome, they're great... when I saw the doctor, she was also really nice." Although Nora was nervous that she would not be able to obtain contraception due to her sexual orientation, other participants knew of Planned Parenthoods reputation as being queer friendly. When asked if she felt comfortable disclosing her sexual orientation to her contraception provider, Charlotte told me she was, because "Planned Parenthood is pretty into that kind of thing." For Charlotte, her comfort in disclosing her sexual orientation to her health care provider was predicated on the knowledge that she would be able to obtain contraception regardless of her sexual orientation.

Institutional trust in Planned Parenthood allowed respondents to feel safe in disclosing their sexual orientation and gender identity when obtaining contraception. However, for Alison and Elle, despite using Planned Parenthood in order to obtain contraception, they felt unsafe disclosing their sexual orientation and gender identity. This was due to the geographic region they were living in when obtaining contraception. Although majority of participants were living in Chicago when they obtained contraception, both Alison and Elle were living in conservative parts of the country at the time they obtained contraception. When Alison obtained contraception, she was attending college in a conservative part of the country. Upon being asked if she had disclosed her sexual orientation at her college town's Planned Parenthood, Alison told me, "I don't believe I did... while Planned Parenthood is on the whole a progressive place, the

town that I went to college in was not as progressive. And I, at times, would selectively chose who I outed myself to.” When asked to elaborate further, Alison told me, “In this town in general, like, it was, I had a friend who suffered homophobic experiences in that town around that time... it felt safer not to mention.” For Alison, her ability to feel safe when obtaining contraception was marred by instances of homophobia her friend experienced in that town.

Elle, another participant had similar fears of safety due to fears of homophobia in her town. When asked if she had disclosed her sexual orientation to her health care providers, Elle stated,

On just like a ‘do you really need to know’ basis. Especially being in Georgia. Like if you don’t need to know, then I’m not going to tell you because ‘We’re in the South’. And that’s really it. ‘We’re in the South.’

Elle’s fear of disclosing her sexual orientation when obtaining contraception at Planned Parenthood was based solely in geography, as once moving to Chicago, she felt comfortable disclosing her sexual orientation. When asked why she disclosed at Planned Parenthood in Chicago, Elle referenced health care intake forms as being a pivotal reason why she disclosed. Elle told me, “When you walk into a place and like in their form they ask for pronouns, identify, male, female, trans, non-binary, it’s a good feeling.” Although both Alison and Elle were afraid to disclose their sexual orientation due to homophobia in their towns, Elle still holds trust in Planned Parenthood as an affirming institution. This is congruent with Baldwin et al. (2017) whose study showed that queer people receiving health care in conservative regions of the countries are both less satisfied with the healthcare they received and less comfortable in their health care interactions.

Although there are characteristics of the health care system that enables queer people to feel safe disclosing their sexual orientation, for some, this comfort was because of the actual healthcare practitioners. Molly and Rachel both describe how characteristics of their health care provider allowed them to feel safe in their appointments. Molly, who obtained contraception from a private provider told me, “I trust my doctor. I feel like I'm not going to be discriminated against for saying that (sexual orientation).” When asked to elaborate further, Molly stated,

I've always had female doctors and I've always been more honest with them. I'm kind of scared of having a male doctor a little bit, even though it's kind of irrational... I definitely feel like I want to be taken care of by somebody who has gone through similar experiences to me in a physical way.

For Molly, the ability for her contraception provider to relate to her bodily experiences was pivotal in her ability to trust her provider enough to disclose her sexual identity. Rachel also described how individual characteristics of her doctor made her feel comfortable enough to disclose both her sexual orientation, as well as other aspects of her personal life. When asked about her provider, Rachel told me:

My doctor was very open and honest and was like, nothing leaves this room, this is all confidential. Like, I told her I smoked weed, I told her like literally every detail of my life I thought maybe would help... I've always been super open, and I mean honestly like part of it was that she was a really nice black woman, and if instead I were with a white man I probably would have not said anything. But she was awesome, and just, she wanted to make me feel comfortable.

Both Molly and Rachel discuss how the gender of their health care providers allow them to maintain a better rapport with their contraception provider. Furthermore, as Rachel demonstrates, her health care provider's openness to discussing Rachel's personal life means that she in turn placed more trust in her health care provider. This trust allowed Rachel and Elle to feel

comfortable disclosing their sexual orientation, and suggests that in order to improve health outcomes for all queer patient's providers should work to establish judgment free rapport.

For some participants, characteristics of the medical care system and individual health care providers allowed them to feel safe enough to disclose their queerness to health care providers. However, other participants indicated that their physical embodiments precluded their ability to attempt to pass in the medical system. When asked if she had ever attempted to pass as heterosexual when obtaining contraception, Cosima told me,

...No. I don't, no, no. I've always been a little, let's say gender variant or whatever. And like I've never thought that I could pass as heterosexual if I wanted to. Like when people look at me on the street I'm like what people think of as gay.

Because of her physical appearance, Cosima indicates that health care providers, as well as most other people perceive her to be queer. As such, Cosima does not feel like she could feasibly pass as heterosexual when obtaining contraception. Both Tyler and Colin also share in this frustration as well. When asked if they had tried to pass when obtaining contraception, Colin responded,

I don't think so because I kind of headed it off before I could have done that. Because I was really upfront about my name and pronouns, 'Cause it's really important to me, and I struggle to get through situations where I have to hide that.

For Colin, their discomfort being misgendered by their medical care providers makes it so they have to 'out' themselves preemptively to their contraception providers. Furthermore, Colin expressed that when seeking health care providers, they have to conduct extra research into their providers in order to ensure they are accepting of transgender and gender non-conforming patients. When obtaining contraception, Tyler also felt like their embodiment of their gender identity made it so they could not pass as cisgender. Tyler told me, "I have to tell them I'm trans because they know what medication I'm taking, and they see I'm taking testosterone and they're

like ‘Why are you taking that?’” For Tyler, Zir’s simultaneous use of testosterone and contraception makes it so Tyler is forced to disclose Zir’s gender identity. Cosima, Tyler, and Colin are placed in situations where their embodiments force them to disclose their gender identity. Unlike the other participants who make an active choice to disclose their sexual orientation and gender identity, Cosima, Tyler, and Colin are constrained in their choice.

Why Queer People Obtain Contraception: Similarities to Heterosexual Women

Another key question this study set out to answer is why queer people chose to obtain contraception. This question is broken down into two sections, as interview data suggests there is a myriad of reasons why queer people would choose to do so. This first section examines the rationale behind obtaining contraception that is shared between heterosexual women and queer people. Among participants, pregnancy prevention was one of the most commonly cited reasons for obtaining contraception. Pregnancy prevention was a crucial part of contraception use, as participants either were not yet ready to have children or never wanted to have children. Much like heterosexual women, queer people also use contraception in order to alleviate medical conditions. Some use contraception for medical purposes in tandem with pregnancy prevention, while for others, treatment of medical conditions is the sole reason for using contraception.

Pregnancy Prevention

Fifteen out of sixteen participants indicated they obtained contraception in order to prevent pregnancy, making pregnancy prevention the most salient commonality between participants. Much like heterosexual women, queer people use contraception to prevent against pregnancy when engaging in sex with men. When asked about her decision to obtain contraception, Siobhan, a bisexual, African American women stated, “I was a senior in high

school, and I had a male partner, and I was concerned about getting pregnant.” Similarly, Natalie stated, “I was having sex that could have gotten me pregnant for the first time, and yeah, got the pill.” Among participants, the desire to avoid pregnancy was inherently linked to the desire to avoid parenthood. When asked about the link between contraception and pregnancy prevention, Harper shared, “Well, at this point in life a parent feels like too much commitment so I’m not trying to be like anybody’s parent and any-no, that would be a terrible decision.” It should be noted that while Siobhan, Natalie, and Harper obtained contraception in order to prevent pregnancy, they obtained contraception after becoming sexually active. This is consistent with the findings of Browne (2010) who found that among heterosexual teenagers, many do not obtain contraception until after their first sexual encounters.

Even for participants who identified as lesbian, their contraception use was intrinsically linked to potential sexual contact with someone that could lead to pregnancy. When asked about her decision to obtain contraception, Nora stated, “I had started seeing a trans woman and had gotten really paranoid about getting pregnant.” Furthermore, when asked about her continued use of contraception, Charlotte stated, “. . . If I happened to have sex with a lesbian who has a penis I don’t want to have to worry about that. It’s kind of like these narrow chances, I want to keep it.” Despite both Nora and Charlotte identifying as only being attracted to people who identify as women, they both either are engaged in a relationship or open to the potential of engaging in a relationship with someone who was assigned male at birth, but who currently identifies as a woman. This openness to having romantic and sexual relationships with someone who is transgender is reflective of a shift in the ways in which queer people, particularly lesbian women, conceptualize sex, sexuality, and gender identity. Unlike trans-discriminatory lesbian movements

of the 1970s and 1980s, this current generation of lesbian women are more open to trans partners (Browne 2010).

Medical Conditions

Of the sixteen participants interviewed, seven indicated that they chose to obtain contraception to help treat medical conditions not related to pregnancy prevention. Of the seven participants, the severity of their bodily discomfort varied a great deal. For participants like Alison, Rachel and Siobhan, their decision to obtain contraception was only in part to gain relief from menstrual cramps. However, for Cosima and Rose, their decision to obtain contraception was primarily informed by their medical conditions.

When asked about her decision to obtain contraception, Alison, a pansexual white woman, cited both fear of pregnancy and menstrual discomfort. Alison stated, “When I was younger, I had irregular periods, and I was originally on the pill to regulate my period... I had had a couple of sexual encounters before obtaining long term contraception, so that was part of it too.” Similarly, when describing the first time she obtained contraception, Rachel told me:

I wanted to get the pill because I had really bad cramps that would sometimes take me out of school. Um, and, like the only way to prevent these cramps was to literally be so on top of taking Advil.

As discussed in the chapter on motherly emotional support, Rachel sought contraception both to help her relieve menstrual cramps, as well as to prevent pregnancy with a new sexual partner.

Siobhan had similar reasons for obtaining contraception. Although she originally sought contraception in her mid-teens because she had a male partner, in recent years Siobhan has been experiencing reproductive health issues. Siobhan told me:

I have an ongoing um, reproductive health issue that I'm trying to get resolved. And I'm getting nowhere fast. Because I have fibroids and I'm trying to see what to do about that. And yeah, I'm not having much luck.

In navigating her reproductive health issues, Siobhan has been trying to find a contraception method that will both help her to prevent pregnancy and help her to alleviate her fibroid pain.

In looking at the experiences of Alison, Rachel, and Siobhan, it is clear that their contraception use is both influenced by their desire to avoid pregnancy and to alleviate pain associated with menstruation and reproductive health conditions. However, for some participants, their need to treat reproductive conditions took priority over their desire to avoid pregnancy. Rose described how she first obtained contraception at the age of sixteen to help alleviate some of the symptoms of her polycystic ovarian syndrome. Although being on the pill helps her manage her symptoms, Rose expressed frustration that for her, being on the pill was perceived by peers and doctors for being for contraceptive purposes. Rose stated:

I'm still largely on it (the pill) for a medical diagnosis, it's a little bit different. But I do think um, like I said, the assumption that I'm on it now, even though I have a medical diagnosis is often read as being for contraceptive purposes.

Cosima shared in Rose's frustration. Cosima told me, "I have a uterine condition that makes me very ill and I was really sick and I needed some birth control or contraception or whatever to make it better." For Cosima, her uterine condition meant that without access to contraception, she would live with debilitating pain. Cosima was upset that the medical system perceived her need for contraception as intrinsically linked to preventing pregnancy. When speaking about other people who use contraception, Cosima stated: "...Their plan is to prevent pregnancy or whatever which is a great option that all women should have, but I'm using it to prevent sickness." Although the desire to alleviate pain and symptoms associated with menstrual pain

and reproductive health conditions is shared between heterosexual women and queer people, Rose and Cosima both express frustration with the link between contraception and heterosexual sex. For them, their use of contraception is distinct from their sexual behavior, and as such, holds different meaning than contraception use for pregnancy prevention.

Why Queer People Obtain Contraception: Differences from Heterosexual Women

Although queer women obtain contraception in ways similar to heterosexual women, my interview data shows that queer people have unique reasons for obtaining contraception as well. Among the sixteen participants interviewed, six identified with a gender identity other than Cis-Gender. In describing their choice to obtain contraception, many cited experiences of dysphoria and bodily discomfort as reasons for doing so. This dysphoria was both related to menstruation, as well as potential pregnancy. Moreover, many participants discussed the current political climate as rationale behind obtaining contraception or altering contraception use. Although participants noted that all people are impacted by government changes to health care access, queer people face particular precarity due to their sexual orientation and gender identity. This heightened sense of precarity is a key component of the third and final finding of this section. Many participants stated fear of sexual assault due to their sexual orientations and gender identities as a reason for obtaining contraception. Although participants knew that contraception use would not diminish their likelihood of experiencing sexual assault, many cited contraception use as a way to mediate the emotional aftermath if an assault were to occur.

Menstruation Related Dysphoria

Of the sixteen participants interviewed, five discussed using contraception in order to alleviate experiences of bodily dysphoria. Dysphoria, which is a “distressed state arising from a

conflict between a person's gender identity and the sex the person has or was identified as having at birth" is commonly associated with transgender and gender non-conforming experiences (Hyderi, Angel and Madison 2016; Merriam-Webster 2018). Felix, Frankie, Tyler, and Colin all described how their use of contraception helped them alleviate their discomfort with being in a female body. When asked about zir's decision to obtain contraception, Felix described: "I was on testosterone shots for a while. And I'm just now starting to get a real period again, and it's horrible. We (partner) were like, we should look into getting birth control pills again." For Felix, zir's choice to go off testosterone made it so Felix experienced menstruation, something that brought zir bodily discomfort. Felix discussed how the presence of zir's period is influencing zir to obtain contraception in order to cease menstruation. Frankie described similar feelings of menstruation dysphoria. When describing their gender identity, Frankie said, "I'm non-binary, super dysphoric and stuff, but not enough to do anything about it." Even though Frankie is "super dysphoric" their experience of dysphoria did not compel them to seek further medical intervention beyond an IUD. Frankie described, "It (the IUD) makes my period a lot less and actually helps with my gender dysphoria."

Even though Frankie did not wish to pursue further medical intervention to aid in her dysphoria, other participants purposefully chose contraception methods that would allow them to fully transition. Colin, a gender non-binary participant described the steps they took as part of their transition:

Colin: so I heard that, um yeah, so part of my transition I was interested in getting a hysterectomy originally, but it really wasn't something that was feasible for me, and my friends told me that IUDS were likely to make your period stop and so I was interested in that as a source of dysphoria. Um, yeah, a lot of the switch (from the pill to the IUD) was around dysphoria issues.

DL: Okay. And if you're comfortable with it, can you talk more about your dysphoria and how it influenced your decision to obtain contraception?

Colin: Uh, yeah, um, so yeah, getting the IUD was definitely trying to reduce some dysphoria related issues.

For Colin, their transition from the pill to an IUD was a purposeful way in which to alleviate their menstrual dysphoria. Tyler, a gender queer participant also described using an IUD to make zer feel less dysphoric. However, unlike Colin, Tyler made direct references to menstrual dysphoria and discomfort with womanhood. When asked if Tyler's IUD impacted the way ze perceived zir's gender identity, Tyler responded, "...I mean, I picked the contraception that I would have to think the least about ever. So I don't really think about it at all. The lighter periods make me feel less dysphoric." When asked to elaborate, Tyler stated:

I mean, I guess it's (menstruation) supposed to be, it's supposed to be tied to womanhood. Menstruating is supposed to be tied to womanhood and if I don't have to deal with that as much then it is more comfortable with me.

For participants who did not identify as cisgender, contraception provided them a way to alleviate dysphoria without taking more drastic medical routes to transition (although Colin and Felix also chose to do so). This was consistent with the findings of Smith (2011), who found that transgender and gender non-conforming people who menstruate use contraception to manage their periods and to alleviate dysphoria.

Even though a majority of the participants who used contraception in order to alleviate menstrual dysphoria did not identify as cis-gender, there were instances of cisgender participants citing experiences of dysphoria. When asked how taking contraception influenced her daily life, Nora responded:

Nora: Not super. Not a huge amount beyond the fact my periods are three months apart, which is great, I love that. I always like am on my period and it makes me the most

dysphoric that I ever am, and so it's a bad time and getting away from that and making it something that I don't have to worry about as often is really nice.

DL: If you don't mind, can you sort of elaborate a little more on that dysphoria thing with menstruation?

Nora: Yeah, it's like, it's just, my uterus is useless to me in a lot of ways. I don't want kids. I don't want to carry kids, I don't- having a period makes me- I kind of built a lot of my identity in strength and being powerful and outspoken and having a period makes me feel weak, and its gross, and it's the constant reminder of like, not just having a uterus but the expectation of pregnancy and I'm not fulfilling that. And it's also just a pain in the ass. Like I have stuff to do. I don't really have time to stop and pay attention to that stuff. It always sneaks up on me, and not having to worry about that anymore has made me feel a lot more comfortable.

Unlike Felix, Frankie, Tyler and Colin, Nora relates her experience of menstruation dysphoria to the expectation of pregnancy. Furthermore, Nora places her identity as “powerful” and “outspoken” in direct opposition to menstruation, which makes her feel “weak” and “gross.”

Nora's experience of menstruation aligns with Carly Woods (2013) writing on the marketing of menstrual suppressive birth control. Woods contends that through using the rhetoric of choice, advertisements for menstrual suppressive birth control uphold ideologies of female cleanliness and sexual availability. This is done by portraying menstruation as unclean and burdensome. For Nora, labeling her discomfort with menstruation as dysphoria and taking menstrual suppressive contraception in order to alleviate that dysphoria allows her to uphold these ideologies of what it means to be an empowered woman.

Pregnancy Related Dysphoria

Although both heterosexual women and queer people share the experience of using contraception in order to prevent pregnancy, for some queer people, pregnancy would place them in a position of physical and emotional precarity. Five out of sixteen participants discussed how their efforts to prevent pregnancy was a way to alleviate body dysphoria. Experiences of

potential bodily dysphoria as a result of pregnancy is unique to queer people, and suggests that queer people experience pregnancy differently than their heterosexual counterpart. Tyler told me, “I guess actually as a trans person, trans people take contraception for that purpose (pregnancy prevention) ... I don’t want to be pregnant, contraception makes me feel less dysphoric.” This sentiment is shared by Colin, who said, “I mean in general I guess the idea of getting pregnant is really dysphoria triggering for me. So I guess I would rather be on contraception and not just rely on condoms to do that.” For Tyler and Colin, taking contraception allows them to feel less dysphoric, as it eliminates the possibility of becoming pregnant, and thus being associated with a female body.

Although Tyler and Colin discussed the individualistic dysphoria they would experience if they got pregnant, others discussed both themselves and their partner. Frankie and Elle both shared that they and their partners would feel dysphoric if either Frankie or Elle were to get pregnant. Frankie, a pansexual ‘gender fucked’ person describes how they use contraception both to alleviate their own dysphoria, but also their partner’s. When asked about their continued use of contraception, Frankie said:

Well mostly because of my dysphoria and gender stuff. I'm terrified of getting pregnant. Um, since I'm dating this beautiful, beautiful transwoman there's the possibility of getting pregnant... birth control is very important to me and just because my dysphoria if I ever got pregnant it would not be good for me. Or her, because of her dysphoria stuff.

Elle, who presents androgynously and is debating going on testosterone has a transgender girlfriend, who Elle states gets socially read as “a gay man.” When asked about contraception for pregnancy prevention, Elle stated:

I don’t want to look like a boy and potentially get pregnant. That just seems- that isn't something I want to do. Like if I were to fully transition I’d want to be that, and not have the option of also being pregnant. Because I'm terrified of surgery and neither of us want

the downstairs redone. That just absolutely terrifies me beyond...and so and then they don't want to be you know, the femme looking, presenting one in the relationship and have me potentially get pregnant. So it kind of goes that way too. That would be a little dysphoric for the, you know? I'm the women, but you're the one who, yeah... it's kind of for both of us.

Elle and Frankie both describe how their contraception use not only alleviates their own dysphoria, but the dysphoria their partners would potentially experience if they could not be read as the feminine one in their relationship. Although to date there has not been sociological literature on gendered dynamics among non-cisgender queer couples, Moore (2006) writes on gender presentation among black lesbians in New York. Moore contends that gender presentation is crucial in establishing relationship dynamics among black lesbian couples, as many perceive butch/femme relationships as ideal. However, within these relationships, there exists a great deal of gender play. For Elle and Frankie, their use of contraception is both linked to their desire to alleviate dysphoria and to avoid pregnancy, but can also be understood as a way in which they are able to expand the possibilities of gender play within their romantic relationships.

Politics and Political Climate

Although this project never specifically sought to study the ways in which the current political administration impacts contraception use, many of my interview participants spoke towards the ways in which they are modifying their contraception use since the 2016 presidential election. In discussing her contraception plans for the future, Alison told me, "I'm researching kinds of IUDs because they're longer term, and if the current administration does break down Planned Parenthood I have that option." For Alison, who is reaching the last year of her three year Nexplanon implant, the political administration is being factored into her reproductive

health choices. Harper is in a similar situation, as her three year Nexplanon implant is also about to expire. When asked about her plans future contraception plans, she responded:

I think that's one of the reasons I am okay with getting the Nexplanon (again), because if I just go and get it done, by time I have to get it out again we will more than likely be in a new administration so unless they're going to come repo it out of my arm, I won't have as many problems with it.

Although Alison and Harper have not yet obtained the long-term contraception they were looking into, Frankie and Rachel have obtained long-term contraception because of the political administration. When asked about her choice to obtain an IUD, Frankie responded, "Um, actually I had a few main reasoning's. I got it as long as Trump was getting elected, so I wanted something that would last a presidency. Because I'm terrified and anxious." Frankie's fear that Trump will restrict her contraception use is shared by Rachel, who has also obtained an IUD post-election. Rachel shared:

And then with my IUD, I blame Trump for that. I actually was like, as they were inserting it yelled 'fuck Trump' cause it was a couple days after the election... because with all this chaos that is happening, I don't want to have to worry. I don't want to worry that I won't be able to get access to birth control... I don't want to bring a kid into this on accident.

Although the current political administration places both heterosexual women and queer people at a heightened place of precarity in terms of their ability to obtain contraception, for queer people, this precarity is twofold. As discussed in Chapter I, many queer people fear their need for contraception will not be perceived as legitimate due to their sexual orientation or gender identity. This, combined with the reality that many perceive the current political administration as hostile to queer people, makes it so some participants feel a double jeopardy when trying to obtain contraception.

Even though Harper, Alison, and Rachel all discussed their modification or potential modification of their contraception use, Cosima does not believe her contraception use will be limited due to her race and social class. Cosima stated:

He's (Trump) not going to get away with it- maybe he'll make it not free, but he can't get away with really restricting access. And as a white woman that won't affect me as much as it would disproportionately women of color and communities of color.

Cosima is cognizant of her social position as a white woman, and as such, does not feel like her use of contraception is in an in a particular position of precarity.

Fear of Sexual Assault

Much like the data gathered on the current political climate, this study also never specifically asked respondents about their contraception use as connected to sexual assault. Yet, when asked about factors that contribute to their continued use of contraception, almost every participant alluded to the possibility they would experience sexual violence. Although participants were cognizant that being on contraception would not shield them from sexual violence, for many, being on contraception gave them peace of mind. Participants linked this peace of mind to pregnancy prevention, although some were more explicit with this link than others. Furthermore, participants like Alison and Tyler made overt connections between their fear of being the target of sexual violence with their sexual orientation and gender identity.

For Siobhan and Rachel their continued use of contraception is predicated on the fear that they would at some point experience sexual violence. When asked if she would stop using contraception if she had a long term female partner, Siobhan and I shared this exchange:

Siobhan: Um, honestly recently I've just been keeping it there as a kind of sort of personal insurance against sexual assault.

DL: Can you elaborate more on that? What does insurance mean?

Siobhan: In the event that that happens, to prevent an unwanted pregnancy.

Despite the possibility of being in a relationship with someone with whom sex could not lead to pregnancy, the fear of sexual assault prevents Siobhan from going off of contraception. The use of contraception as a form of personal insurance was common among the participants who cited sexual assault as a reason for continued contraception use. Rachel referenced this perceived sense of safety contraception brought:

Knowing that if somebody rapes me on the street I don't have to have that worry about having that rape baby. Oh, fuck yeah. Like being raped would be awful, but I never have to deal with a physical repercussion of that. A physical entity of that rape.

For both Siobhan and Rachel, the fear that they would become pregnant after a sexual assault is consciously taken into consideration when they conceptualize their rationale for contraception use.

While Siobhan and Rachel speak more broadly about their use of contraception to prevent pregnancy in case of sexual assault, Alison and Tyler make direct references to their heightened vulnerability to sexual assault due to their sexual orientations and gender identities.

When asked about the impact contraception had on zir's day-to-day life, Tyler responded:

It kind of makes me feel safer in general, just because I am afraid that I'm gonna be the victim of some horrible rape. And I know there's contraception at least, and I know I won't have to get an abortion. I think about that all - I think about that day to day. It effects how comfortable I am walking around day to day.

Tyler spent the majority of zir's interview discussing how being gender non-binary and using testosterone places zir in a heightened place of precarity, as ze is visibly gender non-conforming.

For Tyler, this visibility is directly tied to a fear of sexual assault due to zir's gender presentation. Although Alison both identifies as cisgender and is visibly feminine presenting, she too experiences fear of sexual assault based on her queerness. When asked about her continued

use of contraception, Alison referenced fear of pregnancy resulting from an assault. When asked to explain further, Alison stated:

I mean, I think that, as a woman in America I'm constantly worried about getting raped a little bit, and having birth control means that even if the worst case scenario happened I wouldn't have to worry about a secondary worst case scenario... I think that there's that fear that if you come out to the wrong person it may lead to an unsafe situation, and one of those unsafe situations is if you told a straight white man that you weren't straight, and they try to make you straight. Because that happens in America. And it's horrifying.

Although heterosexual women also experience sexual assault, there is no scholarship showing they preemptively use contraception in order to mediate the potential emotional aftermath of an assault in the same way queer people do. Furthermore, Tyler and Alison both demonstrate that queer people perceive themselves to be at greater danger of sexual violence because they do not conform to hetero-patriarchal values and ideologies. This fear of sexual assault was present regardless of participant's embodiment of gender. It is notable to mention that within these interviews, participants specifically mentioned fear of sexual violence rather than fear of violence in general. This specific mention of sexual violence indicates that queer people perceive rape as a way for hetero-patriarchal ideologies to be forcibly imposed on queer people. Participants view sexual assault to be the most personal form of violence they could experience, as it is inherently tied to their sexual orientation and gender identities. As such, participants indicated that they are both cognizant of their unique risk of sexual violence, and have already taken steps through contraception use to mediate the emotional aftermath if an assault were to occur.

CHAPTER V

DISCUSSION

This thesis set out to answer how queer people obtain contraception. The findings suggest that there is a multitude of ways in which queer people obtain contraception and navigate the medical system. The findings of this study have broader implications for the ways in which scholarship understands the lived embodiments of queer people, both within and outside of the medical system. This section opens with a discussion of the ways in which participants discuss and experience what they describe as gender dysphoria. Despite only a relatively small numbers of participants discussing experiences with dysphoria, their experiences point towards the need for academics to better understand these experiences. This section also discusses the differences between what was expected of the data and the actual findings of the data. These schisms between expectations and the lived experiences of interview participants point towards a greater need to understand the lived experiences of queer people both inside and out of the medical system.

Dysphoria

Of the sixteen participants interviewed as part of this project, five indicated that they used contraception to alleviate menstrual and pregnancy dysphoria. While this finding is consistent with the scholarship on the ways in which transmen use contraception, within this study, this finding is salient. No participant within this study identified as a transman, however four participants identified as gender-non conforming or gender queer. The fact that these participants

indicate they experience gendered dysphoria serves to expand cultural and academic understandings of dysphoria itself. While most use the term to refer to transgender people experiencing bodily discomfort, there is an expanding body of colloquial work suggesting that people of varying embodiments and experiences of gender identity can also experience dysphoria (Mamone 2017). However, this expansion of who can experience dysphoria is still limited to non-cisgender people. My results contrast this, as two cisgender participants indicate they also use contraception in order to alleviate bodily discomfort. This discomfort, primarily around menstruation, has led these participants both to use contraception, but to also label their embodied experiences as dysphoria.

Both this use of contraception and the labeling of this bodily discomfort as dysphoria by cisgender participants brings up interesting theoretical questions on the nature of dysphoria itself. Is dysphoria simply the experience of bodily discomfort, or is it actually a process of experiencing and then alleviating this discomfort? The cisgender participants who experience dysphoria indicate that they were uncomfortable with menstruating, not because of medical reasons, but because they perceived menstruation as “gross,” making them feel less empowered. Participants underwent a process of medicalization in order to alleviate this discomfort. Through contraception use they were able to reach a desired outcome of no longer feeling “gross,” and therefore felt more aligned with their body. While non-cisgender participants underwent a very similar process, they indicated that they felt dysphoric before contraception use, and some indicate that they still experience a degree of dysphoria even while on contraception. The schism between the cisgender and non-cisgender participants in terms of experiences of dysphoria indicate that it is experienced differently based on embodiment of gender. This data suggests that

there needs to be more research both on how (and if) cisgender women experience dysphoria, and the steps they take to alleviate this potential dysphoria.

Expectations vs Data

In completing this thesis, there was no hypothesis on how queer people obtain contraception in the medical system. Rather, this thesis sought to capture participants' individual narratives of their interactions with the medical system. Nevertheless, some of the findings in this thesis defied some of the expectations I had as a researcher. One of the most poignant findings throughout the course of this thesis was how participants used their mother's emotional and instrumental support when obtaining contraception. Although the degree to which this support was utilized varied between participants, an overwhelming majority of participants cited their mothers as a primary influence in their ability to obtain contraception. This finding defied my expectations of how queer people obtained contraception, as both colloquial and academic writing on contraception obtainment suggest that obtaining contraception is a deeply individual choice (Granzow 2007). The only exception to this seems to be in literature on how minors obtain contraception (Morgan and Throne 2010). This overemphasis of individual choice in contraception obtainment rhetoric ignores the reality that for many people, especially adults, they consciously make the choice to include their mothers in their contraception obtainment process.

Another finding that was unexpected was the continued mention of sexual assault as a factor influencing participants' contraception obtainment. Within academic discourse, there is little mention of the role sexual assault plays in contraception obtainment. However, interview participants discussed in depth how the fear of sexual assault was a mediating factor in their decision to obtain contraception. Moreover, some participants linked this fear of sexual assault

directly to their queer identities. This finding was unexpected, particularly because at no point during the interview did I ask about sexual assault or even consensual sexual encounters.

However, the majority of participants either alluded to or directly stated that they would be assaulted due to their sexual orientation or gender identities. There is little scholarship on the way in which queer people use contraception to mediate their fears of sexual assault. Moreover, aside from discourse on corrective rape, little work has been conducted on how queer people, especially those identified female at birth, understand and navigate their real and perceived threat of sexual assault.

Although mother's role in contraception obtainment and fear of sexual assault are two findings that were unexpected, the data were surprising in terms of results that were not found. When discussing disclosure of sexual orientation and gender identity in the medical system, I was surprised by how few participants attempted to remain closeted in the medical system. As opposed to literature from the late 1990's and the early 2000's, the majority of the participants in this study did not attempt to 'pass' in the medical system (DeAngelis 2002). Participants indicated this was largely due to the utilization of inclusive health care providers, inclusive health care intake forms, and characteristics of the medical practitioners themselves. While not every participant had disclosed their sexual orientation or gender identity to their health care provider, based on previous literature, I was expecting to find more participants choosing to remain closeted. This points towards the need to expand and contemporize the literature on queer health care, especially as it relates to both the myriad of factors that influence disclosure of sexual orientation and gender identity and the institutions they use when obtaining medical care.

CHAPTER VI

CONCLUSION

In concluding this thesis, I will discuss the broader implications this study has for queer people when obtaining contraception. This study has a broad reach of implications, both for the medical community and outside of it. Although participants for the most part felt comfortable disclosing their sexual orientation and gender identity, they also indicated that health care providers did not understand their need for contraception. Furthermore, queer people are often excluded from cultural and political rhetoric on contraception. This paper ends with recommendations to health care providers based on the lived experiences of research participants.

Broader Implication

As this thesis demonstrates, there are a myriad of reasons why a queer person would obtain contraception that are both separate from and intrinsically linked to a queer identity. However, in speaking to queer people, it becomes clear that during interactions with the medical system, health care providers are unaware of the unique needs of queer patients. This is in spite of the fact that an overwhelming number of queer people indicate they feel comfortable disclosing their sexual orientation and gender identity. While this comfort points towards a growing *acceptance* of queer patients in the healthcare system, participants lived experiences also reveals that there has yet to be a subsequent *understanding* of their healthcare needs. Although all participants were able to obtain contraception, some felt as they either needed to obscure the

reasons why they were obtaining contraception or place themselves in situations in which their need for contraception may be questioned. This lack of understanding of the health care needs of queer patients extends beyond that of contraception providers, and towards the health care system in general. Queer people, especially those identified female at birth are at a particular risk of health care problems due to providers not understanding their unique health needs (DHHS 2000). Interview data shows that it is this lack of understanding of healthcare needs--not outright discrimination--that serves to perpetuate healthcare inequalities between queer people and their straight counterparts.

Within the rhetoric on birth control, queer voices are often excluded in favor of heteronormative ideologies. Culturally, birth control has been linked to heterosexual sex and the desire on the part of women to be in a sexual relationship (Woods 2013). Queer people have been underrepresented in cultural conversations about birth control, especially as it relates to birth control use to prevent pregnancy. As many participants demonstrated, they use contraception because they are either currently or open to having sexual relationships with somebody with a penis. However, fears surrounding unplanned pregnancy are almost exclusively relegated to ideologies and cultural images of heterosexuality. Moreover, this link between heterosexual sex and contraception ignores that both queer and heterosexual people use contraception for reasons beyond that of pregnancy prevention. This exclusion of queer women in contraception use is also seen in political rhetoric. Political debates surrounding contraception and reproductive rights have always centered on the question of whether women were able to enact choices over their bodies. This desire for bodily choice and control was central in the use of contraception among queer participants, and yet their narratives have been excluded from the

fight for reproductive justice. Even contemporary debates around birth control rely on heteronormative ideas of contraception use, despite the fact that banning contraception would impact people of all sexual orientations and gender identities. The implications of this exclusion of queer people from narratives on birth control is problematic not only in that it impacts rhetoric, but also because this exclusion has real implications in the lives of queer people. Although there are no exact data points on the number of queer people who use contraception, this thesis shows that for many, making the choice to obtain contraception has very real implications for their daily lives. For these queer people, contraception use is not nebulous, but rather an inherent part of the ways in which they feel comfortable in their bodies. Excluding queer contraception use from larger and broader ideas on contraception only serves to invalidate their desire to feel comfortable and to make decisions about their bodies.

Moving beyond the rhetoric surrounding birth control, this thesis was broadly conducted in order to give queer people the opportunity to have their voices and narratives shared as part of the academic cannon. All too often, academia treats the queer experience as theoretical and not embodied. Numbers and statistics are relied on to serve as shorthand for the lived experiences of queerness. Scholars postulate on the significant and meanings of gender identity and sexual orientation without taking into consideration how queer people themselves construct meaning around these narratives. This thesis contributes to the small but growing canon of academic work that allows queer people to give voice to their own unique perspectives and lived experiences. In doing so, this thesis strives to demonstrate that the experiences of queer people are not heterogeneous, but rather warrant further investigation by social science scholars.

Recommendations

This thesis broadly demonstrates a growing comfort among queer people in disclosing their sexual orientation and gender identities in the health care system. However, there are still many more steps that need to be taken before queer people to experience full equity in the receipt of health care. Participants cited that inclusive medical intake forms made them feel comfortable during their medical appointments, as they were able to indicate their sexual orientation and gender identity in written form rather than verbally. Furthermore, participants also linked these intake forms to the inclusivity of the health care institution itself, allowing them to place trust in the multitude of people working in these environments. Given how instrumental inclusive healthcare intake forms were in fostering a comfortable environment for queer people, it is my recommendation that medical care providers integrate inclusive intake forms into their medical practice. In doing so, it is important to note that these forms alone are not enough to foster an inclusive health care environment. Providers must also continually refer to these intake forms when treating their patients. Several participants cited that although they disclosed their sexual orientation and gender identity on intake forms, providers did not refer to these forms in subsequent appointments and consequently assumed participants were heterosexual and/ or cisgender. Inclusive intake forms alone are not enough to assuage the still pervasive heterosexism in the medical system. Rather, it is these forms in conjunction with continual reference to these forms that allow queer people to feel comfortable in the medical system.

Alongside the need for inclusive healthcare intake forms comes the need for health care providers to ask their patients for their preferred name and pronouns. Some participants in this study indicated that their preferred name and pronouns differed from what was listed on their

legal forms. The use of preferred pronouns and names for queer people is important both within and outside of the medical system, as it validates lived experiences and identities. Obtaining contraception has primarily been understood by the medical system as something only heterosexual and cisgender women do. While the purpose of this thesis was to dispel this belief, this cultural link still remains. For patients who do not identify as cisgender, this connection is especially harmful, as this link to womanhood is not congruent with their embodiment of gender. Queer people obtain contraception for a myriad of reasons, and some of these reasons are intrinsically linked to their sexual orientation and gender identity. In acknowledging one's preferred name and gender pronoun, health care providers can convey to their patients that they both understand the reasons a queer person would choose to obtain contraception and respect and accept patients who embody a multitude of gender identities and sexual orientations.

The final recommendation based is for healthcare providers to discuss HIPAA policies with new patients. Among those who did not disclose their sexual orientation or gender identity to their health care providers, many cited geography and fear that their sexual orientation or gender identity would be shared with their parents or other members of their communities. In discussing HIPAA, providers are able to assure patients, especially queer patients that their health care information will be kept confidential. This discussion of confidentiality will also help patients and providers establish a rapport. The ability to establish a friendly rapport with providers was crucial in queer participants being able to feel as if they could trust their practitioners. Discussing HIPPA both gives queer patients the assurance that their information will be kept confidential, but also allows for patients to ask any other questions about the quality of care they may have.

APPENDIX A
INTERVIEW PROTOCOL

Interview Protocol

Introduction: The purpose of this interview is to gain greater insights into the experiences queer women have when obtaining contraception. You have indicated that you identify as a queer woman and have at one point used contraception. This interview will ask questions on your rationale behind obtaining birth control, as well as your experiences obtaining contraception.

Interview question:

Can you describe in your own words your sexual identity?

Do you identify with any labels (Lesbian, Bisexual, Asexual, ect?)

How do you describe your sexuality when talking to others? Does this definition change depending on who you speak to?

Can you describe in your own words your gender identity?

Do you identify with any labels (Cis-gender, Transgender, Agender)

How do you describe your gender identity when talking to others? Does this definition change depending on who you speak to?

Can you tell me about your decision process in obtaining contraception?

Did anyone either positively or negatively influence this process?

Were you interested in a particular form of contraception over another? If yes, how did you know about this form of contraception? What were the merits of this form of contraception over another?

When you obtained contraception, did you use the medical system?

If no: How did you obtain contraception? Were you concerned about not seeking medical advice?

Do you feel as if by not using the medical system, your contraception choices were limited?

What were the benefits of not obtaining contraception through the medical system ?

When discussing your health care needs with your contraception provider, did you disclose your sexual/ gender orientation?

If yes: Can you tell me how you disclosed your sexual/ gender identity? Did your health care provider prompt you to do so?

If no: What prevented you from doing so? Do you regret not disclosing your sexual/gender identity?

(If yes to question two) When visiting your contraception provider, did you feel any pressure to “pass” as heterosexual?

If yes: How did you go about trying to pass? Did you omit information about your sexual/ gender identity and practices to your health care provider? What characteristics of the health care provider made you feel pressure to pass? What characteristics of the medical care system made you feel pressure to pass?

If no: Why didn't you feel pressure to pass? How do you feel about queer women trying to pass when obtaining contraception?

Do you believe it is easier for heterosexual women to obtain contraception then it is for queer women?

If yes/ no: can you elaborate?

Did your sexual orientation/ gender identity influence your choice to obtain contraception?

If yes: In what ways?

If no: Why do you feel that your choice to take contraception and your sexual orientation/ gender identity are separate?

Does taking contraception influence the way in which you perceive your sexual orientation/ gender identity?

If yes: In what ways?

If no: can you explain?

Has using contraception impacted your day to day life

If yes: Does it make your life easier? More difficult?

If no: Does this lack of impact on daily life contribute to your continued use of contraception?

How do you feel taking contraception has influenced your overall health?

Demographic questions:

Age:

Race:

Education level

APPENDIX B
RECRUITMENT FLYER



ARE YOU QUEER AND ON BIRTH CONTROL?

Interview participants needed:

My name is Dana LaVergne, and I am a graduate student in sociology at Loyola University Chicago. For my Master's thesis, I am conducting research on the experiences queer folks have had while obtaining contraception. I am identifying individuals 18 and older who identify as lesbian, gay, bisexual, pansexual, asexual, gender non-conforming, transgender, and queer who have had experiences obtaining contraception to participate in hour long interviews. At the conclusion of the interviews, participants will be given a \$30 Amazon gift card for their time.

If you would like to participate in the study or have any questions, email me at dlavergne@luc.edu or call the department of Sociology at (773)508-2715

**Participants will
be given a \$30
Amazon gift card.**

**Participants will
be asked to
answer question
on how and why
they obtained
contraception.**

**All interview
participation
information will
be kept
anonymous**

Faculty Advisor

Dr. Anne Figert

Afigert@luc.edu

(773)508-2717

REFERENCES

- Allyn, David. 2016. *Make Love, Not War: The Sexual Revolution: An Unfettered History*. Routledge. Retrieved July 19, 2017.
- Baldwin, Aleta, Brian Dodge, Vanessa Schick, Stephanie Sanders, and Dennis Fortenberry. 2017. "Sexual Minority Women's Satisfaction with Health Care and State Level Structural Support: Investigating the Impact on Lesbian, Gay, Bisexual and Transgender Nondiscrimination Legislation." *Women's Health Issues* 27(3):271-278.
- Bernhard, L.A. and J.M. Applegate. 1999. "Comparison of Stress and Stress Management Strategies between Lesbian And Heterosexual Women. *Health Care for Women International* 20: 335-347.
- Browne, Kath. 2010. "Lesbian Separatist Feminism at Michigan Womyn's Music Festival." *Feminism and Psychology* 21(2): 248-256.
- Chrisler, Joan C., Jennifer A. Gorman, Jen Manion, Michael Murgo, Angela Barney, Alexis Adams-Clark, Jessica R. Newton and Meaghan McGrath. 2016. "Queer Periods: Attitudes Toward and Experiences with Menstruation in the Masculine of Centre and Transgender Community." *Culture, Health and Sexuality* 18 (11):1238-1250. Retrieved July 18, 2017.
- Crosby, Richard A., Tom Collins and Lindsay R. Stradtman. 2017. "Promoting Teen Contraceptive Use by Intervention with Their Mothers." *American Journal of Preventive Medicine* 52(3): 271-274.
- DeAngelis, Tori. 202. "New Data on Lesbian, Gay and Bisexual Mental Health: New Findings Overturn Previous Beliefs." *American Psychological Association* 33(2).
- Fuller, Craig B., Doris F. Chang and Lisa R. Rubin. 2009. "Sliding Under the Radar: Passing and Power among Sexual Minorities." *Journal of LGBT Issues in Counseling* 3(2):128-151.
- Gender Dysphoria. (n.d.) In *Merriam-Webster's Collegiate Dictionary*. Retrieved from <https://www.merriam-webster.com/dictionary/gender%20dysphoria>
- Goldin, Claudia. Lawrence Katz. 2002. "The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions." *Journal of Political Economy*. 110(4): 730-770.

- Granzow, Kara. 2007. "De-Constructing 'Choice': The Social Imperative and Women's Use of the Birth Control Pill." *Culture, Health and Sexuality* 9(1):43-54.
- Harbin, Ami, Brenda Beagan and Lisa Gildberg. 2014. "Discomfort, Judgement, and Health Care for Queers." *Journal of Bioethical Inquiry*.
- Hyderi, Abbas, Joseph Angel, Morgan Madison, Amanda L Perry and Leila Hagshenas. 2016. "Transgender Patients: Providing Sensitive Care." *The Journal of Family Practice* 65(7): 450-461.
- Klitzman, Robert L. and Jason D. Greenberg. 2002. "Patterns of Communication between Gay and Lesbian Patients and their Health Care Providers." *Journal of Homosexuality* 42(4):65-75.
- Mamone, Trav. 2017. "Yes, Non-Binary People Experience Gender Dysphoria." Retrieved from: TheEstablishment.com
- May, Elaine T. 2011. *America and the Pill: A History of Promise, Peril, and Liberation*. New York: Basic Books.
- Morgan, Elizabeth and Avril Thorne. 2010. "A Longitudinal Study of Conversations with Parents about Sex and Dating During College." *Developmental Psychology* 46(1):139-150.
- Moore, Mignon. 2006. "Lipstick or Timberlands? Meanings of Gender Presentation in Black Lesbian Communities." *Signs* 32(1):113-139.
- Liao, Pamela V. and Janet Dollin. 2012. "Half a Century of the Oral Contraceptive Pill: Historical Review and View to the Future." *Canadian Family Physician Médecin De Famille Canadien* 58(12):e757
- Lim, Fidelindo A., Donald V. Brown and Sung M. Justin Kim. 2014. "Addressing Health Care Disparities in the Lesbian, Gay, Bisexual, and Transgender Population: A Review of Best Practices." *The American Journal of Nursing* 114(6):34; quiz 35, 45. Retrieved July 18, 2017.
- Newcomb, Michael, Brian A Feinstein, Margaret Matson, Kathryn Macapagal and Brian Mustanski. 2018. "I Have No Idea What's Going on Out There': Parents' Perspectives on Promoting Sexual Health in Lesbian, Gay, bisexual and Transgender Adolescents." *Sexuality Research and Social Policy* 15(2):111-112.
- Nordqvist, Petra. 2008. "Feminist Heterosexual Imaginaries of Reproduction." *Feminist Theory* 9(3):273-292.

- Olson-Kennedy, Johanna, Stephen M. Rosenthal, Jennifer Hastings and Linda Wesp. 2016. "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People." *Center of Excellence for Transgender Health*.
- Ory, Howard W. 1982. "The Noncontraceptive Health Benefits from Oral Contraceptive Use." *Family Planning Perspectives* 14(4):182-184.
- Pfeffer, Carla A. 2014. "'I Don't Like Passing as a Straight Woman': Queer Negotiations of Identity and Social Group Membership1." *American Journal of Sociology* 120(1):1-44.
- Platzer, Hazel and Trudi James. 2000. "Lesbians' Experiences of Healthcare." *NT Research* 5(3):194-202.
- Planned Parenthood. 2017. All about Birth Control Methods. Retrieved from: <https://www.plannedparenthood.org/learn/birth-control>
- Roberts, Dorothy. 1997. "Killing the Black Body: Race, Reproduction, and the Meaning of Liberty." New York: Pantheon Books.
- Rosser, Sue. 1993. "Ignored, Overlooked, or Subsumed: Research on Lesbian Health and Health care." *NWSA Journal* 5(2).
- Sanger, Margaret. 1928. "Motherhood in Bondage." New York: Pergamon Press.
- Sears, James T. 2005. *Gay, Lesbian, and Transgender Issues in Education: Programs, Policies and Practices*. New York: Routledge.
- Scalici, Jennifer, Michael A Finan, Jennifer Black, Mary Danner Harmon, William Nicolson, Heather A. Lankes, William A Brady and Rodney P. Rocconi. 2015. "Minority Participation in Gynecologic Oncology Group Studies." *Gynecologic Oncology* 138(2):441-444.
- Smith, S.E. 2011. "I Use Hormones for Things You Might Not Approve Of." Retrieved from: XOJane.com.
- United States Department of Health and Human Services (DHHS). 2000. Office on Women's Health, Lesbian Health Fact Sheet.
- Weisz, Virginia K. 2009a. "Social Justice Considerations for Lesbian and Bisexual Women's Health Care." *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 38(1):81-87. Retrieved July 20, 2017.
- Woods, Carly S. 2013. "Repunctuated Feminism: Marketing Menstrual Suppression through the Rhetoric of Choice." *Women's Studies in Communication* 36(1):267-287.

VITA

Dana Rose LaVergne received her Bachelor of Arts in Sociology from Elmira College in 2016 where she graduated cum laude. She received her Master's in Sociology from Loyola University Chicago in 2018. Dana will be pursuing a doctoral degree in Sociology from University of Massachusetts Boston in the fall of 2018.

