

EDITORIAL

Writing Where Gender, Health, and All the Rest Meet; Or: the Feminist Health Humanities

Pedagogy: Gender, feminism, and health

Even though Laura Hartmann-Villalta and I, Nicole Infanta Keller, wrote the call for papers for this issue of the *Journal of Integrative and Innovative Humanities* in October 2023, our conversation on the feminist health humanities began more than a year prior, when I invited her, given her previous Core Faculty position with Georgetown University's Medical Humanities Initiative, to speak as part of Chiang Mai University's (CMU) Transformative Humanities lecture series. Since Laura works at the intersection of gender studies and medical humanities, attendance was a must for my 200-level Gender, Culture, & Equality class. Laura's August 2022 lecture, "What the Humanities Bring to Medicine: Examining the Medical Humanities," drew on histories and writings of wartime from around the world – "Disabled" by English poet Wilfred Owen, featuring a young male veteran who lost his limbs in World War I; the biography of Elinor Powell, an African-American nurse in World War II assigned to a German POW camp in Arizona who falls in love with and marries a former Nazi; and the recovered diary of Dang Thuy Tram, a North Vietnamese female doctor who was killed in action – to provide a much-needed expansion of how we understand care practices in medicine globally through a humanities lens.

I started teaching this course, part of CMU's new international BA program, Humanities & Sustainability (BAHS), in April 2021. The BAHS curriculum was designed with the UN's Sustainable Development Goals (SDGs) in mind, so as I planned my class, I designed a course that demonstrated how the work of intersectional feminism was integral to making the SDGs a reality. And it seemed that no matter how I changed the content from semester to semester, the scholars that we studied shared a sustained emphasis on health, marking an important shift from the medical humanities to the health humanities. Writers of diverse intellectual traditions approached the human experience of health not just through a medical interface, but from health defined holistically: physical, mental, spiritual, or social and emotional.

Caroline Criado Perez's *Invisible Women: Data Bias in a World Designed for Men* has been a hit with sections every semester, with student reactions ranging from shock over the gender biases embedded in medical education programs, to anger over women being intentionally left out of important scientific trials and studies because they're "too complicated," and finally to reflective, as they consider their own encounters with data gaps, sharing their observations from their respective cultures. Ann Crittenden's classic, *The Price of Motherhood: Why the Most Important Job in the World is Still the Least Valued*, is similarly provocative, bringing to students' attention the ways in which mothers are consistently denied adequate compensation, health insurance, and parental leave, among other desperately needed supports, all of which have direct impact on child development. As students work in class to research Crittenden's economic data for their own countries, they often return to the problem Perez articulates: there is an egregious data gap when it comes to the economics of motherhood. Crittenden's deterring "million dollar mommy tax" also frames our discussion of reproductive justice, aptly defined by Theodora Danylevich later in this issue as "the application of a human rights framework to issues of reproductive rights," wherein all people have: "(1) the right not to have a child; (2) the right to have a child; and (3) the right to parent in safe and healthy environments" (Ross & Solinger, 2017, p.9, as cited in Danylevich

53). Students are surprised by the degree to which patriarchal systems influence and even dictate these principles. We read from Leta Hong Fincher's *Betraying Big Brother: The Feminist Awakening in China*, wherein Fincher documents increased feminist activity as a response to authoritarian policies and propaganda campaigns. For example, the Chinese government branded single, professional women "leftover women," also the title of Fincher's first book, to shame them and coerce them into marriage and having children for the sake of the national economy.

Course readings and lectures afforded students the chance to see feminist scholarship's potential to mitigate the problems identified by the UN as the most pressing for developed and developing countries alike. Students enrolled in the course with an obvious interest in the feminist perspective's usefulness to Gender Equality (Goal 5), but throughout the semester they came to understand that the feminist lens is also one through which we identify biases and disparities in both health-explicit goals, like Good Health and Well-Being (3) and Zero Hunger (2), as well as in what I'll refer to as the health-adjacent goals: No Poverty (1), Quality Education (4), Decent Work and Economic Growth (8), Reduced Inequalities (10), and Peace, Justice, and Strong Institutions (16). To teach gender and feminism's implications on our expanded understanding of health is to reconcile and put writers of different academic fields in conversation with each other. This is what it has been for me to teach feminist health humanities, and this communication between and amongst disciplines is precisely what this journal issue's contributors are advocating for.

Gender, the sciences, and creating a new field

In 2012, I, Laura Hartmann-Villalta, presented at a conference at Virginia Tech University entitled "Gender, Bodies & Technology: (Dis)Integrating Frames," with keynote speakers Jack Halberstam, (English, American studies and ethnicity, and gender studies); Judy Wajcman (sociology); and Allucquère Rosanne (Sandy) Stone (new media and performance studies). These field-defining scholars would usually not share space with each other and moreover, other scholars from *other fields* would usually not participate in the same scholarly endeavor simultaneously, but with these keywords of "gender, body, technology," the call for participation was legible to that *one person* doing that gender-based work in whatever field. Imagine a conference where one attends a panel on trans memoir, then a presentation by a sex toy vendor, then learns from podcast professionals how to do interviews, and finishes the day with a panel with a medical sociologist, a computer scientist, and a literary scholar, all discussing how medical diagnostic tools affect women's health – to say nothing of the stellar keynotes.

The spirit of that conference was vibrant and – despite international success – only occurred about four times in ten years. Fostering and sustaining the dialogue across disciplines requires more infrastructure than one women's and gender studies department at one university can uphold, no matter how brilliant the idea, no matter how necessary the convening.

When I thought back to my multiple presentations at the "Gender, Bodies, & Technology" conferences, this lack of a defined field suddenly made sense: how feminist endeavors *rarely* receive sustained funding (and the journals and conferences necessary to promote, clarify, reward, and recognize interdisciplinary scholarship); how scholars are still reluctant to classify their scholarship as feminist out of fear it might not be read as rigorous; and how heterogeneous the field of feminist scholarship is in the first place – just to name a few reasons. But we were excited as well, because we *did* find some work exploring feminist encounters with the medical humanities, but nothing sustained.

It's about time to have a feminist health humanities. After all, medical humanities have been around since the end of World War II, and throughout the twentieth century. Within the medical humanities discipline, the humanities have moved from being perceived as the passive support or additive to the more rigorous medicine, to a necessary element of a well-rounded medical education that enhances emotional intelligence, ethics, and empathy.

Its own discipline

When we first devised the call for this issue on the feminist health humanities, what surprised us the most was how this field was still emerging. What seemed evident to us as an interdisciplinary, legible area of academic inquiry with clear stakes was actually still breaking off from the various disciplinary Pangeas. We noted that the field's (re)configuring was evident in its revising of its own name; degrees of distinction and imbrication aside, scholars referred to health humanities' prior iterations as medical humanities, critical medical humanities, and narrative medicine. Thus, in reading this issue, one finds oneself on the bleeding edge of a new discipline being formed, as scholars call it into being.

Health, in the late twentieth century, is defined as broadly as possible, and is not just focused on biomedicine, but also, for example, on relationships between patients and their doctors, and on the socio-historical conditions that create environments that can affect a population's health for generations. In *Keywords for Health Humanities*, Sari Altschuler, Jonathan M. Metzl, and Priscilla Wald (2023, p.4) note that health's "capaciousness and pervasiveness . . . make it a fundamental keyword for today's world," and, in addition to some of the defining traits we've already considered, they also describe health as a "cultural imperative," a "moral judgment," and a "central element of all life". Health is not the purview of any single discipline, and its knowledge-making and communication practices need to reflect that.

The humanities are at the core of this field, for both epistemological and communication practices, but also for methods. Catherine Belling (2015, p.19-20) explains that health care is provided in two steps: in the first, "pure science" is "translated into technologies of diagnosis and therapeutics," which are, in turn, applied to patient care. Both instances of application are "mediated neither by science nor by art but by an entirely discursively-constructed set of communicative and interpretive practices: the material of the humanities disciplines". Communication and meta-awareness are key, then, for success in medicine – not just excellent scientific knowledge. Belling (2015, p.20) also parses medicine's art-science binary, wherein, in James N. Kirkpatrick's words, "technical healing and the art of healing are two sides of the medical care coin," arguing that, in this instance, art does not include the humanities, and that this omission both "forecloses the possibility of questioning the epistemology, ethics, and language of both biomedical and clinical practice," and "deprives medical researchers, practitioners, and educators of a position from which they might understand their work as an historically, socially, and culturally continent activity". Altschuler, Metzl, and Wald (2023, p.5) also articulate the value of the humanities to health care, making the distinction that those embracing and working in health humanities, compared to those working in health *or* the humanities, have the advantage of engaging with both empirical and nonempirical ways of knowing.

In Sherri L. Foster and Jana Funke's (2018, p.3) editorial, "Feminist Encounters with the Medical Humanities," they position feminism, like humanities for Belling above, as needed to productively engage both science and medicine. Foster and Funke credit Jo Winning's work with illuminating "how feminism – in its emphasis on the embodied, the corporeal, and the

material – can open up an alternative practice-based conceptualization of the medical humanities that resists the very distinction between thought and practice”. While that particular journal issue’s authors are not yet working with the idea of the *health* humanities, we believe their ideas about feminism’s interventions still hold true, but with even greater impact given the expansion that comes with moving from medicine to health. For instance, Foster and Funke (2018, p.2) note feminism’s track record “challenging forms of bias and intersectional oppression implicated in biomedicine”. That, combined with feminism’s rich history of fostering engagements across disciplinary boundaries, demonstrates the integral role feminism plays in pushing the health humanities to be more inclusive and accessible for *both* those in need of health care and those providing it.

As a discipline, the feminist health humanities prioritizes understudied or neglected aspects of women’s and others’ bodies, such as the potential depression faced after birthing or adopting a child, and then seeks solutions, based in medicine *and* health, that are careful to avoid essentializing those bodies, from diagnosis to treatment. The feminist health humanities, due to its origins in feminist methodologies, makes space for the personal, nonempirical, and seeks to reveal how social conditions shape one’s experiences in and of health. Foster and Funke (2018, p.3) acknowledge how various scholars and “branches of feminist thought (including black, postcolonial, queer and posthumanist feminisms) have troubled conceptions of the autonomous humanist subject and have provided alternative conceptions of key philosophical categories including subjectivity, agency, resistance, or willfulness”. Schools of intersectional feminism support both recognition and validation of the influence and pressure that identity markers may exert on a person, as well as how these affect one’s health.

Lastly, the feminist health humanities takes seriously scholarship that involves - and importantly, centers and benefits - community members and practitioners who are not necessarily medical professionals, acknowledging that the university and the medical office are not the only sites of knowledge production or keeping. Indeed, these locations of expertise and technological advancement have often been sites of harm and violence for the non-academic community, and the feminist health humanities works to repair these harms.

Feminist health humanities in practice

As one will see in this issue, because the feminist health humanities sits at the crossroads of several disciplines, readers will find themselves engaging with numerous fields at once, with our contributors’ scholarship reflecting disciplinary tensions and making recommendations to affect health writ large.

We open the issue with Laura Gallo Tapias’s “Towards a Feminist Standpoint in Refugee Mental Health Research,” wherein Tapias investigates feminist health humanities’ global implications. Tapias uses a feminist lens to critique migration studies and the psy-sciences (psychology, psychiatry, and mental health research between these), arguing that, when it comes to refugees, gender is ignored by both disciplines. Migration studies needs to move beyond “the assumption that nationality is the key determinant of identity” and rely less on qualitative research, reductively categorizing men and women without considering gender’s complexities and constructedness (13). The psy-sciences need to acknowledge the ways in which the discipline’s understanding of normative roles and standards are exclusionary, oppressive, and fail to represent the lived experiences and vulnerabilities of refugees. Tapias’s triangulation of these disciplines effectively supports her call for migration studies and the psy-sciences to reconsider their practices and methodologies according to the mandates of feminist and gender studies, so that we can better “understand women’s experiences of mental illness”

and “challenge established notions of gender, migration, and mental health while amplifying the voices of marginalized individuals” (21).

Next we have Shirley Huang and Sarah Caston’s co-authored article, “A Phenomenological Approach to Understanding Different Perceptual Interests: Interactions Between Endometriosis Patients and Their Physicians,” which foregrounds endometriosis, a condition in which uterine tissue is present outside of the uterus, as a case study for a feminist healthcare model that challenges physician and institutional bias and empowers patients to share their lived experiences with medical staff who are trained to actually hear these narratives. The legacy of feminist scholarship deeply informs this emphasis on a patient-centered experience that argues for a revision of the pain scale from numeric to qualitative and descriptive. Endometriosis patients wait between 4-11 *years* between original symptoms to diagnosis, only then being able to seek treatment (27). This frankly dismal number is due to the lack of research into the condition, a lack of understanding into what endometriosis symptoms look like (misdiagnosis), and a lack of physician training – what Huang and Caston call “institutional misogyny” (33). But these are not the only reasons for such a long wait, which is where the feminist health humanities come in, addressing gender bias in women’s health: women’s pain is considered less serious than men’s pain (31), especially when the pain is related to menstruation and women have to deal with the stigma of gynecological examinations. Huang and Caston’s article draws much-needed attention to both an understudied and misunderstood condition *and* to improving an important feature of the medical experience that affects *all of us*: we can talk to our doctors like real patients instead of “ideal” patients (32).

Continuing the discussion of understudied features of health, Meghan K. Riley’s “fMRI and Endocrinological Studies of Depression and Anxiety Following the Birth or Adoption of a Child: Towards a Model of Feminist Science” is the third article in our issue. Riley identifies the need for fMRI studies of women with postpartum depression to adopt a feminist model of scientific research “to reduce the likelihood that these studies will lead to reification of sexist concepts, promote more humanistic inquiry, and increase the likelihood that these studies will result in more inclusive and effective treatment of parents with depression” (46). Riley points out that postpartum depression studies are not designed to account for the mental health changes experienced by partners of women who have recently given birth and adoptive parents, even though all of these new parents share the stress of integrating a new child into their home. When studies focus exclusively on women who have recently given birth, the results are likely to validate stereotypes and oppressive essentialist conclusions about women and hormonal behaviors, as well as discourage these women’s partners from seeking support for their own parental depression. In addition to this increased inclusivity, Riley calls for fMRI studies to be conducted alongside the subjects’ contextualizing social risk factors, as they might contribute to the depression or anxiety one experiences following childbirth or adoption. Specifically, Riley observed studies that did not attend to the impacts that race, education level, maternal age, marital conflict, partner support, and other social supports may have on the mental health of new parents. In short, Riley provides us a feminist lens through which to approach this important, neglected aspect of health at the crossroads of mental health and medicine.

In our last article, “Disability Politics and Reproductive Critique in Gayl Jones’s *Corregidora*,” Theodora Danylevich gives us a reading of the novel that “model[s] a feminist health humanities framework that is grounded in the values of reproductive justice and in literary and cultural intersectional disability politics” (53). Danylevich effectively argues that

Corregidora, in its documentation of the reproductive traumas endured by Ursa—the protagonist whose partner assaulted her, resulting in an induced miscarriage and “medically necessary emergency hysterectomy”—and the generations of enslaved women in her family, represents a “[sic]k archive”. As Ursa is growing up, her mother and grandmothers emphasize, in light of their experiences with slaveholders destroying records of their “sexual exploitation, incest, and the systematic severing of kinship ties,” that it will be her responsibility to leave biological and intellectual or creative evidence of her life (54). Biological and archival evidence are interdependent here; both having children and writing personal narratives are crucial acts for marginalized women whose legacies will not be preserved in white accounts of history. Danylevich’s historical contextualization of *Corregidora* reveals the many layers of violence – archival, domestic, and “public . . . by way of medical intervention” – preserved in Jones’s narrative archive (60). Danylevich frames these instances of harm and violence in a feminist health humanities conversation about reproductive justice, but informed by a crip-of-color critique, thus reminding us that every time a character’s reproductive rights are infringed upon, their human rights are also violated.

In an illustrative feature of how feminist health humanities is not just about patients, but also about doctors, we are including Seona Kim’s review of Sandra Cavallo Miller’s novel, *Out of Patients* (2022). Miller is a retired physician, and her novel features Dr. Norah Waters, a specialist in family medicine, managing physician burnout and other challenges. Kim invites readers to consider how Miller’s novel “parallels the interactions between doctors and patients during consultations,” allowing readers their own chance at examination and diagnosis (66).

As we conclude this editorial, we want to draw attention to the fact that the work in this field is only just beginning. Health is relevant to us all, and these articles underscore just how capacious and necessary feminist examinations of health humanities are, providing fresh approaches to such wide-ranging topics as refugee experiences, patient-doctor interactions, fMRI research, and narrative. We hope this special issue will help to define the boundaries around this discipline and show scholars outside of it what this growing conversation in the feminist health humanities can bring to their research.

Nicole Infanta Keller & Laura Hartmann-Villalta
Guest Editors

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