Becoming ꟻreak: A Collective Carnivalesque Resistance through Narrative Re-Imaginings of Women’s Experiences Living with Reproductive Health Conditions

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Abstract

(Re)produced within colonial and patriarchal knowledge systems, medical and psychological literature enacted on women's reproductive health crafts a singular story of feminine pathology and excess. Medical constructions of women's bodies position woman as freak to man, and an analytic review of the literature demonstrates how women with reproductive health conditions become figured as freakier versions of the freak. Through a freaky entanglement of embodied ambiguity, this research asks: how do women with reproductive health conditions that figure their abnormality subʌert pathologisation? Following this question becomes a collective narrative journey through a carnival, exploring how five women story their experiences living with reproductive health conditions. Guided by narrative inquiry, a freaking of academia and the collaborative process of the affective flows of meaning making, I materialise the political forces of figurations that open the possibilities for subʌersive transformations, telling embodied stories of being freak, freaking medicine and the potentials for embodied knowing through bearded ladies, fire-eaters and joyous freaky community. Through the transformative potential of freaking, I engage a response-able response to difference through the emergence of a new figure – partial, multiple, permeable. Together but not the same, we are becoming Ⅎreak.

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My strength is not that of one but of many

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Chapter 1: Introduction

My Story

It was an uncomfortably hot afternoon and I was in the car with my mum after school. I was 15 and had never had a period before; I was vaguely aware that it was somewhat late, but I remember thinking it would eventually happen, we are all different, so there was no need to worry. My mum shared that she was going to take me to the doctor to figure out what was going on. In an attempt to ease the tension she quipped, "they will probably put you on hormones, which will make you even more grumpy than you already are". It was the first time I encountered the narrative of both hormonal chaos and containment in women's bodies. I sat frozen with fear as I began my journey into deeply embodied shame for my bodily difference; I was broken and needed fixing.

When we sought help from my doctor his immediate response was, "well that is not normal", and I cannot overemphasise the power of that comment; it stuck with me for decades. I collided with the binary of normal/abnormal and had been forced to take up the space as someone who was abnormal. All that is left of my memories of the time that followed are brief encounters textured by fear and the sterile approach of the medical system. Anxiety threatened as I nearly fainted in blood tests; I became an object on display during an ultrasound through which I was probed for any other ways my body might also be "abnormal", my secrets free for anyone to hear beyond the (lack of) privacy curtain. "We're not supposed to tell you this, but you have an extremely under-developed uterus". And then nothing…

I moved through the world as an older teenager and young adult plagued by this guilty secret I carried. I was *abnormal*. I was incapable of locating myself within the boundaries that determine who a woman is – I didn't really have a uterus, I didn't experience menstruation, and I guessed that meant I also couldn't have children. I spent years dodging, ducking, and weaving, forever worried someone would figure out eventually how much of a freak I was.

When I was 19, a sports doctor noticed that I had extremely low bone density and after probing about my menstrual cycle, I felt backed into a corner and shared that it was "missing". A tide of relief momentarily swept in as I thought perhaps, he could help me. After reading my notes he then picked up his textbook and read aloud, "often causes severe anxiety", looked at me and said, "yeah, that fits…and ah…you won't be able to have kids…obviously". The relief went away, yet what remained was a glimmer of hope as he offered to refer me to a specialist, so I could understand more about my body. And then nothing…

A year after not hearing anything from a specialist, I felt like I had dodged a bullet and felt relief that I didn't have to endure the horrors of the medical system again. Yet the repeated enactment of neglect meant that I spent seventeen years navigating the world as I had done in the years previously – shrouded in embodied shame and blame for my bodily difference. It was only once I was brave enough to utter my secret then seek help from a doctor and gynaecologist recommended to me, who carried my story with care and compassion, that I was able to understand my body and undergo life-changing medical treatment. Through the collective effort of multiple specialists, it was discovered that I have a rare genetic condition that disrupts the neural pathway to my ovaries, and therefore, hormonal treatment was effective in enabling the healthy development of most of my reproductive system.

I owe it to my younger self to acknowledge the burden of the medical neglect I endured. I spent seventeen years suffering deeply, and had I been given the care I needed as a teenager it could have been prevented. Notably, however, the entire time, I associated my suffering with my bodily difference. After receiving medical treatment, I began to question the connection between my suffering and my body and started to recognise that my body was never the problem, but rather, it was the ways both medicine and society normalise woman's bodies and womanhood that haunted me. To be moved through haunting enabled my curiosity to understand other women's experiences of navigating life with reproductive health conditions, and the start of my resistance to the conditions of our everyday lives within which our distress emerges.

The Singular Story

My curiosity and niggle of resistance sparked an interest in exploring women's experiences for my thesis, and so I began to make sense of the research that is enacted on women's reproductive health conditions to open the space for what my research could bring.

Before we begin, it is important to note that within this research we are working with women's stories. In April, 2025 the United Kingdom chose to define "woman" by law as a "biological female", and closely after, the New Zealand First political party submitted their bill in attempt to do the same here in Aotearoa. The bill was an example of harmful and hateful rhetoric that reinforces the male/female binary of sex and fails to take into account the multiplicities and complexities of women's bodies. As such, within this research, I use the term woman as an inclusive term that extends beyond the binary of man/woman. Woman is any person who has any part of their reproductive system that is associated with being “female” and includes anyone who is intersex and/or identifies as a woman.

Weaving the threads of women’s stories of living with reproductive health conditions that are told within literature reveals a complex cartography of women’s everyday pain and suffering. Their stories echo the gendered and racial power relations within medicine in Aotearoa that craft a dominant singular story (Adichie, 2010; Fine, 2017a) of feminine pathology and excess, and perpetuate the dominant narrative that directly links pain to psychological suffering. When using the term pain, I am referring to the multiplicity of, and interconnections between, the psychological, physical, social, spiritual, and emotional pain that women experience while navigating living with a reproductive health condition. Haraway (2016) reminds us that it matters what story we tell stories with, and the stories being told through research of women’s experiences of reproductive health conditions are partial and limited and restrict what we can know of women’s embodied everyday experiences.

Only particular stories have been afforded a hearing (Waitere & Johnson, 2009) within psychological literature and they are those are told through the lens of commonly medically diagnosed reproductive conditions such as endometriosis and poly-cystic ovary syndrome (PCOS), and reproduce deficit-based representations of women’s experiences. That is, they are stories that use categories and labels created by the Western medical system, and focus almost entirely on the multiplicity of pain women experience while living with a reproductive health condition. The few stories that speak to the experiences beyond endometriosis and PCOS have also been categorised and labelled such as “chronic pelvic pain” (CPP), or vulvodynia, yet many women live without a specific diagnosis either through lack of medical knowledge or dismissal of symptoms (Mikesell & Bontempo, 2023), making it difficult for their stories to be heard.

Due to limited research, prevalence data of women’s reproductive health conditions in Aotearoa is fragmented and difficult to find. Tewhaiti-Smith et al. (2022) report that 25% of women experience pelvic pain in Aotearoa, and international rates of endometriosis are between 5% to 11%. Lawrenson et al. (2014) report that PCOS affects up to 10% of women internationally, and within Aotearoa, 21% of woman present with poly-cystic ovaries, which, however, doesn’t mean they have the condition itself. Vulvodynia is estimated to affect 10%

to 28% of women worldwide (Lountzi et al., 2025), while uterine fibroids have been observed in 7.3% of women in a study conducted in Australia (Wilson et al., 2024). Intersex Aotearoa (2025) identify that there are more than 40 intersex variations and intersex people represent approximately 2.3% of the population. As a collective representation that is nowhere near exhaustive, it is apparent many women are navigating many reproductive health conditions.

Affirmative stories of women' strength, resilience, and the celebration of their reproductive bodies are also scarce and are neglected within psychological literature. As such, it is apparent there are missing stories from the literature made up of those of us who have not been afforded a hearing, and so, it is within the constrained stories that *are* being told, I move with women's embodied experiences and knowledge to make sense of the meaning making that has already happened. In doing so, I may open new possibilities to tell other stories that move beyond feminine pathology and excess, and the individualisation of our pain, so we may also hear stories of resistance, joy, and freedom.

Braidotti (2010a) calls us to work by memory and heart by resisting the repetition and citation of work, and instead, be guided by emotional imprints that are left behind. As I open myself up to such imprints gifted by feminist scholars before me, I can hear the vast and varied ways that women are suffering while navigating living with a reproductive health condition and I have been moved by the emotional turmoil of their experiences. They share stories of: anger, hopelessness, feeling horrified, heartbroken (Soucie et al., 2022); despair, loneliness, violated (Grundström et al., 2020); ignored, dismissed, invalidated, (Mikesell & Bontempo, 2023); whakamā (shame), mamae (hurt), unheard, unsafe (Ellis et al., 2024); inadequate, guilty, defeminised, depressed, excluded (Shallcross et al., 2018); in agony, disgraceful, terrible, devastated, absolutely crazy, minimised (Hawkey et al. 2022); freakish, abnormal, unwomanly, weird, embarrassed, *different…silenced* (Kittzinger & Willmott, 2002).

A Freaky Framework

I feel a responsibility to use my location within psychology to decipher how pain as an affective flow of meaning making is connected, but ***<u>not</u>*** equated, to women's profound suffering while navigating life with reproductive health conditions. In doing so, I seek to challenge the singular story of feminine pathology and excess, so that we can transform the everyday conditions of women's lives within which our distress emerges. To create knowledge that resists dominant understandings of women and their reproductive bodies, I seek to subʌert the way we create knowledge, to open the space and possibilities to know otherwise. As I moved through the research process there was a shift; as I carried with me the haunting from my own painful memories and the curiosity it fostered, there was a moment of recognition through the emergence of our embodiment of carnivalesque resistances, where the pain of being woman (a medical freak) might become severable from suffering (pathologisation) and enable transformational understandings of embodiment. My own embodied haunting – a lingering feeling of dis-ease through gendered power that shaped how medicine responded to my body – manifested a question: How do women with reproductive health conditions that figure their abnormality subʌert pathologisation?

As I follow my research question, my research emerges as a freaky evolution of the embodied journey I navigated as it unfolded over time. As such, the layout does not follow the structure of a traditional thesis. Instead we step into a freaky entanglement of ambiguity between chapters. We begin with a freaky reading through an analytical literature review, where something that looks more like analysis may appear as we encounter the political forces of figurations. As we trace the methodological process we explore freaking as a method of analysis, which sets up the analysis as a journey through a carnival, within which I explore the history of freakshows and bring freaking as an analytical process with us to make sense of our stories. Our freaky journey brings us to the emergence of a new figure through which we reimagine feminine pathology and excess in our carnivalesque subʌersion of medicine. Our subʌersive transformation enables an opening of possibilities for a response-able response to difference through becoming freak *otherwise.*

Chapter 2: Literature Review

Western Medicine's Dominance: Histories, Power, and Enduring Values

To meaningfully engage with women's experiences, we must examine the social and historical conditions that have shaped the (re)construction, and embodiment of knowledge enacted on women's reproductive bodies within Aotearoa. Prior to Aotearoa's colonisation, Māori women were (and are) an essential part of the collective whole and feminine strength was (and is) at the core of Māori existence, located within her sexual and reproductive performance (Mikaere, 1999). Colonisation, however, rendered Māori knowledges, values, and practices predominantly invisible through Eurocentric dominance and the privileging of Western knowledge claims (Mikaere, 1999; Simonds, 2011; Waitere & Johnson, 2009). Consequently, women have been positioned as man's secondary, insignificant other; a hierarchal division that has "(re)defined, (re)fashioned, (re)named and (re)organised into a colonial social order that atrophies who and what Māori women represent" (Waitere & Johnson, 2009, p. 25). The subjugation of Māori women, and the imposition of patriarchy (Mikaere, 1999) was a corruption against women inflicted through colonisation (Johnston & Pihama, 1995) in the quest for the alignment of Māori women to colonial norms of womanhood. Eurocentric dominance enabled Western medicine to fulfil the role of the legitimate and authoritative figure responsible for the care for, and production of knowledge on, women's racialised and sexualised bodies in Aotearoa (Ellis et al., 2024; Moewaka Barnes & McCreanor, 2019; Wilson et al., 2021).

Tracing the historical fragments of (Western) medicine, therefore, constructs the foundations for the ways in which women's bodies have become pathologised, demonised, and subjugated (Ussher, 2004). Produced through patriarchal, white, neoliberal, colonial, capitalist, and individualist ideals (Ellis et al., 2024; Liebert 2010; Ussher, 2006; Young et al., 2019), Western medicine has become the most authoritative producer of knowledge enacted on the body, globally (Liebert, 2010; Young et al., 2019, 2020). The biomedical model has flourished alongside Western individualist ideologies, framing both health outcomes and embodied experiences as the result of autonomous individual choice (Young et al., 2019). Medicine operates under the guise of scientific neutrality claiming objective, value-free scientific practice and is responsible for the categorising, normalising and labelling of bodily experiences (Samardzic et al., 2021; Young et al., 2019).

During the 18th century, the body became medicalised (Young et al., 2020) and fell under the authority of medicine to control and manage. Medicine normalises and privileges a male (masculine), white, able-bodied, heterosexual, and cis-gendered body (Soucie et al., 2022); it is deemed the norm to which women are situated as his *other* (Barkty, 1998; Braidotti, 2012; Samardzic et al., 2021; Young et al., 2019). Any feature of the female (feminine) body that differs from the male (masculine) or cannot be given a male (masculine) counterpart is perceived as evidence of deviation and fault (Young et al., 2019). Women's bodies have been conceived as leaky, unpredictable, lacking secure boundaries, and in need of containment (Cole, 2020; Hallström, 2024). Through the construction of what it means to be a woman, within medicine, masculine and feminine bodies have been determined as "distinct but not equal" (Young et al., 2019, p. 341); any body that exists in opposition to the masculine superior is deemed iniquitous or defective.

Such distinction between the norm and "his" other is particularly troubling given the dualistic logic prevalent within Western medicine that re-produces identity binaries. Medicine's dominance as a legitimated knowledge producer affords the institute with the social authority to determine what is normal versus abnormal, what it means to be "male" or "female", that problems may stem from *either* the body *or* the mind, and who is an expert on bodies and who is *not* (Lupton, 2012; Samardzic et al., 2021; Young et al., 2020). Moreover, women are associated with the body, and men the superior mind (Ryle, 2012), reinforcing the public/private binary that deems the body (women) as a private entity, as opposed to the mind (men) which is worthy of the public sphere (Young et al., 2019). Morgan (1998) argues that "binary oppositions are inherently hierarchical relationships of domination" (p. 362), and through a mutually exclusive existence, one identity (man) is deemed positive, while the other (woman) is grounded in negativity and difference; binary oppositions naturalise the dominance of man over woman. It is medicine's discursive representations of the feminine body that are phallocentric and inscribe our bodies with meaning.

The colonial and patriarchal history within medicine has contributed to a significant lack of knowledge on women's bodies. Western knowledge production is constructed for and by men and its practices exclude, devalue, and subordinate woman and the feminine (Morgan, 1998). Aspects of the body, specifically those categorised as female, or intersex have been systemically rendered invisible (Raz, 2024), resulting in epistemological ignorance within the medical institute (Tuana, 2004). Ussher (2006) emphasises that knowledge is entangled with power relations that determine the legitimate subjects of scientific production; women's bodies are not, and have not been, deemed worthy of thorough scientific inquiry and knowledge production (Lupton, 2012; Martin, 1987; Ussher, 2006).

Furthermore, prevailing patriarchal and neoliberal narratives within medicine commodify women's bodies through the expectation of fulfilling two key roles: enabling heteronormative sex (for the enjoyment of men) (Samardzic et al., 2021; Young et al., 2020) and accomplishing their "biological destiny" of reproductivity and motherhood (Ellis et al., 2024; Grundström et al., 2020; Samardzic et al., 2021; Liebert, 2010; Young et al., 2019, 2020). Women who are unable and/or unwilling to fulfil these roles (LGTBQ+, intersex, infertile, for example) are demonised and their different bodies and lives are deemed as sinful, and/or diseased (Liebert, 2010; Young et al., 2020).

Feminine Figurations: Deconstructing the Mad, Bad, Sad

Psycho-medical narratives reduce women's many and varied stories to a singular, incomplete, dominant story (Adichie, 2010) of feminine pathology and excess. Their (re)production of a woman's body extends beyond description; women come to be understood and responded to through specific narratives that violently shape their experiences. When women's lived realities entangle with medicine's construction of woman, they challenge the very boundaries designed to keep her contained. As women traverse these boundaries, harmful figures emerge that account for her deviance. The combination of medicine's social authority, and its knowledge claims about women's bodies re-produce, re-tell, and re-enforce these deviant figures to the point they are mistaken as unquestioned, legitimate "truths".

Mad Woman: Diagnostic Features

The figure of the hysterical woman is a claim about women's bodies centered on the idea that when a woman's illness cannot be explained by "objective" medicine, it must be a product of her psyche (Jones, 2015; Ussher, 2011). Given the active exclusion of women's bodies in scientific inquiry, a myriad of women's struggles have been deemed psychiatric in nature, and this is reflected in the plethora of psychiatric disorders that are either specific to women, or heavily over-represented by women diagnostically (Grace, 1995; Ussher, 2011; Young et al., 2019). More specifically, Ussher (2011) argues that through the '*Diagnostic and Statistical Manual of Mental Disorders'* (DSM), the medical institute and the psy-disciplines have defined what it is to have a "disordered" mind and constructed the mad (hysterical) woman. Put simply, women's reproductive systems have been deemed responsible for our supposed susceptibility to "madness" (Bayer & Malone, 1996; Ussher, 2011, 2017).

Hysteria discourses are deeply embedded in medical history and stem from Plato's wandering womb theory; an explanatory model of disease in women (Jones, 2015). It was theorised that when women were suffering from distressing symptoms, it was the result of her womb (*hystera* in Greek), wandering throughout her body impacting the parts that were in distress (Jones, 2015; Young et al., 2019). It was even believed that "to deny one's biological destiny is to incite all manner of diseases" (Young et al., 2019, p. 341). Stein and Kim (2009) identify that the uterus, which is the physical and medical representation of the womb, is the only organ a woman has that does not have a 'male' counterpart, highlighting the explicitly gendered nature of the wandering womb theory. It was so pervasive that a hysterectomy was often the treatment for "female troubles" ranging from menstrual difficulties to mood disruptions (Jones, 2015). Consequently, medicine is produced by and productive of underlying beliefs that women's pain is a sign of a neurotic personality; either purely imagined or the result of the "melancholic fate of being a woman" (Shohat, 1992, p. 60).

The modern figure of a (mad) woman with raging hormones that renders her uncontrollable and at the mercy of them sits alongside the figure of the hysterical woman. Koerber (2018) offers a compelling argument that the discovery of hormones replaced hysteria to account for "female problems", and consequently enabled medicine to exert greater control over women's bodies. Koerber claims that in response to the resistance against hysteria narratives, medicine provided a "more scientific" explanation through the discovery of chemicals (hormones) that differ between men and women. Much like the reproductive organs in hysteria narratives, women's hormones are specifically targeted as the primary explanation for women's distress, such as their higher rates of depression or experiences of pre-menstrual dysphoric disorder (PMDD)/pre-menstrual syndrome (PMS) (Ussher, 2004; 2010). Liebert (2010) explains that scientific rhetoric asserts particular hormones are key markers of making women female, which uncovers the insidious gendered nature of the hormone discourse; "to emphasize hormonal dominance in the determination of our moods, feelings and relationships all the more inscribes them into our very subjectivities" (p. 279). She argues that medicine paints women as trapped, damaged, and "inescapable victims of our own bodies - destined to be unstable, irrational, and dependent" (p. 279). As such, women are deemed as biologically inferior and innately dangerous, thus naturalising patriarchal authority over our bodies (Mclelland & Fine, 2008).

We see the hysterical woman plagued with unruly hormones in women whose pain is dismissed or psychologised by medical professionals, or women who felt like they were going crazy as medicine could not provide an answer for their problems through objective measurability. She is also the woman whose physical experiences such as pain or heavy bleeding are normalised as she is seeking help for something that is not worthy of it. She too, is the woman whose emotional responses to her interconnections of pain are deemed as excessive, her presence made visible through any descriptions of powerful emotions such as deep grief, hopelessness, despair, and shame. She is the woman immediately prescribed hormonal treatment to save her from their unruliness. Based on historical theories of endometriosis, she is any woman with the disease who chose to pursue a career over or before motherhood (Ellis et al., 2024; Young et al., 2019, 2020). Essentially, she is any woman who is deemed psychologically unwell, or excessive in her behaviour; she is not well tolerated and her reports of her experiences are deemed unreliable.

Bad Woman: Diagnostic Features

When madness becomes insufficient to contain women's deviance, she transforms into the bad woman, a disruptive monster whose refusal of feminine docility exposes colonial and patriarchal anxieties regarding feminine obedience and control. Critically, the figure of the bad woman is underpinned by the masculine/feminine binary, associating the former with rationality, authority, and strength, and the latter with emotionality, docility, and passivity (Morgan, 1998). Bartky (1998) reminds us that "today, massiveness, power, or abundance in a woman's body is met with distaste" (p. 95). From the binary of masculine/feminine stems "hegemonic constructions of idealized femininity" (Ussher, 2004, p. 254), that position women as the emotional nurturers of others, especially men and children. Consequently, this enables the construction of the binary of good woman/bad woman; the good woman is calm, responsible, in control, and puts others first, while the bad woman is selfish, irresponsible, uncontrollable, angry, and unruly (Ussher, 2003). She is the monster who disrupts the normative expectations of women, exceeding them with her excessive emotion. She challenges the expert status of doctors and rejects the subject position of the passive unknowing and dependent patient; she is assertive, researches her condition and self-advocates. She is the difficult patient for whom medical treatment doesn't work, and demands her pain get taken seriously, the drug seeker. She is the woman who chooses to resist her reproductive destiny and pursue a different life beyond motherhood, or the mother who must put herself before her children because her body demands it. She is the woman who refuses silence and defeat.

Sad Woman: Diagnostic Features

When women's deviance cannot be contained through madness or moralisation, our freakery takes on a softer, more acceptable form as it shifts from monstrous excess to a sense of melancholic lacking. Her body becomes inscribed with pity rather than danger, her deviance positioned as a loss, garnering sympathy: she is the sad woman. She is the woman whose reproductive system and performance of womanhood do not align with Western standards of normative femininity. Such standards are extensive within medical discourse and beyond the expectations of women to reproduce and engage in heteronormative sex, women are expected to be, hairless, slim, and fertile (Kitzinger & Willmott, 2002; Samardzic et al., 2021). The sad woman is the infertile woman, the irregularly menstruating woman, the woman who does not or cannot engage in heteronormative sex, and the woman whose body is too large. You may recognise her through the medical labels of endometriosis, PCOS, CPP, vulvodynia, vaginosis, or intersex among others. The sad woman fails reproductively, heteronormatively, bodily; each failure serves to position her as an incomplete woman.

Women's bodies that deviate from Western normative femininity are pathologised through the construction of diseases marked by the specific ways their bodies deviate from the dominant norm. Women who suffer from endometriosis have tissue where it "shouldn't be" (Hallström, 2024; Hawkey et al., 2022; Peterson et al., 2023; Young et al., 2019, 2020), while women with PCOS have 'too much' of the 'male hormone' testosterone, larger, hairy bodies, and irregular periods (Kitzinger & Willmott, 2002; Samardzic et al., 2021; Soucie et al., 2023). Both conditions are associated with infertility (Young et al., 2019; Soucie et al., 2023). Women who have difficulty with penetrative sex may have any number of women-specific conditions, while women who struggle with their mood can be diagnosed with PMDD (Ussher, 2010). Women whose bodies may not include, or have under-developed, reproductive organs may be diagnosed with rare "disorders" or one of more than forty intersex conditions. Essentially, any way a woman's body deviates from feminine norms as determined by medicine, is pathologised. Commiseration surrounds the sad woman; her failures are not necessarily her fault, she is merely trapped in a body that betrays her, keeping her from what she most certainly wants.

Diagnostic Uncertainty

Tightly bound configurations of women as mad, bad and sad, subject women and their bodies to discipline through medical and psychological authoritative knowledge. Where "male" is the medical norm, woman's excessiveness becomes understood as madness, badness, and sadness. However, another figure has emerged through my analytic review of the literature who is neither mad, bad, nor sad; she is someone who cannot be contained, accounted for, or disciplined by medicine; she is far less tolerable, perhaps even terrifying.

In unpacking the term freak, Grosz (1996) suggests it is not just reserved for those with commonplace bodily maladies and deficiencies, nor for accidental tragedies or internal organ abnormalities; she emphasises that some people deemed freaks are not physically incapacitated at all. A freak is “a being who is considered simultaneously and compulsively fascinating and repulsive, enticing and sickening” (p. 55). Freaks are those who traverse the boundaries that secure the “normal” subject in its given identity (Grosz, 1996). Young (1990) argues that all forms of oppression towards groups such as sexism, homophobia, racism, and ableism are reflected through the image of unsightly, frightening, repulsive bodies. Given woman’s status as ‘other to’ man as the norm, we can come to understand woman as a freak. All women transgress the rigid boundaries of human normativity simply by existing within bodies that differ from man’s. For women with reproductive health conditions, their breaching of taken-for-granted boundaries produced through colonial, patriarchal, capitalist systems to oppress are intensified. She is not the masculine pinnacle of humanity, nor does she fulfil her purpose to man through heteronormative sex and reproduction, therefore, her body not only troubles the boundaries of normative humanity, but also disturbs the stability of heteronormativity.

Intolerably Ambiguous Freak: Diagnostic Features

Beyond pity lies what medicine finds most intolerable: ambiguity. The intolerably ambiguous freak defies all binary categories that maintain order of medical categories. Neither tragic nor monstrous, she becomes something indefinable, an embodiment that unravels the very logic of human normativity. Grosz (1996) highlights that freaks are “an ambiguous being whose existence imperils categories and oppositions dominant in social life” (p. 55). Freaks are those who exist beyond, and in defiance of, the binary oppositions fundamental to dominant manners of self-definition and occupy the impossible middle ground in between. The intolerably ambiguous freak is the woman who occupies the subject position of both masculine and feminine traits that medicine deems as male *or* female; she defies the binary distinctions between man and woman enforced by medicine. She is the woman with facial hair or an “excessively” hairy body, a woman who embodies any form of intersex identity, she has “too much” of the “male hormone” testosterone, excessive tissue growth, she cannot carry a child or engage in heteronormative sex. Arguably, she is the patient who exerts assertiveness, dominance, or is simply physically larger. She is not considered wholly a woman, nor a man, but somewhere in between. As Lindsay (1996) argues “only the true freak challenges the conventional boundaries between male and female, sexed and sexless” (p. 356). Her mere existence is perplexing, opaque, and questionable amid the rigid confines of medical identities.

Figurations

The figures of the mad, the bad, the sad, and the intolerably ambiguous woman embody serious political and affective intensities. Figurations are “politically informed” (Braidotti, 2011, p. 22) mappings of “embedded and embodied social positions” (p. 13). As living, dynamic and multi-layered, figurations trace and materialise the social power relations that shape real lived conditions (Braidotti, 2011; Haraway, 2016). Haraway (2008) speaks of “figuring relentless otherness knotted into never fully bounded or fully self-referential entities” (p. 32), reminding us that embodied social positionings are always open, shifting and relational, formed through connections with others. Figurations are an “invitation to inhabit the corporeal story” (Haraway, 2008, p. 4), to occupy and feel the spaces in, through, and between power relationship binaries - partial, multiple, permeable (Braidotti, 2010a; Haraway, 2016). Figures materialise where embodied politics are particularly dense and in encounter, enabling understandings of the processes of ongoing shaping and forming of embodied positionings through encounters with difference, and the power relationships that produce and shape difference. Complex knotted entanglements of histories, power relations, politics, bodies, and relationships mean that figurations constantly shift and move, always becoming (Braidotti, 2010a) - “the parts do not add up to any whole” (Haraway, 2016, p. 104) nor stay static. Braidotti (2010a, 2011) argues that figurations are creative expressions of our affirmation, transformation, and potentia (positive power), political images that stir counter-images of our subjectivities. Figurations enable the “complex and radical task of subverting conventional views and representations of human, and especially of female subjectivity” (Braidotti, 2011, p. 33). Women’s bodies are always created through medical, social, and affective entanglements, so we can consider what is enabled when women can be figured as always in embodied movement with dense politics.

Figures of feminine freakery frequently emerge through psychological and medical literature enacted on women’s experiences of living with a reproductive health condition. Each of the figures materialised so far – the mad woman, the bad woman, the sad woman, and the intolerably ambiguous freak – emerge, (re)produce and (re)enforce the singular story of feminine pathology and excess. There is of course overlap between these freaky figures, where women may occupy the spaces of being mad, bad, sad, and ambiguously freaky all at once; a dynamic political density that strengthens the socially embedded positioning of woman as freak, regardless of how her reproductive health condition presents. Such figures are explicitly gendered, which Liebert (2010) argues perpetuates gendered power dynamics within medicine, each reproducing medicine's fascination with the 'unruly' feminine body. The danger for women and their bodies is that the singular story of their deviance renders invisible the partiality, multiplicity and contradiction of women's embodied experiences.

Destined to Melancholy? On Recognising our Distress and the Reproduction of the Freaky Feminine Figures

The freaky feminine figurations emerge within institutional and scholarly spaces and Young et al. (2019) argue that even feminist scholars participate in the perpetuation of medicine's power through the dissemination of its knowledge claims within research (see also, Lupton, 2012). However, there is a growing body of psychological literature that seeks to tell alternative stories of women navigating reproductive health conditions. These stories move beyond the biomedical hyperfixation on bodily pathology, and instead, highlight the emotional turmoil of women's day-to-day embodied experiences to foster change. While this work is valuable for highlighting the struggles women face and the inadequacies of healthcare systems, it simultaneously reproduces the freaky figures, reinforcing medicine's fixation on feminine excess and pathology.

Furthermore, Braidotti (2008) stresses that melancholia has become an affective economy, and that pain has long been negatively associated with suffering; linking pain with suffering limits our potential for transformative change. The emotional stories of women's experiences of reproductive healthcare focus on her individualised, painful emotions (categories) that reinforce the connection between pain and suffering and, therefore, still locate the source of women's suffering as within her body, thus also (re)producing feminine pathology and excess. It is, however, worthwhile acknowledging that through the reproduction of these dominant figures, these stories have been afforded a hearing (Waitere & Johnson, 2009) within medical and psychological research, which enables us to understand the ways in which women embody their experiences living with a reproductive health condition in their day-to-day lives, and how medicine as an institution harms women far beyond the four walls of a healthcare centre.

Women report experiencing significant loss of social connection across multiple areas of their lives because of the self-management and avoidance practices they utilise to reduce physical and emotional pain. Women avoid sexual intimacy within romantic relationships due to sex being painful, unpleasant or not physically possible (Peterson et al., 2023; Shallcross et al., 2018). As such, women position themselves as inadequate sexual partners carrying guilt and shame about their failure to perform ‘normal’ (heteronormative) sex (Ayling & Ussher, 2008; Shallcross et al., 2018). The focus on avoidance and the guilt and shame it provokes, paints the picture of the passive, excessively emotional woman, as she traverses the boundaries of the sad, intolerably ambiguous and hysterical woman. Her body betrays her, preventing her performance of normative femininity while subjecting her to social sanctions that discipline bodies; her emotional response is deemed excessive, yet her passivity paradoxically preserves her femininity. Notably, it is her passivity expressed through avoidance that is accountable for her experiences of loss.

The normalisation of heteronormative sex further reinforces women’s experiences of loss through the rejection of other forms of sexual intimacy as worthy (Cole, 2020). In pursuit of a socially acceptable relationship and the desire to fulfil their expected womanly duties by enduring rather than enjoying heteronormative sex (Young et al., 2019), many women choose self-sacrifice, suffering through painful intercourse (Cole, 2020; Hawkey et al., 2022; Peterson et al., 2023). These stories strengthen the image of women as obedient, compliant, and submissive. While she manages to avoid being an intolerably ambiguous freak, she pays the price through her endurance of physical pain; her suffering becomes a product of societal expectations of femininity and ***not*** her body.

Managing pain also extends into wider social circles; Cole (2020) identifies that women who experience severe physical pain pre-emptively limit their social lives to reduce their perceived burden their pain may impose on others. Women often describe their physical pain as obstructing plans and social activities, sometimes requiring them to cancel last minute, which taints them with the reputation of being socially difficult (Hallström, 2024). Such framings echo the societal expectations of women to be self-sacrificing and nurturing, always placing other’s needs before their own. Women, therefore, who opt to cancel plans to take care of themselves are portrayed as the disruptive monster. Yet, in avoiding monstrosity, some women choose to reduce their circle of friends and social contact out of concern for disappointing their friends and family (Cole, 2020). They are then recast as the sad and hysterical woman, suffering through loneliness that is portrayed as emotional excess.

Regardless of their response to managing pain, women are positioned as variations of the freaky figurations, and their suffering a consequence of their pursuit to uphold normative femininity.

Social connections are also lost for women who engage strategies from a young age to avoid situations deemed as “risky” regarding managing difficult symptoms such as heavy menstrual flow (Hallström, 2024), vulva pain (Shallcross et al., 2018), or excess hair (Kitzinger & Willmott, 2002). It is through these stories we can recognise the figure of the feminine body as different, leaky, and freaky; in need of being contained or hidden from others. Women’s suffering through lost social connections unfolds through acts of concealment and avoidance as we recognise both the sad woman whose body is deceiving her and the intolerably ambiguous woman with an unacceptably hairy body.

Hawkey et al. (2022) identify that women also suffer a disruption to the connection they have with their children due to the severe pain they experience that renders them incapable of caring for and interacting with their children. The root of the associated pain with this loss of connection stems from women’s perception that their inability to care for their children during times of severe pain regards them as a “bad (m)other”, that is, a monster. Hawkey et al. (2022) suggests that the sense of being a disgraceful mother is based upon the social construction of motherhood within which mothers are expected to be continuously emotionally and physically available to meet their children’s needs.

Women suffering from reproductive health conditions are required to do motherhood *differently*, and their perceived inability to live up to expected norms of motherhood renders them “depressed” and “anxious” (Jack, 1991). Notably, however, such descriptions are a (re)production of individualised medical categories that are reflective of an unstable psychological state and *too much* emotion, often associated with women (Ussher, 2004, 2011). The figures of bad mothers are those made available to us to understand ourselves, and therefore, women experience their “failures” of motherhood in *excess* of a minor error, and as an assault on their core and sense of identity as woman (Peterson et al., 2023). Women’s enforced embodiment of failure is then cast as a direct reflection of the hysterical tendencies of the mad woman.

Women’s perceived failures of womanhood echo the hyperfixation on woman’s bodies within medicine as existing to enable heteronormative sex and fulfil a biological destiny of reproductivity. Women claim that being able to menstruate, carry a child, and give birth are the fundamental symbols of being a woman (Kitzinger & Willmott, 2002), signifying their internalisation of the motherhood mandate within Western culture that assumes motherhood as the deeply gratifying, natural and expected experience for all women (Russo, 1979). As a result of discovering that their fertility was implicated by having PCOS, women expressed terror, panic, devastation, and despair (Kitzinger & Willmott, 2002) and a deep sense of grief (Hawkey et al., 2022). Within these narratives, the mad and sad figures are once again revived, as women's emotional intensity is positioned as excessive and a symptom of her failure to achieve her biological and social destiny.

The Contradiction of Normal and its (In)validation

Western medicine's idealisation of femininity as slim, hairless, fertile manufactures how women come to understand their bodies as inadequate when they fail to meet such standards. These standards, reminiscent of a pubescent girl (Bartky, 1998), reproduce colonial and patriarchal constructions of women as inferior and in need of control. Larger or hairier bodies become evidence of failed femininity, prompting relentless disciplinary self-management such as dieting and hair removal (Bartky, 1998; Kitzinger & Willmott, 2002). Through these practices, femininity is produced as a "practiced and subjected body" (Bartky, 1998, p. 92).

For women with PCOS and endometriosis, shame becomes a pervasive embodiment (Ellis et al., 2024; Samardzic et al., 2022). Their bodies are positioned as excessive - too big and too hairy, and therefore in need of normalisation. Medicine's commodification of women's bodies perpetuates the demand for normative femininity while simultaneously punishing those who cannot achieve it. Shame emerges not from women's bodies themselves, but from the patriarchal standards of acceptability imposed upon them (Bartky, 1998).

Women describe profound fears of being marked as "abnormal" or occupying the space of difference. To avoid being read as failures of womanhood, many self-silence, hiding pain (Cole, 2020), concealing conditions (Hallström, 2024), and suffering privately. Their language reflects internalised freakery: "unfeminine," "masculine," "abnormal," "weird," "not a woman," "freakish," "other" (Cole, 2020; Kitzinger & Willmott, 2002; Hallström, 2024; Marriott & Thompson, 2008).

Women's identification with abnormality arises across reproductive disruption, (Cole, 2020; Kitzinger & Wilmott, 2002), sexual difference (Cole et al., 2020, Peterson et al., 2023 Shallcross et al., 2018), and bodily excess (Ellis et al., 2024, Kitzinger & Wilmott, 2002; Samardzic et al., 2021). The social sanctions inflicted upon women who transgress the boundaries of normative femininity manufacture an operation of fear that reflects the performance of dominant narratives within medicine on women's bodies and the punishment and subjugation of bodies that are different. Their transgression of the medical boundaries of woman disrupts their sense of identity as woman and fosters profound melancholic emotions and the embodiment of the mad and sad woman. It becomes clear, that their suffering does not lie in their bodies, but the powers of medicine to define normalcy.

The figure of the hysterical woman frequently materialises through the literature produced on women's experiences of reproductive health conditions, and normalises the feminisation of pain; when women's experiences of pain are minimised and deemed as excessive emotion or 'hysterical' (Hawkey et al., 2022). Many women experience the dismissal and minimisation of physical pain from healthcare providers who either normalise their pain or account for it as psychological (Cole, 2020; Ellis et al. 2024; Young et al., 2019, 2020), thus positioning them as mad. Heavy menstrual bleeding and severe menstrual pain are frequently reduced through medical explanations to a "normal", unexceptional experience (Cole, 2020; Ellis et al., 2024; Hallström, 2024; Katz et al., 2024), while women who experience pain during sex are reassured by doctors, friends that persistence is required to ease their pain (Hawkey et al., 2022; Shallcross et al., 2018). These stories demonstrate the colonial and patriarchal narratives that depict women's bodies as leaky, in need of containment, and destined to melancholy and suffering, simply by virtue of being a woman.

Jones (2015) emphasises that the revision of physical pain as psychological not only reinforces hysteria narratives but also prevents appropriate medical intervention. Women, therefore, get angry, self-advocate, or push for treatments and are cast as the difficult or hysterical patient (Young et al., 2019). In her defiance, the hysterical figure rejects the passive, docile, and dependent ideal feminised patient, thereby also locating her as the bad woman. The punishment of her excessively emotional responses to her uncontrollable body is inflicted when women are constructed as "drug seekers", "difficult patients", or "crazy" when seeking medical intervention for their pain (Ellis et al., 2024; Peterson et al., 2023). The positioning of women as mad or bad acts to control them by enforcing their alliance with normative femininity through punishing their deviance.

Many women experience a sense of relief when they receive diagnoses for their reproductive health conditions as it enables a greater sense of legitimacy and recognition for their struggles (Cole, 2020; Hawkey et al., 2022). While the storying of women's relief in receiving diagnoses is targeted at reducing diagnostic delays and improving health outcomes for women, it also reinforces the narrative of women's dependency on medicine to save her from her unruly body. These stories suggest that the recognition of women's bodily experiences within medicine legitimises experiences that would otherwise be questioned, and that medical intervention brings reprieve. Medical control, however, reproduces the normal/abnormal binary that is fundamental to the construction of intolerable ambiguity, as it reduces bodily difference through normalisation, thus reinforcing the boundaries of normative femininity.

The emotional toll of women's experiences is prominent within research that expands beyond the biomedical model of health to draw attention to the impact medicine has on women's day-to-day lives. Such research is helpful as it offers insight into the impact of the forces of psycho-medical authority on women through the social power dynamics that manufacture our suffering. However, across these accounts, women's experiences of living with a reproductive health condition are narrated through an affective economy that reproduces the freaky feminine figures, strengthening their dominance within the literature. Whether positioned as mad, bad, sad, or intolerably ambiguous, women's stories remain constricted through the enduring story of feminine pathology and excess, a story that obscures the multiplicity of their lived realities as only the stories that conjure a woman in distress are afforded a hearing through pathology (Waitere & Johnson, 2009).

Whispers: Threads Overlooked

There are glimpses of alternatives to the circulation of the singular story of women's deviance, as stories of resistance and self-empowerment surface: women are educating themselves, researching their conditions, forming communities for collective support, engaging in social activism and self-advocating within the healthcare encounter (Cole, 2020; Hallström, 2024; Hawkey et al., 2022; Samardzic et al., 2021; Young et al., 2020). Fernley's (2021) study as an example, draws attention to the positive impact doctors have had on patient's experiences of endometriosis diagnosis when they listen to, believe, and provide prompt care or referrals for women seeking their help. Young et al. (2020) found within their research that women seek the position of an *active* agent in the partnership between them and their doctor and have their lived experience valued. Yet these stories are few and far between, brief glimpses and are often an apparent afterthought comprising a paragraph or two at the end of published research. Critically, the hyperfixation on emotions within most research conducted on women's experiences is problematic as emotions themselves become gendered categories that reduce women's experiences to discrete statuses that are constructed within a knowledge economy embedded with the patriarchal and colonial agendas of Western medicine.

When seeking to understand women's journeys navigating reproductive health conditions in Aotearoa, particularly those of Māori and Pasifika, I was met with whispers within psychological and medical literature. The stories of women's experiences of reproductive health conditions in Aotearoa are reflective of those in the broader literature; highly homogenous in their representations, predominantly reflecting the experiences of white, heterosexual woman (Ellis et al., 2024; Samardzic et al., 2021; Young et al., 2020). Critically, throughout the 20th century, endometriosis was coined the "career women's disease" (Young et al., 2019); a disease of white women of higher socioeconomic status due to their delay in childbearing duties and excessive stress (Ellis et al., 2024; Young et al., 2019, 2020). Ellis et al. (2024) question the racial correlation to endometriosis and emphasise that while endometriosis is reported as more common amongst Caucasians, it is unclear as to whether this influence is biological, or social, where access and capacity may limit intervention for certain communities. Ellis et al. (2024) report that within Aotearoa there are no published studies (beyond theirs) on the prevalence of endometriosis among Māori and Pasifika women, nor their experiences of navigating the condition and its associated healthcare. They note that in a recent study, wāhine Māori represented 12% of endometriosis patients, yet the data was not separated from the cohort to draw any specific conclusions, demonstrating the homogenising practices of Western research.

Very little psychological and medical literature details the embodied experiences of Māori and Pasifika (or other non-white) women navigating a reproductive health condition. The few women of non-European ethnicity who have been involved in research report experiencing institutional racism and increased pathologisation in their healthcare encounters (Ellis et al., 20204; Samardzic et al., 2021). Within Aotearoa, Māori and Pasifika express a lack of safety within Western models of health, noting they are driven by masculine values and Western values that fail to meet their culturally specific needs (Ellis et al., 2024).

Mikaere (1999) directs our attention to the culturally specific confines of identity that have been re-created and normalised through colonisation and their gendered implications for Indigenous peoples. It is through the patriarchal processes of colonisation that Māori women's reproductive processes and practices have become marginalised (Mikaere, 1999); "colonisers were quick to impose shame upon the reproductive roles of women, thus disregarding the power and tapu of te whare tangata" (Simmonds, 2011, p. 15). Despite, historically celebrating women's reproductive and sexual functions (Mikaere, 1999), Māori woman now speak to the whakamā (shame) they embody speaking about their reproductive systems (Ellis et al., 2024).

He Wāhine, he Whenua, e Ngaro ai te Tāngata: By Women and Land, Men are Lost

Out of frustration upon finding whispers surrounding Māori and Pasifika experiences of reproductive health within psychological and medical literature, I realised I needed to look beyond its confines. Le Grice and Braun (2017) argue that Western research perpetuates representations of Māori as biologically inferior, and culturally deficient, which results in the ethnic and cultural marginalisation of Indigenous knowledges on reproduction. As I began my search for alternative research within women's gynaecological health I was welcomed by literature that disrupted the dominant narrative of pathology and excess, instead offering stories of resistance that tell and understand women's reproductive health *other*wise through exploring Māori understandings.

Within mātauranga Māori, reproduction moves beyond the individual body and is conceptualised as an interactive and dynamic relationship between biological, social, spiritual, and ecological elements (Le Grice & Braun, 2017). Reproduction is treasured as a deeply sacred phenomena, and Salmond (1985) highlights that all living things embody a life principle that within humans, "progressively unfurls through interweaving transitions through spiritual and ancestral realms to human form" (Le Grice & Braun, 2017, p. 153). The process, as more than human, is enabled through te whare tangata, which directly translates to "the house of humanity", representing the woman's womb and capturing the deeply implicit value placed upon women's bodies within te ao Māori (Le Grice & Braun, 2017; Murphy, 2011). The human qualities of spirituality that travel through pregnancy to birth reveal the importance of caring for, and attachment to the feminine body (Le Grice & Braun, 2017).

The foundational Māori creation story of Ranginui (sky father) and Papatūānuku (earth mother) further reinforces the intrinsic value placed upon women's bodies, as Papatūānuku played a central role in the creation of the world as we know it (Le Grice & Braun, 2017). Ranginui and Papatūānuku's son, Tāne, god of the forests separated his parent's tight embrace causing his siblings to endure a period of te po (darkness) before emerging into te ao marama (the light). Mikaere (2011) identifies that Māori conceptualise the various stages of labour and birth within this framework. The story of Papatūānuku serves as a metaphor for the way women, like the land, nurture future generations across cultural, social, spiritual, political, and economic realms (Mikaere, 1994).Women's gift of nourishment is further reinforced through te whare tangata which allows women to protect and nurture babies (Smith, 2012), and through breastfeeding when a mother becomes the source of sustenance for her child (Le Grice & Braun, 2017).

Due to the sacred nature of women's bodies and reproductive capabilities within mātauranga Māori, menstruation is deemed as a treasured occurrence. Colonial understandings of menstruation position women's bodies as leaky and in need of being contained, dirty, and polluted, an attempt to justify the construction of woman as inferior (August, 2005; Murphy, 2011). The portrayal of "the blood that carries ancestors and descendants as unclean is an extension of colonial violence against the whare tangata" (Murphy, 2011, p. 78). Through her research, Murphy (2011) re-stories and re-claims Māori understandings of menstruation noting that menstrual blood connected a woman to her humanity, divinity, whakapapa and bestowed psychic and spiritual protection. Menstruation is deemed a rite of passage and source of spiritual prestige among Māori (Palmer, 2002).

As I engaged with these stories, I couldn't help but wonder, given women's reproductive capabilities are profoundly sacred within mātauranga Māori, how do Māori attend to questions of white imagination that are enacted on difference? What does it mean to be infertile, intersex, or LGTBQ+, or takatāpui, for example? In strong contrast to Western heteronormativity, historically, emphasis was placed on sexual diversity within mātauranga Māori (Brickell, 2001), and "gendered and sexual diversity was embraced and considered part of the ordinary constellation of individual difference and uniqueness within whānau" (Le Grice & Braun, 2017, p. 157). Reproduction was understood by Māori within a context that spanned beyond an individual desire for a child and rather a social investment from the wider whānau (Glover et al., 2008). Children were collectively raised by the community (Mikaere, 2011) and infertile people were able to engage in the collective effort of parenting and protecting whakapapa (Le Grice & Braun, 2017).

The stories of women's bodies within mātauranga Māori enable us to hear *other* stories that celebrate and treasure women's bodies as spaces of deep worth and sacrality. Thinking back with the stories prominent in research we can recognise that despite decades of research we still find women with reproductive health conditions are suffering in their everyday lives. As we move with the deeply embodied experiences of women and the affective flows of meaning making we can recognise how these stories delve into the melancholy of the world. Yet, as we move with the stories from wāhine Māori we can identify how we can make sense of our distress through the commodification of psychological disorder, which opens the space to delink our pain from suffering. In this moment of recognition, I could sense the transformative potential within the reclamation and re-telling of stories that are missing within literature on women's experiences of reproductive health conditions.

Our Missing Stories

Through the circulation of the mad, bad, and sad figures produced by psycho-medical imagination, I could recognise the individualisation of women's distress that reduces women's complex experiences to personal pathology and excess, isolating her pain from the broader social and structural contexts that shape her everyday life (Liebert, 2010; Ussher, 2010, 2011). Liebert (2010) refers to this as selective hearing loss that prevents the "illumination of, and collective action against, the shared conditions in which women's distresses emerge" (p. 280). The feminine figures expose the commodification of women's bodies in the economy of medical treatment through their controlling and containment, enabling the feeling of the connections between women's bodies and how they are produced. The emergence of the intolerably ambiguous freak through these connections was a process of recognition of how the power that shapes women's bodies might be subʌertible; she cannot be accounted for by medicine, nor contained, and the disciplinary forces used to bring women in line become futile. In her movement in through and between the rigid boundaries of femininity, she exposed our missing stories, and in doing so, sparked a sense of possibility, an opening for our resistance and the potential for transformative change.

Upon completing my journey through the literature, it was apparent that the harm inflicted upon women navigating reproductive health conditions is manufactured through the circulation of the partial, limited, and singular story of feminine pathology and excess. I can now recognise the stories that are rendered silent and untellable by the institutional acoustics of medicine and psychology: they are stories of women who have not been diagnosed with a common medical reproductive health condition, stories of the sacred nature and power of the feminine body within Indigenous understandings, they are the stories of women's resistance to colonial and patriarchal narratives; those that refuse to position women's reproductive bodies as pathologised, excessively different and emotional, hysterical, or in need of control. Identifying the circulation of the dominant singular story embedded in colonial and patriarchal power relations that accounts for the silencing of stories opened the space to consider how I could responsibly respond. As I reflected on my own silences, I began to question how I could disrupt the singular story and enable the hearing of the missing stories so that we may understand *otherwise.*

Chapter 3: Methodology

Reflecting on my journey through the literature I can recognise the collusion between medicine and the psy-disciplines in the (re)production of colonial, patriarchal knowledge claims that manufacture the conditions of women's everyday lives within which our distress emerges. These knowledge claims reproduce a singular story of feminine pathology and excess; they are at the heart of the subjugation of our reproductive bodies, inscribing them with meaning and contribute to the violence inflicted upon them through the lack of recognition of, and care for our reproductive health conditions. The dominant narrative that equates the interconnections of pain to psychological suffering is enacted and normalised through these colonial and patriarchal knowledge claims by force of habit and tradition (Braidotti, 2009), and limits our capacity to recognise and attend to the social power relations that inscribe meaning in and through our bodies and thus manufacture our distress.

As I deliberated on these insights, I could hear Fine (2017a) asking "now that we know, what will we do?" (p. 119). I started to comprehend the aims of this research: to disrupt the singular story (Fine, 2017a) of feminine pathology and excess, to proactively delink pain from suffering by moving through and working with pain differently, and to attend to the epistemological violence against women that occurs within dominant research methodologies through the reproduction and circulation of partial dominant narratives. As we move with the potential of figurations, I recognise this research is a political piece, a site of social activism.

As I moved through the literature and became affected by stories that are (re)circulated about women's reproductive health, I found few stories that embodied the potential to transform knowledge production enacted on women's bodies and move away from the singular story of pathology and excess. Stories told by wāhine Māori scholars opened the potentials for creativity, through their vitality in a space that opens the institutional acoustics of medicine and psychology, that bring us to reimagining a hearing of pain for real. In this opening, I recognised this project as de-pathologising women's stories of pain and delinking them from psychological distress, as we move away from melancholy produced through negative narratives, we begin to move with the affective flows of meaning making instead.

Coombes et al. (2016) highlight the responsibility of psychologists to advance social justice by generating knowledge that supports societal well-being, while remaining actively committed to preventing harm throughout the process. And so, I started to question how I could re-imagine knowledge production in ways that could attend to the aims of this research.

Braidotti (2009) argues that since pain has long been associated with suffering by force of habit and tradition and, it is consequently assigned negative connotations. She reasons that through advanced capitalism, melancholia and lamenting have become a dominant system of power relations that enforce an obsession with pain, wounds, and suffering and leave little space for other possibilities of working with pain. Braidotti asks us to re-think pain as potential through a *transformation* of meaning by shifting our understanding of pain from an individual experience to one that made meaningful in interrelations with others and enables us to *affect* and *be affected* by them. Braidotti (2008; 2010) suggests that in the pursuit of an ethical response to women's suffering, rather than denying pain, we can activate, work through, and move beyond it. Her call to delink pain from suffering is not an appeal to deny pain's existence, rather, she argues that in-depth transformations are demanding at best, and often a painful process.

When we de-psychologise pain and reframe it as an affective process and creative force that carries the potential for collective transformative change (Braidotti, 2009, 2012), we can reimagine how pain moves our embodied subjectivities and fosters ethical relations. Braidotti (2009) argues that all affect flows relationally and the positive transformation of negative affect has the power to put "the motion back into emotion and the active back into activism" (p. 48). Through depathologising women's painful narratives, we can mobilise through the affective flows of meaning making, as we tell our stories, so that we may hear women's pain with purpose, a deeper understanding, and within our collective movement, find moments of joy and freedom (Braidotti, 2012).

Before examining a re-imagining of knowledge production, reflecting on my own location was a process of recognising the limitations and partiality of my own embodied experiences and knowledge. Haraway (2016) describes this concept as situated knowledges, referring to the recognition of knowledge as being partial, perspectival and embodied socially, culturally, and historically (Harding, 1992). Scientific "objectivity" is grounded in colonial, patriarchal knowledge claims and has been operationalised in a way that makes it difficult to detect dominant assumptions conceived as collectively held beliefs, thus it is far from maximally objective (Harding, 1992). Haraway (1988, 2016) and Harding (1992) argue that we can qualify strong objectivity through engaging situated knowledges and recognise that knowledge is embodied socially, culturally, and historically; while we come together, we are not the same.

By apprehending my responsibilities, arising from my location within psychology and feminism, to disrupt western knowledge claims that manufacture sameness and difference, and thereby the other, I am compelled to respond to stories of difference *differently.* Braidotti (2010a) calls for the disidentification from dominant modes of subject formation through the radical disengagement from dominant institutions and depictions of masculinity/femininity and race. It is through the affirmation of our difference to colonial and patriarchal knowledge claims within medicine and psychology that we enable "a more adequate cartography of our real-life conditions and hence less pathos-ridden accounts" (Braidotti, 2010a, p. 412).

I envisage knowledge as a river, carving its way downstream through a valley, changing its course through significant moments in time; a dominant current collecting the flow of its tributaries as it moves. I liken dominant knowledge claims within psychology in Aotearoa to the main current of a river, the tributaries as *other* ways of knowing that can be diluted, unheard amidst the dominant flow. I began questioning what stories and knowledge become silenced through the (re)production of dominant Western, "objective", "value-free" psychological and scientific claims.

Through ongoing processes of colonisation, Aotearoa occupies a socio-political context of Western hegemony within which individualism has flourished alongside neoliberalism that produces individuals who are deemed autonomous and accountable for their wellbeing (Coombes et al., 2016). Through systems of categorisation and normalisation the binary of sameness/difference has emerged enforcing standards of Western normalcy and in opposition to the norm, the "other" is produced, inscribing bodies with meaning (Coombes et al., 2016). As a racialised and sexualised process (Waitere & Johnston, 2009), colonisation significantly impacted the status of wahine Māori by "throwing the hearts of our [Māori] women on the ground" (Mikaere, 1999, p.22). Patriarchal and colonial ideals interweave in ways that reproduce and reinforce the dominant story of racialised and sexualised bodies as different and inferior (Coombes & Te Hiwi, 2007; Mikaere, 1999; Simmonds, 2011; Waitere & Johnston, 2009). Through the enactment of the dominant story that directly associates pain with suffering, the hearing of the stories of wāhine Māori that celebrate and treasure women's reproductive bodies is hindered.

Consequently, through the exclusion of Māori knowledges, values, and practices, and the positioning of women's bodies as hysterical, *different*, excessively feminine, and the lone source of their suffering, the voices and stories of wāhine Māori and their stories of affirmation have been concealed, misunderstood, and assimilated to Western patriarchal narratives (Mikaere, 2009; Murphy, 2011; Waitere & Johnston, 2009). Through unraveling these connections, I understand there are many stories that have not been afforded a hearing (Waitere & Johnston, 2009) and consider the importance of decolonising my own knowledge production practices to seek a hearing for real.

I am a Pākehā woman and acknowledge my own collusion with Western knowledge production through recalling my unquestioned belief in its "legitimacy" up until recent years. I am beginning to understand how Pākehā culture has been naturalised and rendered invisible within Aotearoa, enforced as the unquestioned legitimacy, as opposed to a specific culture. I recognise the ways in which this normalisation perpetuates systems of dominance and the lack of recognition of the harm it causes to Māori. As a researcher within the psychology discipline and academy, I can identify Western/Pākehā dominance within psychological knowledge claims, and subsequently, the epistemological violence inflicted upon Māori (and those who also occupy the space of other). Therefore, I carry the weight of my ethical obligations to Te Tiriti o Waitangi in my own process of knowledge production.

Waitere and Johnston (2009) compel us to acknowledge that listening to stories does not guarantee a hearing; we must consider the institutional acoustics - sociopolitical histories, linguistic, cultural, theoretical, epistemological, and ontological "airwaves" that result in either resonance or dissonance within the listener. As we engage with the stories of women's reproductive bodies within the psychological and medical institutions, it is critical that we understand the ongoing practices of colonisation enacted under the guise of scientific "neutrality" and the patronage of sameness that confine, limit, harm, and silence the voices of wāhine Māori (Waitere & Johnston, 2009). Through the (re)production and (re)circulation of oppression stories (Fine, 2017a) the psychological and medical institutional acoustics coerce readers to resonate with the singular story while simultaneously manufacturing dissonance toward other stories that resist it, through their silencing. Waitere and Johnston (2009) argue that to hear Indigenous stories we must reckon with the "multiple forces of subjugation where sexism, racism, colonialism and class combine and overlap with the political aspirations for self-determination" (p. 15). Within my location in feminism and psychology I recognised that simply listening to and re-telling women's stories was not enough.

Haraway (2016) tells us that "it matters what stories we tell to tell other stories with…what thoughts think thoughts…what stories make worlds, what worlds make stories" (p. 12), that is, how stories are told, and by whom is produced through power relations. “Who speaks? For what and to whom? Who listens?” (Fine, 2014, p. 26). It matters that women’s stories of their reproductive health are being told through colonial and patriarchal narratives embedded in colonial research methodology. It matters that these narratives *think* that pain equates to suffering. It matters that these stories are made by worlds that privilege coloniality and patriarchy, as these stories, thoughts, and worlds are those accountable for the manufacturing of our distress. It, therefore, also matters that we affirm our difference to these dominant narratives and research methodologies. As I affirm my commitment to hearing stories of resistance as well as pain without reducing them to suffering, I realise we can move with them to enable transformative social change. When we resist the psychologisation of pain, we disrupt the singular story that manufactures our distress and open the space for other alternatives.

Fine (2017a) emphasises that the “passing on” of stories is a complex process; their translation a “strategic and delicate social movement” (p. 108). Storytelling is a relational process that engages empathy and connection, enabling a collective process of meaning making and becoming-with. Storytelling helps us understand the multiple, partial realities that contest the singular story and allows us to responsibly and carefully listen, *hear,* and reimagine potentials together (Fine, 2017a).

As I trace the echoes of my own story, I can acknowledge that through its re-telling, I have opened the space to enable people in my world to understand my embodied experiences, otherwise. Through rejecting the exclusive medical categories and narrating my lived experiences as I understood them, I was able to tell my story of difference *differently*. The more I shared my story, the more stories I heard from other women of both similar and different experiences, but all of the ways in which we had endured the lack of recognition of, or care for our reproductive health conditions. Collectively, we started to understand our experiences were bigger than us, our problems not inherently located in our bodies. A deeper knowing stirred within me as I could sense the power and embodied knowledge that lay within women to make sense of our everyday experiences, and re-tell our stories away from shame and blame, opening a space and the possibilities for social transformation.

Narrative Inquiry

Dominant narratives are harmful in that they become reproduced and reinforced to the extent they are perceived as unquestioned, taken-for-granted, legitimate “truths”. Harding (1992) refers to this as the "god trick", a seeing-all, knowing-all, universal, "objective" viewpoint, that is accountable to no one. No story is ever complete (Adichie, 2016); the stories we tell are only ever partial, socially situated, and enacted through power relations (Harding, 1992). There is danger in the singular story as its circulation and normalisation makes one story the *only* story (Adichie, 2016; Fine, 2017a; Woodiwiss, 2017); its reproduction silences other stories rendering them non-existent, unreal, or illegitimate (Woodiwiss, 2017).

Fine (2017a) ask us, "what is narrative desire in revolting times? What do we seek to accomplish as narratives circulate?" (p. 110). She speaks to the mobilising potential of narrative, suggesting that the use of aesthetic encounters enables us to *move* beyond those that numb and suppress affect, rendering readers passive, and instead provoke a "wide-awakeness" that disrupts dominant narratives, and unsettles entrenched patterns of thought and behaviour. Narrative texts "slice a paper cut into our soul" (Fine, 2017a, p. 110) ensuring that we disarticulate ourselves from grave instants of apathy and numbness (Fine, 2017b; Greene, 2001). Narrative inquiry has the capacity to shift the burden of structural violence; it enables us to get a sense of the complex nature of the life stories of others beyond their flattening that reduces them to a category or stereotype (Bradbury, 2017). Fine (2017a) emphasises that narrative work is a collective endeavour, a labour of resistance, re-vision, and responsibility: at the core of circulating and translating narratives is the promise of a strategic and nuanced social *movement*.

Movement and action occur when we disrupt the dominant stories that perpetuate the inequitable power relations of the singular story (Fine, 2017a). Narrative has the potential to promote social change and destabilise the academic colonialism of Western knowledge claims (Fine, 2017a). As researchers, the stories we tell are embedded within, and often constrained by, broader social narratives and the gendered power structures that sustain them (Woodiwiss, 2017). Narrative inquiry enables us to proactively disarticulate ourselves from dominant narratives and research methodology, allowing for a responsible response to issues of social justice.

Women's lived experiences offer necessary insight into the ways we understand the world, enabling the generation of new knowledges from our marginalised location about our lives, nature, and social relations (Harding, 1992). I am reminded of Braidotti's (2012) call for the recognition of the transformative potential that exists within marginalised groups: "The centre is void. All the action is on the margins" (p. 42). It is critical to engage in a research process that speaks with those within the margins as opposed to *for* them (Coombes et al., 2016; Woodiwiss, 2017); stories make visible the multiplicity of subjectivities that are concealed by dominant singular narratives.

Storytelling is a relational process that evokes both empathy and connection that enable a hearing of the affective flows of women's everyday lives. It is a process of collective meaning making and shared acknowledgement. Bearing witness to the pain, wounds, and injustice of the missing affective histories of those who have been excluded from discursive representation is central to the radical ethics of memory work (Braidotti, 2010a). Narrative responds to the silencing of our painful memories; it demands the recognition of historic and future temporal flows, and events of both major significance, those that rupture lives and identities, and those that alone, may seem modest, but in fact are repetitive "stress fractures" wounding the soul (Bradbury, 2017; Fine, 2017a). As we recognise the value in seeking these repetitive stress fractures, we can make sense of how seemingly insignificant everyday experiences can unfold as "slow violence" (Fine, 2017a) in their accumulation, collectively manufacturing harm in the day to day lives of women.

Fine (2017a) reminds us that we must consider how stories not only look inward reflecting poignant and painful experiences within our complex subjectivities, but also radiate outward in enactments of resistance to the structural inequities and social power dynamics that shape our everyday lives. She affirms that we can tell stories of both quiet and loud resistances. As we come together in a process of the affective flows of meaning making, we can collectively make sense of how our stories radiate out, which is where transformative social change begins. Narrative enables us to re-tell and re-articulate our painful memories differently, resisting the narrative of pathology and excess, or that pain equates to suffering, challenging the idea that there is something inherently wrong with us. It permits us to tell ourselves away from stories of shame and blame and open up possibilities of becoming-with (Braidotti, 2010a; Haraway, 2016) as we respond affirmatively to our difference from dominant stories.

The intent of narrative is to not simply replicate stories that have already been told, but to engage creative repetitions that re-tell, re-configure, and re-visit experiences from different angles; an affective mapping of our relations and interactions (Braidotti, 2010a). Fine (2017a) reminds us that re-vision is a form of resistance; a delicate art of resisting the present, while being worthy of it (Braidotti, 2010a). We must critique and resist the injustice and violence of the present, while engaging affirmatively and creatively to foster the potential of hope. By engaging a process using the affective flows of meaning making, we can recognise the violence against our bodies in our everyday lives that remains invisible to those who are privileged by colonial and patriarchal power relations (Harding, 1992). Yet, by challenging the forces of normativity inflicted on our bodies, that limit what can be told by hegemonic Western knowledges, we can also be open to new possibilities of collectively making sense of the untellability of our experiences navigating living with a reproductive health condition within our colonial and patriarchal society.

I think back to the river of knowledge and ponder, what demands a change of course within the dominant flow? Typically, a significant moment in time, a storm. When a river floods, the collective impact of its tributaries that span its catchment have more force than the dominant flow itself. Suddenly, the main current of the river is inundated with *other* flows, an eclectic mix of streams from different places and spaces, enough to change its course. Each story collected within this research, each piece of research we conduct that disrupts dominant colonial academia, acts as a rain drop, collected within a tributary, eventually contributing to the dominant flow of knowledge. When there is enough rainfall, the river will change its course. McFarlane et al. (2024) offer the concept "he awa whiria"; a braided river as a framework that enables the coming together of Indigenous and Western knowledges to support bicultural partnership, which drew attention to the potential ways I could move forward with this research.

In seeking a research process that is both responsive and responsible, it is important, from my location as a Pākehā woman in the psychology discipline, to acknowledge the decolonising work that is taking place by Māori scholars. This work is considered a process of recovery, re-cognition, re-creation, and researching back against Western hegemonic research constructs, as Māori use their Indigenous epistemological frameworks to claim space for the legitimacy of Māori knowledge (Lee, 2009; Smith, 1999; Woodhouse, 2019). Storytelling has always been a process that protects and sustains Indigenous knowledge (Smith et al., 2016).

Pūrākau are cultural narratives rich in mātauranga Māori, embedded with a diverse and complex knowledge base (Le Grice & Braun, 2017). The sharing of pūrākau is a process that enables Māori to impart knowledge, values, and worldviews, as well as make sense of the world by understanding themselves within context and place (Tapiata, 2024). Critically, pūrākau is a process inherently relational that fosters empathy, connection, respect, and meaningful interpretation through reciprocity (Lee, 2009; Woodhouse, 2019). Pūrākau enables the telling of emotional realities (Woodhouse, 2019) and the "creative reworking of narratives for new contexts" (Le Grice & Braun, 2017, p. 152).

Lee (2009) highlights that pūrākau has emerged within academia as a relevant and creative methodology in response to the harm manufactured within colonial research. I understand, therefore, my ethical responsibilities, to not exploit, but recognise and be guided by the values of Māori resistance to Western hegemony within research. By understanding the principles of pūrākau, I can begin to make sense of how I may contribute to decolonising and depathologising knowledge produced on women's reproductive bodies. From my location within psychological research, what I can hear is the energising potential of pūrākau as a relational process, that enables women to engage a collaborative process of the affective flows of meaning making. Collectively, there is transformative potential to creatively rework narratives for new understandings; it is less so the stories themselves, but the relationships within storytelling that matter.

Oakley (2016) reminds us that stories are a gift, often given through altruistic intent as people share a part of their life story previously unheard, so that others may *hear,* be *moved,* or understand differently. Ultimately, the story we come to tell through our research is 'our story of their story' (Limerick et al., 2016 as cited in Oakley, 2016); it is a co-creation of knowledge, and the gift is in the relationship that unfolds in the storytelling.

Fine (2017a) emphasises that we are deeply responsible for the careful translation of stories; a delicate labour of reflexivity. She challenges us to consider how our accountability extends beyond the research itself. As we acknowledge storytelling as a relational process and consider our accountability to those who gift their stories as well as those who are impacted by them, we can begin to comprehend the importance of ethical relationships in our research.

Relational Ethics

At the heart of this research, I am responding to the missing affective histories within the knowledge production in Aotearoa enacted on women's experiences of navigating reproductive health conditions. Through understanding this is a relational process of collective meaning making, as women gift their stories, I take on the delicate and fraught responsibility of re-telling them (Fine, 2017a). I acknowledge that my accountabilities extend beyond this research itself, which draws attention to the principle of tika within this research; it's purpose. For Braidotti (2010b), ethics are "about the cultivation of affirmative relations" (p. 413) and Coombes et al. (2016) speak to our ethical obligations to reimagine possibilities within our research and engage with “ways of doing humanness differently” (p. 445), to revolutionise our socio-political landscape. Simmonds (2011) compels us to acknowledge that our difference(s) matter(s); by rejecting difference as deficit (Taylor et al., 2016), we can celebrate the in-betweenness, complexity, contradiction, and inconsistencies we embody. We can ethically respond and engage a “responsible response” (Coombes et al., 2016) to suffering through *affirming* difference (Braidotti, 2012) and navigating an ethical relationship with the other, ensuring we listen to their pain for real to open possibilities for negotiating meaning (Coombes et al., 2016).

Within our ethical relationship with the other, we must recognise the social person as becoming, rather than fixed (Coombes et al., 2016). Braidotti (2012) warns us that the memories of minorities are not “just static splinters of negativity forever inscribed in the flesh of victims of history” (p. 32). Through mobilising neglected resources such as creativity and imagination, affirmative ethical relations can transform the negative through the “creation of alternative social relations and other possible worlds” (Braidotti, 2009, p. 5).

Braidotti (2012) tells us that storytelling becomes a political act of remembering and memories are crucial for our practices of accountability; they are a creative force that enable us to imagine an alternative world with more compassionate and sustainable social systems. Nomadic memories are “affirmative, destabilising forces that propel subjects actively toward change, they are the kind of memories that are linked to ethical and political consciousness and concern events one *simply forgot to forget”* (p. 32, italics added). As we collectively re-member our missing affective histories together and refuse the silencing of our painful memories, we importantly engage in the provocation of the conditions and relations that empower creative alternatives (Braidotti, 2012).

The relational process of storytelling is an ethical movement of care (Hydén, 2013; Taylor et al., 2016) within which empathy, reflexivity, and careful interpretation inform the knowledge we create together (Fine, 2017a; Taylor et al. 2016). Hydén (2013) recognises that storytellers and researchers connect in mutual respect to collectively develop narrative accounts, therefore, who is speaking, and who is listening are critical considerations as infinite factors scaffold their relationship (Taylor et al., 2016). Braidotti (2010a) suggests that engaging our politics of location is a cartographic method that accounts for the multiple differences that shape both power locations and power relations: it is a methodological movement toward an ethically accountable and politically empowering vision of subjectivity. Through the affective flows of our storying, our location is "constructed together with, that is to say, in the encounter with others" (Braidotti, 2012, p. 35). Through ethical relationships we can attend to the partiality of our stories, remembering they are reflections not only of our experiences, but the broader social power dynamics that influence them (Braidotti, 2010a; Harding, 1992).

Relational ethics ask us to acknowledge our responsibilities in the research process as narrative conjures complex, sensitive, and difficult to speak of experiences (Hydén, 2013). Haraway (2016) reminds us that we can be response-able, by staying with the trouble and by engaging a process of becoming-with. As we move with those who share stories of pain, we must establish a relationally safe space through being an attentive, present, and interested *listener* (Hydén, 2013) and attend to the ways in which the interaction between researcher and storyteller shapes narrative accounts (Taylor et al., 2016). Oakley (2016) challenges us to reconsider the non-reciprocal, exploitative dynamics in the traditional researcher-participant relationship, alternatively offering the relational space between storyteller and research as a site for genuine connection. Moving with relational ethics, the principle of whakapapa, empathy, connection, respect and reciprocity all enable a process of collective meaning making. The coming together of our stories and becoming response-able to our stories are the heart of this project. As Braidotti (2010a) reminds us, we are in this together…but not the same.

Method

Collaborative Conversations: Weaving Stories and Making Meaning Together

In my endeavour to both hear and affirm the affective histories that are missing from psychological literature, I sought to connect with women, over the age of 18, who thought that they may have a story to share of their everyday experiences navigating life amid reproductive health struggles and their social consequences. It was the coming together of our stories, the gift of the relationship that unfolded in the process of storytelling and collective meaning-making and the delicate and fraught responsibility of caring for and bringing our stories to life (Fine, 2017a) that were the heart of this research.

Guided by narrative inquiry, storytelling as a process of meaning making both enabled me to recognise the purpose of this research, as well as ensure a response-able and ethical response. As I reflect on my own journey, I acknowledge that for a long time I believed my experiences were unique, my embodied sense of blame and shame valid due to the abnormality of my reproductive body. I thought my experiences were so rare that they were irrelevant. I embodied what I regarded as a logical silence, my story untellable because not even doctors, whom I understood at the time as experts, could make sense of it. After seventeen years of silence, it was through the successful care I received from my doctors that I developed a nagging sense of resistance toward the previous failures of the medical system. I started to reflect on how its neglect had shaped my everyday life and I began to question where my sense of shame and blame was really coming from.

My questioning moved me to begin sharing aspects of my story and as I spoke more freely and openly, I started to recognise a pattern – the more women I spoke with, the more I came across other women who had also begun the process of resistance toward their experiences of living with reproductive health conditions; women had either endured similar experiences or knew of someone who had. Despite navigating a diverse range of experiences within our reproductive bodies, our stories collided in a shared space of blame, shame, untellability, and a desire for transformative change.

These early relational conversations and the curiosity they sparked transformed into ethical relationships when I engaged in community consultation for this research within a social media support group. Within this process I began building connections and unearthed a sense of responsibility to listen to, affirm, and responsibly share women's experiences, especially those excluded from psychological and medical research through mobilising untellability. As I pondered the principle of tika (purpose), I realised it could actually *do* something; foster the potential for transformative social change by disrupting the singular story that excludes and silences the affective histories of many women.

After gaining ethical approval (MUHEC OMI 25/57) I invited women to share their story as a part of this research by circulating the participant information sheet (see Appendix A) among my close social network, namely, with people whom I had previously shared my story, or chatted to about this research. I encouraged them to share it among their social networks also, asking that any women who were interested in participating to contact me via email. It was in the following days that this research came to life, and with energy and momentum I never expected. Within a week eight women contacted me who were eager to share their story; five women consented to their participation, three were unable to due to unexpected health issues, or their limited availability at the time. All of the women who participated took the opportunity to participate online via Zoom, which has become an everyday practice of connection.

The recorded conversations varied in length from roughly one to two hours. Time was spent before recording started to engage in the process of whakawhanaungatanga (relationship building), and I took guidance from each woman to determine what felt like a fitting time to start recording. Once the conversations came to a natural end, the recording was stopped, and together we took time to debrief our chat, check in with each other, and ensure we both felt okay leaving the conversation. I then re-connected with each woman a couple of days after our conversation to check in and ensure they were still doing okay. With some women, our conversations continued through email as further reflections were shared. Several women expressed that they enjoyed the process and reflected on aspects of their story they hadn't previously considered, suggesting the process of storytelling moves us into action.

Sharing meaningful and painful memories is an affective process and I was guided by relational ethics to ensure I established a relationally safe space that allowed women to feel comfortable sharing their stories. Guided by the principle of whakapapa, empathy, care, and reciprocity were important in the process of establishing meaningful connections within which we could engage in the affective flows of collective meaning making. To support women in sharing their personal stories, I shared my location as someone with lived experience who was willing to share something of myself also. Some women were curious to hear my story first, and others were happy to begin with their own, having thought about it prior to our meeting. Throughout all the conversations, in moments it felt appropriate to do so, I shared threads of my story, where the meaning we made was woven through our relationship in the process of storytelling.

To engage manaakitanga, which I understand as upholding the dignity and respect for the stories being told, I engaged a collaborative and reciprocal process of meaning-making. The women engaged in a conversation with me, within which they were positioned as both experts of their own stories and co-creators of this research. The goal was to gather a collection of unheard stories in their multiplicity and partiality. It was within the process of storytelling that enabled a relationship of responsibility to take care with women's stories of resistance and relational pain and produce a collective affirmative story of difference that moves us. Our storytelling opened space to understand pain differently; not a lone wound carried, but a shared force circulating between us, that allowed us to affect and be affected by (Braidotti, 2009) one another's stories. Hanging out with women in a conversational space allowed for relational connections and the movement of stories in and through the affective flows of meaning making, where care flows between researcher and participant.

The process of storytelling brings to life our embodied memories as they weave together in the moment of recognition. And as we made sense of our experiences through a particular story, another story was unfolding, opening spaces for the affective flows of meaning making. It was in these moments that the painful embodied memories, the stories steeped in pain and loss moved our affective sense making into action through a dynamic and energising collective story of resistance.

Holding with Care: Carrying Women's Stories Responsibly

I was reminded of the weight of my responsibility when working with the women's stories, and recognised how memories move us, in the midst of transcribing our conversations. One morning, during a walk after a night of rainfall, I came across a Kānuka tree, its leaves glistening with droplets of water. I paused to admire them and reached out to touch one; it slid gently onto my fingertip, trembling as I lifted it to my eye. Through the droplet, the world appeared *different*. In that moment, I recognised I was carrying the women's stories with me, much like the droplets, passed carefully onto my tender touch to write a collective story, through my eyes, that carries transformative potential to affect and be affected. I was reminded of the delicate and fraught responsibility (Fine, 2017a) embodied in the collective story - that brought coherency to our differences in its circulation. It was the process of becoming responsible to the aims and response-able to how stories are told with purpose that is vital to the project. Each participant was asked what brought them to this research and I recognised my ethical responsibility to hold their vision closely as I moved through the next phase of the research.

After each conversation, I engaged a reflective process of moving in nature to contemplate and process, not only the stories that we shared, but the storytelling relationship that unfolded between us; the process by which we were making sense of our memories, *together*. After the conversations, I took note of the thoughts and feelings that circulated as a process of capturing the affective flows I both heard and felt; a stream of consciousness recorded in the form of a reflective journal. I transcribed each conversation as soon as I could in an attempt to keep the affective flows of our meaning making alive in my memories. I spaced out our conversations to avoid overlap between transcribing and hearing different women's stories, and continued to add to my reflective journal throughout this process. As I engaged in these conversations, however, I began a process of meaning making as each woman's story began to mingle with each other, and the process of hearing became more layered and complex as I (we) moved through the process.

While written consent was agreed upon (see the consent form in Appendix B), consent was continuously negotiated with the women in an ongoing process, an ethical process of responsibility in relational space (Hydén, 2013). Once the transcripts were complete I returned them to the women for them to comment on. As I was working with women's lived stories, this was an invitation for the women to reflect on their storytelling and confirm they were happy with the use of their transcript; they were welcome to amend their transcript as they felt was necessary before approving of its use (see Appendix C for a copy of the Authority for the Release of Transcripts Form). This process enabled an opportunity to engage in further connections and foster an ethical relationship between us.

Once I collected our stories and started preliminary analysis, in the pursuit of genuine co-collaboration in this research, the opportunity to participate in a feedback process was offered to each woman to ensure our collective meaning making process was adequately represented. Participants were provided with a preliminary analysis of the findings and invited to provide feedback or clarify meaning where it appeared it was misrepresented or misunderstood. This was an optional process and an invitation for the women to continue to engage as co-collaborators within the research.

Informed consent also required attending to the ways that I could care for women's stories, both by guaranteeing their safety and ensuring they were accurately represented. Confidentiality was guaranteed using pseudonyms that the women had the option of choosing themselves, and all identifying information was removed from their transcripts. The women were made aware of the procedures for storage and destruction of their information and were encouraged to ask questions throughout the entire process.

Method of Analysis: Freaking as a Form of Subʌersion

In the early stages of this research, while working with the literature, I had a moment of recognition that gathered momentum and shaped how this project unfolded. As I was remembering with my own story, I reflected on how I felt like a freak as a woman within medicalised gynaecological healthcare. The image of freakery stuck with me, and I began to identify differing forms of freakery emerging through the literature. Recognising freakery as a shared experience among women moved me to produce the freaky feminine figurations and their emergence became pivotal in the analysis process. In particular, the emergence of the ambiguous freak signalled a shift in this research; her ambiguity and impossibility of containment opened the space for resistance within our stories.

The analysis process began in real time as the conversations with each woman unfolded and our relationship of meaning-making developed. As I listened to their stories, the freaky feminine figures became recognisable as they surfaced in and throughout each woman's memories. Yet their surfacing was more than merely a presence, it was a site that became the potential for the affective flows of meaning making that took place between us. It was in hearing the women's stories through the feminine figurations that I could hear their pain for real, not through their alliances with them, but in how they made sense of their entanglements with the figures, and even more so in their resistances to them that followed.

As I moved through the conversations, I took notes reflecting on the stories I heard, particularly those that moved me and stirred an embodied experience; a felt intensity that circulated between us. I had a moment of recognition in *feeling* the energy and aliveness that hummed between us, stirring a sense of excitement, potential. We each spoke from a place of our pain having transformed into purpose, knowledge into resistance. Together we came to recognise that it was our suffering that demanded the process of the affective flows of meaning making. As we made sense of our suffering through social power relations and ***not*** our bodies, there was a determination that pulsed between us that brought to life our resistance that took place in the form of subʌersion.

As I went through the process of transcribing our conversations, then re-reading through our stories, continuously reflecting on how they circulated between us, I realised that the figure of the freak became central to our process of subʌersion; we were collectively making sense of our stories and disrupting the dominant story through freak*ing.* Freaking, as a process of subʌersion shifts the power away from the figure of freak as a passive, fixed label inscribed with pathology and excess to an *active* mode of becoming. Freaking is an embodied resistance that enables us to make visible the boundaries that define normal and instigates our refusal of conforming to them. So, rather than being the freak as object, we become a freaking subject; we *move, unsettle, and disrupt*, a practice of resistance and redefinition. We were freaking the system, freaking expectations, freaking norms, and in doing so allowed a process of troubling the social power dynamics that manufacture the day-to-day conditions within which these norms, expectations and systems are inscribed on our bodies.

Our freaking was an energetic force shared between us as a collective and joyful process. The figure of freak was no longer an insult or pathology but a site of resistance and empowerment; a reclamation of our deviance. Through our freaking we engaged in a social movement of becoming as we refused to comply with binary labels and understandings. We sought the indistinct in between, refusing to be one or the other, nor fixed in place, but forever shifting. Our process of freaking enabled shared moments of joy and freedom within our resistance and troubling of systems that have manufactured our harm. We were able to expose the absurdity of the rigid boundaries of such systems, while forming new found understandings of ourselves and our embodied experiences. Our freedom came from relinquishing our obedience to dominant narratives as we released the blame, shame, and pressure we embodied to perform womanhood a certain way. As we laughed together, rolled our eyes, shared scoffs, sighs, and dark humour, we made room for something else beyond our suffering; a transformation.

Within our process of freaking, the women who shared their stories (and me), found ourselves connecting over expressions of dark humour. Laughter, irony, and sarcasm traversed our conversations and felt like moments of shared joy and freedom. Rather than an avoidance of our pain, they became an embodied release and form of resistance that moved us into action. As we retold our stories with satire and defiance, we embodied a refusal to conform to expected narratives of feminine emotion. It was a *movement* away from despair, tragedy, and melancholy as we carried our painful memories together in a process of resistance. Braidotti (2019) reminds us that interrupting the flow of negativity is a “process of becoming something else” (p. 472) and offers potential for creating other possible futures; we can disengage from it “stating a positive passion: ‘I would prefer not to comply’” (p. 472). Dark humour becomes a multi-layered form of subʌersion as we expose the absurdity of particular social power dynamics make their slow violence (Fine, 2017a) visible, and unsettle the narrative of feminine emotional excess. Within the carnival, these moments of laughter, irony, and sarcasm disturbed the boundaries of what is permissible for women and stood in defiance of our subject position as “inescapable victims of our own bodies” (Liebert, 2010, p. 279).

Guided by the process of freaking as a form of subʌersion that unfolded in our storytelling process, as a form of analysis, I was able to bring the women’s stories to life differently through the politics of freaking. Our freaking takes us on a three-stage journey of analysis through the women’s stories. Different fonts are used to visually distinguish each woman’s story, highlighting the multiplicities and differences of our experiences; a reminder that while we come together in collective disruption, we are not the same. By resisting homogenising our stories, we also make visible their relationality when held alongside one another.

Firstly, we begin by examining Western medicine as a system exposing its lack of knowledge on, and control of, women’s bodies driven by its enduring colonial and patriarchal anxieties. We then reflect on the ways that our stories have entangled with the freaky feminine figurations as we bring our embodied memories to life and begin to understand the power relationships that manufacture our suffering. Our resistance of the feminine figurations is a critical turning point in the analysis that brings us to stage two, which explores our affective flows of meaning making, as collectively, we do something else; through freaking, our pain becomes dislocated from our bodies and we begin to explore the stories that are hard to find in the literature.

Finally, we come together amidst the cacophony of the carnival chaos, different pathways of knowledge converge, threatening to re-route the dominant flow of research enacted on women’s reproductive health into less certain spaces. Our freaking becomes a collective process of becoming as we embody the ultimate freak loudly and proudly, affirming our difference and owning our ambiguous uncontainable bodies as something to be celebrated and loved.

Chapter 4: Analysis Part One – Stepping into the Carnival

As we begin the process of analysis, I invite you to step through the entry gates of a carnival to an analytic space for understanding our stories. As we wander its pathways, we encounter the freakshow that is medicine, re-trace our movements through the freaky feminine sideshows, and then arrive at the laughter, joy, chaos, and possibility that pulse through the carnival's other corners. Historically, the carnival has represented a world turned upside down, a space in which people could live a second life (Bakhtin, 1984). Bakhtin describes the carnival as a site where social hierarchies and institutional order collapse, and where people reclaim their freedom through laughter, performance, and collective creativity as embodied subʌersion. Russo (1995) extends this, emphasising that the carnivalesque both resists and destabilises the boundaries and distinctions embedded in organised society through mockery and degradation; a "counterproduction of culture" (p. 62). For Russo, the grotesque is celebrated: bodies usually shamed or hidden take centre stage, becoming sites of process, change, and becoming. The carnival, therefore, becomes not only the narrative opening for this analysis, but the method itself. Freaking too is foundational to our journey through the carnival as it enables us to make sense of how we resisted getting stuck at the feminine freaky sideshows and were able to move beyond them to the joys that the carnival offer us.

As we are guided by freaking, it is also important to trace the historical threads of freakshows as a grounding framework to build from. Thinking with the figure of the freak, we can recognise that they are inherently contradictory; a source of awe and shame, dangerous yet powerless, other-worldly while also understandable, privileged and cursed (Fordham, 2007). These dichotomies are prevalent through the history of freakshows and become important sites for our movement with freaks and freaking within the analysis.

Fordham (2007) notes that in their more recent history, freakshows were shrouded in disrepute due to their degrading of bodily difference and the negative connotations associated with different bodies; however, they were not always a site of disgrace. The traditional freakshow was deemed as morally uplifting, educational, and an opportunity to engage with fascinating science: a lecturer led the audience through each spectacle offering vivid details and 'true facts' of their lives and bodies. Within this dynamic, the audience acts as the:

> "infallible "knower" whose norms are reinforced as the viewer looks at the bodies of the performers. The audience observes from the perspective of reason and science, guided by the "Professor" and the

> scientific context…to view the performer as an Other, explicitly defined by bodily characteristics". (Fordham, 2007, p. 223)

A critical piece in understanding the history of freakshows is understanding that freaks were not born, but socially *created* (Bogdan,1990). Fordham (2007) argues that what makes a person a freak is not their body, but the ways in which they are exhibited and the notions of normalcy that dominate the society they are within. Bogdan (1990) builds on this arguing a freak is not reflective of a physical state, but an enactment of tradition and "state of mind, a set of practices, a way of thinking about and presenting people" (p. 3). It is the social construction of physical difference that accounts for discrimination against their bodies (Fordham, 2007). Yet, even within these structures, freaks performed complex acts of resistance as they played with audience expectations, exaggerating their difference (Bogdan, 1990). The rise of the medicalisation of the body shifted the freakshow from the carnival to the clinic where unusual bodies were increasingly viewed as sick or medically disordered (Fordham, 2007). Fordham identified that through scientific advances in eugenics, for example, medicine built (and continues to build) its capacity to reproduce the "normal" and thus contain the "abnormal"; deviant bodies became a threat to genetic purity, and, therefore, were conceived as dangerous.

As such, within the narrative of freakshows there was the misunderstanding that extra-ordinary bodies were destined for a life of unemployment, poverty, and disgrace due to their bodies and, therefore, freakshows "saved" freaks as the only place they could find employment (Fordham, 2007). Fordham notes that while this was the case for some people, many reflected that they actively made the choice, after being discriminated against by the majority: the freakshow was a community within which they were accepted and appreciated. Most importantly, while freakshows often encouraged dominant social views of different bodies, the traditional freakshow culture centres around the critique of its audience (Fordham, 2007), freaks were not solely there as a spectacle to be observed, but performing their own resistance to the discrimination of different bodies.

Fordham (2007) discusses that while some freaks took joy in their participation in freakshows, it was acknowledged that their consent to be displayed as a freak also contributed to the stigmatising effects of those with unusual bodies who chose not to identify as freaks. Alongside this, the eugenics movement meant that humour and mockery became stronger elements of the freakshow positioning them as a threat to the morals of society

(Fordham, 2007). As such, freakshows became a site for law making: freakshows that exploited and stigmatised unusual bodies, and taught intolerance of physical difference became legally controlled (Fordham, 2007). However, Fordham (2007) emphasises that others became a source of employment and belonging for those with unusual bodies, enabled the expression of free speech, and fostered critical discussion about physical difference.

It is critical to acknowledge that the history of freakshows is contested; some people found home and community within the carnival gates, whereas others experienced extraordinary horrors and abuses, particularly through the enactment of racialised and sexualised injustices (Fordham, 2007). Taking up the metaphorical space of freak/freakshows/freaking is not to trivialise the lived horrors of many; instead, it is to engage a politics of transformation through an embodied metaphor that brings with it a deliberate, yet carefully navigated, contested history.

The tension between spectacle and subjectivity, exploitation and agency remains central in our discussions. It is within this space of contradiction that I locate our relationship with medicine; a site of objectification, yet most importantly of transformation through our freaking. As with original freaks, we find ways to reclaim the stage and freak the very system that seeks to contain us.

The Fortune Teller Tells Us What is Coming: A Collective Rupture of Medical Expertise

Broken is not even the right word, like, non-existent is probably more of a word. *It's you're just another number. And, you know, it doesn't affect them too much, so they don't bother [scoffs].* I was like, "I don't want to go the doctor, because we know they won't help" [laughs]. *[Laughs] Women just have the same body as me, just with different parts.* I look back now, I'm like "holy shit", yeah. So then I was like, well, I'm not going to get any help in the medical system [laughs]. Um, my doctors were never involved at any stage of this, so, they were just useless, basically. So I just totally avoided engaging with my doctors at all. *So in the doctor's opinion, there was nothing wrong with me. It's actually out of women's health, ironically, ironically, out of women's health, that we have some really good rights. But we don't have any women's healthcare [laughs].* Yeah, and I've done, yeah, heaps of my own research, and I've actually learned more off my own research than any freaking doctor. At times I've known more than the freaking doctors have. And [pauses] from that experience, I learned that the medical system could not support me. But I'm also just like, the doctor doesn't know everything…So, yeah, that whole thing around doctors being experts, mmm [pauses] defi-, I don't, I think I'd like to challenge that

Medicine as Freakshow

As we encounter the freakshow that is medicine, it becomes important that we cast our minds back and reflect on the literature that tells us of how medicine has asserted its authority over the body, positioning it as a field of expertise that casts woman as dependent upon medicine's help to save her from her unruly body. Much like the traditional freakshow, medicine observes, interprets, and classifies bodies that are deemed different. Within this performance the "professor" assumes authority and as patients we become a subject and spectacle .This claim of expertise was echoed through our stories as we each turned to medical doctors when we first had the sense that something was not quite right within our bodies. Through their encounters, however, each woman began to question medicine's expertise, and ultimately came to engage in a resounding resistance to it. Through our conversations, together we traced the gaps in medicine's knowledge and its failure to care[1] for the bodies it claims to know. It is through our stories we came to understand and observe the spectacle that is medical freakery.

After already being let down by doctors as a young girl, Tui turned back to them for care when she encountered problems with her menstrual cycle:

> I was young, yeah, never thought anything of it or anything. And then I was, [pauses] I think I was 16 when I got my first period, so yeah, I was yeah, really late and it was oh my gosh it was so excruciating and it was, yeah, it was not a fun time. But I didn't tell my mum, because I never really told her anything. So I just dealt with it, and the-e-n, u-m, I would get maybe one period a year, if that, yeah. And they were always, yeah, really, really bad. Um so I actually went to the health nurse at school um and told her, and so then, like, she could then go back to the doctor. And so then the doctor just prescribed me the pill, as they do. Yeah, so went on the pill. I swear that mucked me up even worse. And then from about the age of maybe 17,18, I started doing my own research, because I kn-e-e-w that something wasn't right, and like, I have all the facial hair and all of that beautiful fun stuff as well. Um, so I self-diagnosed myself. Um and I didn't want to go to the doctor to actually get diagnosed, because I knew what they were going to say, and then they'll just be like, "Here's more hormones. You're not going to have kids. Blah, blah, blah".

Tui's reflections tell of the continued presence of the wandering womb theory and it's harms within current day medicine. Liebert (2010) reminds us that the hormone discourse is deeply gendered, and while offered through the façade of scientific objectivity as a legitimate

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[1] When using the term care, I refer to this a holistic practice that takes into account the physical, social, emotional, spiritual, and psychological needs of a person. Much like our pain, care can be understood as the multiplicity and interconnections of care that can be engaged to improve one's wellbeing.

explanation for bodily challenges, hormones have become the modern day substitute for the hysterical womb (Koerber, 2018). This continues to locate women's suffering as within their bodies, thus legitimising medical control over them. Much like historical hysteria discourse, hormonal regulation, as opposed to uterine removal focuses on containment rather than understanding. This uncovers the particular kind of care that medicine produces; through Western androcentrism, colonial and paternalistic "care" is performed through the discipline of all bodies into normative bodies.

Tui resists, however, engaging the process in her storying of challenging medical expertise and their ability to provide effective care by reclaiming authority over her body through self-diagnosing her PCOS in conducting her own research when the medical intervention (the pill prescription) did not address her pain. As she speaks of her experience of having facial hair, she carries with her, the figure of the intolerably ambiguous freak; speaking with irony as she refers to it as "beautiful fun stuff", Tui unsettles the medical gaze, reframing what has typically been pathologised as a source of humour on her own terms, perhaps not unlike the Bearded Lady, a staple of the traditional freakshow. Her humour continues when she refers to doctor talk as "blah blah blah", suggesting that women's reproductive health concerns are met by doctors predictably – with set responses and outcomes, and little consideration. Mocking the medical predictability doubles as a way to resist the doctor's position as expert and portraying their words as meaningless, unhelpful and boring.

Tui explores what she perceives as the common practice of prescribing hormone medications regardless of what a women is presenting with, emphasising the lack of thought that goes into that decision. Her reflections draw our attention to the dominance of masculinist medicine that treats *every* woman's body as a freak that needs to be controlled through medical intervention. Tui's storying of her visit to the doctor tells us of the ways in which the medical system dismisses women's concerns through lack of genuine investigation and the ease at which hormone therapies are prescribed as a treatment in response to women's pain.

Brooke also navigated the consequences of doctors immediately prescribing hormones for her reproductive health struggles without a clear explanation for their purpose:

> *There was phone consultations, and she just kind of said, "Well, let's try you on the pill". Ahh [pauses] the pill made me bleed, for [pauses] three months non-stop. And she's like, "takes a while for it to work". [Laughs] I was like "well, it's not working". It's, yeah. So then I just [pauses] and each kind of appointment was ridiculous amounts of money. So I just stopped everything,*

> *stopped the pills, and didn't talk to her [laughs] again [laughs]...Yeah, it wasn't helpful – it wasn't going anywhere - and it was kind of like, "Oh, I don't know what's wrong with you now". And it's like, "okay?" [pauses] and that's not very helpful... So over the course of like, three years, I tried multiple different pills [sighs]... Still didn't know what was going on... all hormone pills, um, contraceptive hormone balancing pills. Which none of them worked, and I would get quite sick.*

Brooke's story is marked by laughter, capturing the absurdity of years of cycling through ineffective hormonal treatments. Her laughter, an affective release, makes medicine laughable, as a system that insists on hormonal regulation and bodily control despite acknowledging its own ignorance. Her doctor's persistence with hormonal medication despite a lack of reasoning reinforces hormones as the modern day hysterical womb; in the face of uncertainty, doctors turn to hormonal regulation, and as women's bodies are inherently uncertain to medical science, hormonal regulation as a practice is reinforced.

Both Tui and Brooke reflect on hormonal medications as exacerbating their struggles, therefore framing their encounters with doctors as ones that caused more harm than the initial challenges they were facing. Through her sighs, Brooke signified her enduring frustration revealing the gap that existed between the chaos of her embodied experiences and the authority of her doctor. Within the context of the freakshow of medicine, we ask what happens when the performer (Brooke) and the viewer (doctor) are in attendance together, from differing perspectives, but for the same purpose: controlling the body? From Brooke's perspective, she is there as the freak seeking to control her body to survive it well, whereas her doctor is there to control her body for the (re)production of normativity. Ultimately it is the differences in their relationship to freaking that becomes the site of the breakdown in care. Brooke's eventual decision to cease seeking care from her doctor was an expression of both her exhaustion in repeated deferrals of care and her rejection of the expert status of her doctor. Tui and Brooke's stories collide in shared recognition of repeated failures of care, their rejection of medical authority and a reclamation of embodied knowledge that transforms their frustrations into resistance.

Tui and Brooke's memories of being prescribed hormonal medication were layered as they both reflected on the contradiction of doctors emphasising that their medication doubled as birth control, despite neither needing it:

> And pretty much was just, "Yep, this is what you've got. Um, you'll never have kids. Here's some birth control. You may need surgery, and you'll if you ever

> do end up having kids, you'll need a hysterectomy". I'm like "ok cool". So then I was just like, "oh well, okay, cool" - carried on with life. - Tui

Tui draws our attention to the inconsistencies in the messaging she received from her doctor in their offering of birth control as a form of treatment, despite suggesting she was navigating infertility. Her lack of trust in medicine is reflected in her ironic response, a mockery of their supposed expertise that highlights their own contradictions. Reflecting that she simply carried on with life despite receiving such significant information about her body signals her resistance to such information suggesting it carried little weight. From medicine's perspective, only a freak would respond such ways when being told they could not fulfil their feminine biological destiny, yet Tui owns it; instead of becoming the sad woman, she reinforces her rejection of medicine as the knowledge keeper of her body.

Brooke's frustration with being provided birth control exposed the enduring patriarchal and colonial values of medicine to this day:

> *Not that I needed them for contraception, and nor was I using them for that. It was just [pauses] to try and regulate my periods and suppress the pain... Um-m-m [pauses] once again to they keep adding a bonus of, "Oh, and it's good for contraception", which I kept reiterating, "I don't need that. Like, that's not what I'm here for" [sounds frustrated]... Yeah. Well, I mean being a female and having female reproductive issues, they just assume they need to make everything covered for contraception as well, so they, there's one doctor that touched on a pill that I could possibly use that might be really good, but won't give me contraception so she just bypassed it. And with that, I said, "Hang on, hang on. I don't need that. I don't need contraception". She's like, "Well, we'll try on this one first that", I was like, "I don't need that" [laughs].*

I remember the frustration Brooke shared re-telling this story as her treatment was dictated by a need that was non-existent resulting in her missing out on something that could have been effective in managing her symptoms. Brooke had shared that she was seeing a woman at the time, hence why she did not need contraceptive medication, however, her doctor had made the assumption that she was engaging in heteronormative sex, a reflection of the enduring fixation of heteronormativity within medicine. Brooke speaking freely and openly about seeing a woman at the time and her comfort in doing so was reflective of the increased social acceptance of the LGBTQ+ community in recent times. Her memory highlights that as a discipline, medicine appears to be stuck within colonial and patriarchal values enacted on people's sexuality, and as such, aspects of their care is becoming irrelevant.

Brooke continued to speak of how, in heteronormative relationships, she manages contraception differently and has outwardly expressed contraception is not a factor in her treatment, yet she is continually offered it as a "bonus". Such practices become a process of conditioning the normal. Brooke's repetition of "I don't need that" takes on life as a mantra continuously gifted to her doctor as an act of rebellion, mirroring the lack of thought going into her doctor's suggestions, just as she didn't have to think about her response. In doing so, Brooke is actively resisting medicine's conditioning and disciplining of women who traverse the acceptable boundaries of normativity. Her doctor's persistence in failing to listen to and meet her needs triggered Brooke to embody the disruptively monstrous bad woman by stepping outside of the passive compliant patient role; instead she disrupted the doctor-patient binary by becoming assertive by repeatedly demanding she did not need contraception. Within this story we can see Brooke's performance of freak is grounded in her critique of medicine as the audience.

Brooke turned to humour to emphasise the absurdity of the approach of her doctor; rather than quoting them verbatim she recreated the conversation to expose their lack of thought in their decision making:

> *So I guess the process to getting diagnosed was very, very long. So starting with that, you know, getting a surgery…no, no um diagnosis there. Uh, [pauses] back to back doctors' visits. You know, "We'll try you on this pill". And you know, they say, "Give it three months". Tried it for three months. They say, "Oh, okay, well, we can either double your dose, even though it's making you throw up and have your period and see what happens. Or we can try you on something else, but first we'll double your dose".*

Through recreating her doctor's words, Brooke transforms the clinical encounter to a form of dark comedy, freaking medical discourse and exposing a system incapable of moving beyond its narrow understandings of women's bodies. Her humour signals her refusal to conform as an embodied act of resistance to the narrative of medical expertise. Both Tui and Brooke's stories cast light on the very real impact the dominance of the hormone discourse has on their health as they acknowledged their health took a turn for the worse as a result of being prescribed hormonal medication. Their narratives of medical encounters reveal the enduring influence of patriarchal, heteronormative, and colonial discourses within medicine that locate their source of their suffering as within their body. However, through irony, dark humour, and refusal, they "freak" medical authority, subʌerting the figure of the women ruled by hormones by reclaiming agency over their embodied experiences whilst exposing that it is medical discourse that is accountable for their suffering.

Within our conversation, Fern and I discussed the power these dominant narratives within medicine hold as they trickle down into our day-to-day lives, shaping the way both we and others view our bodies. As we reflected on the narrative of women's bodies being at the mercy of their unruly hormones, Fern responded with a simple, yet powerful statement, to which we both erupted in laughter:

> Well, men have hormones too!

Taken together, the women's stories demonstrate how contemporary medicine continues to enact control over women's bodies through hormonal regulation and heteronormative assumptions. Their humour and frustration expose a system that enforces control upon both body and identity. In voicing their refusal, much like the freaks in the freakshow, they begin to critique these narratives, unsettling the authority of medicine in their mockery of its (lack of) logic. Yet, as their stories and those that follow show, the regulation and containment of women's bodies extends far beyond hormonal management. It circulates through the image of the womb itself as a site of medical control; both as the problem and the cure.

The narrative of hormonal dominance operates as a modern, more subtle version of the wandering womb theory, yet traces of its explicit presence in current day medicine circulated among the women's stories. As mentioned previously, Tui shared that if she were to have children she was informed that she must undergo a hysterectomy to manage her PCOS. Given a hysterectomy is not identified as an appropriate and effective form of treatment for PCOS (Te Whatu Ora, 2025), and there are significant consequences of having a hysterectomy (Madueke-Laveaux et al., 2021), such a recommendation is a reflection of the historic perspective of the womb as the source of all "female troubles" (Jones, 2015) and needs to be controlled medically, even in extreme, untested ways. Such enactments construct women's freaky bodies as always available for medical experimentation.

Fern also encountered this suggestion, even from an extremely supportive medical professional in the consideration of the management of her fibroid:

> For me, a hysterectomy was a very last choice option. I was still very much on the fence about having kids, but I wanted to explore all other possibilities before taking, what I saw, as being an extreme solution. Interestingly, I remember when [surgeon] presented this option to me, it was quite early on

> in the piece, and I was shocked and a little angry that she would suggest such a radical solution when we hadn't even really explored other options. But, once I explained that I wanted to keep the possibility of having kids on the table, she didn't speak about it again and was clear in her notes that this was important to me.

As her story unfolded, Fern, through the help of her surgeon, was able to find an effective treatment for her fibroid that protected her uterus and she eventually ended up having a child. Through her shock and anger at the ease at which her surgeon suggested removing her uterus, she was able to resist their expertise and push for other less impacting alternatives. The anger and shock that Fern embodied through her refusal to accept a hysterectomy as a solution for her fibroid alongside her request for alternative options was multi-layered. Fern's affective response became an act of freaking the echoes of the wandering womb theory, medical expertise, and the binary of her doctor as the expert and herself as passive patient. It also became a process of turning the medical gaze, shifting the meaning of her body away from a site of medical intervention and control to a part of her as known and loved. This shifting of power through her deviance away from her expected location of passive, docile, unknowing patient became an affirmation of her difference to medicine and to their enactments of power on her body.

Charlie also challenged the validity and efficacy of hysterectomies through reflecting on her mother's experience:

> *I think my mother probably had very painful periods. She had a partial hysterectomy when she was about, just in her 40s...I think my mother probably had endometriosis as well, but because of the time, she just was never diagnosed, and she had four kids, so they just didn't think beyond it. Yeah...But yeah, so she just sort of yeah, probably went through that, but without knowing about it. Which has probably led to the partial hysterectomy to stop the pain. Whether that works or not, because it depends ah where the tissue grows…. you can get endometrial tissue anywhere in the body… so not around their reproductive organs at all.*

Charlie offers insight into how medicine overlooks women's pain in the face of normative performances of womanhood. Charlie's mother had children, therefore, little thought was put into her physical pain, almost as if her womb was weighed down by the babies she carried within it, preventing it from wandering around her body as the source of her troubles; her pain was dismissed instead. Through her own experience, Charlie understands that the growth of tissue in endometriosis is not limited to the uterus alone, and her challenging of hysterectomies as a treatment for endometriosis is a direct rejection of the expertise of doctors as she points out a hysterectomy as a bizarre solution for tissue growing elsewhere in the body. Tui tells a similar story:

> Because it is a whole body thing, and that's the big thing, too. Same with endo, like, it's not just gyne. It's, it affects everything. And trying to say that to the doctors, and they're like, "no, it's not". I'm like, "yes, it is". Like, "Why does it affect this, this and this, and that's nowhere near you freaking uterus?" And they're like "no, it's just gyno"… even at the end of it, they still, they've still said that, after having kids and stuff, I'll just have to get a hysterectomy. And I'm like, "This still doesn't solve anything". I'm like "Then what? Then I'm going to be on hormones for the rest of my life?" Like, cool, such an awesome win [sarcastically].

Through her frustration that comes from the direct correlation between her bodily challenges and her uterus, she explicitly unveils the very presence of the wandering womb theory still to this day. Her use of sarcasm makes visible the violence of doctors' ease with which they decide to perform a hysterectomy despite it not being an effective form of care, and in response, she offers the very real embodied impacts of such extreme measures. Tui's sarcasm engages a process of shifting power; within the freakshow 'normal' people went to be entertained; however, Tui as the freak has turned the performance in her laughing at the doctors, now the source of entertainment.

Charlie further questions the ways that medicine as a discipline has not upheld their position as experts through their failure to produce valuable knowledge on her condition:

> *I have endometriosis, and they say one in 10 women have that. Why do we have, not have more knowledge about this condition?*

I recall responding to her question by highlighting that endometriosis was discovered a century ago and we acknowledged that it was an active choice to neglect understanding the condition more. Tui also highlighted that PCOS is almost as common as asthma yet significantly less research goes into PCOS. Through our frustration and confusion we considered the ways in which medicine has actively chosen to remain uninformed on women's bodies. As I continued to reflect on the active resistance within medicine to understand women's bodies, I pondered whether it is reflective of medicine's positioning of women as freaky, leaky, unruly, and in need of control. If a body is irretrievably freaky by nature of being a woman, then why waste time trying to "fix" it? Instead the goal becomes control, which can account for the gendered epistemological ignorance and systemic invisibilisation of women's bodies through their exclusion in medical knowledge production (Raz, 2024; Tuana, 2004).

Tui then went on to make her resistance toward medical expertise explicitly clear:

> Yeah, and I've done, yeah, heaps of my own research, and I've actually learned more off my own research than any freaking doctor. At times I've known more than the freaking doctors have.

It is ironic that through her resistance in her exclamation of knowing more than "freaking doctors" as a fixed noun, she has also exposed the very dynamic process we are engaging in.

Each of us had experienced disappointment with medicine somewhere along our journeys and as we made sense of these moments together, we recognised that we were navigating a system lacking the knowledge, time, and relationality needed to care for our bodies. The circulation of these encounters across our stories revealed that medicine's failures were not only individual, but systemic, embedded in a structure that prioritises efficiency, measurability, and expertise over embodied knowing and relational care:

> *Ah-h-h [pauses] sometimes it feels like they don't have enough time to, like, invest. But when I went privately, was when I actually got results. I guess it's the public system. It's, you're just another number. And, you know, it doesn't affect them too much, so they don't bother [scoffs]...I wouldn't say it stems individually through, like [pauses] each doctor's practice or anything like that. I'd say it stems from way above, where the lack of staffing causes the overcrowding, causes the lack of interest in trying to research more, and therefore, you know, "we got 10 minutes here for you, 10 minutes here for you", just rapid-fire. - Brooke*

Brooke outright explores the issue of a lack of time as a systemic issue across the board that not only impacts the on the ground care received in the form of rapid fire consults of limited time, but has flow on effects including doctors' lack of capacity to engage genuine care and a lack of resources allocated to developing knowledge that implicates treatment. While this is the reality for everyone, this issue becomes amplified for women with their 'non-normative'/freaky bodies. Furthermore, this rapid-fire approach of doctors is reminiscent of the traditional freakshow itself with medicine as the infallible knower backed by science and logic, enforcing its norms as doctors look at one body, then move onto the next:

> Um, and so I think, you know, when we talk about the health system, it's chronically underfunded, like doctors are so under pressure so they don't - it's like teaching you don't have the capacity to actually see your students as

> much as you would like to, as human beings, as individuals, and meeting them and their needs where they're at. You can only do so much in a 15-minute consult. And um, you know that people are paying a shit tonne of money to be there most of the time, you know? Like, $70 dollars for 15-minutes and people want results. And you have to ask the questions that are most likely to elicit the things that are going to give you an actionable response…. Um, so the human connection piece is missing. It gets sidelined. Um, I think also [pauses] blows my mind that training, you know, doctor training, does still not cover the basics that that need to be covered in this. You know, like, so when you don't even have knowledge, how can you even know what to ask or how to respond appropriately? Yeah, you don't know what you don't know, right? - Fern

Fern emphasises that she does not believe the issue is within doctors as people, but within the structure of the system they operate in that constrains and restricts what is possible. Through her reflection on human connection as a missing piece she unveils the biomedical fixation as a core value of medicine, and as such, patients are not seen as people within systemised healthcare, but a series of bodies to be observed. The clinical gaze that detaches bodies from their lived experiences accounts for its limitations in what it can offer for women's bodies, which is then compounded by the lack of knowledge that exists within the discipline on our bodies already. Fern's reflection "you don't know what you don't know" highlights an epistemological crack so significant it cannot be recognised from within.

As I reflected on Fern's thoughts I recalled that within a couple of conversations I spoke with women about the lack of our presence in medical research. Both Maia and Charlie had reflected they thought it was because of the complexities we bring as women due to our menstrual cycle that complicates medical studies reliant upon control groups and minimising variables between people. I remember thinking "but that is the very reason we should be involved!". The exclusion of women in research reinforces both man and non-variation as the norm and, therefore, woman as freak. There was always an obvious connection between the lack of care for women's reproductive health and the lack of knowledge within the medical discipline, however, I now realise there is a connection between that lack of knowledge and the time pressure that is placed upon doctors. The lack of time becomes a gendered issue as doctors are drawing on their limited knowledge under time pressure; men's bodies are better and more thoroughly understood as the norm, therefore, it is easier to provide appropriate care within a short space of time. Women's bodies however, are not only far less understood, but more complex in their exceeding of the taken-for-granted male norm, compounding the need for more time within the medical encounter to ensure adequate care is provided.

Charlie shared her perspective of how medicine perceives women's bodies:

> *[Laughs] Women just have the same body as me, just with different parts.*

Her joking about medicine's ignorance exposes the very means by which the discipline fails to consider how the complex systems within our reproductive bodies implicate our health. The positioning of women as the freaky version of man with their extra body parts that cause the body to leak and need to be contained and concealed both silence complex bodily systems and invisibilise them as critical factors to consider in women's health experiences.

It is at this stage, through the women's stories, an important figure emerges: the 'normal' woman. Her body represents Western normative expectations of femininity as slim, hairless, and fertile, her reproductive system intact and body not too large, not too skinny. Yet her existence is tenuous; as she menstruates her body becomes leaky, uncontained, and in need of management; her hormones unsettle and take over, rendering her excessively emotional as she walks around in physical pain, but not *so* much that she is pathologised. She becomes a site of contradiction, her ideals near impossible to achieve, a delicate balance between perfection and inherent feminine melancholy and suffering. Her existence blurs the lines of what is acceptable in a woman's body, and what is not, and she normalises pain and discomfort. Yet in her fragility she still exists, an idealised figure that keeps women in a relentless pursuit of locating themselves within her strict and narrow inclusions. She is important, because she is the standard from which the freaky feminine figures are crafted as per their deviance from her.

Maia's story reflects the invisibilisation of women's complex systems, the normalisation of feminine pain and discomfort, and the limitations of working within the biomedical model:

> And I told him about, like, my low iron and just feeling tired and um, he said, "oh, it's just, it's all the running that you're doing". And I was like, "actually" [pauses] I don't, and I, at the time, like, I didn't have, like, my self-advocacy, like, experience and skills, and I was just like, I was just so <u>stunned</u>. I was like, I've, like, I've come from like, multi-sport and triathlon we're doing, like, trying to do like, three or four disciplines a week, so running actually is really like easy! It was like, like, reflecting on it um [pauses] way later, I was just like, there's no questions about what was going on in my life. Like it was like six months in, to the grief and loss time. No question about my periods at all. No question about diet [pauses] I was [pauses] yeah. I look back now, I'm like "holy <u>shit</u>".

> Yeah, so then I was like, well, I'm not going to get any help in the medical system [laughs].

Maia exposes the atomistic approach that is common among our stories as her doctor focused solely on a particular physical aspect of her body in seeking a justification for her ongoing fatigue. From a position of being better informed about her bodily experiences, in her reflection back on this memory, Maia was disturbed by the lack investigation into the significant contributing factors to her struggles. Her experiences of fatigue and exhaustion became fragmented into measurable symptoms rather than understood as an experience embedded within an interrelated body and life. This, alongside menstruation deemed as something we don't speak of, enabled her doctor to overlook her heavy periods through their normalisation as a major contributing factor to her struggles. Given the direct link between menstruation and anaemia, the lack of considering menstruation as causing Maia's symptoms of fatigue is an example the invisibilisation and dismissal of women's complex bodily systems. Fern too struggled with anaemia while also trying to maintain participation in her usual day-to-day activities:

> It was so debilitating because I was anaemic, but my doctor didn't click that possibly I was anaemic. So I went through for like, probably 2 years doing some adventure racing. And she, like, did every other test under the sun, apart from look at anaemia. Um, [pauses] a-a-nd so I was experiencing massive like tiredness and a bunch of other symptoms related with that, trouble breathing during hard exercise, which, "Oh, I wonder what this is?" you know, doctor musing... *Hello!?*

As Fern retold this story I distinctly recall our laughter, eye rolls and head shaking as her humour targeted the disbelief we embodied that doctors as "experts" couldn't piece together very basic and common connection between heavy bleeding in women and low iron, an answer that seemed so obvious, its absence became comical. Again, our laughter, alongside making fun of the idea of medical expertise performs as a turning of the gaze that shifts the power within our relationship; we no longer become the body as the source of entertainment, instead we critique the lack of basic knowledge within our doctors as they become the spectacle and we become the entertained. Both Maia and Fern's stories demonstrate how the figure of the normal woman and the normalisation of heavy bleeding renders important contributing factors to their health invisible.

The women's stories revealed the ways in which the epistemological crack not only implicated the medical encounter, but manufactured the conditions of their everyday lives when it came to navigating their health conditions. As Maia thinks back on her earlier experiences of heavy bleeding and severe pain during her period she highlights how the lack of knowledge within medicine of endometriosis or unusual periods was so prominent that it permeated socially, meaning she too lacked insight into her experiences as indicators something wasn't right in her body:

> Imagine if I'd been to the GP when I was 15, 16, for anything else, like [pauses] the physical or glandular fever or something. Um. And then they would have, if they had asked, like, "what's happening with your periods?" Like, my whole, [pauses] like, maybe it's, it probably still would have been hard, because the support wouldn't have [pauses] been there or like that the options wouldn't have been what I have now. But I think I would have had a diagnosis earlier. I would have known that what I was experiencing wasn't normal, that there are ways like [pauses] I mean, maybe like [pauses] I think I'm someone that [pauses] doesn't [pauses] like, I don't need like, a label or a diagnosis, but I like to understand [pauses] like, you know, with like, anxiety, I wouldn't call it anxiety, but just be like, I like to understand what's going on, why I'm feeling these things. Yeah, I think even [pauses] having like, a diagnosis of [pauses] heavy periods, or I probably wouldn't have got the endo diagnosis back then but if it'd been like, you are experiencing something that's different from what everyone else does. Yeah, they would have been like, "you know, take a day off school, or off uni", or, you know, probably that compassion. Understanding brings compassion.

Maia draws attention to the unlikelihood she would have received an accurate diagnosis or treatment for her endometriosis at the time, another example of the ways in which medicine has failed women in upholding their expert status. She, however, uncovers an additional layer of the ways in which the lack of medical knowledge impacted her day-to-day life. Maia shared that her days experiencing her period were marked by constantly having to sit down due to pain and extreme fatigue, yet she continued to push herself to attend university lectures and participate in life. This habit predominantly continued for the next twenty years as she and others around her didn't understand that her experience wasn't typical for women. Through Maia's story the normal woman figure emerges again: pain and discomfort during menstruation is normalised into a woman's body. Maia's reflection of the importance of understanding our bodies and the associated compassion that can ease the intensity of our experiences draws our attention to the everyday burden women carry, sometimes for decades, because their body is not understood medically, and due to medicine's social authority, nor is it by those in our lives.

Tui reflects on how this lack of knowledge unfolds within the schooling system, often a place where many women learn about their bodies and systems:

> Well, like, even when you're doing, um like, learning about puberty and stuff at school, you only learn the normal, this is what should happen. You never learnt, like, you know, if this happens then you need to go and get checked, like, or, you know, anything like that. It was just, this is what's going to happen, and that's that. There's no other variation.

Several women reflected on puberty as a pivotal time in the development of their reproductive health conditions, as this was often when signs of their reproductive health condition first appeared, however, for most women they did not realise that what they were experiencing was not expected, and were an indication that something needed attention in their body. This common story is reflective of the feminisation of pain, as the dominant story of painful periods, and general discomfort that women should expect is circulated, that is, the materialisation of the normal woman figure. As such, many women in their teenage years assume their crippling physical pain, and heavy periods are expected experiences of being a woman, that they are supposed to deal with. The consequences of this lack of knowledge are further exacerbated by doctors failing to engage in information-seeking regarding women's menstrual cycles as a part of routine healthcare. As such some women navigated their reproductive health conditions for up to twenty years without the care they needed.

Navigating the challenges of living with a reproductive health condition for a long time was a common thread in women's stories, despite their frequent and enduring attempts to gain help from multiple different medical practitioners on multiple occasions. Women were continuously met with unclear answers and ineffective treatments and in some cases, access to necessary care was prevented. These experiences are not only reminiscent of a system that is overloaded and lacking knowledge, but of one that doesn't take seriously the interconnections and multitudes of pain that women are enduring:

> Oh, just frustration, really, like [pauses] being told, "Oh yeah, you're on the wait list. It'll be, you know, six to eight months", and then it's longer and longer and longer. And so then I was like, nah, I'm not dealing with this. So yeah, would just start ringing [pauses] them every day. "Has there been a cancellation today, has there been one today?" Um. But, yeah, it is, it's all stuff that's the only way to see any gyno, really, especially here. - Tui

> Um, and we couldn't afford it at the time to go privately. So I went [pauses] back. I was like, right I'm going to get in the public system. So that happened, and got on the wait lists for surgery and that was that happened pretty quickly, because I'd had [pauses] this, um, I had the letter from the other specialist. Um, but then I [pauses] was told, like [pauses] so that was kind of around July, last year? Was it? Yeah, July? And then they're like, "Yeah, probably October, November, we think we'll get you in for surgery".

> And then I called up in September, just to be like, you know "what's happening?", they're like, "probably not before Christmas, but January, February". And then I called up in January, they're like, "oh no, not till May". And I was like [pauses] ohh, like [pauses] yeah, the whole [pauses] all of it was just doing my head in – Maia

Just like Maia and Tui, for several women it was within the public health system that they sought care for their reproductive health conditions and for some, it wasn't until they entered the private system that they received the care they needed. There was an overwhelming sense that the public system was simply not capable of providing care regardless of who was seeking it because of how overloaded it is. If the system is failing those it privileges, we must then consider how those failures compound for those who are deemed as the freak located within their gendered deviant bodies that defy the boundaries of normalcy. Maia even referred to private healthcare and health insurance as a luxury item, signalling that health is no longer a basic human right, but a privilege that favours those most protected in a colonial and patriarchal society.

Not only were specialist encounters difficult to access within the public system, but when they eventually took place, women were met with a dead end, not only due to lack of knowledge, but the active dismissal of their interconnected experiences of pain:

> M I got a referral from the GP to see a gynaecologist um [pauses] got told that because I have, I was had been working with [naturopath/dietician] for a wee bit at that point, and she told me that [pauses] I'm fine "You don't have anything wrong with you" And I was like, "<u>ooh yeah?</u>" and then [naturopath/dietician] was like, because I had the letter and everything and [pauses] um sent, you know, they sent everything back through to [naturopath/dietician]. And then she was like, "So I have on here on paper, what the specialist is saying, but what did she actually say to you in person?" and I, I can't remember what it was, but I relayed it to her and she was like, "I respectfully disagree" [Laughs]. And it was like, wow, because at the time, I was like [pauses] walked out of it being just like [pauses] "Well, what is it?…What do I do now?"
>
> C And so I just, like to make sense of that, sh- the specialist has been told that you've got crippling pain?
>
> M Mhmm
>
> C Heavy periods, and you've got like, these energy issues, and yet [pauses] without what? Doing <u>any</u> investigations, just decided, "Oh, that's, you've got nothing wrong with you"?
>
> M Mhmm

C So that complete dismissal of [pauses] everything you've brought to her?

M Yeah

C Wow

Maia's encounter with her gynaecologist was multi-layered regarding the lack of care she received, through the enactment of Western, androcentric, paternalistic medicine that proved inadequate in addressing her pain. Maia experienced the overt dismissal of her embodied experiences that are commonly linked to having endometriosis as she was cast as the normal woman, with "nothing wrong", yet also walking around in extreme pain, bleeding profusely. Further to that, her specialist acted as a gatekeeper preventing her from accessing the additional care she needed in the form of a laparoscopy, which is required to confirm and, therefore, treat endometriosis. Two key threads intertwine within Maia's story that were prevalent among all of our stories: the feminisation of pain and the limitations of medicines reliance on objective measures.

The feminisation of pain is starkly obvious in Maia's story as her doctor's refusal to acknowledge and then act upon her physical pain and heavy periods served to both minimise and normalise her pain as a standard feminine experience. The impossibility of the normal woman begins to emerge within Maia's story; she is simultaneous and contradictory, thinkable and unthinkable, she makes no sense and yet she materialises everywhere. She serves as a disciplinary force in shaping docile bodies. In recognising her also as a freak, we shift the power dynamic that assumes normalcy, tearing at the normal/abnormal binary, as she herself becomes monstrous.

Due to Maia's embodied knowledge that something was not right and her ability to articulate her experiences, both her and her naturopath knew she had endometriosis, yet the fixation on objective measurability within medicine accompanied with her doctor's dismissal of her experiences prevented diagnosis and treatment. Maia's trust in her embodied knowledge led her to pursue care for her endometriosis outside of the medical sphere, an affirmation of her difference to medicine as she rejected the need for diagnosis through observable measures to do so.

Fern and I reflected on that feeling you have when you just *know* something is wrong within your body and she captured the ways in which medicine's rejection of embodied knowledge and fixation on objective measures enable and reinforce the subject position of woman as freak through the feminisation of pain:

> You hear so many stories about people with like cancer or other illnesses where they're like, something doesn't feel right, and they get fobbed off time and time and time again and not taken seriously. You know, like that hysterical woman syndrome. You know that, "No, you're just blowing this all up in your head. You're stressed".

The feminisation of pain surfaced in a variety of ways through women's stories. Through doctors' overt dismissals, the normalisation of pain as an expected experience of being a woman, that is, the normal woman figure:

> Just live with it. You're a female. You'll be right. Suck it up….I feel like it's because, you know, women are just supposed to just suck it up and carry on. – Tui
>
> "*This is just women's problems"- Charlie*

Tui's story invokes the figure of the bad woman when she ended up in hospital due to severe physical pain:

> My worst one was an old male doctor who blatantly told me to my face, I was there to get drugs and that he was not even going to give me Panadol, even though that doesn't do anything. I will only go down there if I'm like, I know myself, and I know when I'm about to get to the point where I'm literally, like, can't move. So that's the only time I'll go there, because I hate going there. Um, my nurse at that point, she was amazing. She was really good. She fought for me. And he was like, "Nah, I'm sending you home, just go to your GP. You're just here to get drugs. Look at ya, you look like a mess". I was like, "maybe because I'm in so much fucking pain" Yeah. Um, and then my the nurse came in and was like, "Do you feel comfortable going home?" I was like, "No. No, in a few hours, I'm not going to be able to move". And she was like, "Yeah, okay, I'm going to go and talk to the doctor again". And I heard them arguing, and she was like, real, sticking up for me. And he was just nah, not having a bar of it. And then he came back and stood over me and was like, "I heard, you want to talk to me". And so I was just like, "Oh no, don't worry about it". I was like, bawling my eyes out. I was like, nah, I can stand up for other people, but when it comes to myself...

Tui's memory casts light on the limitations of objective measurability within medicine and the ways it reinforces the gendered biases that texture the medical encounter. Her story is a reminder of the burden women carry, her response to his accusations an affective rupture as a refusal to accept his suggestion that she was fabricating her pain; a form of disrupting woman as passive, quiet, and docile. Interestingly, her description of the doctor as an old male appeared numerous times throughout my conversations with women and at times we laughed as ourselves for the assumptions we had made about how they would approach our challenges, reflecting that sometimes they were helpful. However, this image serves as a representation of the social power dynamics we are up against when navigating the medical system and Tui's embodied memory of him towering above her stands as a prevailing symbol of the power and dominance both colonial and patriarchal values have when it comes to women's reproductive health. Tui resists engaging in freaking the medical system simply by explicitly pointing out it's partial and limited values system within a real-life figure. As we are move through the carnival and remember with the freaks who joyfully chose to partake in the freakshow, we are within an inverted world and the powers that typically control and dominate us become a site of mockery and subʌersion.

Brooke, too, encountered the dismissal of pain through her collision with the hysterical woman figure:

> *Because some …some doctors can go along the lines of "Oh, maybe it's chronic pain and now it's just in your head". And then you're just like, [pauses] "It's not, I promise" [laughs]. I was strong. Determined. Still had my, you know, head on my shoulders, and able to communicate to doctors. It was like, yeah, okay, this actually really hurts. And I'm not just thinking it's in my head…It's actually… I'm strong, and this is not right.*

Unlike the stories that frequent psychological literature, Brooke did not question her sanity once in the face of doctor's psychologisation of her pain, instead, through an act of disruptive monstrosity, she firmly rejected it and refused to give up on her pursuit for the treatment of it, rejecting the embodied positioning as passive docile or hysterical woman. The women engaged humour on several occasions to make visible the gendered violence of medicine by asking to consider what would it look like if it were men embodying our experiences? While approached in a humorous way, it was a genuine question as we agreed that we truly believed the response would be different. Once more, our laughter becomes an affective rupture that emphasises the absurdity of medicine dismissing our pain simply because we exist in a woman's body:

> Yeah, and I see like some people asking the question of, you know, if, if any um, these types of things were experienced by men, what kind of [laughs] what would support and treatment for that look like? – Maia

> It’s so bad, like, I wish there was like, a way to, like, transfer it on, like, the pain onto them. So then they’re like “oh shit. oh, okay”. Like men, oh if there in the tiniest bit of pain [pauses] “Oh here's everything under the sun”. - Tui

Charlie’s resistance to medical expertise played out by calling out her doctor’s behaviour explicitly, naming the presence of the hysteria discourse. Her story emphasises the insidious and powerful nature of the hysteria discourse, given a simple and affordable test was all that was required to find the cause of her symptoms:

> *And then he said, “Oh, it just must be in your head”. I said, “Did you just seriously diagnose me with hysteria, doctor?”... “Are we on the same page?” I said, “For you to make that diagnosis, you do realise you need to have a psychiatrist in the room with you, because you both need to be able to make”, and anyway, it was my midwife she goes “Well did anybody check your B levels lately?” and she said, “You've got a vitamin B12 deficiency”. And as soon as she worked that out, I had an injection, and it all went away. Yeah so he sort of just palmed me off and said, “No, you just, it's in your head”... And it took a blood test.*

An undercurrent of resistance flows in, through and between these stories as women refuse to accept that their pain is concocted or imagined. Through our resistances, we can see medicine as the freakshow as a discipline that relies solely on objective and measurable factors to determine the next steps in medical care, despite many medical experiences being intangible or invisible beyond our embodiment of them. Medicine serves to look and observe, fix if it deems worth it, then move on. Out of resistance to the feminisation of pain, women shared they have developed strategies to ensure they are taken seriously in their health encounters, demonstrating the ways medical neglect textures our everyday lives:

> And I spoke with a woman, a paramedic, on the phone, and she was just like, she was like, affirming everything about my pain and, like, I almost cried on the phone because I was just like, “oh my gosh”… because I was all prepared to, you know, like, over emphasise what was happening… I was like, “Holy shit, someone's taking me seriously” [laughs]. So I had no idea it was gonna be serious, like, I have pain like this all the time. Or like that level of pain, just in a different kind of place. - Maia

Maia’s response to the paramedic taking her seriously underlines how scarce these experiences were for her, to the point it nearly brought her to tears. Our laughter, an embodied form of freaking the system exposes the ways in which the slow violence of medicine unfolds; a medical professional taking Maia’s pain seriously has become laughable.

Maia's preparedness to over-emphasise her experiences was a practice Fern encountered through her story as well:

> That was the advice that I got given, is to exacerbate what my condition actually was, to be able to be taken seriously. Which is fucked, because if everyone exacerbates what their real condition is, then we all just get escalated, which is what we need. But it's, yeah, the systems chronically fucked.

Fern's memory demonstrates how women's pain is continually minimised within medicine, such that to receive adequate care they must amplify their pain, knowing it will inevitably be discounted. In this sense, women are adopting a performance of freakery, conjuring the figure of the hysterical woman who will get a response. By bringing the hysterical woman to life, women are again, shifting the power by turning the gaze to mock the viewer.

Out of desperation to have their pain taken seriously, some women resorted to bringing their partners (men) to appointments as they believed they carried more legitimacy within medicine and could provide valued evidence that proved their pain was not fabricated:

> *There's been times when I've taken my husband to me with the doctor, to the doctors and he'll sit there and say, "Speak to her. It's her body. What do I know?". They have to hear it from him…when I'm in my 30s and 40s, having to take my husband to a doctor's appointment, because you just get ridiculous diagnoses of like, you know, there was a term they used, it wasn't hysteria. I called it hysteria because, well, it's just modern day hysteria*
> *- Charlie*

Charlie suggests that her husband acted as a layer of protection from doctors' inclinations to psychologise her pain, a reflection of the colonial and patriarchal tendencies to associate men with rationality, logic, strength and power (Morgan, 1998) as opposed to women as being weak, emotional, passive, and ruled by their bodies (Young et al., 2019). Morgan (1998) reminds us that these binary relationships of domination naturalise dominance of man over woman, and thus place men's accounts of women's bodily experiences as more reliable and valuable than women's. Brooke too experienced the effects of her partner legitimising her embodied experiences:

> *And as um [pauses] as doctor's visits have like, gone on as well, I've also taken my fiancé, [omitted] too…which is quite helpful. And, you know, he kind of advocates like "She's not mucking around. This is the real deal"*

Brooke and Charlie brought their male partners to medical appointments as a last resort tactical approach rather than an act of dependence. Aware that men's voices were often granted more credibility within medicine's androcentric logic, they used this dynamic to their advantage by turning the system's own patriarchal values back on itself in a strategic performance of compliance. While it could appear as though their partners were 'saving' them, these women's stories reveal a mockery of the medical authority that privileges men's testimonies over their own. Their performances expose the absurdity of a system in which men must validate women's pain for it to be believed, echoing the carnivalesque inversion where power is both parodied and momentarily unsettled. In this sense, bringing a partner operates as both a survival strategy and a subʌersive gesture.

As a collection of stories, together our memories highlight the ways that medicine as a discipline, still to this day, continues to construct, and mediate the feminine body as the freaky other of man. We exposed the enduring colonial and patriarchal structures that both texture our medical encounters and shape what (limited) care is possible. In our embodiment of the carnivalesque within the location of the medical freakshow, through our humour, mockery, and irony we were able to unsettle the authority of medicine in a process of subʌersion. This enabled a turn of the gaze, and a shifting of the power, as we recast medicine as the spectacle itself, re-positioned as the source of our entertainment, in response to the absurdity of its claim to expertise.

Our Entanglement with the Freaky Feminine Sideshows

As we moved through the freakshow that is medicine in our re-tellings, through the cracks in the walls we could see glimpses of the freaky feminine sideshows as they lingered in the background. Their presence was both distant, yet familiar. As the women and I engaged in the collective process of storytelling, I began to recognise that how we shared our memories, allowed them to unfold, and made sense of them flowed in similar currents, echoing familiar pathways with one another. Despite the many ways our stories diverged, each of us began by transporting ourselves back in time, bringing our memories to life, and speaking of them as we had embodied them in the moment. For most of us, that meant casting our minds back to a younger self, ten to twenty years ago, and reflecting on a person who made sense of our experiences differently from how we do now.

While the intent of this research was to resist the singular story of feminine pathology and excess, to hold the embodiment of our stories with care, it is also important to acknowledge the ways our stories became entangled with it. I began to recognise that our stories collided with the singular story through the freaky feminine figures and our embodiment of them. However, critically, in other moments we began to resist them also. In this next movement through the carnival, we turn directly toward the freaky feminine sideshows, the figurations that medicine both produces and depends upon - the mad, the bad, the sad, and the intolerably ambiguous women. In doing so they become a reflection of the ways we had internalised and performed the expectations of medicine's gaze, yet also how we began to rewrite them, disrupting their containment through our shared acts of remembering.

As I remember alongside the literature, I recall how these freaky feminine figurations fold into one another, crossing and overlapping in ways that refuse containment. Their identities are not singular or stable, but interconnected, much like the conjoined twins of the historical freakshow, they exist in relation, inseparable and multiple, defying the clean lines through which medicine has tried to classify them. To think with these figures is to accept their rhizomatic nature, to refuse the singular, and to write through the multiplicity that women embody.

The surfacing of the freaky feminine figurations within our stories serve as a signpost to the burden that women carry in their day-to-day lives when navigating living with a reproductive health condition. Some women's journeys spanned decades, and it was their embodied encounters with the freaky feminine figurations as a lived, affective experience that contributed to the development of their resistance to the dominant singular story. Therefore, our entanglement with these dominant figures becomes a pivotal and influential thread.

The hysterical and hormone-fuelled (mad) woman was prominent throughout women's resistance to medical expertise, primarily in the form of the psychologisation of pain and the hormonal control enacted on women's bodies within medicine. Tui continued to encounter the psychologisation of pain and the tarnishing of herself as the hysterical woman who fabricated her pain:

> It was like, yeah, the one of the gynos that I seen, like, years ago, the one that told me that it was yeah, all in my head and stuff like [pauses] I was so angry. I was like, "how can it be in my head when I'm literally", yeah I don't know. I feel like it's because, you know, women are just supposed to just suck it up and carry on.

In her response to being positioned as the mad woman, Tui further embodied a strong emotional response of anger towards her doctor's enactment as a means to resist feminine emotion as pathology. While Tui's response reinforces her as the mad woman under the medical gaze, it is an intentional expression of emotion employed to reject her doctor's psychologisation of her pain. Her emotion no longer serves as a marker of her madness, but an embodiment of her resistance to both the mad woman figure, and doctors' dismissals of feminine pain. Tui's story also becomes entangled with the figure of the normal woman, as she is expected to endure crippling pain as a normative feminine experience.

Each woman had moments within their story within which they embodied both powerful and deep emotions, reflective of those reserved for the excessively emotional mad woman, however, through their storying, women shifted emotion away from pathology to a site of resistance. Much like many women represented in the literature, Fern speaks to the traumatic nature of some of her experiences and how important moments along our journey can be deeply upsetting in moments that medicine cannot meet our needs:

> Yeah. I mean, it's funny [pauses] I think throughout the whole thing, it was traumatic and it was difficult, and I remember when I cried my heart out when my first surgery [pauses] was cancelled.

She further speaks to the loneliness, isolation, and anxiety involved with navigating a reproductive health condition:

> So it was quite [pauses] an anxiety producing time and to not have that social support from even, like, re-e-a-lly close friends, because I think it's like any medical event or any life event, unless you've experienced it yourself, or you're there with the person, like [partner] was awesome. He was so supportive. Um, but [pauses] yeah, you're alone. No one knows what you're going through, especially if they don't live in the same place as you, and they don't see the impact that it has on you.

Fern's memories move away from pathologising individualised emotion and resurface the impact of the lack of knowledge among our social worlds that trickles down through medicine's epistemological ignorance and the silencing of women's reproductive bodily systems. Fern identified that oftentimes others don't know that the conditions we are navigating even exist, which can make it hard for women to feel they can openly speak about their experiences. She emphasises the lack of emotional support due to ignorance as the problem; something Brooke makes sense of as she re-tells her story:

> *But, you know, just making it normal to be like, [pauses] making everything [pauses] able to talk about yeah and more… I guess I never had that, and I would have loved to…'Cause then you don't have to try and figure things out*

> *for yourself and [pauses] the like anxiety involved with all of that. And…yeah. And just to know that someone's in your corner regardless of what's happening.*

Not only does she speak to the emotional burden of her experiences as she was living them, she highlights the ways that painful emotions can endure beyond the initial embodiment of our experiences. However, in her embodiment of pain as a relational experience she both affects and is affected by other women's stories in her resistance. By normalising talking about challenging bodily experiences, Brooke rejects emotionality as pathology, manufacturing support for both herself and the women in her life. In harnessing the transformative potential of her e*motions*, Brooke shifts the lack of societal knowledge by actively educating those around her, and they do the same in return; a collective disruption of ignorance.

Later in our conversation, Fern revisited her resistance of emotional pathologisation, noting the importance of care instead:

> I love that framing that you just used "go and get some care" that's such important framing, because it doesn't um problematise what they're experiencing. Like yes, there might be some challenges and some suffering involved which means that we want to make sure that their life is enhanced but it's about being cared for and supported in that process, rather than the person being a [pauses] problem.

Charlie's story too, offers insight to the emotional burden she carries reflecting back on the decades of the multitudes of her painful experiences:

> *And I just, it's hard. I don't know, but yeah, so my reproductive journey has just sort of been what it i-i-s. And [long pause] would I wish it upon anybody else? N-o-o-o [laughs].*

While acknowledging the pain embedded in her story, Charlie disrupts expectations of feminine emotional excess and resists being crafted as the mad and sad woman through her dark humour, moving with her pain through laughter, refusing to remain stuck within it.

Maia explores the emotional burden that comes with making decisions around potential parenting when living in a body impacted by a reproductive health condition:

> Yeah, and it's definitely, um [pauses] oh, I was talking about this with [naturopath/dietician] the other day as well. Actually, you know, it's like a double-edged sword that having put in so much thought around parenthood…. You know, for some

> people, they kind of just fall into it as the next thing to do in life and then figure it out, whereas people like us think about [laughs] all… and while that can be like a mental, emotional burden, I also [pauses] like that whatever decision we come to would be a really conscious and really well thought out one.

Whilst reflecting on the emotional toll of such decisions, she rejects the pathologisation of her emotional embodiment and instead reframes the burden of her decision making as an important and valuable process. Maia also draws attention to the dominance of the motherhood mandate within society as she identifies parenting as an expected or 'natural' next step in life. Yet, in her resistance Maia frames the decision many women make as an uncontrolled action, through their falling into it, demonstrating the ways social power dynamics enforce women's alignment with the normal woman figure. Instead, she chooses to align herself with the bad woman in her challenging of women's passivity in this decision and her consideration of not having children. She, therefore, takes ownership of her entanglement with the bad woman as an act of resistance.

As previously explored, Tui has stepped into the performance of the disruptive monster in her confrontations with doctors regarding her physical pain:

> I'd said to the doctor too. I was like, "Look at my fucken history. You're going to see", because one of the times they had tried literally every painkiller they could, and nothing was working. I'd already been there for 72 hours in the ED like they hadn't, like put me up into the wards, and I hadn't slept because I was in so much pain.

Tui's affective rupture in the form of swearing at her doctor demanding that he follow her instructions and read her notes, shifted her out of the acceptable performance of femininity and patient as she took ownership of her care and insisted the doctor follow her demands. Notably, her response was out of rejection of her doctor positioning her as the hysterical woman, making up her pain, yet even in her act of resistance she *also* becomes the bad woman. This dynamic exposes how no matter what women do, the power dynamics of medicine leave them trapped within the location of the freaky feminine figures. It is through these acts of refusing emotion as pathology that place woman as the disruptive monster that we begin to understand their entanglement with her is due to their resistance. Women's embodiment of the bad woman becomes an active and intentional choice and signals their process of freaking as affirmative.

In other areas of Tui's story, she continued to embody multiple forms of the freaky figurations at the same time:

> I just done my own research, you know, the good old Dr Google and put in all my symptoms, and yeah, straight away came up with polycystic and then I just dug deeper and deeper. And I was like, I have absolutely everything that it is listing off. And so then, yeah, with, then with the um infertility side of it, that's what scared me of going to actually go and get checked, because I've known, like, ever since I was a little kid, I said I was going to have 12 babies. Yep, if I could, I probably would already have 10, like. Um [pauses] so yeah, that's probably why I reckon I didn't go and get it checked for so long because I was just so scared of [pauses] that side of things.

Much like the other woman, Tui also experienced powerful emotions that are associated with the hysterical woman, particularly fear regarding the potential that she may not be able to have children. Her fear was so strong that it contributed to years of avoiding seeking help for her PCOS, which aligns with normative ideals of feminine passivity. Yet even in her fear, Tui resisted being the passive woman as she sought understanding of her body through her own research; an example of her rejection of the idea that woman are ruled by their uncontrollable emotions. Tui's fear located her in the realm of the sad woman, whose reproductive body is betraying her desires to have children. However, instead of accepting her bodily betrayal and submitting to a melancholic destiny, as an embodiment of resistance, Tui has actively sought fertility treatment in the hope of having children.

As Tui reflected back on what it felt like to be in her body as she began to try and understand what was happening within it, she demonstrates how medicine reinforces women's entanglement with the sad and hysterical women:

> Kind of like a prisoner, almost. Like, because you just couldn't do anything to escape it. You try and do something and you just [pauses] nothing worked. couldn't talk to anybody. Couldn't [pauses] no matter what pain meds ya took, it was always just painful, and, yeah, it was horrible…But then, yeah, we're back to gyno again, like, just with the pain, like, just, it was ridiculous you just learn how to live with it, like, pretty much, like, you know, you're in pain every day. Some days are worse than others, but you just, you don't have a choice. Life's got to go on…. Like, you just get so used to it.

Tui reminds us of her enduring attempts at seeking appropriate care for her PCOS and identifies how medicine's failures to attend to her pain kept her stuck in a body that was betraying her. The figure of the normal woman emerges again, as her painful body becomes an ordinary part of her existence, reinforced by the lack of care provided by her doctor. In light of Tui's ongoing resistances, it becomes apparent that it is the social power dynamics of medicine that render her the sad, and hysterical woman and not her body. Medicine fails to care for her body, leaving her navigating physical pain, and in her emotional responses to the consequences of such failures, she is cast as both mad and sad.

During the time Tui felt like a prisoner in her body, she speaks of the pain inflicted by those in her social world regarding her physical experiences of PCOS:

> I had my partner at that time too, um [pauses] and [pauses] he-e, well, mainly, more his, his family, his family were horrible. Would give me shit about, like, my facial hair and stuff, but, like, and I was already so self-conscious about it. But, you know, didn't know what to do about it, but at the same time, knew where it was coming from, but didn't want to get that done. And then, yeah, like, when I first started, yeah, going through gynae and stuff, nup, never talked about it or anything.

We can understand Tui's self-consciousness about her facial hair, and the mockery inflicted by her partner's family as echoing the intolerability of the ambiguous woman, whose characteristics don't align with normative femininity. Her facial hair was perceived as an unacceptable rupture of the boundaries that separate man from woman, rendering her in the intolerable space in between the two. Her memory of refusing to talk about it alongside her feelings of being self-conscious draw our attention to the shame women embody when they traverse the boundaries of what is permissible for a woman's body. As we remember with Barkty (1998) we reflect on shame as an indicator of obedience to the patriarchy. Tui eventually chose to resist being silent and started speaking openly and freely about her experiences, which we can recognise as her rejection of the patriarchal gaze and release of embodied shame.

Tui further collided with the intolerably ambiguous freak when she became a literal spectacle at the freakshow:

> Oh, that's right, that's another one. Um [pauses] apparently, I'm a rare case. I, I learnt about 15 minutes before getting knocked out um for my surgery when about 20 med students came into my room [pauses] and said that they had been using me as a case study since I'm a rare case, and asked if they could watch my surgery. Yeah, I was just like, "I mean, I suppose you's have got to learn, but, yeah, it would have been nice to know you were studying me. But, yeah, cool, go for it".

Not only was Tui already positioned as the freakier version of the freak as a woman with PCOS, but she also then became somewhat undefinable and incomprehensible as her freaky condition of PCOS took on the form of a rare case, so undefinable, she became the spectacle of the medical students, displayed on her hospital bed as the stage. This image reinforces the idea of the woman's reproductive body as something to be observed, measured, and put on display due to its deviance and bodily difference; Tui literally became the exhibit at the freakshow with the audience and professor observing and talking about her. Charlie also became the spectacle at the freakshow when she was living on a small Pacific Island:

> *And he goes, "Oh, do you mind if my girls watch this pap smear?",…I said, "of course, I have no problems with them learning",. A-a-nd [pauses] so I get up there and I've got my feet in the stirrups and I look out and there's [laughing] like 45 nurses from all these different departments.*

Both Tui and Charlie's stories demonstrate a freaky body putting on a medicalised performance. Medicine has taken charge of the gaze, however, both women have agreed to helping, so that the viewers may learn. This performance is reminiscent of the earlier freakshow politics within which freaks engaged in subʌersion through enabling critical discussion and education on bodily difference; freak's themselves became the educators, disrupting the audience's authoritative knowledge. While Tui and Charlie were the freak on display, they also opened the space to challenge medical expertise, exposing its lack of knowledge by putting their bodies on display.

Through the women's stories, multiple figures emerged, partially and simultaneously, that speak to the power relationships that enable and constrain how women can navigate reproductive health conditions. The ways that the figure's inclusions overlap with each other mean that women, regardless of their reproductive health condition, and their responses to their experiences, remain stuck within the subject position of a freakier version of the freak that is woman within medical discourse. It is through locating the freaky feminine identities as inseparable, multiple identities like the conjoined twins at the freakshow, that we can understand their realisation as a dominant and singular narrative within the literature, as it is near impossible to escape their embodiment; when shifting away from one, women end up meeting the inclusions of another.

However, as we moved through our stories it was clear that the recognition of ourselves within the dominant story was more so a connection we located in our past; we each shifted our narration from an embodied memory, reflecting how it felt at the time, to our current selves making sense of our stories differently in real time. As this moment in our storytelling unfolded, it was apparent we were engaging in the affective flows of meaning making. There was an energy shifting between us, an undeniable active resistance to the dominant figure and a conscious choice to challenge and disrupt it as we began to re-tell our stories differently allowing ourselves and other women to know otherwise.

The freak only exists within the landscape of sameness and difference requiring rigid boundaries of normalcy to defy. Harnessing the energy of the women, I remembered the freak is simultaneously and compulsively fascinating and repulsive, enticing and sickening. Yet when reflecting on the literature, it is apparent the figure of freak performs the repulsive and sickening aspect, the one we turn our eyes away from in horror and marginalise. So, where is the fascinating and enticing freak, full of joy and freedom?

In pondering where she was, whilst also trying to make sense of the energy that was moving in, through, and between us, I realised as I was moving with the stories that emerged that I had not seen within the literature, she was right there, she is *us* within our process of freaking. As we leave behind the shady corners of the freakshow that is medicine, and the freaky feminine sideshows, together, we turn toward her, stepping into the light to celebrate the possibilities of our freaky bodies as sites of joy, transformation, and collective becoming as we begin our journey of embodied subʌersion in the further corners of the carnival.

Chapter 5: Analysis Part Two – Leaving the Freakshow Behind and Joining the Carnival

Multiple Moving Street Performers: Freaking Normative Femininity

As we emerge from the shadows of the freakshow and turn to the bright lights of the carnival, the women move through a dynamic landscape where multiple performances unfold simultaneously, blurring the boundaries between subject and object, performer, and observer. The meaning of our differences comes to life, always moving and shifting. Women observe, cheer on, join in, learn from, and respond to the ongoing energy surrounding them. Some take on the performance of a contortionist, demonstrating the extreme flexibility demanded of women, while fire eaters turn rage into spectacle. The Bearded Lady strokes her beard, and the strong woman flexes her muscles. The daredevil stunt driver shocks expectations, while the jugglers expose the absurdity of trying to balance them, and the ring-mistress takes leadership and demands attention. The performances are endless and ongoing, the motion, noise, and chaos converge in a collective disruption.

It feels fitting to begin this piece of our analytical journey through the carnival with our freaking of normative femininity as an affective and political foundation to build from as it is the patriarchal and colonial forces within medicine and their definition of normative femininity that account for our suffering as women navigating life with a reproductive health condition. Our process of freaking normativity allows us to affirm our differences to the colonial and patriarchal anxieties of psychology and medicine and begin to celebrate our embodiment of ambiguity and what it allows us to do.

Within our conversation, Fern was chatting about traditional views on menstruation and gender stereotypes, and I asked her what she meant by that, and how she thinks such views have become so dominant socially:

> I think when I use that term, I have it quite like a narrow focus on, and when I mean narrow, it's actually like massive. I feel like it's like an iceberg, like we talk about this traditional stereotyping of gender and menstruation being a part or [pauses] reproductive um issues or experiences being a part of that, but actually underneath the tip of the iceberg is this whole um [pauses] bigger contributing, um-m [pauses], narratives, experiences, thought, um, theory that we never really get to take the time to unpack it or reflect on it. So when I talk about the tip of the iceberg that we see and regularly refer to, I'm talking about the binary men and women, and I’m talking about, um, the stoicism and toughness um and power and dominance that is often traditionally related to

> being a man. Softness, um [pauses] weaker, lesser than, um, gentle, um, nurturing, mmm characteristics that are typically associated, historically at least, with being a certain type of woman.

Fern then goes on to discuss the patriarchal and colonial dominance that have shaped these values and their prevalence, noting that the industrial revolution and capitalism reinforce these systems. Fern's reflections speak to the balancing of multiple and contradictory ways of being embodied woman, mirroring what the literature tells us are the standards of normative femininity and while they are extensively reproduced within medical and psychological literature enacted on women's reproductive health, among our stories and storytelling there was a loud and firm resistance to them. Each woman had differing versions of their resistance that they juggled, overlapping and diverging from each other and Simmonds (2011) reminds us that our difference(s) matter(s).

Maia grappled with the concept of motherhood as the apotheosis of womanhood throughout her story as her and her partner have remained unsure as to whether they want children:

> And he was like, "Have you and [omitted] popped out any babies yet?", like, through the conversation, and I was like, [pauses] um [pauses] I was like, you know, it's such a big topic. Like, how do I just keep it kind of light and breezy? [Laughs]. I was like, oh, I just, I said something like, "I don't know if it's for us", something like that. And he's like, "Oh, do you do you mind if I ask why?", and I was like, again, like, it's still too much to go into much layered conversation. Just gave a couple of sentences about [pauses] um health and lifestyle. And then it kind of also earlier in that conversation is like, what are you training for? Because that's, you know, how we're that's, you know, how we're connected. And, yeah, in the past, that would have been, both would have been training for something. But I said "I'm training for my 90th birthday. Like [inaudible] and strength training. And, yeah, low impact endurance" [laughs]. Um. And then so his response to that was just like, "I um, I think it's so sad that you get to your 90th birthday and never have kids, and that yo-o-u're [pauses] oh, the greatest gift a woman can give a man as a child". And I was like, "what!?" this is coming like, let alone coming from someone I thought, like, I could trust and yeah, like, but also like, that kind of stuff is coming straight out of the church or [laughs].

Maia's re-telling of this emotionally charged encounter with her friend serves as an example of the ways colonial and patriarchal values permeate our social worlds in our everyday lives. Her shock at her friend's response and signalling that it was a rupture in their trust marks her rejection of the motherhood mandate and her alliances with the bad woman, a daredevil out to shock as she defies normative expectations. As she quips that his behaviour is something straight out of the church, she draws our attention to the ongoing processes of colonisation within Aotearoa that enable such values to circulate with dominance to this day, producing the subversion of heteronormative motherhood as a dangerous activity. Within our freedom in the carnival, the church as a system that serves to monitor and control women's bodies becomes the site of mockery; its values that permeate the medical system no longer carry any weight; a balloon we let go of and watch drift away with the wind at the carnival. Notably her humour serves to remind us that such values and expectations of women to provide children *for* men is embedded within a culturally specific values system, and we can defy such expectations, if we dare. As we talked further about mothering, Maia shared that she was writing a book on this very topic:

> I suppose it is like, how, what does a woman look like if she's not a mother? And like within that there's so much as well, because obviously there's, there's women who wanted it, but kind of, but circumstances, or for whatever reason [pauses] didn't end up, so it's almost like it's almost in my brain, I'm getting like an image [laughs] like a hierarchy. There's like women who are mothers and do it, or there's like women who do everything, women who are mothers, women who wanted kids but couldn't have them. And then there's [laughs] the rest of us…
>
> …which maybe comes into the bigger stories around how, like [pauses] yeah, I suppose, like being pregnant and then is, like [pauses] the most amazing experience, and then having kids are the best thing you ever do as well.

Maia's image of a hierarchy of womanhood based on their enactment of normative femininity regarding motherhood reminded me of the feminine figurations; the further down the hierarchy a woman is positioned, the less tolerated she is by society. Towards the bottom we see the sad woman who wanted children, but couldn't have them, therefore, people feel sorry for her as she has been denied life's greatest gift. As Maia jokes about "the rest of us", her laughter signals her deviance from the motherhood mandate; she *is* the bad woman who dares to defy her destiny of gifting a man children and becoming forever selfless and nurturing in motherhood. Maia proceeds to identify the ways in which these colonial and patriarchal values of normative femininity and motherhood infiltrate medical encounters:

> There were definitely a couple of occasions where [pauses] I [pauses] not explicitly said, but I definitely got a strong sense that had I said, "oh, and you know what, we're not worried about having kids or we don't want them" that I would have been treated differently…how is my quality of life [pauses] less important than falling pregnant?

Maia's stories how she defies medicine's expectations, making a mockery of how the level of care women may receive is dependent upon their performance of normative femininity. Her questioning of the prioritisation of her reproductivity over her quality of life stands as a resistance to the ways women's lives become reduced to a body as a vessel for creating, birthing, and caring for children (and men), and little else.

Charlie's resistance to normative femininity entangled with Maia's rejection of the motherhood mandate through her resistance of women as expected to be selfless, always putting others first, and for mothers to be continuously emotionally and physically available to meet their children's needs:

> *I found in the healthcare system, with feeding, ah they really push the breast and not a lot, and some women just can't do it. I find it that that's a bit hard, I think bed is best. And I think the less stress that you the less amount of stress you put on the mum, the better…they say, oh, you know, "Breast is best", it can be. But if mum's really stressed, and focusing on it, then [inaudible]. So anyway, so I was, I ended up because, um, I didn't produce enough milk when he was jaundice so he ended up being bottle fed anyway, because we needed to flush his system because I wasn't producing enough milk…*
>
> *…I'm like, "No, you've got to listen to me, my child, you can come back any time you want, but I'm still going to say the same thing. And quite frankly, you're just making this more stressful process than it has to be".*

As Charlie shared this memory, I remember feeling astounded by this idea that medical staff would continue to pressure Charlie to breastfeed her child when her body wasn't able to do so to a sufficient level. This pressure serves as a form of disciplining Charlie's performance against the norm created within medicine that is grounded in normative feminine ideals. Through her fiery resistance of embodying the idea that she must physically provide for her son, she ultimately enabled him to receive the care he needed, whilst also caring for herself. Her story brings attention to the ways in which, within the medical system, the expectations of our obedience to normative femininity become more important than our own health, and enraged responses can have transformative potential – rather than swallowing the fire, Charlie unleashes it, challenging medicine's gaze with her own spectacular performance.

Fern's health was significantly impacted by her relentless pursuit of normative femininity when she was younger as she lost her menstrual cycle in seeking a slim body. Her reflections of that time emphasise the power of the narrative that positions slimness as a marker of femininity, and the ways in which its power is reinforced by those in our social worlds:

> Well, I think it's interesting, because that time so I lost it because I over exercised and I ate as a way to control the only thing that I could in my life at

> the time…Those activities were triggered. I've always had massive body shame, and that's come from my mum. And society. But that that had, that was something that I could control. So I did that, and losing the period was like, sweet I don't have to deal with a period anymore. Like, I never had a feeling of concern. My mum never talked to me about it. But I realised I only had a problem with my, how unhealthily thin I got when my friend's mum told me, after a long period of time, who I didn't have a great relationship with, was like "Ooh, you're looking rather sick, [omitted]". But my mum and my dad were positively reinforcing how I was taking care of myself…Anyway, I think I felt great because I looked great. I felt great until I realised I actually felt really fucking sick. Um, because I had performed my femininity and the way that people wanted me to, or society expected me to, and because I didn't have to deal with having a period…
>
> … And it also happened at another stage of my life, too. I can't remember when, but again, that positive reinforcement, and I just remember thinking, people don't fucking get it, like, I'm really sick, like, and yet, like, "You look so great". I'm like, "I feel fucking sick. And why am I doing this to myself? I need help". And not feeling like you could acknowledge that because, you were now, you now had the right body… It's crazy that these, these ways of thinking continue to persist.

Fern's story is an example of the real-life consequences of medicine's pathologising of larger bodies and the troubles that can exist within thin feminine bodies. Notably, both the fat lady and the skeletal woman were put on display as spectacles within the freakshow (Dennett, 1996) drawing our attention to the narrow boundaries that contain the normal woman; too fat is freaky, too thin is also freaky. Fern's story exposes the ways in which the patriarchal and colonial values of medicine, combined with medicines social authority, manufacture the conditions of our everyday lives within which our suffering both unfolds and is perpetuated. Fern's pursuit of slimness is an example of the near impossibility of attaining the idealised figure of the normal woman; as she reshaped her body into a slimmer version, she then lost her menstrual cycle, she was no longer enduring a cycle of pain and leakiness, while also lacking fertility. In her movement away from the ambiguous freak by making her body smaller, the figure of the normal woman materialises - controlled feminine weight marks normality, even as lost menstrual cycles continue to trouble the boundary between normal and intolerably ambiguous.

Fern's explicit naming of the social power dynamics at play within her story are the foundation for her resistance, as is her ongoing commitment to resisting slimness as a marker of femininity, yet she reflects on the difficulties of such resistance:

> In spite of everything that we've learned and that we know, I know that's so insidious and so embedded, yet despite the fact that we talk about them really openly now, in particular circles, at least we talk about body image, and, you know, like it's so deeply entrenched, it's [pauses] crazy that we still have the number of people that we do with eating disorders, with body dysmorphia, with just being unhappy in themselves.

Fern casts our attention towards the power of enduring dominant narratives and their values systems, even when alternative narratives begin to circulate, emphasising the importance of disrupting the singular story.

Both Brooke and Maia's health was also implicated in relation to the performance of normative femininity, however, this time in their freaking of it. Brooke and Maia acknowledged they had a stubborn approach to navigating their severe pain from endometriosis, refusing to let it take over their life, instead choosing to try and continue with life as much as they could. Brooke and Maia's stories stand in contrast to the many stories of women navigating physical pain within the literature that are centred around their avoidance of activities, experiences of loss, and their emotional responses to their pain:

> *And [pauses] I wa-as keeled over in the doctors too, so was crouched right over. Because I also thought, like, usually I'm quite stoic and try to hide if I'm in pain…I would consider myself to have a high pain tolerance. Um, yeah, I'd say I'm quite good at pushing through…not that it was necessarily a good thing. Like, I spent my work breaks sleeping and keeled over [laughs].*
> *– Brooke*

> U-u-m, I probably never really took time off until seeing [naturopath/dietician], I'd just, well I was young [laughs] more energy back then [laughs] and like, didn't look after myself in those ways…strong minded, didn't want to be seen as weak. Also didn't know that other women weren't experiencing that. So I was like, oh, like, they're dealing with this fine. [Laughs]…My approach was probably more stoic than, than hysterical. Like a subdued or, like, repressed [laughs]. – Maia

Whilst both Brooke and Maia reflect on their management (or lack of) their physical pain as not being overly beneficial to their well-being, they both reflect on their rejection of being perceived as weak by harnessing a level of strength and determination to contort through their pain as opposed to being overcome by it. As we reflect on the figure of the normal woman and consider how she endures extraordinary pain in silence, we can understand that being loud about pain would be seen as weakness, an embodiment performed by the mad, bad, and sad women. This too, offers us insight into the disciplining of docile feminine bodies and how monstrous the ‘normal’ woman is. Brooke and Maia’s stoicism then performs as a process of freaking feminine weakness as contortionist, bending and holding in ways that take the pain with them. Their endurance of pain can be understood as double-edged, however; while they are actively resisting feminine weakness, they too are engaging in a performance of femininity that seems impossible. As Maia mentions, she was not aware other women were not experiencing what she was, so she was aligning her performance of femininity with that of the other women surrounding her. While the figure of the normal woman shapes constrained understandings of embodied femininity, and keeps us silent, Brooke and Maia’s endurance of physical pain serves to challenge the image of women as weak or hysterical in their responses to pain, engaging instead the flexibility of the contortionist as they move their bodies in awkward and impossible ways.

Having celebrated the various performances of freaking normative femininity within the carnival, we arrive at a moment of collective joyful performance through which all the women subvert and re-embody the disruptive monster and intolerably ambiguous freak, taking proud ownership of the very figures medicine produces to contain them. Strength became a site at which every woman’s stories collided through a prominent story of freaking feminine passivity. Feminine passivity relies on the portrayal of woman as the inferior, weaker version of man, expected to accept what comes her way, dependent on others to help her, rather than actively responding and taking action. The dynamic of masculine assertiveness and feminine passivity is reinforced through the doctor-patient binary within medicine that crafts women as reliant upon medicine to save her.

As Fern re-tells her story she begins troubling the medical system and how it reproduces the concept of a patient as passive within the medical encounter:

> And so reflecting on my own experiences, I was like, “Ha, well, I know myself the best. I can advocate, the best. I can support my well-being”. So I did the training to become a holistic health coach. Primarily, initially, to empower myself and to provide myself with knowledge and information, which then kind of [pauses] went into my teaching. But I think also gave me this really good grounding, because I understood some of the things that you've talked about around the challenges of the medical system and the ways that it views bodies and people, and it's quite separate, and we do it to you or hopefully

> that's changing, but it's something that happens to us patients. Um and this really challenged that way of thinking. So again, that it's kind of been, I guess, building blocks over time that has informed my ability to advocate for myself.

Through her process of troubling, Fern reflects on her active (irony intended) resistance to women as passive in her journey of self-empowerment by developing her knowledge and skills to support her health and well-being – she would be the ring-mistress of her own embodied carnival. Fern traverses the boundaries of masculine and feminine by educating herself and engaging both her mind and initiative. Instead of relying upon medicine to provide her with expertise from a position of passivity, Fern actively took control of her health journey and in doing so built important self-advocacy skills so that she may take charge of medicine's interventions into her life. Women frequently encountered the dominant narrative of doctors as experts meaning that self-advocacy became a core thread of their stories – a freaking of the power relationship where women might become able to lead their medical experiences. Most of the women had to engage in relentless self-advocacy to ensure they were taken seriously and received the care they needed. Through this process they rejected themselves as a dependent woman awaiting medicine's help to save her, becoming ring-mistress.

Brooke spent several years trying multiple different doctors seeking care for her eventually diagnosed endometriosis:

> *I would say, listen to your body and you know you best. Yeah, if you've got a feeling that something's not right, follow it until you figure out what's going on. I guess you can try and do your, your own research, but definitely just listen to your own body, you know, what does and doesn't work. Or you'll quickly figure it out. Yeah, but have a...have a say. Don't just sit back and listen, definitely. And express your concerns... express what your concerns are, you know, if you don't want to do it because of this, or, you know...create a safe space to be able to talk about what you feel like you need.*

As explored previously, Brooke, had to resist the dominance of medical expertise on numerous occasions. As her experiences unfolded she became more assertive and vocal in her resistances to doctors as she refused their repeated attempts at dismissing her knowledge and enforcing harmful and ineffective treatments.

Tui had a similar experience when navigating her first miscarriage in the emergency department in hospital:

> So he argued with me about how far along I was. And I was like, “I know exactly how far along I am. Like, I know when my transfer was. I know to the day how far I am”. He's like, “No, that's not right. You're only four weeks”. I was like, “No, I’m, six weeks and three days”. U-u-m, and then, so then he done an ultrasound by the bed, and he's like, “Oh, even if there is anything in there, we're not going to see it anyway, because you're only four weeks” I was like “I’m not four weeks”….

Tui’s story demonstrates the ways in which women must engage vocal resistance through arguing with doctors to dispel the façade of medical expertise over embodied expertise. Tui’s protesting becomes an attempt at calling for her humanity to be recognised, for her to be seen as more than a freaky body. As she rejects her positioning as a body on display that is subject to medicine’s gawking, Tui shifts the power dynamic of observer and object within the freakshow, turning the critical gaze towards medicine, positioning herself as an embodied ring-mistress with knowledge that the doctor lacks, but could learn through engaging with her expertise. Tui’s active resistances took place outside of the medical encounter also, when on multiple occasions she had to activate her assertiveness to ensure she was provided the results of her surgery and given the opportunity to meet with a specialist:

> Um, so got my surgery done. They didn't tell me anything after surgery, um and then just said, yeah, you'll get a letter. And so then I rang, yeah, rung my GP a couple of weeks later, because they took biopsies and stuff. Rung my GP and they said, “No, you have to talk to your specialist. We're not allowed to tell you the results”. So as soon as they said that, of course, alarm bells went off in my head. I was like well, that's bad news. So I was then ringing the specialist probably three times a day. Left multiple messages…
> …So yeah, would just start ringing [pauses] them every day. “Has there been a cancellation today, has there been one today?” Um. But, yeah, it is, it's all stuff that's the only way to see any gyno, really, especially here…So it's, yeah, you've just gotta self-advocate for yourself, like, [pauses] it's just ridiculous, which is so hard to do, but yeah, no. I was like, no, I'm gonna be a Karen and go Karen on it.

Tui’s memories offer insight to the day-to-day experiences of being dismissed and neglected by the medical system and the impact that can have on women’s well-being, particularly if women were to adopt the expected embodiment of feminine passivity. Tui’s story, however is an example of her refusal to sit back and wait for action to unfold. As she later reflected:

> If you don't fight for yourself, no one else is going to. You're just going to get lost in the system.

Interestingly, Tui's labelling of her behaviour as being a Karen reveals the ways in which patriarchal and colonial narratives of normative femininity structure our everyday lives. Karen, as a derogatory term used to describe entitled, demanding, or self-centred behaviour, is typically associated with white, middle-class women and performances of entitlement and privilege. A Karen could be understood as the epitome of the disruptive monster; an extremely poorly tolerated figure of a woman who calls upon colonial entitlement to enact power. Tui's use of the word Karen as a structural dynamic becomes multi-layered as it echoes the embodiment of her self-advocacy as a socially unacceptable behaviour, however, she also owns the term through her summoning of the monster that is Karen. In her harnessing of the disruptive monster, Tui ultimately subʌerts the social power dynamics that punish her assertiveness and resistance to feminine passivity and medical dismissal.

Tui's memories made me think back with Bartky's (1998) reflection of the distaste that exists toward massiveness, power, and abundance within a woman's body and Fern draws our attention to the burden that can come with resistance to feminine passivity:

> Resistance comes from being a woman who is confident in her own body in terms of what I can advocate for, what I know, what my rights are, the care I have for my body, because I have always listened to it…and I think being confident in that way, you know, like um [pauses] not backing down, not giving up easily…that resilience and not being afraid to be a little bit outside of the box.

Fern's storying suggests that self-advocacy is a location of difference for women engaged in healthcare for reproductive health conditions. Within the everyday conditions of sameness and difference, and the punishment of difference it does require confidence and a collective and shared strength among women to persist for the benefit of fighting for our care.

Charlie was aware that her ability to stand up for herself was critical in her care and ponders the consequences for those who are yet to develop those capabilities:

> *I don't want any other person to go through it, because I, [pauses] I'm, I wa-s-s a [job title] who fought f-o-o-r people in that way, and so I had that in me anyway, and I could do it for myself but I would like you would just sit there and think, god, if I can't get the help that I need as a woman with a mouth on me that knows my rights, how the hell do other women come in here and actually fight for… young women, women of minorities that may not, English may not be their first language, Indigenous women, Pasifika women, you know? How do they get the help that they need in the way that they need that help?... I, my, I've always advocated for other people through*

> *my [work]. Advocating for those who didn't have a voice, so that's why I would tell people's stories.*

Charlie draws our attention to the potential of the connections between women that help to engage advocacy and change as a community movement. She too, highlights the layers of identities that can intersect and collide making it even more difficult to advocate for oneself; the connections that are lived and felt as most intense and intimate. Intersectionality becomes critical in understanding the ways that colonial and patriarchal dominance manufactures the conditions of women's everyday lives within which our distress emerges. As we think back on the literature we recognise the white, heterosexual man as the norm; with every identity a woman embodies that exists in opposition to this ideal, is another layer that must be resisted. In thinking with our freaky feminine figures and women with reproductive health conditions as the freakier version of the freak due to their deviance from the norm, we must then ask, what about the multiple identities of other that begin to collide with these figures of freak? What about women of colour, or those who identify as a part of the rainbow community, for example? In asking this we begin to comprehend the multiple layers of marginalisation and oppression that women become entangled in beyond those inherently located within being the freakier version of the freak, and the implications that has on being able to advocate for oneself.

It was apparent that women's experiences have contributed to the development of strong self-advocacy skills and their resistance to passivity as they have learned to become assertive to ensure they receive the care they need. Ultimately in sharing their stories these women have become advocates for other women, who may not yet have these skills, through their disruption of the singular story, gifting empowering alternatives so that others may be able to see themselves within these stories and be moved by them. The women expressed that they were hopeful that in hearing these stories other women won't have to go through such long journeys and painful experiences to understand how dominant narratives inscribe meaning onto our bodies and may feel empowered to also disrupt the singular story, so that eventually women may know otherwise:

> While it's really unfortunate and it shouldn't be the case [laughs] at this point in history, we have to advocate s-o-o strongly for ourselves. And like [pauses] do our own research, get more than a second opinion, Um. Yes that's tiring and it shouldn't be that way, but we just have to do it. Through this experience I have become a more well-rounded woman, who understands her body, won't settle for anything less than optimal health, and stands in her own power to make that happen. - Maia

Fern further notes that our self-advocacy as a resistance becomes more than resisting feminine passivity:

> Something that I've just been reflecting on as we've been talking is I've noticed that we both say [pauses] advocating for ourselves and I really like [pauses] I feel like it's [pauses] well, it's not easier said than done. But like, what is advocating for yourselves, and how do we support and promote and, how do we support and promote that? Um [pauses] you know, like just thinking about, you know, sharing our stories and talking to other people about our experiences and the things for us. And we can say, make sure you advocate for yourself. They're like, "what the fuck does that look like?" You know? Like, what, what actually makes up advocating for ourselves? …And that totally aligns with the conversations that we've been having about gender, right? And the performance of gender and expectations. And, you know…even the power dynamic between a doctor and a patient.

In her reflections, Fern draws attention to the complexities of engaging self-advocacy and the power dynamics that inherently make such performances difficult. She sparked a reflection on my own story and I acknowledged that even if someone had told me as a teenager to advocate for myself or stand up to my doctor, at the time, there was no way that I could have done it, I simply didn't have the skills or confidence to disrupt my embodiment of feminine passivity within the medical encounter. In pondering self-advocacy, it becomes important to acknowledge that regardless of women's self-advocacy, the disciplinary powers inflicted upon women are still in force. In our process of freaking, however, we begin to open space for more resistance, and as we gather more momentum, there is potential for a transformative collective impact. It was only through my seventeen year journey that I developed the knowledge and capacity to engage my own resistances, which draws attention to an important piece of disrupting the singular story of feminine pathology and excess.

While we, as women, are engaging in the transformation of knowledge enacted on women's reproductive health conditions through disrupting the singular story, this process needs to, and does, take place within medicine itself as well. Through multiple acts of self-advocacy, ongoing trust in their embodied knowledge, and continuous pushing for care, each woman was able to eventually receive the care they needed through eventually meeting doctors who performed their role differently.

The Playhouse – Doctor’s Freaking Medicine’s Power from the Inside

At this point in the carnival, the women move from their kaleidoscope of different performances and arrive as an audience within the playhouse. The doctors occupy the stage, cloaked in the costumes of medicine, their performances aligned with its familiar script. Yet, within the playhouse, moments for improvisation emerge, openings through which doctors can expand their performance and engage in creative gestures that resist biomedical order and authority. Some even invite the women onstage, welcoming them into a co-performance that reimagines the very foundations of medical care.

Through our processes of freaking, it became important that we refuse to engage in the homogenising practices of the systems that harm us by following a singular narrative current within the wider flow. Within my own and every women’s stories a foundational thread centres around the doctors who freaked the system of medicine from within as they resisted the very practices that accounted for the harm we endured. These encounters were a pivotal moment in our stories as not only did they allow us to receive care that for many of us drastically improved our quality of life, but it also helped us to make sense of our experiences as we understood our bodies better. Perhaps most importantly, this act of freaking the system enables us to expose the particular performance of medicine trapped in enduring colonial and patriarchal practices as the freakshow that must be controlled due to the harm it is inflicting on the freaks both within it and beyond: a limited, culturally-specific system that fails to live up to the expertise it claims to embody:

> I only worked initially through Family Planning, and then once I was um, entered into the hospital system, I worked with my amazi-, amazing surgeon, my surgeon was amazing. She really, I could tell she really cared about me. She would, um, I knew that she was doing her best to try and um, like she'd always give me options like of what kind of surgeries to have. We had um, an attempt at a less invasive surgery to start with. which failed because I just bled too much during the surgery, so they had to abandon the surgery. Then she said, “Here are some other options. What do they sound like to you? What would you like to do? Here are the pros and cons” and throughout all this, she'd like, kind of keep me updated and just check in every now and then, because she knew that I was really struggling. – Fern

Fern’s surgeon rejected the doctor-patient binary, opting instead to invite Fern as a collaborator in her care meaning she was actively engaged in the decision-making process and maintained her agency within the medical encounter. Fern and her surgeon’s relationship became one grounded in partnership and autonomy fostering a shift in the power dynamic between them. They actively embodied the subject position of the intolerably ambiguous freak as they resisted the boundaries of one or the other, instead opting to locate themselves within the space between.

The power of Fern's encounter with her surgeon was more than just their partnership:

> So then I recovered fine, and [omitted] would check in on me and, like, just see how I was. And I ended up, after like, my full recovery, I gave her some a little gift and a card and stuff. And I just said "We need more doctors like you, more surgeons in our hospitals where you relate to the patients, where you care, where you", I said to her, "I really felt like you cared. You advocated for me, you listened to what I wanted".

Previously Fern reflected on her perspective that the medical system views bodies and people as separate, and that medicine is something that happens to us. Fern's gifting of a koha, however, is symbolic of deep gratitude and a sign of a meaningful and respectful relationship. The difference of her surgeon's approach emphasises the transformative potential that lays within the medical encounter *becoming* relational in nature. I shared with Fern that I too had been deeply moved by the care of my specialist and had been inspired to gift him a pounamu in an attempt to express my gratitude. In my brief re-telling I shared that when we met face-to-face, before we discussed anything clinical, he took the time to ask questions about my life, reflected on how he believed my experiences would offer deep insight into the complex embodiment of identity, and stated that he would be by my side until we understood what was happening within my body, promising not to neglect my story as previous doctors had done. The depth of care and advocacy he showed during the time we worked together transformed my relationship with my body and gifted me with a quality of life I had previously not believed was possible. On another layer, we can understand the act of gifting a koha as signifying the actions of our doctors far exceeded our usual encounters; partnership, time, and a genuine relationship of care were unusual experiences for us, and the power of the experiences can offer insight as to what healthcare could be:

> *That was the life changing thing was seeing that specialist, and yeah, she is basically an advocate for me I don't need to advocate for myself, because she is amazing…I guess I just felt listened to. Like, yeah, she understood. She [pauses] she's seen it before. You know, it wasn't like, a, "Oh, weird. I don't know what's going on". It was like, "Okay, well, we can, we'll look at this way, then that way, then that way". And, you know, nothing was kind of, "we'll try this" like, like, wasn't just, yeah, "Try this drug. We'll see what happens". Yeah, so, but she was like, "We'll do this, and then if that doesn't*

> *work, we'll give you this amount of time to do that, and then we'll do this". And then, you know, so it was like a full on kind of [pauses] six months lined up, and she wasn't just trying to take my money, you know, even though she was private, she was like, "Well, we'll have this plan and we can call after if we need to", sort of thing. - Brooke*

Brooke's experiences are reflective of both Fern and mine as she reflects on the importance of being gifted options, choice, and agency. No longer a spectator of the show, she was now on stage alongside her doctor as they together, decided what was next, a shift in power that moves us away from the figure of a freaky body in need of control, to a person. Within the collaborative dynamic between doctor and patient women can find community that enables us to survive our bodies well, together. Brooke's relief that came with a specialist who had knowledge of her condition and experience in treating it reflects the power of knowledge within the medical encounter, which was lacking in her previous experiences. Furthermore, Brooke reflects on the significance of being listened to and understood by a medical professional indicating that medical care is more than diagnosis and treatment, but a relational encounter.

Maia's story also reflects the importance of being listened to, especially as an act of moving beyond objective measurability to understand our bodily experiences:

> And, you know, straight away, she was like "I'm pretty confident that you have endometriosis". And so that was and she was like, um [pauses] "My wait list is, like, six weeks to six to eight weeks or something, we could have you in in like, a couple months' time". And I was like, "oh, wow". Like, that's a big [pauses] I hadn't really thought about it till now talking about it, but like, that's a big turnaround from being like, "what's wrong with me?" to being like "You actually do have this or, I'm, you know, pretty sure and we could get you in for surgery".

Tui has experienced multiple visits to the emergency room due to severe pain and reflects on the contrasting experience she had from her previous stories of having her pain dismissed and knowledge of her body questioned and challenged. Her insight reveals the transformative potential of care when women's pain is believed and action is taken to best support them, including engaging ongoing care beyond the initial encounter and minimum that can be expected:

> My second one [miscarriage] though, luckily, they were amazing…took me in straight away. I was so the first one, we would have only been in there for maybe an hour, hour and a half…This time I was in there for probably 12 hours. As soon as I got in, they gave me morphine, made sure that I was

> comfortable, all of that, um, they did swabs, and then they were gonna [pauses] let me go home and come back in the morning for an ultrasound, but then they were worried about it being ectopic as well so they're like, “No, you're staying here”. [Pauses] just kept topping me up with um [pauses] painkillers and stuff like that, making sure that I was all good, give me anti-nausea, everything like that. And then explained everything that came up on the ultrasound. Um, that, yeah, they couldn't really see anything, so it was like a missed, miscarriage, yeah. Um, and then discharged me, but kept me under the Early Pregnancy Clinic, so kept getting bloods done every day to see what was going on and stuff like that.

This story emphasises how Tui was seen as more than a vessel carrying her baby during this miscarriage a stark contrast to the approach given by her doctor in her first miscarriage when he refused her pain relief due to his belief that she was pregnant even though she wholeheartedly knew she no longer was. Tui’s story shows us the transformative potential of working *with* our bodies as opposed to reducing them to a freaky object of the medical gaze.

Charlie reflected on her sense of relief that came with younger gynaecologists coming through the system who appeared to reject pregnant women as a body carrying a child, instead viewing her holistically:

> *I said, “You're just so interested, like, just giving me time”, and it's changing like they were actually interested in me, they just weren't interested in my body. Things are changing…These young gynaecologists are coming up and actually looking at things differently and so and he just said, “Do you mind if I sit down and have a chat?”, I said, “of course”, “I need to ask you questions”… I just think that that was a different experience again, and it was a good experience. It was one that I thought, “Okay, things are changing”. And it made me feel relieved more than anything else, yeah.*

Charlie’s expression of relief is an affective moment that represents her embodied knowing that our health needs to be understood far beyond biomedical frameworks. For several women, despite employing multiple strategies to receive much needed care, even when they worked with helpful doctors, Western medicine proved incapable of providing the wrap around care they needed.

Following the Smell of Incense: Visiting the Witch, Tarot Reader, and Crystal Healer; Complementary Medicines

Leaving our collaborative performance within the playhouse behind, we stumble across a few smaller dimly lit tents within the carnival, shrouded with the smell of incense as the witch, tarot reader, and crystal healer take centre stage. These performers, long cast as eccentric and untrustworthy offer forms of care that exist beyond the sanctioned boundaries of medicine. Within these spaces, women have found the time, relationality, recognition, and healing that medicine could not provide. In turning to these alternative figures within complementary care, women have not abandoned medicine entirely, rather extended their understanding of bodily care, reclaiming the "alternative" and "quirky" as sources of wisdom and care.

The following encounters invite us to reconsider what counts as bodily care, who is permitted to offer it, and how the image of witchcraft, typically feared as dangerous might instead symbolise a compelling form of feminine knowing. In freaking medical expertise by trusting their own embodied knowledge, *knowing* that something wasn't right in their bodies, women engaged in the ultimate form of freaking the expertise of the medical system by seeking care from other providers who could better meet their needs.

Fern speaks of her active exclusion of her doctors as she chose to seek care for her fibroid through Family Planning alongside other modalities of healthcare:

> I chose to not engage my doctors because I think it was almost like a self-preservation thing, knowing that they wouldn't, and perhaps unfairly, but perhaps not, um, that they wouldn't have the knowledge or time or interest in supporting me in the ways that I needed to be supported, and knowing what I knew [pauses] I could advocate more authoritatively through [pauses] other people, you know?...So I sought a lot of additional help. So I saw a naturopath. I was getting osteo and acupuncture treatment, and and continue, I found this incredible um, acupuncturist. He's like the most knowledgeable of the body I've ever met without him working on my scar and all the scar tissue and um supporting my reproductive system through acupuncture and osteo that I wouldn't have been able to get as, like, as easily pregnant as what I did, because I didn't have all this residue stuff, but again, I have the knowledge of the positive impact those modalities can have. And, I know what a good practitioner looks like.

Charlie offers an insightful critique on the marginalisation of these complementary medicines within Western society:

> *And so I really think that, like um, alternative or they call it alternative. I don't, I, I, um, ah complementary I call it, complementary medicines can do a lot of good in in healthcare as well. Like, ah well, I suppose acupuncture, for muscle therapy…So I think complementary medicines have their place as well. And I don't think we should just dismiss them out of hand because they're not medically, you know. And so if it helps someone, why not? And who, who did a lot of the complementary stuff before it became medicine? Women. Yeah, that's why it's been shafted as if it's witchcraft, as you know, "Oh, they can heal with herbs".*

As she reflects on the active dismissal of alternative methods of treating the body she exposes the active exclusion of such practices as a form of gendered marginalisation. As she reflected on this in our conversation I remember highlighting that Indigenous people, too, utilised other modalities for healing that have been excluded and marginalised through the colonial and patriarchal dominance of Western medicine. To engage in these forms of care has allowed women to reject the dominance of Western medicine as the only experts on the body and find a form of healthcare encounter that works for them. As Maia told her story she reflected on the ways in which her naturopath/dietician was able to meet her needs:

> Yeah, so talking with her was like [pauses] all the piece of the puzzle, most a piece of the puzzle coming together, and just confirmation that what I was going through wasn't normal, that she had ways to help me fix it… there was already that element of, like [pauses] having a feeling like she knew her stuff [laughs]. Her approach was [pauses] like [pauses] so broad, like really aligned with how I wanted to do things, you know [pauses] anything but take some kind of pharmaceutical [laughs]…Just like asking everything, go through, like a full health history timeline you know, anything from like, things that, um, like reproductive health related, but also just everything, like, all the stomach bugs that you've ever had…Whole lots of other questions. And, yeah, like just the [pauses] time itself and the very first consults are so comprehensive um [pauses] and her manner as well…I think, like, actually, it was the first time that … she would ask questions, I would say something, and then she'd ask more questions. So it's just like, that, I guess, that feeling of like, this is valid, and this matters because, and she's sitting here, has all this time to listen to me… I think the time and ongoing support and just like practical, like [pauses] holistic stuff.

It was apparent that Maia had found a professional that provided what medicine couldn't: time, knowledge, relationality:

> I think the [doctors'] limited view of the body is part of it, limited…maybe limited understanding of how the systems are all working with each other, limited resources probably goes hand in hand with that. Like, obviously, they, they can't be taking bloods from everyone for everything [laughs]. Um [pauses] but I've also, I think maybe it was the first time, like in working with [naturopath] and getting trying to get, like, a full lot of

> bloods done, like the normal ones, plus extras that she wanted, and I went in with the letter and the tests to the GP, it was definitely a male. And he was like, “Oh, all these naturopaths, they just want all these” [laughs]. I like, it was quite dismissive. And I was just like, “Mm mm, that's not okay!”. I didn't say anything, but I was just like. Like, it's coming back to me now that you know that's just another part of this attitude of [pauses] and I can say now that someone like her, who's asking for all these tests, has actually done a world of good that no GP ever could.

Through our encounters with medical and complementary professionals who have freaked the patriarchal and colonial values of medicine, we were able to better make sense of both our bodies and our experiences of living within them with a reproductive health condition. For many of us, that meant we released our grip of shame and blame for what we were experiencing, as we made sense of our experiences as shared with other women. As we moved our understandings of our bodies from being in need of fixing, to something to work *with*, we opened ourselves to the ways we can hear it as it moves. And as we moved *with* our bodies and emotion, we allowed ourselves to speak more openly about what we were navigating, an empowering experience for each of us as we began to work with our pain differently and gather momentum towards a social *movement*.

Chapter 6: Analysis Part Three – Feminine Festivities

Song and Dance in Resisting the Private Sphere

As the night continues the sense of excitement and celebration builds as we join together in the open square. Music pulses, feet stamp as we dance, glasses clink together, and food is shared, voices join singing loudly among the laughter and eruption of joy. Here, we abandon the expectation of discretion and silence that once confined our pain to the private sphere. This collective festivity becomes a politics of joy and freedom; through shared celebration, we transform what was once a site of isolation into a communal space of recognition and resistance. We are no longer in denial and suffering but transforming our stories into something speakable, liveable, perhaps even beautiful. In this final act of festivity, we reclaim the public sphere through our embodied voices as we rewrite the narrative of women's reproductive health as one from silence, blame, and shame to one of connection, freedom, and collective resistance.

As I reflect back on beginning the process of having conversations with women, I acknowledge that I was ready to support women in re-articulating their stories from an empowering perspective so that we may know ourselves otherwise. However, I soon realised that each women had already been through this process and were recreating knowledge of women's bodies already among their social networks and beyond. I felt like I stepped into a force of transformative social change, as if I stumbled across them already dancing in the square singing, and as they danced together, their arms intertwined, they grabbed me on the way past and welcomed me to the party.

It is important to note, however, that the energy for change emerged from the burden we each carried for some time through our silence and the untellability of our stories. Through the re-telling of our stories we each revealed that social expectations of us as women to be quiet and keep our reproductive bodies and stories contained, concealed, and hidden prevented us from understanding our bodies and seeking the care we needed for them, and for some of us, the endurance was decades. Through our reflections we could recognise that this silence manufactured our suffering through our obedience to normative femininity and the embodiment of our individualised blame and shame.

Through freaking medical expertise, we can recognise that knowledge is powerful and that medicine's *lack* of knowledge on women's bodies trickles down into our social worlds resulting in a generalised lack of knowledge among society that is enacted on women's bodies. The silencing of women's experiences within their reproductive bodies then reinforces this generalised lack of knowledge, perpetuating its power.

As previously explored, predominantly due to the feminisation of pain, some of the women didn't know their experiences embedded within their reproductive health conditions weren't the usual and expected experiences of being a woman, and, this prevented them from seeking help for them, which ultimately led to years of navigating pain. It wasn't until they eventually either spoke with other women about their experiences or heard women's stories within which they identified they were struggling with embodied experiences that were not expected or "normal".

Brooke reflects on the silence that surrounds conversations about periods and sex and how that then perpetuated her own silence:

> *I guess it was kind of going through the pain with, like, periods and things like that. That was one of the things that it was like oh, you don't really say anything. You just kind of keep that to yourself. Yeah. So it's [pauses] and the stuff that like can follow through with that like, pain. [Pauses] For me, one that was considered something that you don't often share is pain during intercourse, which isn't meant to be there [voice softens and rises]. And it definitely took me about two years before I actually mentioned anything to anyone.*

When I asked her why she thought these things weren't something people talked about she believed it was a result of social norms. When she eventually decided to reject her experiences as something that should be kept private, and spoke with a friend she was able to recognise she needed to seek help:

> *And then I was like, finally mentioned to a friend, being like, "Hey, do you ever kind of, you know, [pauses] like, bleed sometimes [after sex]?" I can't even remember which friend it was, but I just kind of mentioned it, like, you know, "Does that sometimes happen?" And it was like, "N-n-no, that shouldn't happen". And I was kind of like, oh okay, I probably should [pauses] probably, it's when I was like, okay, I should probably go to the doctor.*

Charlie had a similar experience in that she didn't know that her heavy and painful periods weren't what most women experienced until she moved in with her girlfriends and realised their experiences of having a period were very different to hers, and they articulated that her experiences weren't that of a normal period, triggering her to seek medical help. Again the figure of the normal woman appears within our stories and she accounts for the many and varied ways women experience ongoing pain within their bodies. She normalises the experience of the multitudes of pain during a women's menstrual cycle, rendering it difficult for women to understand when their experiences exceed what is expected, after all pain and bleeding intensity are a subjective embodied experience.

Maia further explores the idea of silence enacted on women's reproductive health as a prominent practice:

> And I just think [pauses] [sighs] there's so much like things are changing, but there's so much that we still don't talk about…And I went to Ruth Shaw's talk in [omitted] the other day. I haven't read any of her books [laughs] but she was, [pauses] um, she must have, in her, maybe in her second book, wrote about prolapse. And she said, like, every second woman that came up to her at a book signing, like you could tell which ones were the ones that had also had it. And I was like, how are we still not [pauses] you know, talking about these things, that create so much shame?...
>
> …And I've still had, like, a couple of friends who-o [pauses] told me after the fact [pauses] and like, I can never be in those shoes. So I don't know, but it, in a way, it breaks my heart [pauses] to that [pauses] like, for me personally, but also just as collective as women collectively, like [pauses] I get the whole thing about sharing after the 12 week scan, but also like, [pauses] if you're not sharing that information, like not sharing that you're pregnant, how can someone know to support you if there is a miscarriage?

Maia draws attention to the silence around women's experiences of reproductive health conditions that are foundational to our embodied shame. Through medicine's epistemological ignorance we have been denied the language to speak about many of our experiences, and even when we have the language we are coerced into concealing our experiences. As such, we sense that we are the only ones experiencing such things and the problem becomes individualised as within our body as opposed to the social power dynamics that keep many of us silent. Our silence then perpetuates our belief that we are alone in our experiences, as we do not realise how many other women are also navigating them. The concept of the freakshow deepens our understanding of silence as docility for freaky bodies, as freakshows performances are largely bodily with few involving speech, so as each of us remains on display as the freak, the walls that separate our exhibits prevent us from knowing that we are not alone, someone is right there, on the other side of the wall.

Fern's story also traced the concept of concealment as she resisted the idea that menstruation is something that should be hidden:

> And it's funny that I use the word manage, because now, with my own thinking and ways that I talk about menstruation, I'm like, we shouldn't have to manage periods. You know, that's part of that narrative around hiding it and shame and secrecy. Because actually, if we just <u>are</u>. And we can <u>be</u>. We shouldn't need to manage something which is part of that kind of concealment piece …
>
> …That's why I started to develop [menstruation in the outdoors resource], which started off as a very traditional resource [pauses] menstruation is experienced by girls and women, um, and it was about how to manage your period practically in the outdoors, um, tips and tricks, blah, blah, blah. Kind of trying to break down some of those traditional stereotypes about, you know, bleeding is gro-o-ss, and it being a women and girls' issue only. And it's, you know, like kind of maintaining that shame and secrecy.

Maia and Fern both draw attention to the idea that silence prevents us from receiving important social support through challenging experiences. Fern's story aligned with Maia's reflections:

> I actually found the whole experience really isolating too, because so-o many people are affected by fibroids, um [pauses] and yet we don't talk about it…So it was quite [pauses] an anxiety producing time and to not have that social support from even, like, re-e-a-lly close friends, because I think it's like any medical event or any life event, unless you've experienced it yourself, or you're there with the person, like [Fern's partner] was awesome. He was so supportive. Um, but [pauses] yeah, you're alone. No one knows what you're going through, especially if they don't live in the same place as you and they don't see the impact that it has on you.

In her reflection of the isolation and lack of support Fern received during the time she was navigating living with a fibroid, she highlights that while fibroids are extremely common, most people know next to nothing about them, or that they are a common feminine experience, and so they cannot provide the social support needed during such a time. As her story continues, Fern remembers the ways her story became more complex, intensifying her isolation as she navigated different layers of her experience:

> The drugs that I was on put me in a temporary menopause. So, I experienced all kinds of crazy things associated with that as like a, normal, not quite, but menopause experience, and that in itself, was also another challenge to kind of navigate these new bodily sensations and experiences on top of the the [pauses] the very different and um, not normal experience of having fibroids [laughs]. Especially as it wasn't anything my friends of the same age could

> relate to! So, I found myself speaking with my older work colleagues about it instead who were very empathic and supportive.

Through Fern's rupture of her silence surrounding her experience, she was able to receive important social support during an isolating time form women who had knowledge of some of the things she was navigating. As a result of her experience, Fern had toyed with the idea of publicly sharing her story:

> I remember during the experience, I was going to write about it, and I was going to talk about it, and I was going to like do a Facebook post about my experience, just to say you know that I've had this experience and that I was happy to support people but I never ended up doing it. I know it's never too late to talk about my experience but it doesn't feel as um [pauses] like relevant, even though, for other people who are experiencing right now, my experiences means that I can still empathise and relate to them and provide what I felt was missing. It's funny that, it's because it's not as recent, I'm less [pauses] motivated? Or I feel like I'm less legitimate [pauses] you know? Like I feel like doing a post like that on social media could be considered as just like attention seeking rather than it being this immediate thing that I've just gone through, that people can understand why I'm now talking about it.

What stood out most to me about Fern's story that we proceeded to talk about was her fears around posting on social media about her experience and the potential that it would be perceived as an attention-seeking act rather than an offer of genuine support. I couldn't help but think it was the forces of normative femininity reinforcing and perpetuating her silence, that if she rejected feminine quietness and spoke aloud then it would be perceived as seeking personal emotional gratification through being given attention, a performance surely the hysterical woman would employ in her madness. A key part of Fern's story, however, is that she has wholeheartedly rejected the idea that women's reproductive health is reserved only for the private sphere through her active engagement in research and the production of resources that focus on educating people on, and advocating for women's reproductive health:

> We need to ensure, and this came through in my research, um, about what the research into [menstruation resource] and talking with young women, they're like everyone, boys need to be like taught about menstruation and what it is and we need to know more about their bodies and their experiences. Ah, yeah. So I don't know where I was quite going with that, but apart from the fact that I think it has [pauses] we need to feel psychologically safe, emotionally safe, um, spiritually safe, physically safe, to be able to share

> our stories and ah, that's really challenging, I think, and particularly in this political environment we find ourselves in, where everything's really divisive.

The collective acknowledgement of our pain located within our silence and the silence of others enabled us to connect with each other in shared understanding. Together, we have recognised the power in seeing ourselves in other women's stories, speaking about our experiences, and ensuring knowledge on women's reproductive health is *heard*. These realisations were motivation for us to harness our pain and shift the singular story that maintains women's reproductive health as belonging in the private sphere, by openly speaking of our experiences. This process has become the collective pulse of this research:

> *What I would want to contribute to this project is letting more females know that they're not alone when they're going through issues that they're not so sure about. Um. And that it's actually more common than you think. As soon as you start communicating, there's going to be a lot more people going through the same [pauses] same thing, and it's not considered, doesn't have to be considered a tapu subject that you don't talk about and you hide away and deal with on your own…Wanting to share my story is why I want to participate in this, to [pauses]…someone might relate to my story…you're not alone. – Brooke*
>
> *I'm happy to share my story with anybody who asks about it, um because the more we tell these stories [pauses] the more common they become. The more common they become, the less likely they are that they can be ignored. Or that's just an anomaly, or that's just something that happens to women. Actually. Yeah, it is something that happens to women. We're 50% of the population. So, so the more, more stories that are told, the more stories are told more often, the more knowledge of it comes. And then we're not an afterthought. – Charlie*
>
> Anything that is researching women's health, I'm all for it because it's [pauses] so broken is not even the right word, like, non-existent is probably more of a word like, so, anyone doing anything for it, I'm, yep, all for it, like, and if I had more time, like, maybe eventually, one day, um I would love to then, like, you know, go on boards and stuff like that, and be an advocate.
> – Tui
>
> U-u-m, I think after everything I've [pauses] like that I've been through [pauses] and I just know from, you know, other experiences as well, that hearing from other people who are kind of on the other side, in whatever form that looks like is like a light at the end of the tunnel. Um, or no, you know, like [pauses] they, you know, you can't take the way, like [pauses] the [pauses] that, whatever challenges they kind of have to go

> through, but that there will be some kind of [pauses] I don't know like relief or resolution isn't quite the right words, but like, there's something else there, on the other side. Um-m [pauses] and I spent so long, like [pauses] in it, and, like, probably wouldn't have talked about it [pauses] outside, like, friends, close friends or therapy um, but now I'm in a place where I can and like that. - Maia

> I think, because I have always, well, not always, but I've [pauses] in the last maybe 10, 15, years, been really passionate about ah gender equity and about, particularly about ah [pauses] menstruation, particularly from an equity lens and the impact that it has on people's lives, and how it's, ah, very limiting and traditional views of menstruation, um, have a real profound impact on people's participation, particularly in [her field of work]. But more generally, I'm really passionate about um reproductive health, and um [pauses] people's health, and specifically women's health, people who identify as women um their health as well… And I just think it's so important if we want to be awesome humans, that we're inclusive in the most broadest sense of the word, um I'm really passionate about it. I still do lots of reading. I still do lots of engaging around it, um, contribute to research when I can all that kind of stuff. – Fern

Each woman's participation is just one example of the ways in which they are continuing to resist women's reproductive health as something that should remain silent within their everyday lives. Tui draws on how eventually talking about her experiences motivated her to continue to do so as she recognised the positive flow-on effect as she was able to encourage other women to seek help and feel comfortable talking about their experiences:

> And then, yeah, like, when I first started, yeah, going through gynae and stuff, nup, never talked about it or anything. Whereas now I'm the opposite, because I'm like, it's so common and people don't talk about it, and it needs to be talked about because just it's not okay… talking like openly with people about it feels better. And like [pauses] being able to almost like, help others? And like and yeah, push them to get checked and stuff like that.

> …And because of that, like, um, one of my sisters she she's similar too, she's had fibroids and stuff like that, we're real open with her um kids, so they know what everything is. Like, they're only young, but they know, yeah, they know what period is. They know what tampons are for. Like, they've known ever since, like, she's always been open about it so they know that they can just talk about it freely. – Tui

Both she and her sister are actively engaging in freaking the private sphere and the embodiment of the ambiguous freak through rejecting the act of being quiet. They have made the choice to normalise talking about women's reproductive health with the children in their family; a gift that removes the shame and stigma inscribed upon women's reproductive bodies, and serves as a rejection of women's silence.

Brooke has made the active choice to follow a similar path with her step-daughters:

> *So, because I've got step daughters now and they're teenagers, I've been really focusing on trying to make whatever they have going on or whatever they want to talk about being absolutely normal and fine to talk about. So the youngest she has um [pauses] thrown up a few times on her period. So she's vomiting. And I was like, "What's going on? Did you eat something? Is it your period?" And she's like, "Oh yeah, it's my period. I get this from time to time". And I was like, "Okay, me too. We can talk about this when you're not throwing up". But, you know, just making it normal to be like, [pauses] making everything [pauses] able to talk about yeah and more. I guess I never had that, and I would have loved to.*

Brooke's story reminds us of the burden we carry in recognising the gift we are passing on to younger women is something that could have had a profound impact on our own experiences. However, instead of being stuck within the pain of these memories, the women have harnessed it and transformed it into an action of freaking the silence that harmed us within our stories. Brooke has extended this gift to her friends also emphasising she has created her own norm through her disruption of silence:

> *But yeah, it was kind of me that kind of switched it…so people, people often come to me and tell me their things. So, like, friends might come and say situations that they've gone through, and I've gone "Hey, look, that's actually normal, because I do that. I have that too". So I've kind of started, like, my own norm [laughs]…And started to be comfortable within myself to be able to kind of spread that, to let other people know that, you know, we can talk about this. It's fine. We don't need to run away and hide.*

The women's resistance to women's reproductive health as reserved for the private sphere was LOUD and *clear*. It extends beyond sharing stories and re-writing social norms enacted on speaking about our bodies. As previously mentioned, Fern is bringing conversations about women's reproductive health to the public sphere through research, the creation of menstruation resources and contributing a chapter to a book about menstruation in sport. Maia is embarking on an endeavour to write about mothering asking the question: "What does a woman look like if she is not a mother?", while reminding us of the other types of mother that exist; mother earth, mother mountain. Charlie is currently going through a career change with the intent to provide support for women that was lacking for her, and Tui and

Charlie are both active members of online support groups for women navigating reproductive health conditions, a gathering of the freaks!

Final Chapter: The Carnival Never Leaves us…Becoming ꟻreak

I imagine beautiful raranga putiputi (woven flax flowers), each of their threads interweaving with each other, beginning from the outside and working their way in to the centre, and I remember Braidotti's (2012) call, "The center is void. All the action is on the margins" (p. 42). Braidotti locates us as those marginalised within a system as being in a privileged location that enables the opening of empowering and transformative alternatives. She also emphasises the importance of the stuck, self-perpetuating majority and the minorities to "untie the knots of envy (negative desire) and domination (dialectics) that bind them so tightly" (p. 42). A key piece of this work requires a critique *of* the centre *from* the centre a process of undoing, re-mapping, re-creating, and reinventing through nomadic means: change over stability.

Our ongoing acts of resistance to feminine pathology and excess remind us that while we may leave the carnival, it does not leave us. We carry its unruly energy with us, into workplaces, clinics, communities, homes, and friendships; its transformative potential lies in the ways it has reshaped what we imagine is possible. Our carnivalesque process of freaking and acts of subʌersion reappear in our everyday gestures; each act of self-advocacy, each refusal to be silent, each story shared, and moment of laughter, joy, and freedom in the face of pathologisation and marginalisation serves as an enduring imprint of what collective transformation feels like. And among our stories, we can begin to see her, a new figure emerging, showing us other ways of knowing of what it is to be women living with reproductive health conditions; a transformation into becoming freak *otherwise,* where the freakiness of woman is transformed into an embodied politics of freakery that subʌerts power. And in our subʌersion of medicine's power, as we take up the woman's body as liveable; reimagined through the carnivalesque, we engage a subversive transformation toward embodying response-ability for difference *and* embodying difference response-abley.

she is multiple
she is celebratory
she is dynamic
she is not alone
she understands her body
she knows
she refuses
she questions
she is sick
she wants to just be
she knows shame
she is not ashamed
she needs safety
not boundaries
she shares stories for change
she subʌerts

We, together, but not the same, are becoming ꟻreak.

Becoming ꟻreak

You're not just you're not alone. There’s many, many people going through the same thing. We're not an afterthought. Through this experience I have become a more well-rounded woman, who understands her body, won’t settle for anything less than optimal health, and stands in her own power to make that happen. If you don't fight for yourself, no one else is going to. Don’t take no for an answer. Just push. Resistance comes from being a woman who is confident in her own body in terms of what I can advocate for, what I know, what my rights are. Yeah, and I've done, yeah, heaps of my own research, and I've actually learned more off own research than any freaking doctor. *I was strong. Determined. Still had my, you know, head on my shoulders*. How can it be in my head? You know your body best I know myself. I know myself the best. I can advocate, the best. I can support my well-being. The doctor doesn't know everything. I started doing my own research, because I kn-e-e-w that something wasn't right. Strong minded. *My grandmother raised me to speak my mind and own what I was doing*. I'm like, “fuck no!”. I was a bit stubborn [laughs]. *I need to do better than they can offer*. Like needing to step into I either call it the masculine or like your own Mama Bear mode, to be advocating yourself I straight refused. I wasn't going to be passive in this experience. *I'm like, “no, you’ve got to listen to me”. But that strength and determination and grit that you show during that time is not talked about…* It's almost like harnessing that to get an outcome. We know we have it…using it to support ourselves and get the support that we need rather than punishing ourselves. I just remember thinking, people don't fucking get it, like, I'm really sick, like, and yet, like, “you look so great”. I'm like, I feel fucking sick. And why am I doing this to myself?... It's just crazy that we put these extreme limitations on ourselves and hold each other and ourselves accountable to these ridiculous claims. *But why? Why do we go through it? Why do we have to go through this sort of internalised misogyny that's been, you know, “because that's just reality of how we've been raised and lived with”, yeah, it's like, no. ... the narrative has to be changed. So I've kind of started, like, my own norm [laughs].* Being confident in that way, you know, like um [pauses] not backing down, not giving up easily…that resilience and not being afraid to be a little bit outside of the box …I know what I want for myself, in terms of my health, my well-being. I want to embrace and enjoy my body as it is. I have all the facial hair and all of that beautiful fun stuff. *And so the whole concept of abnormal normal is just lost on me*. probably leaning more towards deciding not to have children. *That is your body and your choice!* What does a woman look like if she's not a mother? *I'm definitely-y a lot more comfortable within my own skin. So I'm kind of, “this is, this is me. This is what's happening”. Take it or leave it. I'm happy as being me [laughs].* You know, that's part of that narrative around hiding it and shame and secrecy. Because actually, if we just are. And we can be. *Doesn't have to be considered a tapu subject*. How are we still not [pauses] you know, talking about these things, that create so much shame? That's why I started to develop [menstruation resource]. Kind of trying to break down some of those traditional stereotypes about, you know, bleeding is gro-o-ss.... And it's, you know, like kind of maintaining that shame and secrecy. Understanding brings compassion. *I'm happy to share my story with anybody who asks about it, um because the more we tell these stories [pauses] the more common they become. The more common they become, the less likely they are that they can be ignored.* I never talked about it or anything. Whereas now I'm the opposite, because I'm like, it's so common and people don't talk about it, and it needs to be talked about talking like openly with people about it feels better. And like [pauses] being able to almost like, help others. We need to feel psychologically safe, emotionally safe, um, spiritually safe, physically safe, to be able to share our stories. *We have to make sure that women…wāhine…all feel that they are heard and believed*. we need everyone to understand and challenge those gender stereotypes. My vision is for a world where we are all empowered and holistically supported through life’s hard things, and for these experiences to be gateways of evolution, where we reclaim our authentic selves and step into the aligned, vibrant life we deserve. I think we can be bold, we need to be bold, and we need to share our stories. And we also need to create communities and systems and networks and ways of being and living, um that support [pauses] people to share their experiences. We need to basically have radical acceptance across the world!

If we don't change the narrative, nothing will ever change…

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Appendix A: Participant Information Sheet

TE KUNENGA KI PŪREHUROA | MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

Re-Storying Women's Experiences of Living with a Reproductive Health Condition: A Collective Narrative Journey

Participant Information Sheet

Kia ora, I am Cat, a researcher from Massey University. After navigating a 17-year-long diagnosis journey for a reproductive health condition, I have become interested in women's experiences of living with a reproductive health condition and how we make sense of our journeys. I still remember my longstanding silence; no matter how I tried to articulate what I was experiencing, it felt impossible. I believed I was alone in my experience and embodied a deep sense of blame and shame for my perceived abnormality, lack of femininity and capacity to embody womanhood. I also struggled to find empowering and affirmative stories from women with similar experiences to mine.

Within the literature a dominant story is reproduced that portrays women's reproductive bodies as inherently pathologised and excessively feminine (emotional, passive, less than). Two figures emerge within this story: the hormone-fuelled, hysterical woman with excessive emotions, and the woman whose reproductive body and performance (or lack) of motherhood do not align with normative standards of femininity. Psychological and medical gazes reduce our interconnections of mental, physical, emotional, spiritual, and psychological pain in response to our reproductive health conditions, to pathology, leaving other stories about our reproductive bodies silent or untellable; these are the missing stories that fall outside of common medical categorisations and feminine pathology and excess. I wonder, how can we collaboratively change this narrative and delink our pain from suffering by moving through and working with pain differently? As we come together to tell stories of resistance and empowerment, we can mobilise so that we may hear our pain with purpose and within that, find moments of joy and freedom. It is through this movement and the sharing of our emotional realities we can attend to the silencing of our painful memories, tell ourselves away from shame and blame, and gift affirmative alternatives to the literature.

What is Involved

This research is being completed as a partial requirement for the fulfilment of a Master of Arts (Psychology). I am hoping to connect with 5 to 6 women over the age of 18 who wish to share their day-to-day experiences and understanding of living with a reproductive health condition, regardless of diagnosis, through a conversation with myself.

The stories you share will be met affirmatively and with care, and to engage reciprocity, I will share some of my story with you in return throughout the conversation, if and when it feels appropriate. The intention of sharing my story with you is so we can locate ourselves within a shared story and hopefully I can support you in feeling comfortable sharing yours. Through our conversation, as a collaborative process we will collectively make meaning of our experiences allowing us to recognise the broader systems of power that influence us socially, politically, and culturally. It is the relationship, the coming together in our stories, and the celebration of our resistance and differences that are the heart of this research.

If you choose to participate in this research, we may connect prior to our conversation if you wish, to discuss the project in further detail; you can also ask any questions you may have before agreeing to move forward. Anything discussed during this process will not be used in the research. We will then meet for a conversation that will be recorded, either face to face in a location you are comfortable with, or if necessary, via Zoom. I estimate these conversations will take 1-2 hours, with the opportunity to connect again, if you feel it is necessary, to ensure you feel comfortable that you have had enough time to tell your story.

I will then transcribe the conversation, remove any identifying information, and send the transcript to you for your review. You may add, remove, or amend any information you wish. It is expected this review process should take no longer than one hour. Once it is available, I will share a preliminary analysis with you for your review and feedback, to ensure I have accurately interpreted and represented our collective meaning-making process. Participation in this feedback process is optional and is considered an open invitation to you as an active co-creator in this research; it should take no longer than one hour. The final research report will be made available for public access and use through the Massey University Research Online website. As I would like to disseminate the findings within the community and contribute to conversations on this topic, both in Aotearoa and internationally, there is the possibility that the findings may be published elsewhere, for example, in academic journals or via a presentation to my local community.

Potential Risks and Discomfort

Sharing meaningful stories can be an emotional process and I want to assure you that your wellbeing will be prioritised in this research. I hope to form a genuine relationship with you so that you feel able to trust me in this journey. It is possible, that throughout our conversations you may feel discomfort in sharing parts of your story, and it is my intent to meet these moments with care and empathy. We can take time after the formal recorded conversation to process our discussions and ensure we feel comfortable moving forward. If at any stage throughout the conversation you feel uncomfortable or wish to take a break, or even end the conversation, you may do so. Your consent to participate in this research is negotiated in an ongoing process throughout the study and you may withdraw from the research at any stage up until you have signed for the approval of the use of your transcript. I encourage you to share any questions or concerns you may have at any stage of the research process.

Confidentiality

Both your transcript and signed consent form will be stored in separate locations to ensure confidentiality. Your transcript will be stored on my Massey OneDrive and consent forms will be kept on my supervisor's Massey OneDrive for 5 years after the research at which point they will be destroyed. Any identifying information will be removed from your transcript by myself, and you may choose a pseudonym under which it will be stored; transcripts and audio recordings will be destroyed upon completion of the project. During the transcript review process, you may remove any information you wish from your transcript, and the return date of your transcript will be negotiated between us.

Your Rights and Protections

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline answering any questions
- Withdraw from the study up until you have signed the transcript approval form. If the transcript approval form is not returned by the date as negotiated between us, this will be considered as a withdrawal from the research and your transcript will be destroyed.
- Ask any questions regarding the research at any time during your participation
- Provide information with the understanding that no identifying information will be used
- Be provided with a summary of the research findings when it is concluded
- Request the recording be stopped at any time during our conversation

Contacts

If you have any questions regarding this research project, please contact myself or one of my supervisors.

Cat Kearsley	Email: cat.kearsley.1@uni.massey.ac.nz

This research is being conducted as the thesis component and the Master of Arts program at Massey University under the supervision of Dr. Leigh Coombes and Dr. Geneva Connor.

Dr. Leigh Coombes	Email: l.coombes@massey.ac.nz
Dr. Geneva Connor	Email: G.D.Connor@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 25/57. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email humanethics1@massey.ac.nz

Appendix B: Participant Consent Form

TE KUNENGA KI PŪREHUROA | MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

Re-Storying Women's Experiences of Living with a Reproductive Health Condition: A Collective Narrative Journey

PARTICIPANT CONSENT FORM

I have read and understand the Information Sheet and have had the details of the study explained to me. Any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I understand participation is voluntary and that I may withdraw from the study at any time up until I approve the use of my transcript.

I agree to participate in this study under the conditions set out in the information sheet. I have received a copy of this form.

Declaration by Participant:

I __________________________ [print full name] hereby consent to take part in this study.

Signature: ________________________ Date: _________________

Appendix C: Authority for the Release of Transcript Form

TE KUNENGA KI PŪREHUROA | MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

Re-storying Women's Experiences of Living with a Reproductive Health Condition: A Collective Narrative Journey

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the conversation that I participated in.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: .... **Date:** ....

Full Name - printed ....