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THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE'S ENCOUNTER WITH THE MEDICAL MIS-EDUCATION OF WOMEN: A CONCEPTUAL AND HISTORICAL INQUIRY

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THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE'S ENCOUNTER WITH THE MEDICAL MIS-EDUCATION OF WOMEN: A CONCEPTUAL AND HISTORICAL INQUIRY

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DEPARTMENT OF EDUCATIONAL LEADERSHIP AND POLICY STUDIES

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For Bruce – my husband, adventure buddy, and best friend. Your sacrifices and unwavering belief in me made this possible. One lifetime with you will never be enough.

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Abstract

This study of the educational thought of the Boston Women's Health Book Collective (BWHBC) uses Jane Roland Martin's concept of *cultural miseducation* (2002) to theorize the "medical mis-education of women," which is revealed as an oppressive force in the lives of women (Chomsky 2002, Woodson 1933, Dewey 1938). Also evident in secondary schooling (AAUW 1992), women's medical mis-education begins in the history of women's health (Ehrenreich and English 1989, 2010, 2011; Achterberg 1990; Brumberg 1997; Greenspan 1983; Sherwin 1992) that is perpetuated through contemporary sex education in schools. Evidence shows that the abstinence-only sex education curriculum in the United States creates a hostile learning environment that has left students unprepared to care for their own health and bodies (Klein 2005, Garcia 2012, Valenti 2009, Luker 2006, Carlson 2012). The guiding question of this inquiry is: What can schools learn from the BWHBC to remedy the medical mis-education of women?

Constructing an interdisciplinary educational inquiry protocol for what I call the "Oral-Theorizing Interview" (OTI), derived from philosophical, historical, and social scientific methods (Given 2008, Yow 2005, Van Manen 1990, Marshall and Rossman 1995, Martinich 2005) while utilizing a feminist lens (Lather 1991, Crenshaw 1991, Collins 2000, Martin 1985), I identify and name problems that defined women's medical mis-education for BWHBC founders: Deference, Isolation, Inferiority, Knowledge, Experience, and Control. My analysis of their thinking about their work on these problems formulates the "Isolation-Knowledge Remedy," the "Inferiority-Experience Remedy," and the "Deference-Control Remedy." Suggesting these remedies' possible

applicability to schooling, this study recommends utilizing the OTI to examine the new thinking of more racially and sexually diverse contemporary women's health movements' leaders to construct educational wisdom needed if sexuality and health education in diverse public schools is to honor the intentions of Title IX for all.

Chapter One:

"Very little understanding of our own health care needs":

Introduction

And so the women…realized that they had very little understanding of our own healthcare needs at all.

Joan Ditzion

In 1969, women's health activism of the "second wave"[1] feminist movement was building momentum in the United States. Women were beginning in great numbers to question the status quo and to create for themselves opportunities to improve not only their own lives, but the lives of all women. The women who would come to be known as the Boston Women's Health Book Collective (BWHBC) were no exception. The members of the BWHBC met at a women's conference in Boston and bonded in a discussion group on women's health. In speaking to each other about their experiences with the medical establishment, the women realized how much about their bodies had been kept from them and how much they needed to learn for their own well-being. "We had all experienced similar feelings of frustration and anger toward specific doctors and the medical maze in general…we wanted to do something about those doctors who were condescending, paternalistic, judgmental, and non-informative."[2] They continued

[1] I use the term "second wave" here to echo the words used by Vilunya Diskin and Joan Ditzion from my interviews with them. The complexities of this term will be discussed later in this chapter.
[2] BWHBC, *Our Bodies, Ourselves: A Book by and for Women*. (New York: Simon and Schuster, 1973), 1.

to meet after the conference with the idea of creating a community health course for women and would go on to produce one of the biggest cultural icons of the Women's Health Movement, the book *Our Bodies, Ourselves*, first published commercially in 1973.

Their work was a response to their experiences with professionalized medicine and the professional medical culture that established a subordinate role for women. It was a culture that pathologized much of what are normal and natural health processes for women. The medicalization of women's reproductive processes from menarche to the menstrual cycle to pregnancy to menopause can largely be shown to be intentional practices built on misinformation, meant to control women's bodies and remove them from public life. Professional medicine was called upon very early on to justify social hierarchies that greatly benefited the status quo. The professionalization of medicine also resulted in the coordinated systemic removal of women and women's traditions, knowledge, and experiences from the practice of medicine. The relationship between professional medicine and women is one in which women have historically been silenced.

Fortunately for women everywhere, women's health activists have proactively engaged in a democratization of medical knowledge by creating educational experiences that connect the lost knowledge of women's health to the lives of women. The BWHBC produced *Our Bodies, Ourselves* as an intentional educational project to correct the medically-based oppression that had become a constant presence and pressure in the lives of women. Indeed their book transformed women's lives through

education. And when education serves as a remedy, mis-education must be at the heart of the problem.

The creative approach to self-education and community education established by the BWHBC was innovative even within the women's liberation movement. Indeed their work was and is making a real difference in the lives of individual women and communities. The education-based form of resistance and remedy to counter the medical oppression that had become a standard part of women's lives forces a closer examination of the problem. If a solution could be found in education, what would be learned by examining the problem from the perspective of education?

Mis-education has been a source of concern for educational philosophers across eras and serves as a vital evaluative tool far beyond schools. An exploration of the work and words of the BWHBC from an educational perspective identifies particular problems and remedies that confirms the existence of systematic mis-education that perpetuates the medically-based oppression of women – something I have named the *medical mis-education of women*. It also shows that women's health has largely been ignored as a serious subject of educational concern. The American Association of University Women (AAUW) discuss this in terms of "The Evaded Curriculum" as part of their 1992 report *How Schools Shortchange Girls*. The Evaded Curriculum is indicative of

> matters central to the lives of students and teachers but touched upon only briefly, if at all, in most schools. Those matters include the functioning of bodies, the expression and valuing of feelings, and the dynamics of power.[3]

[3] American Association of University Women. *How Schools Shortchange Girls*. AAUW. 1992., pg. 131.

In this inquiry, I will engage in an exploration of the medical mis-education of women and its influence on the lives girls and women. I will argue that the BWHBC's ingenuity as ad hoc adult educators offers a possible historical and philosophical foundation for devising practical approaches to the medical mis-education of women as it takes shape in schools – that is, as sexual and reproductive health education.

Taking my cue from BWHBC's founding member Joan Ditzion who identified the nature of gender inequalities as "culturally determined,"[4] I utilize Jane Roland Martin's concept of *cultural miseducation* (2002) as a philosophical framework to formulate this educational theory that expresses itself historically as ongoing oppression of girls and women through medical action and consequences. Schooling itself becomes an unwitting accomplice in the medical mis-education of women through the standard abstinence-only sex education curriculum in the United States that has left students unprepared to care for their own health and bodies.[5] Indeed this curriculum establishes fundamental inequalities between school girls and school boys coming of age to adulthood, as it is the girls transitioning to womanhood who must carry the burden of unplanned pregnancies and childrearing. Schools may argue that they are addressing the Evaded Curriculum through abstinence-only sex education. However, as I will make clear in Chapter 2, abstinence-only distorts the knowledge that should grow out of sexual and reproductive health education and contributes to the medical mis-education of women.

[4] Joan Ditzion, interview with author, April 2016.
[5] As will be discussed in greater detail in Chapter 2, abstinence-based sex education is the only form of sex ed to be eligible for federal funding from the early 1980s through 2016. The 2017 budget signed by President Barack Obama in 2016 finally changes this requirement. I predominately use the term abstinence-only throughout this dissertation as it was the most common term I encountered during my research.

The BWHBC, who have authored nine editions of *Our Bodies, Ourselves*, have engaged in critical re-education of adult women concerning their sexual and reproductive health. Their work speaks to the need of women to be active participants in leading and learning in educational spaces, particularly where women's bodies are concerned. The educational projects of the BWHBC have served as a model for community health care sites regarding how and what to teach patients, caretakers, and public health professionals. I will argue that schools can learn much from their work how to approach curricular and pedagogical reforms that the medical mis-education of women makes necessary in order to achieve Title IX's aim of gender equality.

In schools, Title IX is the federal law that is supposed to protect students from sex-based discrimination. Signed into legislation in 1972, in response to women's rights activists who were dissatisfied with the vast gender inequalities found in compulsory education. Among the problems they noted were:

> Textbooks that perpetuated invidious gender stereotypes, counselors who urged students toward sex-typed courses and career options, curricular differentiation with boys excelling in math and science and girls in humanities, teachers who favored boys and athletic programs that glorified male sports. Feminists also point out that school administration was dominated by men, conveying the impression that males naturally wield authority.[6]

Title IX tied federal funding to eliminating sexism in schools, levying financial consequences to noncompliance with the law, much in the same way that Title VI blocked federal assistance to programs that perpetuated discrimination based on race, color, or national origin in the 1960s. Title IX's primary objective is to ensure that federal money does not contribute to sex discrimination in educational settings,

[6] John L. Rury, *Education and Social Change: Contours in the History of American Schooling*., 4th Edition, (New York: Routledge, 2013), 197.

allowing all students a fair chance at successful learning. It affects public as well as private preschools, elementary and secondary schools, vocational and professional, and institutions of higher education.[7] It states: "No person in the United States shall, on the basis of sex, be excluded from participation, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving federal financial assistance."[8] Thus the educational goals of the BWHBC and Title IX are aligned through their mutual desire to eliminate obstacles to the learning and growth of girls and women.

The primary questions leading my exploration throughout the dissertation are:

1. What are the problems identified by the BWHBC that reveal the existence of the medical mis-education of women?
2. What are the educational remedies identified by the BWHBC that demonstrate that the medical mis-education of women is a problem grounded in education?
3. What can schools learn from the BWHBC to remedy the medical mis-education of women?

My primary resources for this inquiry will be the 1973 edition of *Our Bodies, Ourselves* and interviews with founding members of the BWHBC, Vilunya Diskin and Joan Ditzion.[9] Their thinking about the beginning of their collaboration and the events

[7] James W. Fraser, ed. *The School in the United States: A Documentary History*. 2nd Edition., (New York: Routledge, 2010), 330.
[8] Fraser, *The School in the United States*, 330.; Rury, *Education and Social Change*, 197.
[9] Biographical resources were also important to my understanding of the BWHBC. See, Kathy Davis, *The Making of Our Bodies, Ourselves: How Feminist Knowledge Travels Across Borders*, (Durham: Duke University Press, 2007).; Sandra Morgen, *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990*, (New Brunswick: Rutgers University Press, 2002).; Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave*, (Chicago: University of Chicago Press, 2010). I also viewed interviews and documentaries to better understand the founders

surrounding and leading up to their first nationally published edition of this book are particularly revealing of the educational nature of their work. In addition, the 1973 edition of *Our Bodies, Ourselves* is an important resource for several reasons. Its widespread availability was profound in the lives of women who could not easily access information in 1973. It also represents what is truly the beginning of a women's health revolution. Its publication is perhaps one of the most significant moments of the American feminist movement of the 1960s to the early 1980s, and most certainly of the women's health movement. The personal accounts held within its pages and the conversations with the founders themselves demonstrate its importance in the history of women, feminism, health, medicine, and health information.

Medical and Educational Roots of the Problem

It would be easy to put together a rich library on the medical mis-education of women. In this inquiry, I am abstracting my own narrative from secondary sources chosen for their likely curricular value in initiatives to remedy the medical mis-education of women. I have relied most heavily on works by Barbara Ehrenreich and Deidre English, Jeanne Achterberg, Joan Jacobs Brumberg, Miriam Greenspan, and Susan Sherwin, though others have certainly informed my thinking and understanding of the history of women's health. In this section, I will present a brief look into the history of women's health that contextualizes the experience of women not only as

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including PBS's *Makers Profile* series on the BWHBC, see, http://www.makers.com/boston-womens-health-book-collective, and the documentary *She's Beautiful When She's Angry*. See, *She's Beautiful When She's Angry*. Directed by Mary Dore. International Film CIrcuit, 2014.There is also an archive of the BWHBC at the Schlesinger Library at the Radcliff Institute for Advanced Study at Harvard University in Cambridge, Massachusetts. I was unable to visit the archive for this project but hope to do so for future work on this topic.

patients, but also as heathcare providers. The ways in which women are taught to defer their needs and desires within institutionalized settings and to men in positions of power sets a noteworthy standard to which women are held in other aspects of their lives.

Midwives were the original obstetricians and gynecologists from a time when women's health was exclusively guarded by women. In early America, men were not allowed to be part of the birthing process as "[i]t was considered immodest, improper, indecent, and even immoral for a man to observe a woman during childbirth or to examine a woman."[10,11] The midwife therefore was a vital member of the birthing party, attending to the actual birth during what was called the "lying-in" period. Lying-in turned childbirth into a communal, social, educative occasion during which the female family members and friends assisted the midwife in caring for a woman during labor. After the midwife had completed her duties, the remainder of the female support group would stay for weeks afterward to allow the "new mother to rest, lie-in with her new baby, and regain her strength before resuming her household responsibilities."[12] Under the care of a midwife, women gave birth in a supportive, caring, learning environment,

> The event of birth presented an important, perhaps the primary, occasion for female solidarity. Women could help in practical ways at birth, but they attended also, it may be supposed, because they sought to hearten the expectant woman, to share their own knowledge and experiences of birth, and to prepare themselves for their own future deliveries. The laboring woman must have

[10] Helen Varney and Joyce Beebe Thompson, *A History of Midwifery in the United States: The Midwife Said Fear Not*, (New York: Springer Publishing Company, LLC, 2016), 9.
[11] A male doctor would be called only in the event of a complication. "When the midwife determined that the birth was not going to occur normally, she called for the help of the physician surgeon for him to perform a craniotomy, dismember and extract the fetus – hopefully, before it was too late to prevent the death of the mother. Furthermore, the physician surgeon had to do everything by touch. Often he crawled into the lying-in chamber in dim light. Cushions, blankets, and sheets were arranged in such a way that the woman could not see the person examining her. If there was too much light and the woman could see that a man was in the room, the examination was done under sheets tied around the physician's neck so that her body, and especially her perineum, was not exposed to his views." Varney and Thompson, *A History of Midwifery*, 9.
[12] Varney and Thompson, *A History of Midwifery*, 9.

> gained confidence from being surrounded by women who had themselves suffered and survived, often to old age. The potential medical value of the psychological support these female friends offered should not be undervalued; the presence of women provided particular reassurance during a woman's first birth, helping her to relax and thus to ease her pain.[13]

This lying-in period was very important in forming community among women and passing along valuable knowledge.

The dismantling of midwifery and the tradition of female care came about as medical men began the process of professionalization. A long history existed of men colluding against women healers starting with the witch trials when "the partnership between Church, State, and the medical profession reached full bloom" (Ehrenreich and English 2010, 56).[14] The charge of witchcraft could be levied against a midwife who, for instance, attended a stillbirth or the birth of a disfigured baby. Doctors would also serve at trials as medical experts and were given the authority to identify a witch or determine whether witchcraft had induced someone's illness. The Church, in turn, endorsed professional male doctors, "denouncing non-professional healing as equivalent to heresy: 'If a woman dares to cure *without having studied* she is a witch and must die.'"[15] The fact that women did not have access to the formal study of medicine and were likely illiterate is not lost on anyone. In *Witches, Midwives, and Nurses* (2010), Ehrenreich and English make clear the lasting psychological, social, professional, and political impact of this scheme:

> The distinction between "female" superstition and "male" medicine was made final by the very roles of the doctor and the witch at trial. The trial in one stroke established the male physician on a moral and intellectual plane vastly above the

[13] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, (New Haven: Yale University Press, 1977), 4.
[14] Barbara Ehrenreich and Deirdre English. *Witches, Midwives, & Nurses: A History of Women Healers*. 2nd ed. (New York: Feminist Press, 2010), 56.
[15] Ehrenreich and English, *Witches, Midwives, & Nurses*, 56. (emphasis in original)

> female healer he was called to judge. It placed him on the side of God and Law, a professional on par with lawyers and theologians, while it placed her on the side of darkness, evil, and magic. He owed his new status not to medical or scientific achievements of his own, but to the Church and State he served so well.[16]

The witch hunts in America appear to follow a similar structure and showed that how deeply ingrained these ideas about women healers had become. That men retained power over women's intellectual work, traditions, ability to survive economically, their physical bodies, freedom, and even their lives speaks to the power of historical narratives that plagued early midwives *as women.* As a result of the witch trials, midwifery would be forever be associated with superstition. This finally gave the middle-class men who practiced medicine a level of credibility to allow them access to the previously impenetrable world of women's reproductive health.

Establishing formal medical education helped solidify the place of professional medical in the medical hierarchy. Early midwives were not a product of formal educational programs nor did they have any standing formal organizational structure – in other words, they were not a profession,

> Rather, midwives succeeded one another by selecting themselves, or being selected by other women, to attend births. The fund of knowledge about birth practices was widely shared among women who had given birth themselves and aided others to do so. A midwife had to satisfy the expectations of such groups of women.[17]

This informal curriculum in which women learned from each other is how women healers were trained for centuries to serve the needs of others. This was true across cultures in America – for the English midwives who dominated in New England, the

[16] Ehrenreich and English, *Witches, Midwives, & Nurses*, 57.
[17] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, (New Haven: Yale University Press, 1977), 6.

traditional African midwives who were brought to this country enslaved, the curandera-partera found throughout Hispanic communities, and the granny midwives who represented one of the last strong-holds of midwifery caring for the poor of all races in the South of the late 1800s, early 1900s. Indeed many of these women felt that they were answering a calling of sorts and had spiritual or even "deeply religious."[18] motivations for their work. Medical schools, on the other hand, admitted well-off career-minded white men careers almost exclusively. [19]

In the sixteenth and seventeenth centuries, rapidly advancing medical knowledge, to which women still did not have access, helped with understanding women's reproductive anatomy and the physiology of labor. Other scientific advances

[18] Varney and Thompson, *A History of Midwifery*, 1.

[19] When the American Medical Association (AMA) was formed in 1848, the organization made an effort to improve the quality of medical education and the public perception of medical men. Many of the first medical schools were little more than diploma mills. There were no standards, low entry requirements, and they would often issue a diploma to anyone who could afford to pay. The AMA estimates that between 1765 and 1905, there existed more than eight hundred medical schools. See, Wertz and Wertz, *Lying-In*, 50. Most of these schools met the definition of a diploma mill. The release of the AMA-commissioned Flexner Report in 1910 did a lot to change that and bolster the authority of the AMA over medical practice. The report would decrease and restrict the total number of medical schools, raise the requirements for entry into medical schools, set standards for medical education, strengthen state laws with regard to medical licensure, and place medical schools in charge of clinical education in hospitals. For more, see Wertz and Wertz, *Lying-In*., Varney and Thompson, *A History of Midwifery*, Ehrenreich and English, *Witches, Midwives, and Nurses*, 2010, Charotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 170-1920*, (Cambridge: Harvard University Press, 1995). Though this would serve to improve the overall quality of medical education and care according to the white male model, this report also gave the AMA a lot of power over which schools would remain open. Among the schools that were considered to be unworthy of saving were the "smaller, poorer schools, which included most of the sectarian schools and special schools for blacks and women." See, Ehrenreich and English, *Witches, Midwives, and Nurses*, 83. By the time it was all over, six out of eight of the black medical schools would be closed as would most of the schools that had been established for women. See, Ehrenreich and English, *Witches, Midwives, and Nurses*, 83. The Flexner Report would also ensure that medical school was a process that would be accessible only to those white men who could afford the cost and time of attendance. See, Ehrenreich and English, *Witches, Midwives, and Nurses*.

in childbirth such as forceps[20] and anesthesia[21] were also made exclusive to men. This helped medical men claim a scientific advantage to potential clients, left midwives vulnerable to accusation of ignorance and outdated care practices, and helped medical men lure patients away from traditional female healers. Doctors could advertise that they and they alone were able to facilitate complicated births and ease the pain of childbirth – even if their outcomes were not always good. All of this allowed men to cultivate a previously inaccessible customer base. Male practitioners

> consolidated their position by overselling the dangers of childbirth… They frightened women into believing that extraordinary measures – that could be performed only by men – were necessary more times than not. And men were quick to blame the midwives for anything that went wrong.[22]

These educated men of medicine were rewarded for their mis-educational agenda with a new and expanded source of income and elevated their status within the medical profession.

As childbirth came under the purview of medical men, the childbirth experience changed drastically for women. Gone were the days of lying-in and a community of

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[20] Forceps became widely used by 1750 and it was made clear that "training in the use of the tools was to be given to men only – especially to physicians and surgeons, who guilds had determined the use of instruments in health care was their exclusive right." See, Jeanne Achterberg, *Woman as Healer*, (Boston: Shambhala, 1990).

[21] Ether and chloroform were used in childbirth beginning in the 1840s and "twilight sleep" (which relied on a combination of morphine to dull the pain of labor, scopolamine to induce amnesia, and either ether or chloroform as the fetus entered the birth canal to alleviate the pain caused by pushing the head out) was introduced in the U.S. from Germany in 1914. Physicians were unexpectedly concerned about safety and efficacy of these medications in practice and were often reluctant to use them. However, as word got out, women demanded access to a pain free birthing experience. The New England Twilight Sleep Association was formed in 1915 by "journalists, suffragists, feminists, and women physicians determined to have control of their childbirth experience and to make twilight sleep available to all women." This movement successfully ushered in the routine use of twilight sleep on demand, though the victory would prove to be rather hollow. It would ironically cost women their position of authority over childbirth that had always been. The administration of twilight sleep required that the birth be moved to a hospital because of access to the drugs, special equipment, and trained personnel that could not be brought to the home. See, Varney and Thompson, *A History of Midwifery*, 46.

[22] Achterberg, *Woman as Healer*, 129.

women sharing their knowledge and experiences. Childbirth moved to the hospital where medical situations were arranged for the comfort of the physician. The new form of care, delivered by medical men, was not concerned with a woman's well-being,

> The hospital was not the domain of childbearing women. Their only control was to decide to give birth in a hospital. Physicians had control in hospitals and their concerns for puerperal fever led to the separation of the woman from her family, so-called sterility involving full perineal shaves, cleansing enemas, sterile drapes from head to toe on a delivery table with her legs strapped down in lithotomy position, and wrist restraints (to avoid the woman contaminating the sterile field). Furthermore, with the woman in a semiconscious state, physicians could conduct the delivery with whatever instrumentation they thought best with their philosophy of childbirth as a complicated medical specialty fraught with danger. This was recognized by obstetricians who noted that "anesthesia gave absolute control over your patient at all stages of the game…You are 'boss.'" No longer was birth a natural event occurring in the home under the control of women and their female midwives within the construct of family and friends. [23]

This, of course, was just the beginning for women. Even though midwives had been practicing a safer, higher quality of care with better outcomes, doctors painted a picture of midwives as dirty, incompetent, and ignorant.[24] The propaganda waged against midwives in the face of the new science was too much to overcome. Likewise, the connections that the regulars had to the business and legal worlds gave them power that the midwives did not have. Doctors used their considerable influence to pressure states to pass laws making midwifery illegal and giving doctors the only legal right to practice obstetrics. Obstetricians had professionalized to consolidate their power and eliminate competition, and it finally worked. Their great success meant that women's care and the care of women's bodies would suffer. This was particularly true for poor and working-class women who would often receive worse or no care at all under the

[23] Varney and Thompson, *A History of Midwifery*, 48.
[24] Ehrenreich and English, *Witches, Midwives, & Nurses*, 86.

authority of professional medical men.[25] As stated by Ehrenreich and English, "Women had been routed from their last foothold as independent practitioners."[26]

As the OB/GYN became the only source of women's reproductive health care, the process of medicalizing women's reproductive health began in earnest. Women's bodies and the care they received would be defined in professional terms according to who could afford to pay for services and who could not. The professional doctor saw especially poor women in hospitals as nothing more than training materials, bodies upon which to practice mainly surgical skills. The professional doctor "was not about to sit around for hours, as one doctor put it, "watching a hole"; if the labor was going too slow for his schedule he intervened with knife or forceps, often to the detriment of the mother or child."[27] Childbirth had become a surgical event for the convenience of the doctor – rather a stark difference from the approach of the midwife who let nature dictate the pace of delivery and only took extreme measures when lives were in danger. Likewise, the rest of women's reproductive life cycle would also become medical events.

Medical men like Dr. Edward Clarke, who was also a respected educator, built a career around theorizing that physiological differences between women and men meant that women lacked the ability to compete with men in the public sphere. The menstrual period, it was suggested by many physicians of the day including Clarke, induced mental and physical fragility. It was also pointed to as the primary reason women were

[25] "For instance, a study of infant mortality rates in Washington showed an increase in infant mortality in the years immediately following the passage of the law forbidding midwifery." See, Ehrenreich and English, *Witches, Midwives, & Nurses*, 87.
[26] Ehrenreich and English, *Witches, Midwives, & Nurses*, 87.
[27] Ehrenreich and English, *For Her Own Good: 150 Years of the Experts' Advice to Women*, (New York: Anchor Books, 1989), 97.

inferior to men. Menstruation was accompanied by "hysteria, listlessness, and even stupidity."[28] In other words, mental illness was inherently a part of femininity.

The mental health arena of medicine was particularly helpful in classifying women as incompetent. Freud, the father of psychotherapy, established the scientific and medical norm of woman as an incomplete, mutilated man. He defined the characteristics of a so-called "normal" woman to include excitability, emotional instability, immaturity, over-reactivity, self-dramatization, self-centered, vain, and usually dependent on others. These characteristics, coincidentally, also match his diagnostic criteria for a "hysteric" – a now debunked diagnosis that was established as a mental disorder by Freud and applied almost exclusively to women.[29] As traditional therapy developed in the model of Freud, women were granted identity as either a weak, helpless, dependent patient in need of guidance, or as a sad, fearful, self-loathing victim in need of protection.[30]

> [P]sychiatrists and other mental health workers consider the norms of "healthy" womanhood to be ones that are unhealthy for adults, so non-feminist therapists "help" women conform to the standards of femininity – that is, to behavioral norms that they judge to constitute evidence of illness for adult existence.[31]

Illness thus became the standard of gentile womanhood and, what Ehrenreich and English explore as "female parasitism," became the goal for the well-bred woman.[32] The "ornamental wife" became the ultimate trophy for a successful man. "Her delicacy,

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[28] John S. Haller and Robin M. Haller. *The Physician and Sexuality in Victorian America*. (New York: W.W. Norton & Company, 1974), 58.
[29] Barbara Ehrenreich and Deirdre English, *Complaints and Disorders: The Sexual Politics of Sickness*, 2nd ed., (New York: Feminist Press, 2011).
[30] Miriam Greenspan, *A New Approach to Women & Therapy*, (New York: McGraw-Hill, 1983),
[31] Susan Sherwin, *No Longer Patient: Feminist Ethics & Health Care*, (Philadelphia: Temple University Press, 1992), 179.
[32] Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women*, (New York: Anchor Books, 1978).

her culture, her childlike ignorance of the male world gave a man the 'class' which money alone could not buy."[33] Through this "sexuo-economic relationship," the ornamental wife had to be idle and, "if you have to be idle, you might as well be sick."[34] Therefore, the expectation that middle- to upper-class white women were sickly, justified their idleness.[35] This "gentle imprisonment," as many feminist writers have called it, became a cycle of oppression for women of all races, ethnicities, and classes. If the well-bred white woman was too sick and pretty to attend to the household chores, someone must be brought in to assure that the domestic duties were done. This meant that poor, mostly brown and black women would be employed at low wages to care for families that were not their own. And the women who performed the domestic labor of well-off white families were apparently not privy to the same kinds of diagnoses that their white counterparts were. Physicians endorsed the idea that poor and non-white women were naturally healthier and immune to disease. This meant that women of the working-class were not granted time away from work to tend to their menstrual cycles, their own pregnancies, or even to their body and health needs after childbirth.[36] This, despite the fact that poor and non-white women suffered far more from reproductive complications and infectious diseases than the ornamental wives of well-off white

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[33] Ehrenreich and English, *For Her Own Good*, 106.
[34] Ehrenreich and English, *For Her Own Good*, 108.
[35] This also meant that physicians like S. Weir Mitchell could justifiably deploy his "rest cure" treatment to the gentile Victorian wife. The rest cure is most vividly illustrated in Charlotte Perkins Gilman's story, *The Yellow Wallpaper*. This story is in fact a fictionalized account of Gilman's experience with the rest cure (prescribed by Mitchell himself) and the main character's decent into insanity. The character was suffering from what was most likely post-partum depression and was essentially locked in a room alone, with nothing but a bed upon which to lie, no intellectual or physical stimulation of any kind, not even the company of her new born baby. Over time, she becomes obsessed with the yellow wallpaper that adorns the walls of the room and loses her sanity. The character's biggest affliction appears to be that both her husband and brother are physicians. She remarks at one point in the story, "John [her husband] is a physician, and perhaps… perhaps that is one reason I do not get well faster" See, Gilman, Charlotte Perkins, *"The Yellow Wallpaper" and Other Stories*, (Mineola: Dover Publications, 1997), 1.
[36] Ehrenreich and English, *Complaints and Disorders*.

men.[37] Of course, professional men of medicine had businesses to run and customers to secure which also likely influenced what medical and scientific knowledge they supported.

But it was not just that women were deemed by white men of science and medicine to be dimwitted, incapable, or insane. There was an active campaign to keep women ignorant of their bodies. Menstruation, pregnancy, and childbirth used to be a normal part of being women and discussed freely and confidently among them. The lying-in period of childbirth was, after all, a time for women to educate other women. However, it became difficult to discuss such matters in private after they became medical matters. Science began to cloud nature and women felt less sure of their ability to effectively communicate about things that had previously been considered a woman's domain.

> Because most mothers did not understand the relevant biology and stammered over what to call their own (or their daughters') body parts, they were willing to turn to physicians for explanations of normal life experiences, including the growth and sexual development of their daughters. The medicalization of menarche meant that, in the twentieth century, doctors shared with women the important job of socializing adolescent girls about their bodies. What physicians did not acknowledge, of course, was their own self-interest: by establishing themselves as experts in the management of menarche and menstruation, they enlarged the constituency for their services and filled their waiting rooms with women of a wider age range than ever before.[38]

Information was withheld and girls and women became unaware of important processes happening in their own bodies. A girl's first period was often more of a terrifying hemorrhagic surprise than a natural step in the lifecycle. A study done by one physician in 1852 showed that twenty-five percent of girls were unprepared for the onset of

[37] Ehrenreich and English, *Complaints and Disorders.*
[38] Joan Jacobs Brumberg, *The Body Project: An Intimate History of American Girls,* (New York: Random House, 1997), 34.

menarche; by 1895, another study showed that it had jumped to sixty percent of girls.[39] The timing not coincidentally corresponds with the takeover of women's health by medical men.

This was the world of professionalized medicine. Men fought to delegitimize women as healers and as humans in order to increase their customer base and secure their professional status. The medical mis-education of women was not the result of natural differences between women and men. There was in fact a concentrated effort on the part of professional medical men to introduce the idea of women's supposed natural inferiority to men and fortify it into our collective consciousness. Their efforts were supported and encouraged through other institutions with education being perhaps their biggest ally. Women have long been aware of the inequities they face in the public realm and feminist philosophers have for centuries expressed concerns over the state of professionalism as it was established by men. Mary Wollstonecraft in the late 1700s and Virginia Woolf in the 1930s called for a rethinking of the professions and education, the gateway to the professions.

In *A Vindication for the Rights of Woman* (1792), Wollstonecraft made an unprecedented argument in favor of women's equality via education. She looked to the legacy of the Divine Right of Kings[40] as a mis-educational and "tyrannical" motivation

[39] Brumberg, *The Body Project*, 13-15.
[40] The Divine Right of Kings is "a political and religious doctrine of royal absolutism. It asserts that a monarch is subject to no earthly authority, deriving his right to rule directly from the will of God. The king is thus not subject to the will of his people, the aristocracy, or any other estate of the realm, including the church. The doctrine implies that any attempt to depose the king or to restrict his powers runs contrary to the will of God and may constitute treason. The origins of the theory are rooted in the medieval idea that God had bestowed earthly power to the king, just has He had given spiritual power and authority to the church, centering on the pope." See, New World Encyclopedia. "Divine Right of King." Last modified October 17, 2008. http://
http://www.newworldencyclopedia.org/entry/Divine_Right_of_Kings.

for the hierarchies that are built into personal and professional relationships.[41] Like a King whose absolute power is granted by God, it is believed that it is men's God-given right to sit atop of the social hierarchy which grants them ownership of not only things but people too. Wives, children, and slaves were property every bit as much as homes and cattle.[42] Without a social equal to challenge this mis-educated thinking, men could only believe in their own superiority. Men then replicated this power structure within the professions, and the professions became a space where men grapple with one another for control, money, and prestige to exert their divine authority. Wollstonecraft reasoned that relationships based in power and property – particularly when people were considered property – cannot help but corrupt a man's thinking. However, she believed that tyranny is not inherently in the nature of men and that men are mis-educated into a way of believing and being.[43]

This was a power structure that kept women uneducated and economically dependent on men for their survival. Women were thus relegated to the domestic sphere and obligated to attend to the needs and wants of the men to whom they owed their existence. This grants men a position of ultimate power in personal relationships since women, who have no intellectual or economic resources to live independently, have no choice but to defer to the authority of men. Whether to husbands, fathers, or brothers, women must defer their autonomy in order to survive. In response to this ongoing and

[41] Susan Laird. *Mary Wollstonecraft: Philosophical Mother of Coeducation*, (New York: Continuum International Publishing Group, 2008), 5.
[42] Wollstonecraft has been credited with being the first writer to discuss issues of colonialism, slavery, and gender inequalities as "dehumanizing property relations wrought by the Divine Rights of Kings." See, Laird, *Mary Wollstonecraft*, 93.
[43] Laird, *Mary Wollstonecraft*.

seemingly ubiquitous disparity, *A Vindication of the Rights of Woman* is a most emphatic feminist argument in support of the equal education of the sexes.

Wollstonecraft argued that allowing women to remain in a state of perpetual ignorance was bad for families and society. She maintained that women were not the intellectual equals of men simply because they were not educated as men were. Wollstonecraft believed that women must be allowed to be rational, informed, and active and understood that only men could make that change possible. She wrote, "Would men but generously snap our chains, and be content with rational fellowship instead of slavish obedience, they would find us more observant daughters, more affectionate sisters, more faithful wives, more reasonable mothers – in a word, better citizens. We should then love them with true affection, because we should learn to respect ourselves…"[44]

It is worthy of note that Wollstonecraft died from septicemia ten long and painful days after the birth of her second daughter. After a delivery that was considered unusually long for a second birth, complications developed. The midwife attending Wollstonecraft sent for the male obstetrician as it was "standard practice" to "call in a man in difficult cases, although obstetricians were no more trained than midwives."[45] The care Wollstonecraft received was "within the limits of the usual medical practice of the time, they did all that they could, little as it was."[46] The exact source of the infection

[44] Mary Wollstonecraft and Janet Todd, *A Vindication of the Rights of Men ; A Vindication of the Rights of Woman; An Historical and Moral View of the French Revolution*, (Oxford: Oxford University Press, 2008), 231.
[45] Janet Todd, *Marty Wollstonecraft: A Revolutionary Life*, (New York: Columbia University Press, 2000), 451.
[46] Lorch, *Mary Wollstonecraft*, 61.

is unclear.[47] Though in all likelihood, one of her attendants infected her with unwashed hands.[48]

Woolf later joined into the conversation with *Three Guineas* (1936). Just as in Wollstonecraft's time, Woolf lamented that women had limited options for education that consequently limited options within the professions. "[T]he daughters of educated men," she notes, "received an unpaid-for education at the hands of poverty, chastity, derision and freedom from unreal loyalties. It was this unpaid-for education… that fitted them, aptly enough, for the unpaid-for professions."[49] Women had honed their skills in the work of caring for families, husbands, and children and Woolf wondered what would become of women should they join in men's performance of public life. She asked, "…how can we enter the professions and yet remaindzk civilized human beings: human beings, that is, who wish to prevent war?"[50] Would it be necessary for women to adopt men's customs and attitudes if they were granted access to men's spaces? Or could women make their own impression on education and the professions? In *Learning Together: A History of Coeducation in American Schools* (1990), David Tyack and Elisabeth Hansot illustrate the conundrum of educating women,

[47] "Though it is likely that the infection in the womb which caused septicemia came from Dr. Poignand [the OB], it is also possible that it was transmitted by Mrs. Blakenship [the midwife]: both could have brought it from the Lying-In Hospital." For more, see Jennifer Lorch, *Mary Wollstonecraft: The Making of a Radical Feminist*, (New York: St. Martin's Press, 1990), 60-61.
[48] "[T]wo years before Mary died, a Scottish physician, Alexander Gordon, had published his findings that the women who died of puerperal fever had been attended by a practitioner or nurse who had been in previous contact with a woman suffering from the disease. His discovery went unheeded. In the mid-nineteenth century a Viennese physician, Ignaz Phillip Semmelweiss, insisted that all medical practitioners and students in the Vienna Lying-In Hospital should wash their hands in chlorinated lime before entering a labour ward. His advice, too, went largely unheeded elsewhere. It was not until well into the twentieth century that puerperal fever was successfully controlled." See, Lorch, *Mary Wollstonecraft,* 61.
[49] Virginia Woolf and Jane Marcus, *Three Guineas*. Annotated ed., 1st Ed., (Orlando: Harcourt, Inc., 2006), 95.
[50] Woolf, *Three Guineas,* 91.

> But what did equality of the sexes entail for the education of girls if it was "moral and social" and not economic and political as well? If girls gained an education similar to that of boys, would they not challenge the whole gender order of adult society? In a period when Americans were struggling to keep the sexes in their separate cultural and economic spheres, would not a rigorous education unfit young women for their separate destiny? Opponents and proponents for full rights for women agreed that education would disrupt separate gender spheres, although the former condemned the change in the status quo and the latter welcomed it. But most proponents of schooling for girls thought that education would simply make women more effective in their own domain.[51]

So the argument became that women could be educated to be more effective in the home – but would that leave them wanting more?

Perhaps ironically, one of the first opportunities for American women in the professional world was in the classroom. Women were granted access to limited education when a need for teachers arose to fill the posts in schools that were opening up across a growing nation. Women were considered ideal for teaching because of their relegation to the domestic realm. Women were believed to have a "maternal disposition of patience and affection"[52] that would help them especially with young children in a classroom. The sexual division of labor found in the family structure was reproduced in the world of work largely because "society assumed that men and women entered the labor force with different personalities and capabilities, seeking different rewards."[53] Even in fields in which women were numerically dominant, they have "never achieved formal, legitimate authority within them."[54] In schools, for instance, men make up the

[51] David Tyack and Elisabeth Hansot, *Learning Together: A History of Coeducation in American Schools*, (New Haven: Yale University Press, 1990), 29.
[52] Rury, *Education and Social Change*, 79.
[53] Silver, Linda R. "Deference to Authority in the Feminized Professions." *School Library Journal* 34, no. 5 (1988): 23.
[54] Silver, "Deference to Authority," 21.

majority of administrators and curriculum developers.[55] The "feminized" professions or, more accurately, semi-professions of teaching, librarianships, social work, and nursing are "adapted to society's conception of women's proper role"[56] of women as nurturers and men in roles of authority. Allowing a woman to work "provided her with the means to fill the needs of others – if not her family's, then society's."[57] And, because this care role was replicated outside of the home, "women's work" was by extension considered "worthless, both in pay and status, compared to jobs characterized as masculine."[58] None of this was accidental, however. There were many reasons that women were allowed into a limited number of fields in which they were highly controlled, just as there were reasons to remove women from others. Those reasons were largely dictated by economics (women could be paid less in subordinate roles) and how men (and men's power and authority) were affected by the presence or absence of women in the work force.

That would begin to change as women organized around issues that affected their political, economic, and physical well-being. After women began to be accepted into medical schools in greater numbers, the culture of medicine would change to some

[55] A survey done by the RAND Corporation showed that in 1999-2000, women made up forty-four percent of public school principals, though men continued to have a higher presence in secondary schools in the role. This division is reflective of the early structures that desired women for their maternal capabilities. Meanwhile, only approximately eighteen percent of principals were members of racial or ethnic minorities. At the superintendent level, there has not been nearly as much advancement. In 2000, women occupied only thirteen percent of posts, and racial and ethics minorities filled a little over five percent of these positions. Considering that women still make up a majority of teachers and student bodies are becoming increasingly diverse, the lack of leadership representative of the workforce and the students they serve is disturbing, though not surprising based on this historical discussion. See, Susan M. Gates, Jeanne Ringel, Lucrecia Santibanez, Catherine H. Chung and Karen E. Ross, *Who is Leading our Schools? An Overview of School Administrators and Their Careers*, (Santa Monica: RAND Corporation, 2003).
[56] Silver, "Deference to Authority," 21.
[57] Silver, "Deference to Authority," 23.
[58] Silver, "Deference to Authority," 23.

extent.[59] Medical researchers would also later begin to include women into clinical trials, acknowledging that women and men might react differently to medications or procedures.[60] These changes were driven in large part by women who organized around women's health issues during the Civil Rights era, a period of resistance against Jim Crow, whose segregated culture framed and limited the BWHBC efforts despite their obvious sympathies with civil rights. Women not only became better informed consumers of healthcare, they were also able to drive changes that would improve medical care for other women. These are the circumstances under which the BWHBC formed and found their voices. The next section will discuss a brief history of the organization.

The Boston Women's Health Book Collective

The women who would become the BWHBC met at a women's conference in May of 1969. Founding member Joan Ditzion recalled the impact of a talk called "Women and their Bodies." She described,

> It was primarily focused on childbirth and reproductive rights issues, you know lack of abortion and all that stuff. And so the women who went to that realized that they had very little understanding of our own healthcare needs at all. Many of them had had children at that point and had tried to do natural childbirth… but there was this whole very male dominated gynecological medical model that was shaping these very natural women's experiences.[61]

[59] It is difficult to quantify how much educating women under the male definition of women in medicine affected the female physicians' views of women patients.
[60] Clinical trials were conducted on men alone until the mid-1980s because it was thought that women's hormones would skew the desired results of testing. Until then, it was just assumed that women would have similar experiences. See, Steven Epstein, *Inclusion: The Politics of Difference in Medical Research*, (Chicago: The University of Chicago Press, 2007).
[61] Ditzion, interview with author, 2016.

The women called the workshop "exhilarating" as they discussed topics ranging from those that Ditzion noted along with sexuality, masturbation, and topics that had been considered off-limits for casual discussion. In their conversations, they realized that they all had "a 'doctor story' – that is, a tale about male physicians who were sexist, paternalistic, judgmental, or simply unable to provide the information that women needed."[62] This encouraged them to continue to meet after the conference to further their education. Ditzion was inspired to continue learning

> about my own healthcare needs and at times [how to] be an advocate for myself… When the group first gathered after the conference and started to work on the course, we started as "The Doctors Project." The idea there was that we had to make a list of quote good doctors. [We wanted to avoid those who] were sexist and not good doctors, [as if] our problems would be solved if we just found some good doctors and that was it. And there was a shift and everyone realized that no, it's not a question of finding a good doctor… we have to learn this for ourselves and we also have to figure out what information and what knowledge needs to be accumulated because there are lots of holes in what the professionals call women's health. And then that became the question, we had to figure this out and had to learn on our own in a way. It's important to know as much as possible in a medical situation. I mean medicine has become so technical and complex that it's hard for most people to understand it, it's complicated in a new way, not [just] because of sexism.[63]

The group decided that their goals would be to learn about their bodies, to understand the medical issues involved in caring for themselves, and to be able to advocate for their own health. Further, they wished to organize the knowledge they gained as a result of this project into "an accessible format that could be shared and would serve as a model for women who want to learn about themselves, communicate their findings with

[62] Kathy Davis, *The Making of Our Bodies, Ourselves: How Feminist Knowledge Travels across Borders*, (Durham: Duke University Press, 2007), 21.
[63] Ditzion, interview with author, 2016.

doctors, and challenge the medical establishment to change and improve the care that women receive."[64]

Of course in 1969, there was no internet to aid in their search and very little research available to laypeople about women's health. This was a challenge to the women, none of whom had any kind of medical background or education, but it was not impossible. They had all had at least some college education and felt comfortable with research, it was just a matter of locating appropriate information to help. They turned to friends with medical backgrounds, those who were medical students, medical texts, and libraries to help their research. But some resources were harder to access than others. For example, "It was often difficult to even get into medical libraries and sometimes involved the clandestine borrowing of library cards from bona fide medical students."[65] Nevertheless they persisted and were rewarded for their hard work – as were we all.

The 1973 edition of *Our Bodies, Ourselves*, which was the first to be published nationally, demonstrates the thoroughness and thoughtfulness that went into their work. The book includes fifteen chapters that cover a broad range of topics necessary for a diverse population of women to be able to live full and healthy lives. Those chapters include such titles as The Anatomy and Physiology of Reproduction and Sexuality, Living with Ourselves and Others: Our Relationships, In Amerika They Call Us Dykes: A Boston Gay Collective. Rape and Self-Defense, Venereal Disease, Birth Control, Abortion, Deciding Whether to Have Children, Childbearing, Menopause, and Women and Health Care. In addition to their own research and insights, they include first-person

[64] Our Bodies Ourselves. "History," Accessed December 14, 2015. http://www.ourbodiesourselves.org/history.
[65] Davis, *The Making of Our Bodies, Ourselves*, 21.

accounts by contributors – that is, women who were not officially part of the BWHBC. Their work acknowledges the full life span and lived experiences of women and restores intellectual and academic integrity to the topic of women's health.

It is important to note that the group did not initially have a formally structured membership, women could come and go and help with the project as they could or as their interest moved them. It was not until 1972 when they were being pursued for a national publishing contract that the group incorporated with fixed membership as The Boston Women's Health Book Collective. The founding members are officially acknowledged on the Our Bodies, Ourselves website as the following:[66] Ruth Davidson Bell Alexander, Pamela Berger, Vilunya Diskin, Joan Ditzion, Paula Doress-Worters, Nancy Miriam Hawley, Elizabeth MacMahon-Herrera, Pamela Morgan, Judy Norsigian, Jane Kates Pincus, Esther Rome, Wendy Sanford, Norma Swenson, and Sally Whelan. They describe themselves as mothers, grandmothers, wives, partners, and widows. They earned graduate degrees, became CEOs of businesses, wrote book chapters, made groundbreaking films, worked with marginalized communities, and have been constant activists and advocates for issues surrounding women's health. Two of the founders, Pamela Morgan and Esther Rome, have died and are both remembered with great fondness by the other founders.

I was quite fortunate to be able to speak with Vilunya Diskin and Joan Ditzion. Both women were brilliant, funny, engaging, and remain very active participants in the ongoing women's liberation movement in both thought and action. During our conversations, Diskin and Ditzion both made overt connections between the

[66] Our Bodies Ourselves, "History."

consciousness-raising process that was so formative in their work and the education. They embraced the educational nature of their work, just as they understood the profound political statement that they making. I had also been in contact with founders Judy Norsigian and Ruth Bell, but their very busy schedules made it impossible to coordinate time to speak with me for the purpose of this dissertation. I am, however, still hopeful that I will be able later to extend this study by amending it with their interviews as well.

The biographies they include on the website show how they have grown professionally and personally since the inception of the organization. However, in 1973 they had only just accomplished the first major step in their more than forty year journey. This is how they introduced themselves in *Our Bodies, Ourselves* readers in 1973,

> You may want to know who we are. We are white, our ages range from 24 to 40, most of us are from middle-class backgrounds and have had at least some college education, and some of us have professional degrees. Some of us are married, some of us are separated, and some of us are single. Some of us have children of our own, some of us like spending time with children, and others of us are not sure we want to be with children. In short, we are both a very ordinary and a very special group, as women are everywhere.[67]

They were aware of their homogeneity and of the relative privilege their whiteness gave them,

> We are white middle-class women, and as such can describe only what life has been for us. But we do realize that poor women and non-white women have suffered far more from the kinds of misinformation and mistreatment that we are describing in this book. In some ways, learning about our womanhood from the inside out has allowed us to cross over the socially created barriers of race, color, income and class, and to feel a sense of identity with all women in the experience of being female.[68]

[67] BWHBC, *Our Bodies Ourselves*, 2.
[68] BWHBC, *Our Bodies, Ourselves*, 2.

They made a point of not speaking for other women in their work. Just as they have felt silenced by the medical establishment, they did not want to do that to other women. They looked outside of their collective to bring in diverse voices to speak to the problems that they have faced. They describe,

> Many, many other women have worked with us on the book. A group of gay women got together specifically to do the chapter on lesbianism. Other papers were done still differently. For instance, along with some friends the mother of one woman in the group volunteered to work on menopause with some of us who have not gone through the experience ourselves. Other women contributed thoughts, feelings and comments as they passed through town or passed through our kitchens or workrooms. There are still other voices from letters, phone conversations, a variety of discussions, etc., that are included in the chapters as excerpts of personal experiences.[69]

Indeed voices of contributors are evident throughout their book – a feature that has remained in each of their updates and new editions.

Working together made them all better and created a better learning experience for them and for the women whose lives they touched. Their process, as I will discuss in greater detail in Chapter 4, involved talking to each other, making relevant connections between information and experience, and sharing their personal knowledge to help other women. They borrowed this from a practice called *consciousness-raising* that was inspired by the practice of "testifying" used during the civil rights movement and is not unlike the lying-in period that used to feature around a woman's childbirth experience.[70] They realized that their power to enact change would begin with their own abilities to make change in themselves. They describe,

> Like most early women's groups, we talked to each other about what life was like for us, growing up female. The underlying purpose of this introspection and analysis of our past was to have some basis to figure out how we wanted to

[69] BWHBC, *Our Bodies, Ourselves*, 2.
[70] Janet L. Freedman, *Reclaiming the Feminist Vision: Consciousness-Raising and Small Group Practice*, (McFarland & Company, Inc.: Kindle Edition, 2014).

> change the ways we thought and felt about ourselves. We could act on this new sense of self in our lives to create a broader sense of what it means to be female. To do this very personal work we made an accepting environment for ourselves – a place where we could talk and work together and think out loud. Probably the most valuable learning for each of us was learning to feel good about speaking for ourselves and being ourselves.[71]

But this self-examination in a group context did not come easily to them at first. The ability for women to trust their own voices had been hampered by the professional medical men who had established women as untrustworthy sources of information. The physical and mental isolation that is imposed on women in society also inhibited them at first. They had to learn to trust each other and themselves in order to do the work necessary to accomplish their goal. They describe their initial hesitation and the learning curve they somewhat unexpectedly encountered,

> At first we feared disclosing personal information. We each thought we might be ridiculed, rejected, misunderstood, gossiped about by the others. Many of us were friends before the group began and we were shy about getting into personal discussions about our relationships with men. Our fears of other women were exaggerated. We turned out to have a lot in common as women. And as we related to each other in more direct and honest ways, more genuine relationships were possible…[72]

As they learned from each other, they learned about themselves. They came to understand how their internalized sense of inferiority and socialized deference of their own needs to the needs of others also affected their relationships with other women. The community of women that had once been a normal part of women's lives had to be rebuilt,

> We also feared rejecting each other. We would see traits in others we did not want to see in ourselves, which were different from our own or which we did not like. We realized that as women we have been raised to be nice to everyone, to please everyone, and that we had not allowed ourselves to experience

[71] BWHBC, *Our Bodies Ourselves*, 6.
[72] BWHBC, *Our Bodies Ourselves*, 6.

> ambivalent feelings about ourselves and others. Facing this allowed us to be more honest with ourselves and others.[73]

This process allowed them to make connections between the cultural problems that created the inequalities they experienced in their lives. They realized that the internal struggles they felt were not the result of some issue or deficit that came from within them, those struggles were given to them through a lengthy process of socialization. And, through their intense work on learning about themselves, the experiences of other women, and their bodies, they began to break through and realize their own value and power as women. The thinking of the BWHBC surrounding their project and the purpose and motivations behind it reveal that the medical mis-education of women has roots in both education and medicine with identifiable problems in each realm. There are also identifiable educational remedies to this mis-education that can be found in their work, thus demonstrating the existence of the medical mis-education of women as an education-based problem.

The BWHBC have changed women's health on a personal, national, and international scales. There have been nine editions of *Our Bodies, Ourselves* published, the most recent being 2011 and a new edition is being written. The topics that have been included in each edition are updated to be relevant to current issues. Besides the chapters on sexual and reproductive health that are mainstays in each edition, more recent editions include chapters on such topics as infertility and reproductive technologies and environmental health concerns. By 2016, *Our Bodies, Ourselves* had been translated into thirty languages with adaptations coming in Farsi and other

[73] BWHBC, *Our Bodies Ourselves*, 6.

languages.[74] The book is available in Nepal, India, Moldova, Albania, Bangladesh, Russian, and Senegal among other countries. Their website, launched in 1998, receives more than 500,000 visits each month and is being continually updated with the recent and relevant information on women's health and sexuality.[75] Their influence and reach is now global, and the organization shows no indication of slowing down after over forty years of engagement.

I quote the BWHBC extensively throughout this text. As I engaged with the BWHBC regarding their thinking on the medical mis-education of women, it was important that I let them speak for themselves rather than paraphrasing their words. Many of the quotes are quite large as it was equally important that I let them elaborate fully their ideas and thinking. Unlike the medical professions, I was unwilling to cut them off or silence them. Their lived experiences and their voices are invaluable to elucidate the problems and remedies that come through in their work – and are invaluable to me, as a woman.

The "Second Wave" of Feminism

The wave terminology associated with feminism and feminist movements is complicated. Widely credited to Martha Weinman Lear with her 1968 article "The Second Feminist Wave," the wave metaphor has been regularly used since the publication of that article as a common way to denote the changes in political activism associated with each time period.[76] The so-called "second wave" is associated with the

[74] Our Bodies Ourselves. "History."
[75] Our Bodies Ourselves. "History."
[76] Nancy A. Hewitt, "Feminist Frequencies: Regenerating the Wave Metaphor," Feminist Studies 38, no. 3 (2012), 658-60.

American women's movement that took place during the 1960s through the early 1980s that focused on issues of women's equality and during which time women's bodies were a site of legal and political contention. Some feminists argue that the waves metaphor is an appropriate illustration of the ebb and flow of a wave, which is indicative of the gains made during the designated time period, followed by political and social backlash of the periods in between.[77] Others have argued that the use of the term "wave" suggests that feminism is a cyclical fad that comes and goes when in fact women of all ethnicities and races are a constant force for change in the world. The primary argument against this terminology is that it denies the ongoing efforts of women who work outside of the acknowledged "waves."[78] For the purpose of this work, I have chosen to use the descriptor of the American feminist movement of the 1960s to the early 1980s to discuss the time period in which the BWHBC and *Our Bodies, Ourselves* came to be. The term "second wave" will be used only when I am directly quoting a source.

Even though this dissertation focuses on the work of the BWHBC, it is important to note that feminism is not exclusive to the works of white women. In *Separate Roads to Feminism* (2004), Roth discusses the "whitewashing" of "second wave." Because white middle-class women had the kinds of resources necessary to act on the issues that they found objectionable, their grievances became associated with a national agenda of feminism.[79] Certainly activist Gloria Steinem and author of *The*

[77] Hewitt, "Feminist Frequencies."; Kathleen A. Laughlin, et al. "Is It Time to Jump Ship? Historians Rethink the Waves Metaphor." Feminist Formations 22, no. 1 (2010), 76-135.
[78] Barbara Houston. 1996. "Feminism." In *Philosophy of Education: An Encyclopedia*. New York: Garland Publishing
[79] Roth, *Separate Roads to Feminism*.

Feminist Mystique (1963), Betty Friedan, are women identifiable with the American feminist movement of the 1960s to the early 1980s on a national scale, but this has carried with it the broader assumption that white women were the only ones organizing. In *Feminism is for Everyone* (2000), bell hooks brings attention to the fact that "When the contemporary feminist movement began the issues that were projected as most relevant were those that were directly related to the experiences of highly educated white women (most of whom were materially privileged)."[80] hooks further notes that class biases were evident in the national focus on abortion rather than reproductive rights as a comprehensive category. While safe and legal abortion will always be a relevant issue to all women, white women in positions of privilege could identify specifically with how an unwanted pregnancy could affect their lives.[81] That does not mean that issues of reproductive rights – issues that ranged from "basic sex education, prenatal care, preventative health care that would help females understand how their bodies worked, to forced sterilization, unnecessary cesareans and/or hysterectomies, and the medical complications they left in their wake" – were being overlooked by everyone. [82] Roth describes feminist activism that organized along race and class lines, forming distinct movements during the period of the American feminist movement of the 1960s to the early 1980s. Feminists of color engaged in intersectional work that addressed issues that directly affected women in their communities while simultaneously maintaining a presence as participants in and in alliance with white feminist organizations.

[80] bell hooks, *Feminism is for Everybody: Passionate Politics*, (Cambridge: South End Press, 2000), 25.
[81] hooks, *Feminism is for Everybody*.
[82] hooks, *Feminism is for Everybody*, 26.

Theoretical Approach

This project focuses on the work of the BWHBC whose transformative book, *Our Bodies, Ourselves*, serves as a model of the educational work of women's health activists. Their work is part of a restoration of a legacy of women as healers and validates the intellectual contributions of women to the history of medicine. *Our Bodies, Ourselves* was one project that gave the voices, experiences, and knowledge of women the legitimacy they have always deserved, but have not been given. I see this project as a beginning effort to remedy the Evaded Curriculum in educational theory which affects taken-for-granted assumptions that are foundational for the schooling of children and adolescents (urban and rural), as well as medical and educational professionals. A key feature of this effort is its grounding in a reconfigured concept of education that is much broader than the essentialist equation between education and schooling. In this dissertation, I examine the work leading up to, surrounding, and contained within the publication of the 1973 edition of *Our Bodies, Ourselves* to see what pedagogical tools can be extracted and applied to other learning situations. I specifically explore the possibilities that the BWHBC's work can have to enlighten and inform sexual and reproductive health education for girls in American schools.

The educational philosophy of Jane Roland Martin serves as a philosophical foundation for this inquiry. I turn mainly to her theory of cultural miseducation that she describes in her 2002 book *Cultural Miseducation: In Search of a Democratic Solution* to build a conceptual framework of mis-education as both an action and a consequence. Her exploration of education as a cultural experience not limited to the school helps us

all to realize the responsibilities we have in how and what others learn. Martin's particularly feminist works including *Reclaiming a Conversation: The Ideal of the Educated Woman* (1985) help me to understand and convey the importance of education to the lives of women. In addition, her reimagining of school in *The Schoolhome: Rethinking Schools for Changing Families* (1992) and in *Education Reconfigured* (2011) are important texts when education needs to be reconceptualized as a more caring and productive venture. Finally, I turn to Noam Chomsky's *Media Control: The Spectacular Achievements of Propaganda* (2002) to help clarify the political, social, and cultural scope of the problem of the medical mis-education of women. Bringing together Martin and Chomsky successfully politicizes Martin's work, which is necessary to move education – health and body education in particular – to the realm of social justice. This is especially important to understand how the medical mis-education of women has led to women's reproductive *in*justice.

As women are objectified in so many facets of their lives (including in health care settings where it should be imperative that their needs and knowledge are actively sought and respected), research about and for women gains value and validity by allowing the voices of women to be heard. Feminist research methods make a point of putting women central to the research by reconnecting the lived experience of women with their voices and their understandings of the circumstances of their lives.

> This reconstitution of knowledge [is] essential because of a basic discontinuity: women's perspectives were not absent simply as a result of oversight but had been suppressed, trivialized, ignored, or reduced to the status of gossip and folk wisdom by dominant research traditions institutionalized in academic settings and in scientific disciplines.[83]

[83] Kathryn Anderson, Susan Armitage, Dana Jack, and Judith Wittner. "Beginning Where We Are: Feminist Methodology in Oral History," from *Feminist Research Methods: Exemplary Readings in the Social Sciences,* (Boulder: Westview Press, Inc., 1990), 95.

Because this dissertation focuses on how education and mis-education affect women, it is particularly important that feminist methods of analysis are employed to understand women's thinking on women's lives. Patti Lather (1991) wrote, "The overt ideological goal of feminist research in the human sciences is to correct both the *invisibility* and *distortion* of female experience in ways relevant to ending women's unequal social position."[84] Though this is work in educational humanities, rather than the human sciences, it aims to correct the female experience within medicine. Therefore, this dissertation employs feminist research methods that are meant to engage women's voices and to learn from their understanding of the world.

The concept of intersectionality is significant in any feminist discussion that engages women's thinking and women's bodies. Intersectionality is a term coined by Kimberle Crenshaw in 1989 that explores the ways in which gender and race "intersect in shaping structural, political, and representational aspects of violence against women of color."[85] The concept speaks to the multiple identities that exist within individuals – for example, gender, race, sexuality, ability, etc. – and the ways in which they intersect to complicate that individual's experience with oppression or discrimination. Even though it was not named until Crenshaw, it was a concept that had been actively addressed by women of color for centuries. Sojourner Truth's 1851 speech, "Ain't I a Woman?," addressed her multiple oppressions as a black woman, and Anna Julia Cooper talked about how race, gender, and class affect the lives of black women in *A*

[84] Lather, Patricia, *Getting Smart: Feminist Research and Pedagogy With/in the Postmodern*, (New York: Routledge, 1991), 71. (emphasis in original)
[85] Crenshaw, Kimberle, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color." Stanford Law Review 43, no. 6, (1991), 1244.

Voice From the South in the 1890s. The BWHBC and other white women organizing in the American feminist movement of the 1960s to the early 1980s did not have an appropriate term for this complexity to help them inform their work. However, these were all women who came of age during the Civil Rights Movement. That the BWHBC acknowledge their whiteness in their 1973 book indicates that they were aware of their relative privilege. They explained, "…we do realize that poor women and non-white women have suffered far more from the kinds of misinformation and mistreatment that we are describing in this book."[86] Their efforts to ensure that they were not speaking for other women by inviting women of diverse backgrounds to make their own contributions to their book was certainly vital to the authenticity and appeal of their work. Of course, their having a limited understanding of the issues of intersectionality also limited their understanding of the topic. Likewise, their whiteness does not allow them to experience intersectionality in the ways that women of color are unable to escape. Similarly, this also limits my understanding of the topic, as a white woman, though I have the distinct advantage of being able to draw on recent theoretical accounts of intersectionality to inform my work.

As a feminist researcher working on a feminist project, I feel it is important to discuss my relationship with the topic. The inspiration for this inquiry and for the development of the concept of medical mis-education of women was largely the result of my professional experience in health care – I have been a registered pharmacist for over twenty years – and from my lived experience as a woman, as well as my interactions with the medical professions as a female patient. As I witnessed routine

[86] BWHBC, *Our Bodies, Ourselves*, 2.

practice in medicine that devalues and distrusts the word of women, and teaches women to devalue and distrust their own experiences, it became painfully obvious to me that the suppression of women in the medical world was merely one aspect of a larger pattern of oppression. With my graduate coursework in education and women's studies, I started making overt connections between education and care. I quickly realized that education was the key to making the positive changes in healthcare that could change the relationship between women and medicine.

I did not learn about *Our Bodies, Ourselves* until I began my doctoral studies in education. As I began to envision this project, I spoke with a female gynecologist, curious to know her thoughts on *Our Bodies, Ourselves*. She had never heard of it, but was excited to write down the name of the book and explore it further. I believe this to be a fairly significant gap in our education in the healthcare professions. We had learned to revere peer-reviewed literature and honor evidence-based medicine, but there was no space made for the thinking of individuals and groups who had devised approaches to women's health to improve the health of women, their families, and communities – approaches that worked. That women's health organizations like Planned Parenthood can provide resources like *Our Bodies, Ourselves* to women is important, but it is equally important that projects like this are embraced by the larger medical community as valid sources of medical knowledge.

My early engagement with *Our Bodies, Ourselves* was mostly analytical as I was trying to determine why this book was considered to be so special. I began with great admiration for their work and the unique way they had integrated their personal experiences into factual material. I also saw a clearly educational intent behind their

work that I appreciated. However, speaking with Diskin and Ditzion completely changed my relationship with *Our Bodies, Ourselves*. The enthusiasm that they still have for this project was evident in their voices and, as they shared their experiences with me, the history of this book and the thinking behind it came alive. They have an obvious passion for their work and I was able to understand their depths of their commitment to women's health, reproductive justice, and to the larger feminist movement. Their willingness to share and learn together, first for their project and very recently with me for my own project, makes their historical and ongoing work personally and professionally meaningful to me in ways that I am sure I have not yet fully realized.

When determining an appropriate approach to this inquiry, I faced a particular challenge. I was primarily interested in learning the BWHBC's thinking on and theorizing of the medical mis-education of women and how it inspired and informed the creation of their book *Our Bodies, Ourselves*. It was necessary to document the historical events, encounters, and experiences related to their work on *Our Bodies, Ourselves*, but it was most important to uncover and acknowledge their thinking. As this conceptualization was necessarily interdisciplinary, I drew from methodologies across disciplines including philosophy, history, and social sciences to inform my work. To understand my approach, it is necessary to describe was it is as well as what it is not. This study resembles narrative inquiry in that the voices of the BWHBC are made central through written and spoken engagements in order to learn about and interpret their stories.[87] However, it differs from narrative inquiry in that the primary engagement

[87] Lisa M. Given, ed., *The SAGE Encyclopedia of Qualitative Research Methods*, Volume 2. London: SAGE Publications, Ltd., 2008.

with interviews and textual analysis was to learn their thinking about events in their lives. This work resembles an oral history in that the feelings and perspectives of the women I interviewed were important to understanding the events and experiences in their lives.[88] However, these were not in-depth interviews that addressed the subjects' growth over the course of their lives, and were instead very event-specific. This work resembles lived experience research (hermeneutic phenomenological research) in that it aims to interpret descriptions of lived experiences.[89] However, this project also aims to acknowledge and understand the thinking of an individual or group revealed through descriptions of lived experiences. This study resembles historical analysis in that it aims to uncover and document factual events.[90] However, this study explores subjects' thinking about historical events through the lens of a philosophical framework. This work also resembles philosophical analysis in that it tries to identify key issues involved in a theory to see how they interact and inform each other.[91] However, this study uses empirical evidence to inform my theory and analysis. The complexities do not end here. The fact that I was looking to uncover the group's thinking and theorizing proved problematic when selecting a methodology, and I was forced to reimagine my approach.

There is if fact a great tradition of feminist philosophers inventing their own approaches to inquiry. Sara Ruddick had to "make it up" to reach her concept of maternal thinking in a world where the thoughts, actions, intuition, and "knowing" of

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[88] Yow, Valerie Raleigh, *Recording Oral History: A Guide for the Humanities and Social Sciences*, 2nd ed., (Lanham: AltaMira Press, 2005).
[89] Max Van Manen, *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*, (Albany: The State University of New York Press, 1990).
[90] Catherine Marshall and Gretchen B. Rossman, Designing Qualitative Research, 2nd ed., (Thousand Oaks: Sage Publications, 1995).
[91] A.P. Martinich, *Philosophical Writing: An Introduction*, 3rd ed., (Malden: Blackwell Publishing, 2005).

mothering had been devalued.[92] Patricia Hill Collins described that subordinate groups have needed to develop their own standpoint and "have done so by using alternative ways of producing and validating knowledge."[93] Collins consequently embarked on a distinctive epistemological approach to research that included validating the intellectual contributions of black women who were not typically considered to be intellectuals, like mothers, housekeepers, and churchwomen. Her conceptualization of the black feminist standpoint as a critical social theory makes sense of power relationships from the perspective of the black woman. Jane Roland Martin argued that it is unreasonable to expect "marginal people" to subscribe to "established channels of communications" in educational theory.[94] Rather, the effort to interpret the world through the experiences of marginalized people will have to include sources of knowledge "that the history of educational thought regards as far from standard."[95] Among those potential sources of knowledge, Martin includes personal letter, diaries, pieces of fictions, and oral sources. She also makes room for alternate modes of theorizing. Martin argues that "some of the most interesting and significant theories of female education may have been authored not by single individuals but by groups of individuals… and others may have simply emerged out social movements."[96]

It thus makes sense to embrace this feminist tradition and find a way to address my approach. Rather than having to list what it is and what it is not whenever I discuss my approach to this inquiry, I will name it the Oral-Theorizing Interview (OTI) and

[92] Sara Ruddick, Maternal Thinking: Toward a Politics of Peace, (Boston: Beacon Press, 1989), 61.
[93] Patricia Hill Collins, Black Feminist Thought, (New York: Routledge, 2000), 270.
[94] Jane Roland Martin, Reclaiming a Conversation: The Ideal of the Educated Woman, (New Haven: Yale University Press, 1985), 180.
[95] Martin, *Reclaiming a Conversation*, 180.
[96] Martin, *Reclaiming a Conversation*, 180.

define it as such: this is a new approach to feminist theoretical research in education that I envision as an inquiry tool that will be particularly helpful to curricular theorists. It is necessarily enmeshed with educational theory in order to structure open-ended interview questions that encourage "thinking aloud"[97] to elicit the interviewee's own theories surrounding an event by allowing their understanding of the event to unfold in a way that is applicable and relevant to their own lived context.[98] For my project, questions were guided by the same educational concept that structures the overall inquiry, Martin's cultural mis-education. For example, the BWHBC's understanding of Martin's concept of "problem of generations" – which speaks to the pieces of cultural stock we do or do not pass on to new members of our culture – was teased out through any number of questions that evoke that imagery. What do we need to teach girls and women with regard to body and health? What were you taught that was important? What were you taught that was misleading? What were you not taught that you wish you had been taught? What were you taught that you wish you had not been taught?

Autobiographical sources are also important in OTI as they are in other forms of feminist inquiry to "place the voice of the author at the centre [sic] of the knowledge-production process."[99] Virginia Woolf notes, "There is that marvelous, perpetually renewed, and as yet largely untapped aid to the understanding of human motives which is provided in our age by biography and autobiography."[100] Indeed, the use of

[97] Use of this term is credited to Susan Laird.
[98] The term "thinking aloud" is attributed to Susan Laird.
[99] Jane Martin. "The Hope of Biography: The Historical Recovery of Women Educator Activists." *History of Education* 32, no. 2, (2003): 220.
[100] Woolf, *Three Guineas*, 9.

autobiography as an educational tool and its potential to create transformative learning experiences is made explicit by Irene Karpiak. She describes,

> Through stories, our own or others, and through our listening, we further a classroom space that is more accepting, more sustaining, more respectful, and more caring— a space in which we as learners and as teachers open ourselves to others' views and thereby to enlarging our own.[101]

Women's traditions also show us that sharing brings us closer and learning from the experiences of others is valuable to our own empathetic development – and what are educational and medical spaces without empathy? Though Karpiak's work focused on the higher education classroom, her research can be easily transferred to other learning spaces and to the expectations we have within those spaces. Therefore, both the informative and educational uses of personal stories, perspectives, and experiences will be important in framing an OTI. For this reason, The BWHBC's book *Our Bodies, Ourselves* serves as a primary source in this project. Historian of education Gary McCullough distinguishes between primary and secondary sources as such: primary sources are first-hand accounts, produced in the time period being studied, whereas secondary sources are assembled by historians utilizing primary sources at a later time.[102] I believe that the vast amount of autobiographical detail included in the book and integrated into their medical and health research that was produced within their lived historical experience indicates that *Our Bodies, Ourselves* is a primary source of information.

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[101] Irene E. Karpiak, "The Weir: Storytelling that Transforms." *Canadian Journal of University Continuing Education* 34, no. 1 (2008): 81-94.
[102] Gary McCullough, *Documentary Research: In Education, History, and the Social Sciences*, (London: Routledge, 2004), 29-31.

As with any work that explores gender, race, and class, there are some issues that are difficult to navigate. I am a white college educated woman who has been able to find independence and financial security in a health profession through education. However, I realize that this is not the case for far too many women. Like the BWHBC, I do not claim to understand the lived experience of any other woman of any race, ethnicity, nationality, class, sexuality, etc., I can only speak directly to my own life and experiences. Nor do I intend to speak on behalf of any other woman. I use my voice to inform others of my findings and my understanding and interpretation of those findings. I seek diverse voices to inform and educate me and my work, and I hope that I can inform and educate others along the way. Just as the BWHBC were able to gain an understanding of their connectedness to other women by learning about themselves "from the inside out,"[103] I believe we can find mutuality in our shared humanity and woman-ness through listening to each other, believing each other's stories, and valuing our diversity.

Furthermore, I am not presuming that this study is applicable to the experiences of all women. This is a study of the BWHBC and as such reflects the limitations of their focus which, as white women, does not allow for an exploration of how the medical mis-education of women affects the lives of women of color. Their self-identification as middle-class women also limits the applicability of this study to the lives of women in other socioeconomic classes. This study also necessarily works in a cisgendered framework and does not speak to how the medical mis-education of women manifests in the lives of trans women or trans men – both of whom experience interactions with

[103] BWHBC, *Our Bodies, Ourselves*, 2.

professional medicine as “women” at some point in their lives. As I use the word “woman” or “women” throughout this text, I am not making any assumptions nor drawing any conclusions that the experiences of all women in a particular setting or context are the same. Indeed, when I say “woman” or “women” in this work, it is potentially a place for critique along racial, class, or identity lines. The significance of this work is not that it is ubiquitously applicable to all lives of women, it is that it offers a tool to explore these varied populations from an educational perspective.

Aims of This Study

The aims of this study are four-fold. First, I introduce the oral-theorizing interview as a new feminist methodological research tool. I believe that this will be a particularly useful tool for curriculum theorists of health education who aim to correct mis-educational problems and elicit remedies that result in education that promotes intellectual and emotional growth and physical well-being. Second, is to offer the two OTIs in which I engaged with Vilunya Diskin and Joan Ditzion. As their words appear throughout this dissertation, their thinking and indeed the depths of their own educational theorizing are evident. Third, the OTIs allowed me to identify problems of both education and medicine along with educational remedies within the work of the BWHBC that contribute to the theoretical foundation of the medical mis-education of women. Finally, this dissertation is initiating a new field of curriculum inquiry to interpret, critique, and reimagine health education in schools and elsewhere, using OTIs to build theory that can ground practice.

Organization of Chapters

Chapter one is an introduction to the topic and to concepts important to understanding this work. I introduce the medical and educational histories that establish the medical mis-education of women as an active force in the lives of women. I also introduce the Boston Women's Health Book Collective. I explore the sources and methodological approaches used in this dissertation and introduce the OTI method of feminist educational research.

Chapter two introduces Martin's educational philosophy and the theoretical foundation of the medical mis-education of women. I also explore a contemporary connotation of the medical mis-education of women as found in sexual and reproductive health education in American schools.

Chapter three names the problems identified in the works and words of the BWHBC. Those problems of education and medicine are named the Deference Problem, the Isolation Problem, the Inferiority Problem, the Knowledge Problem, the Experience Problem, and the Control Problem. I explore these problems and the thinking of the BWHBC that reveals their existence.

Chapter four names the remedies identified in the works and words of the BWHBC. This chapter will explore the educational remedies in which the BWHBC engaged to remedy the problems they identified with medical learning in adult women. The educational remedies are named the Isolation-Knowledge Remedy, the Inferiority-Experience Remedy, and the Deference-Control. I theorize each of these remedies, comparing the BWHBC's thinking with other cultural artifacts that have engaged the medical mis-education of women somehow.

Chapter five will explore ways in which the educational remedies to the medical mis-education of women experienced by adult women and identified by the BWHBC can be adapted to sexual and reproductive health education in schools. I will also look ahead to the next logical step in research for this project. As society becomes increasingly diverse, it will be necessary to look toward more diverse voices to construct educational remedies to the questions found within the contemporary manifestation of the medical mis-education of women.

Chapter Two:

"It's all about education.":

The Medical Mis-education of Women as Cultural Mis-education

It's all about education.

- Vilunya Diskin

Throughout this dissertation, I will engage in an exploration of an educational theory that I call the medical mis-education of women and its influence in and on the lives of girls and women. My discussion of mis-education, a concept that has captured the attention of philosophers of educations for ages, takes places within the context of the teaching and learning that results from encounters with professionalized medicine. It was the medical establishment that the Boston Women's Health Book Collective and other women's health activists organized their activism around. Their educational projects like the BWHBC's book *Our Bodies, Ourselves* that aim at re-educating women about their health and bodies are a direct reaction to the limited knowledge to which they had access as a result of medicine becoming a profession. Their work speaks directly to the medical mis-education of women and restores intellectual and academic integrity to the topic of women's health.

While the BWHBC directed their energies toward the re-education of adult women, the medical mis-education of women affects girls and women all along the age spectrum. In order to better understand how it continues to permeate the lives of women, I will describe the case which lies at the intersection of medicine and

education: sexual and reproductive health education in American schools. Because sexual and reproductive health in public schools has become so highly politicized, it has become a space rife with mis-educational potential. The importance of each of us having a thorough and accurate knowledge of our bodies cannot be understated – and the consequences of mis-education in this area are shown time and again as being particularly disastrous for women and their families. The BWHBC understood this and worked diligently to remedy it.

The chapter serves several purposes. Here I will discuss the philosophical framework of the medical mis-education of women. I utilize Jane Roland Martin's concept of cultural mis-education (2002) as a philosophical framework to formulate the medical mis-education of women that expresses itself historically as ongoing oppression of girls and women through medical actions and consequences. Martin's work provides a lens through which we can understand the links between learning and culture. Indeed, through this lens the educational nature of oppression and our individual and collective cultural responsibilities becomes clear.

I will explore sexual and reproductive health in public schools as a conduit of the medical mis-education of women. Abstinence-only education has been endorsed through federal funding as the sole form of acceptable sexual and reproductive health education in the United States from the 1980s until 2016. Because of this granted exclusivity, abstinence-only has been the primary source of sexual and reproductive health education offered to a majority of school aged children and teens for a generation. The controversial curriculum of abstinence-only has been found to be rampant with scientific and cultural inaccuracies, distortions, and harmful stereotypes

that have resulted in dire health consequence and knowledge deficits. The medical mis-education of women is thus perpetuated within a curriculum that is assumed to be educative.

Finally, I will begin to explore how the work of the BWHBC can begin to describe how the medical mis-education of women manifests in the lives of women. The BWHBC, who have authored nine editions of *Our Bodies, Ourselves*, have engaged in critical re-education of adult women concerning their sexual and reproductive health. Their work speaks to the need for women to be active participants in leading and learning in educational spaces, particularly where knowledge of women's bodies are concerned. The educational projects of the BWHBC have served as a model for community health care sites regarding how and what to teach patients, caretakers, and public health professionals. I will argue that schools can learn much from their work how to approach curricular and pedagogical reforms that the medical mis-education of women makes necessary in order to achieve Title IX's aim of gender equality.

Framing the Medical Mis-education of Women

Mis-education is a concept that has concerned philosophers of education for generations. Three of the most significant theorists regarding my work are Carter G. Woodson, John Dewey, and Jane Roland Martin. Woodson, known widely as the Father of Black History, was perhaps the earliest theorist to explore this concept with his 1933 book, *The Mis-Education of the Negro*. Dewey followed with *Experience and Education* in 1938, and Martin brings a contemporary voice to mis-education with her 2002 book *Cultural Miseducation: In Search of a Democratic Solution*. Rather than

discussing these books chronologically, I find it most helpful to explore them in terms of their contributions to formal education and cultural education.

Formal Education

In *Experience and Education* (1938), Dewey contemplates the challenges of progressive education to become relevant to contemporary societies. By reflecting on the traditional approach to formal education which "consists of bodies of information and skills that have been worked out in the past"[104] – studies that celebrate the contributions of a very narrow subset of society: white, well-off men in positions of power – Dewey notes that the purpose of schools has mainly been to pass on this canonical knowledge to the next generation. Unfortunately, the subjects that have been deemed worthy of study are not made relevant to the lives of students who exist within a society that supports education primarily as a means to prepare them for the world of work. It is also problematic that subjects stand isolated from each other and disconnected from the needs and experiences of students. Dewey instead saw the need for connections to be made not only between subjects (for example, how are math and history related and why is that relationship important?) but also, and perhaps more importantly, between students' experiences and learning if it is to be at all meaningful and educative. He argues, "I assume that amid all uncertainties there is one permanent frame of reference: namely, the organic connection between education and personal experience[.]"[105] For Dewey, the experience is the primary factor determining

[104] John Dewey, *Experience and Education*, (New York: Simon & Schuster, 1997), 17.
[105] Dewey, *Experience and Education*, 25.

educational value. His vision of experience consists of continuity (all future experience is affected by all past and present experiences) and interaction (all past experiences interact with the present situations to influence each person's unique experience of the present). In other words, context is everything and the context of our lived experiences influences how we are able to process and react to future experiences. And although he valued experience in education, he did not believe that all experience was educative in a manner that resulted in positive outcomes for learners. Dewey explains,

> Experience and education cannot be directly equated to each other. For some experiences are mis-educative. Any experience is mis-educative that has the effect of arresting or distorting the growth of further experience. An experience may be such as to engender callousness; it may produce lack of sensitivity and of responsiveness. Then the possibilities of having a richer experience in the future is restricted.[106]

One of the challenges of education therefore is to create learning experiences that are "fruitful" for learners and avoid those that are restrictive. Dewey further contends that "The only freedom that is of enduring importance is freedom of intelligence, that is to say, freedom of observation and of judgment exercised in behalf of purposes that are intrinsically worth while [sic]."[107] The connection that Dewey is making between mis-education, experience, and freedom is not difficult to see. How can we expect students to be able to engage in larger problems and ideas if mis-education is an active component of learning? And how can we expect mis-education to not affect the ways in which the mis-educated interact with the world?

Dewey's progressive take on education makes suspect many of the educational standards that are endorsed in schooling. With regard to sexual and reproductive health

[106] Dewey, *Experience and Education*, 25.
[107] Dewey, *Experience and Education*, 61.

education, the U.S. government has overwhelmingly endorsed abstinence-only education to represent the canon of this subject in this country.[108] The fear within coeducational spaces in schools is riddled with concerns over the purity of girls and distractibility of boys – a fear rooted in the idea of the voluntary active sexuality of girls and women. The divisive subject of sexuality in the United States can likely be traced directly to the protestant version of morality that invaded schools and other institutions early in the nation's history. This protestantism has essentially defined socially acceptable expressions of sexuality. In American schools, this control is enforced primarily through sex education.[109]

Sociologist Kristin Luker describes two competing ideas about sex that typically come up in debates about sex education in schools. People see either "sex as pleasure versus sex as danger, sex as something that reasonable humans can handle verses sex as something that needs all the help it can get to keep from running amok."[110] One side argues for comprehensive education that provides accurate information that would allow people to make informed decisions about safe sex. The other relies on religious notions of morality to deny sexual intercourse until marriage – with both sex and marriage being defined very narrowly as heterosexual acts.

Abstinence-based sex education has been receiving federal funding since 1981 under Ronald Regan with the Adolescent Family Life (AFL) Act.[111] The AFL allowed

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[108] For more on the history of sex education in the U.S., see Jeffrey P. Moran, *Teaching Sex: The Shaping of Adolescence in the 20th Century*, (Cambridge: Harvard University Press, 2000).
[109] Marty Klein, *America's War on Sex: The Attack on Law, Lust and Liberty*, (Westport: Praeger Publishers, 2008).
[110] Kristin Luker, *When Sex Goes to School*. (New York, NY: W.W. Norton & Company, 2006), 9.
[111] The AFL is also known as the Chastity Act and "often advocated specific religious values" in their curriculum. Jessica Valenti, *The Purity Myth How America's Obsession with Virginity Is Hurting Young Women*, (Berkeley: Seal Press, 2009), 112. In fact their religion-infused curriculum prompted a lawsuit by the American Civil Liberties Union (ACLU) in 1983. The ACLU argued that programs receiving

for funding only to pregnancy prevention programs that "offered abstinence as the only appropriate course of action,"[112] while programs that discussed abortion as an alternative form of care were cut off from federal money. Later, a 1996 provision attached to the welfare-reform act guaranteed abstinence-only programs $50 million dollars every year for five years.[113] This money would go only to those programs that utilized the federal definition for abstinence-only programs that include a set of eight guidelines, A through H, based in traditional religious moral values. These guidelines of course include abstaining from sex outside of marriage, and such declarations as "sexual activity outside of marriage is likely to have harmful psychological and physical effects."[114] They also require that any discussion about contraception mentions its failure rate, not its success rate. In fact, the only discussion of failure rates that is prohibited is "the failure rate of abstinence, which is *never* discussed."[115] More tax dollars would be made available to these programs via the 2001 Community-Based Abstinence Education Program (CBAE) established by conservative Republican congressmen. This ensured that programs "*must* teach all eight points of the abstinence A-H guidelines, *must* target children ages twelve to eighteen, and absolutely cannot provide students with any positive information about contraception."[116] Between 2001

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federal money could not endorse religion as it was a violation of the separation of church and state. The case was not settled until 1993 and came down on the side of the ACLU and "forbade the AFL-funded programs to include religious references and required the information they dispensed to be medically accurate, among other stipulations." See, Valenti, *The Purity Myth*, 112. Despite this, it is unclear how these programs are able to continue with their heavily religious and scientifically inaccurate content.

[112] Valenti, *The Purity Myth*, 112.

[113] Valenti, *The Purity Myth*, 112.

[114] Marty Klein, *America's War on Sex: The Attack on Law, Lust, and Liberty*. (Westport: Praeger Publishers, 2008): 9.

[115] Klein, *America's War*, 9. Emphasis in original.

[116] Valenti, *The Purity Myth*, 113. emphasis in original

and 2007, the CBAE infused an additional $113 million into abstinence-only education which is a 465 percent increase in funding.[117]

So, what does all of this mean in terms of the education that students have been receiving under abstinence-only education? "A 2004 report from Representative Henry Waxman (D-CA) indicated that over 80 percent of federally funded abstinence programs contain false or misleading information about sex and reproductive health."[118] The report cited multiple common offenses including: failure to educate students on choosing a contraceptive method and using it appropriately, inaccurate information related to condom effectiveness, misinformation related to abortion risk, conflation of religion and science, reinforcing socially constructed gender stereotypes as scientific fact, and outright bad science.[119] Among the scientific falsehoods found in these programs is that HIV transmission is possible through tears or skin-to-skin contact and that abortion results in "sterility, mental retardation, and premature births in future pregnancies."[120]

The Abstinence Clearinghouse is one of the most powerful organizations in the abstinence movement. Founded in 1997, it "provides resources for accessing information, speakers, and curriculum materials for abstinence programs."[121] Their curriculum explicitly and incorrectly links adolescent sexual activity to clinical depression and suicide, claiming that medical studies had proven a causal link.[122] They

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[117] Valenti, *The Purity Myth*, 113.
[118] Valenti, *The Purity Myth*, 104.
[119] Klein, *America's War*.; Valenti, *The Purity Myth*.
[120] Valenti, Jessica. *The Purity Myth*, 105.
[121] Dennis L. Carson, *The Education of Eros: A History of the Education and the Problem of Adolescent Sexuality*. (New York: Routledge, 2012): 110. According to Carlson, the Abstinence Clearinghouse includes on its advisory council representatives from Religious Right organizations like the Heritage Foundation and Focus on the Family. For more information, see Carlson, *The Education of Eros*.
[122] Carlson, *The Education of Eros*, 110.

and other abstinence organizations like Sex Respect engage in what educational philosopher Dennis Carlson calls a "pedagogy of fear."[123] They rely on scaring students into conforming. Fear of mental health issues, pregnancy, STDs, or disappointing parents are emphasized over the idea that teens can critically assess factual information and engage in mature discussions on relationships, responsibility, and consent. Carlson notes the "great irony in a Christian-based movement emphasizing fear more than love; but it is consistent with traditional religious beliefs about the need to instill fear in children through corporal punishment."[124] They promote the idea that love must remain "pure" and, "if it is not 'pure' and thus chaste, it is spoiled and ultimately destroyed, bringing down everyone and everything, from the young couple to civilization and 'the future of family life.'"[125] Certified sex therapist and public policy analyst Marty Klein points out one of the many flaws in this thinking. "[T]hey want kids to think of sex as something dangerous to fear, something seductive that leads to shame, pain, and a ruined future. Somehow, this is all supposed to change on their wedding night."[126] The conflicting messages teens receive throughout school are bound to lead to confusion as they move into adulthood and out of schools into the world.

According to Dewey's definition of education and mis-education, this would most definitely constitute a mis-educational experience that distorts the future growth of students as it pertains to their sexual and reproductive health and well-being. The inclusion of Carlson's and Klein's observations of sex education in schools suggests that schools are also cultivating a sense of fear in students that can introduce lasting

[123] Carlson, *The Education of Eros*.
[124] Carlson, *The Education of Eros*, 111.
[125] Carlson, *The Education of Eros*, 111.
[126] Klein, *America's War*, 9.

harm in their lives. Thus, the need to discuss abstinence-only as mis-education in the context of Title IX is important. As noted in Chapter 1, under Title IX, federal law prohibits federal money from being used in educational settings that contribute to sex discrimination. Title IX's purpose is in part to set an administrative tone in schools that is conducive to learning for all students and free from sexual harassment and sex-based inequality.[127] In the AAUW Report, *How Schools Shortchange Girls*, the connection between curriculum, growth, and the potential harm in mis-education is made,

[127] The most significant impact made by Title IX to date has been in athletics. In the decade immediately following passage of this amendment, there was a five-hundred percent increase in competitive sports participation by female students. See, Rury, *Education and Social Change*, 197. Because of the amount of attention turned toward Title IX's importance to women in athletics, it is not surprising that it is assumed that Title IX applies only to sports. However, athletics is only one key area addressed. It is all-encompassing and applies to all education programs or activities that receive federal funding. Title IX is meant to protect students against sexual harassment and sexual violence, break down barriers for girls in STEM, and protect the educational interests of pregnant and parenting students, among other things. Title IX addresses the following areas in addition to athletics: access to higher education; breaking down sex-typing in career education (i.e., home economics versus shop); removing barriers to secure employment at all levels of education, including administrative positions; encouraging girls and women into STEM fields; removing gender disparities in standardized testing; protecting the educational rights of pregnant and parenting teens; removing gender stereotyping from the learning environment, including textbooks and classrooms; and, eradicating sexual harassment in schools. See, titleix.info. "History of Title IX." Accessed August 21, 2016. http://www.titleix.info/Default.aspx.

It would be unfair to say that Title IX has failed girls and women in schools, as of now we can really only say that Title IX has failed to be enforced to its full extent. There remains plenty of evidence of the devaluation of girls within schools as shown by ongoing disparities of female representation in "hard" sciences. According to the National Girls Collaborative Project, only 11.1% of physicists and astronomers, 7.9% of mechanical engineers, and 10.7% of computer hardware engineers are women. See, National Girls Collaborative Project. Accessed August 20, 2016. https://ngcproject.org/statistics. This devaluation is further evident in the documented accounts of sexual harassment and violence that flourishes at educational institutions at all levels. Here, I am thinking of such cases as the Stubenville rape case and #yesalldaughters that originated here in Norman, Oklahoma – only two very prominent cases of many that have made headlines in recent years. It wasn't until 2013 in a "Dear Colleague Letter" that the Department of Education clarified that Title IX does in fact protect pregnant and parenting students from being forced out of schools. That it took forty-one years to make explicit the details of this protection makes clear that girls continue to suffer from a double-standard where their sexuality is concerned. Until the public and educators understand fully the extent to which Title IX can be enforced to protect the educational interests of girls and women in schools, it is unlikely that we will see full equity extended to them. See, U.S. Department of Education. "Dear Colleague Letter." Last modified October 15. 2015. Accessed August 22, 2016. http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201306-title-ix.html.

Despite Title IX's promise to protect the educational interests of pregnant students and student parents, the so-called teen pregnancy "crisis" was successfully reframed for political purposes as a welfare issue and "a legitimate social concern" giving the public a "societal right" to have their "fiscal and moral" interests protected thus moving much of the policy-making power out of the educational realm. See, Wanda S. Pillow, *Unfit Subjects: Educational Policy and the Teen Mother*, (New York:

> The formal curriculum is the central message-giving instrument of the school. It creates images of self and the world for all students. The curriculum can strengthen or decrease student movement for engagement, effort, growth, and development through the messages it delivers to students about themselves and the world.[128]

Furthermore, the AAUW understand that curriculum is not the only source of learning within schools.

> Students can learn as much from what they experience in school as they can from the formal content of classroom assignments. Classroom interactions, both with the teacher and other students, are critical components of education. These interactions shape a school. They determine in large measure whether or not a school becomes a community: a place where girls and boys can learn to value themselves and others, where both the rights and the responsibilities of citizens are fostered.[129]

Curriculum contributes to the learning environment of a school as much as it contributes to knowledge. Certainly a mis-educative curriculum that hoards knowledge and promotes fear and misinformation can foster a sense of inferiority and isolation in students.

Of course, Dewey's *Experience and Education* was directed toward teachers and focused primarily on formal educational settings, but it is easy to extrapolate these concepts to informal education settings as well, such as professional medical practice. The experiences described by the BWHBC that I will discuss in the following chapters demonstrate that their learning and teaching about women's health did indeed constitute

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RoutledgeFalmer, 2004), 47. It is also important to note that the G.W. Bush presidency enacted other policies that directly impacted teen mothers and single mothers that shifted the focus from care of the mother to the care of the fetus or "unborn child" – an attempt to redefine pregnancy and erode the right to accessible and safe abortion. See, Pillow, *Unfit Subjects*, 49. Of course, the clearly intentional outcome of this reimagining of the pregnant, single teen has created a violent, unwelcoming world for her, both in schools and in the world at large.

[128] AAUW, *How Schools*, 105.

[129] AAUW, *How Schools*, 118.

education, even though it took place outside of school. Dewey would certainly credit them as progressive educators.

Cultural Education

One of educational historian Lawrence Cremin's biggest criticisms of progressive education as a whole is the "tendency to focus so exclusively on the potentialities of the school as a lever of social improvement and reform as to ignore the possibilities of other educative institutions."[130] In his book *Public Education* (1976), he gives equal importance to what he calls incidental (or informal) learning that we gain through life experience and intentional (or formal) learning obtained through schooling. To strengthen his argument, Cremin references the work of Charles E. Silberman, a journalist and author of such books as *Crisis in Black and White* (1964) and *Crisis in the Classroom: The Remaking of American Education* (1970) whose work addressed important social issues like racism and education. Silberman argued that "mindlessness" was at the heart of the problems with American education – that is, educators, both formal and informal, lack motivation to engage in meaningful, fruitful education. The solution thus "lies in infusing the various educating institutions with purpose and, even more importantly, with thought about purpose and about the ways in which techniques, content, and organization fulfill or alter purpose."[131] The insights provided by Cremin and Silberman help to connect the medical mis-education of women not only to the formal abstinence-only curriculum that shapes students' ideas about sexual and reproductive health, but also the informal curriculum that takes place in medical

[130] Lawrence A. Cremin, Public Education, (New York: Basic Books, Inc., 1976), 3.
[131] Cremin, *Public Education*, 13.

environments as established in the history of women's health. The mindlessness with which educators and medical professionals engage women's health, whether through enforced curriculum or social conditioning, harms women – something the BWHBC's mind*ful* work both reveals and remedies.

Martin is equally critical of the progressives' narrow focus on schools. Referencing his work, *Democracy and Education*, she notes that Dewey himself acknowledges that schooling is only one method of cultural transmission. Martin expounds, "It has certainly been my experience that one who looks at education from a cultural point of view will eventually start scanning the landscape to see what institutions besides schools are dedicated to preserving and transmitting the vast amount of cultural wealth."[132] Indeed a cultural approach to education shows that this tendency of educators to apply Dewey's work solely to schools impedes our ability to understand society as a whole. Like Cremin, Martin adopts a broader view within the scope of her work, exploring education that takes place both within and outside of schools and challenging us to infuse purpose into our teaching and learning.

Dewey's concept of mis-education is a good starting point for my work – certainly growth can be both arrested and distorted through institutionalized mis-educational practices. However, Martin's cultural formulation of mis-education speaks directly to the teaching and learning that takes place within a culture. By applying her concept of cultural mis-education to the culture of the profession of medicine, I am able to identify problems that shape my concept of the medical mis-education of women. BWHBC founding member Joan Ditzion described a sort of epiphany that arose from

[132] Jane Roland Martin, *Cultural Miseducation: In Search of a Democratic Solution*, (New York: Teachers College Press, 2002), 4.

their learning, in which the participating members of the group realized that gender roles were not biological, but rather are "culturally determined."[133] Likewise Martin's work recognizes that institutions like education and medicine are formed and preserved within a cultural context, and it is imperative that the relationships within and around institutions be examined as such.

In *Cultural Miseducation* (2002), Martin is focused on this larger idea of education. She contends that any situation that results in learning is educational. Therefore, learning can be either intentional or unintentional, curricula can be overt or hidden, and learning can take place in either formal or informal settings. For worse or for better, this means that education includes mis-education. By expanding the parameters of education, Martin's definition of mis-education takes on a more historical and cultural context than did Dewey's. She argues, "Cultural miseducation occurs when so many cultural liabilities or such devastating ones are passed down that a heavy burden is placed on the next generation; or, alternatively, when invaluable portions of the culture's wealth are not passed down."[134] Hence mis-education is both an action and a consequence for individuals, communities, and beyond. Martin's work provides a lens through which we can explore human exchanges not confined to a single institution.

However, Martin is not the first theorist to make this connection between learning and culture. Woodson's critique of mis-education in *The Mis-Education of the Negro* (1933) was built around a critique that American society indoctrinated black people into not only accepting inferior roles, but also deferring their needs and desires to the needs and desires of white society. This mis-education was accomplished through

[133] Ditzion, interview with author, 2016.
[134] Martin, *Cultural Miseducation*, 6.

societal processes as well as through social institutions like schools. In schools, the exclusion of the accomplishments of black people from the canon of education implied that they did not contribute to and, by extension, should not feel a cultural sense of pride associated with building social thought or structures. Woodson explains,

> The same education process which inspires and stimulates the oppressor with the thought that he is everything and has accomplished everything worth while [sic], depresses and crushes at the same time the spark of genius in the Negro by making him feel that his race does not amount to much and never will measure up to the standards of other peoples. The Negro thus educated is a hopeless liability of the race.[135]

Woodson reasoned that black students learned to settle for less fulfilling lives while black and white students learned that social hierarchies were justified. Black people thus were mis-educated to abandon their cultural identity and emulate white lives. People can only act on what they have learned, what they believe to be true. This kind of mis-education impairs the ability of individuals to experience true agency as they learn to feel inferior because of their race, ethnicity, gender, sexuality, or any other identifier that makes them different from the white male that is idealized in educational thought and cultural experience. This serves as a form of control. If someone believes that they are unworthy, why would they reach higher? Woodson declared,

> When you control a man's thinking you do not have to worry about his actions. You do not have to tell him not to stand here or go yonder. He will find his 'proper place' and will stay in it. You do not need to send him to the back door. He will go without being told. In fact, if there is no back door, he will cut one for his special benefit. His education makes it necessary.[136]

This is one of the most important insights made into the effects of mis-education. Cultural mis-education creates an environment in which already marginalized people

[135] Carter G. Woodson, *The Mis-Education of the Negro*, (Wilder Productions, Kindle Edition, 2008), 7.
[136] Woodson, *The Mis-Education of the Negro*, 5.

police themselves according to the way that other people define them and within the boundaries prescribed to them.

Based on the standard curriculum endorsed by abstinence only organizations, the abstinence movement has no intention of adding to any sense of agency among women and girls. Their messages appear to target women and girls in particular by promoting the idea of deference in traditional marriage roles and the biological necessity of having children. They reinforce their agenda by presenting their falsehoods as if they are scientific fact. As feminist author Jessica Valenti asserts, "why stop at condom-failure rates when you can fit a whole ideology in there?"[137] Their curriculum formalizes and legitimizes their ideology when presented in the trusted forum of schools. Within their message,

> Women are often described as weak, intellectually inferior, and needing men's financial and physical protection. In Waxman's report, one text was said to have listed "financial support" as one of the "5 Major Needs of Women," and "domestic support" as one of the "5 Major Needs of Men." Another describes how girls don't "focus" as well as boys.[138]

To back up their claims of girls' inability to focus, they fall back on old stereotypes of girls being overly emotional and unable to separate emotion from logic. Some programs even include in their message the idea of women as property. While others promote the antiquated notion that women do not like sex "and if they do, something must be amiss," and that boys "have no sex-control when it comes to anything sexual." [139] Sociologist Lorena Garcia found that "teachers and sex educators prefaced or followed lessons with a statement about the need for girls to be mindful of their respectability,

[137] Valenti, *The Purity Myth*, 106.
[138] Valenti, *The Purity Myth*, 106.
[139] Valenti, *The Purity Myth*, 107.

emphasizing that they should behave like 'good girls' or 'young ladies.'"[140] Not surprisingly, the idea of respect was not attached to the sexual behavior of boys.[141] Garcia further notes that girls are often disciplined for being actively engaged in sex education classes, even when teachers have encouraged questions from students. "In other words, it was possible for female students to be too interested in learning about sex."[142]

This sets up a cultural dynamic that has far-reaching implications about sexual relations between women and men. Sexuality is considered normal, inevitable for males while virtue is a concept applied to the sexuality of females. Women therefore have the duty to protect their virtue against the tide of raging male hormones and are held responsible should they fail. Whether women chose to participate in a sexual encounter or whether they experience rape, the woman is at fault for not protecting her virtue. It is thus deemed appropriate, especially in schools, to closely monitor girls' bodies via their clothing, public displays of affection, or any action or inaction that might be interpreted as enticing to boys. As Valenti points out, this is typical of "rape-apologist excuses."[143] She has found that "when abstinence curricula contain information about sexual abuse or assaults (though they often don't), the message is similar: The onus of preventing sexual assaults is on girls – not on men."[144] Valenti argues that "Making women the sexual gatekeepers and telling men they just can't help themselves not only drives home the point that women's sexuality is unnatural, but also sets up a disturbing dynamic in

[140] Lorena Garcia, *Respect Yourself, Protect Yourself: Latina Girls and Sexual Identity* (York University Press, Kindle Edition, 2012): 61.
[141] Garcia, *Respect Yourself*.
[142] Garcia, *Respect Yourself*, 60.
[143] Valenti, *The Purity Myth*, 108.
[144] Valenti, *The Purity Myth*, 108.

which women are expected to be responsible for men's sexual behavior."[145] This also conveniently makes any discussion about consent unnecessary. Girls and women should just not get sexually assaulted or voluntarily engage in sex or get themselves pregnant. The burden is girls and women to refute any male attention for their own good and, apparently, for the good of the man as well.

These programs also reinforce negative stereotypes about homosexuals and people of color. Carlson cites a report by the Applied Research Center which stated that these programs "promoted and legitimized homophobia in not recognizing homosexual behavior as acceptable in any circumstances, and in linking homosexuality exclusively and inaccurately to HIV/AIDS."[146] Programs promoted the idea that HIV/AIDS was commentary, a form of punishment, by "nature" on the sexual behavior of homosexuals.[147] The report also reviewed learning materials distributed by Sex Respect that described African-Americans of both sexes as promiscuous. Additionally, African-American men were portrayed as unfaithful, irresponsible partners, and African-American women were described as being unattractive and seeking out sexual attention from men to boost their low self-esteem.[148] Garcia writes, "While middle-and upper-class white youth are often perceived to be in need of intervention to guide them through their 'normally abnormal' hormone-besieged adolescence, youth of color are typically constructed as always 'at risk' and a source of danger."[149] Endorsing these stereotypes as fact protects the power of white, heterosexual men in families and

[145] Valenti, *The Purity Myth*, 108.
[146] Carlson, *The Education of Eros*, 112.
[147] Carlson, *The Education of Eros*, 112.
[148] Carlson, *The Education of Eros*, 112.
[149] Garcia, *Respect Yourself*, 58.

society. And when this information comes from people in positions of power and trust like doctors and teachers, it is assumed to be fact despite any and all evidence to the contrary. This makes reclaiming knowledge, histories, and bodies all the more difficult, and further isolates and controls marginalized people with sense of inferiority.

Education, Medicine, and Politics

There are several terms that Martin defines within her theory of cultural mis-education that are important for understanding the medical mis-education of women. She defines our cultural "stock" as consisting of both *assets* (or *cultural wealth*), those bits of our culture that we should embrace and nurture, and *liabilities*, those bits of our cultural stock that we should discard. Martin gives examples of assets that include care, concern, and connection – what she calls the "three Cs" – and examples of liabilities that include violence and hatred, vices we should all be able to agree[150] should be purged from our collective cultural existence. It is important to note that the concepts of care that Martin embraces are pieces of cultural wealth that are traditionally tied to women and women's work. Yet women's work of caring, like women themselves, has been systematically devalued in our society. Motherhood, teaching, midwifery, and nursing are all jobs for women because of their association with domestic care, nurturing, and nature. Martin explores the "two-sphere split" that divides the work of women and men, which she also refers to as the nature/culture divide, in greater detail

[150] It is worth noting here that the 2016 U.S. presidential election would appear to contradict this statement. It seems evident that hate, violence, racism, misogyny, xenophobia, etc. were in fact endorsed through the election of Donald Trump. The course of Trump's campaign included calling all Mexicans "rapists," mocking a physically disabled man, and brushing off an audio clip of him bragging about grabbing women "by the pussy" as "locker room talk."

in *Education Reconfigured* (2011). She notes that this split, "does not merely signal an institutional divide. Rather, it draws a line of demarcation between the activities, processes, tasks, duties, responsibilities, knowledge, skill, attitudes, values, and worldviews associated with home and family on the one hand, and with work, politics, and the professions on the other."[151] The work of men – that is politics and the professions – is of course given superior status.

> In the two-sphere ideology, the public world is portrayed as the area where intellect, theoretical knowledge, and rationality hold sway. In contrast, the world of the private home is the place where childrearing, nursing the sick, and caring for the elderly are located. Given that tending to bodily functions is a central component of these activities and that whatever knowledge and skill is required to do this work is believed to be instinctual, the inferiority of the world of the private home is thought to be assured.[152]

It is perhaps ironic that medicine, which to this day is still largely viewed as the domain of men, is a field in which the body takes center stage. However, the professional divide built into medicine serves to reinforce this social divide and the social hierarchy that oppresses women. And this is a phenomenon that is replicated in other institutionalized professions. It is no wonder then that education and medicine, both of which are originally based in women's traditions of care and healing, are too often sites of oppression and pain.

With her cultural-wealth approach to education, Martin develops an inclusive perspective that goes far beyond the standard accepted boundaries. By including "the works, experiences, practices, and achievements of people who have always been part of society but have never quite been acknowledged as members of culture,"[153] she

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[151] Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change*, (New York: Routledge, 2011), 30.
[152] Martin, *Education Reconfigured*, 31.
[153] Martin, *Cultural Miseducation*, 8.

moves quite soundly into the realm of social justice. Martin argues that cultural wealth is not solely the domain of any one elite group or institution, an idea supported by the conventional school curriculum. Rather, "it includes the whole range of human activities" with "all members of a culture – not just some privileged racial, religious, gendered, or other elite"[154] having the right to contribute to our collective cultural wealth. In other words, because we all make up and participate in our culture, what we do and create within the context of that culture becomes a legitimate part of our cultural stock. This puts the voices of otherwise marginalized people on an equal plane with the powerful, and denies the message that is so central to abstinence education.

In *Experience and Education,* Dewey discusses the importance of the freedom of intelligence which is necessary to realize "genuine and continued normal growth."[155] He distinguishes freedom of intelligence from traditional notions of freedom which generally speak only to freedom of movement. Dewey sees this physical, external freedom as only one piece of true freedom. He writes, "The educational problem is not solved when this aspect of freedom is obtained."[156] Freedom of intelligence engages what he calls a "stop and think" psychology. Essentially, when instead of automatically acting on an instinct we pause to critically consider the action and its associated consequences, we are exercising that freedom. I would argue that it actually goes further than that and Martin again provides the tools. She states, "To think critically a person has to be able to spot logical fallacies, identify arguments, isolate assumptions, and assess conclusions."[157] But – how is a person supposed to do that if they are given

[154] Martin, *Cultural Miseducation*, 3.
[155] Dewey, *Experience and Education*, 61.
[156] Dewey, *Experience and Education*, 61.
[157] Martin, *Cultural Miseducation,* 123.

only a selected portion of information? The traditional curriculum is one in which we "expect everyone to adopt the white man's point of view, memorize his history, and cherish his achievement."[158] The knowledge deemed important and worthy of education was established long ago by those in power – that is, white men. It was they who decided what was a classic novel or whose version of victory we should celebrate. This limited scope of education excludes the valuable contributions of women and people of color and systematically erases the reality of their histories. What happens to learning when the curriculum is not reflective of its student body? If we teach that marginalized people are absent, at fault, or inconsequential to the story of our culture, how do we not expect to perpetuate the same problems that education proposes to solve? If we teach that certain people are sexually irresponsible, and therefore less valuable, how do we expect others to respect them and how do we expect them to respect themselves? How do we expect any student to think critically about their own lives, the professions, institutions, and the world at large if they are not taught the value of all people? We are in fact restraining freedom of intelligence and perpetuating cultural mis-education by limiting the scope of peoples' knowledge.

This level of mis-education is what is known in political terms as *propaganda*. Propaganda is a prominent, long standing, and very effective example of cultural, institutional mis-education with known, severe consequences. Edward Bernays, the man often referred to as the Father of Public Relations, argues, "Propaganda becomes vicious and reprehensive only when its authors consciously and deliberately disseminate what they know to be lies, or when they aim at effects which they know to be

[158] Jane Roland Martin, *The Schoolhome: Rethinking Schools for Changing Families*, (Cambridge: Harvard University Press, 1992), 69.

prejudicial to the common good."[159] In other words, when they knowingly engage in a course of mis-education that has intentionally mis-educative consequences. In his book *Propaganda* (2005), Bernays offers the following definition, "Modern propaganda is a consistent, enduring effort to create or shape events to influence the public to an enterprise, idea or group."[160] Interestingly, Bernays wrote his book around the same time that John Dewey was working out his progressive theory of education. As educators were busily theorizing corrective actions to be taken in schools that were meant to improve critical thinking skills and educational experiences for students, the emerging field of public relations was joining forces with the government to embark on various campaigns that have been detrimental to U.S. society. Noam Chomsky explores the evolution and purpose of propaganda in *Media Control: The Spectacular Achievements of Propaganda* (2002).

Chomsky begins his book by delineating two very different versions of democracy. In the first, we find the ideal in which "a democratic society is one in which the public has the means to participate in some meaningful way in the management of their own affairs and the means of information are open and free."[161] In the other, we find a version in which "the public must be barred from managing their own affairs and the means of information must be kept narrowly and rigidly controlled."[162] This means that people can be more easily controlled by limiting their access to knowledge. Chomsky convincingly argues that the United States finds itself mired in the second

[159] Edward Bernays, *Propaganda*, (Brooklyn: IG Publishing, 2005), 50.
[160] Bernays, *Propaganda*, 52.
[161] Noam Chomsky, *Media Control: The Spectacular Achievements of Propaganda*, (Seven Stories Press, Kindle Edition, 2002), 9.
[162] Chomsky, *Media Control*, 9.

variety of democracy due in large part to the power of propaganda.[163] Undeniably the character of a democracy also has an effect on and in the democratic institutions that exist within in it as well. Both American education and medicine arguably fall into the second form of democratic institution, spaces where neither students nor patients have much say over how they experience their learning or healing.

Cultural Mis-education and the Medical Mis-education of Women

In contrast to the lessons of propaganda, Martin cultural mis-education is a more holistic approach to education, one that takes individual contexts, lives, needs, and outcomes into consideration. Within her framework, living and human interaction are the most basic forms of education. We are all constantly learning and engaging in activities that foster either growth or misery. It is the job of educators – that is, each of us – to ensure that our actions contribute positively to the best possible version of living. To clarify the cultural nature of education and mis-education, I will elaborate on Martin's terminology that serves as a basis for her theory. I focus on three terms that are

[163] Chomsky illustrates his argument using the example of the U.S. entry into World War I, an idea that was initially wildly unpopular among a largely "pacifist" American population. After the establishment of the Creel Commission, a governmental commission for propaganda, public opinion was changed. The Commission "succeeded, within six months, in turning a pacifist population into a hysterical, war-mongering population which wanted to destroy everything German, tear the Germans limb from limb, go to war and save the world." See, Chomsky, Media Control, 11. This was the first of many achievements of the Creel Commission. Interestingly, Chomsky lays a portion of the blame for the U.S. entry into WWI at the feet of John Dewey. He calls out the "people of the John Dewey circle" for celebrating in their writings that they, the "more intelligent members of the community," were able to effectively assist in perpetuating the propaganda that led to the country into war. See, Chomsky, Media Control, 11. Educational philosopher Paulo Freire would remind us that propaganda is contrary to liberation and transformation, two of the ideal goals of progressive education. See, Paulo Freire, Pedagogy of the Oppressed, 30th Anniversary ed., (New York: Continuum, 2000), 60. Chomsky notes that the benefits of recruiting educated people like Dewey and his learned cohort by propagandists were quickly realized. Similarly, the educated men of medicine have been shown to have been relied upon to sway public opinion on women, women's health, and the ways in which women's health affected women's capabilities. A mis-educational curriculum, after all, is more effective when delivered by a qualified teacher.

particularly descriptive of and important to the framing of the medical mis-education of women as a form of cultural mis-education. The terms are: educational problem of generations, multiple educational agency, and circulating the gifts.

Educational Problem of Generations

Briefly, *educational problem of generations* speaks to how we, as a culture, decide which pieces of our cultural stock we are to pass on to new members of our culture and which we are to expel. As the membership in society is constantly changing, it is especially important that we choose our stock wisely and make room for the ideas of new members whose contributions can increase our cultural assets. In this light, we should also consider how we transmit culture within professions. In a professional setting, it is unclear how much consideration is actually given to its culture and the types of assets and liabilities that are shared amongst its members and beneficiaries. The educational problem of generations can thus become the problem of professions when thought leaders of professions give little credence to what knowledge, action, and inactions shape their culture.

Within the medical professions, it is evident that new information is welcomed – new studies and innovations are always under investigation that expand the abilities of medicine to heal and comfort. However, questions remain regarding how much thought has been given to changing attitudes and ideas that have been passed from generations of doctors, nurses, patients, researchers, and others who participate in health care. We must wonder how much historical mis-education is still used as a foundation for new information. History makes clear that professional medicine has had little interest in

seeking outside input into their methods and practices. The professions have a tendency to assume that their own knowledge generated from within is best, and outsiders – a category that includes patients, who are often considered outsiders, non-authorities to their own lived experience – have nothing to contribute. Because of generational hierarchies that put professionals on top and patients on the bottom, there remains a two-way knowledge gap in medicine where patients know more about their own bodies, and physicians know more about the science of the generic body. Until physicians learn to take seriously the insights and understanding patients have of their bodies, the educational problem of generations within professions will remain.

With regard to sexual and reproductive health education, the educational problem of generations is allowed to flourish as a result of the millions of dollars that have funded it for decades. The results of this medical mis-education are quantifiable, and quite damning. According to the Centers for Disease Control and Prevention (CDC), twenty-two percent of all new HIV diagnoses in the U.S. in 2014 were found among people aged 13 to 24; and half of all newly reported STDs each year, approximately 10 million cases, occur in people aged 15 to 24.[164] One of the primary stated intents of abstinence-only education – preventing out-of-wedlock teen pregnancies – has also failed spectacularly. The CDC indicates that in 2014, approximately 250,000 babies were born to teenaged girls, aged 15 to 19.[165]

Klein reports that the failure rate of abstinence-only, which is not allowed to be discussed as part of their curriculum, is eighty-eight percent. That is, only twelve

[164] Centers for Disease Control and Prevention, "Sexual Risk Behaviors: HIV, STD, & Teen Pregnancy Prevention." Last modified July 18, 2016. Accessed September 21, 2016. https://www.cdc.gov/healthyyouth/sexualbehaviors/
[165] CDC, "Sexual Risk Behaviors."

percent of students who make abstinence pledges – a common form of publicly declaring commitment to no-sex-before-marriage endorsed by the abstinence movement – are successful.[166] One study from 2007 reported that teens were just as likely to have sex whether they were involved in abstinence-only education or not. This same study indicated that abstinence students believed condoms to be ineffective against STDs and HIV.[167] Another study from 2005 "showed that teenagers who took abstinence-only education classes and pledged their virginity were not only less likely to use condoms, but also more likely to engage in oral and anal sex."[168] After all, if a sex act could not result in procreation, they can say that they have remained true to their pledge of abstinence. If students are taught to associate shame with premarital heterosexual vaginal intercourse, it makes sense that they will find other ways to explore their curiosity. Klein points out that,

> Although the emotionally abusive message of abstinence programs don't shape adolescents' sexual *behavior* much, they do shape the *emotional context* of the sexual behavior. So these young people use contraception less, understand less about how sex actually works, feel worse about themselves, and talk less about their sexual feelings or experiences with their parents. So abstinence programs create the worst of both worlds: nonabstinence, lower rates of contraception and disease protection, and less intelligence about sex – not only logistically, but emotionally and spiritually.[169]

This medical mis-education effectively halts any productive conversations about healthy relationships and silences teens who come to believe their curiosity about sex to be abnormal. It also discourages teens from looking any further for accurate information because they are supposed to be able to believe what they are taught in school.

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[166] Klein, *America's War*, 15.
[167] Valenti, *The Purity Myth*.
[168] Valenti, *The Purity Myth*, 120.
[169] Klein, *America's War*, 21. Emphasis in original.

Multiple Educational Agency

Next, *multiple educational agency* begins by decentralizing the concept power. "When the equation between education and schooling is rejected and education is in its turn decentralized, so is the list of educational agents."[170] Martin names multiple examples of common learning environments outside of schools including families, communities, museums, fire departments, zoos, playgrounds, orchestras, banks, TV, and churches, among others. These individuals, organizations, and institutions all perpetuate our cultural stock, both assets and liabilities, whether it is intentional or not. Through their actions and inactions, they become *educational agents*. If we were to keep adding to the list of educational agents, we would certainly include doctors' offices, hospitals, community clinics, pharmacies, pharmaceutical companies, medical schools, and so on. But this list does not end with people and places. Books, databases, medical journals, and other textual sources also serve as educational agents. Of course, by this definition, we are all educational agents – and the entire structure of medicine bears responsibility as agents of medical education and mis-education. Indeed abstinence organizations become educational agents of a mis-educational agenda through their work.

Abstinence organizations, those who determine the abstinence curriculum, and the educators who must deploy their curriculum are all educational agents who engage mis-education to do their work. Klein points out that abstinence-only education employs several strategies in their curriculum. One of the most important in terms of medical

[170] CM, page 37

mis-education is that they, as educational agents, must convince young people that "contraception and disease protection are so unreliable that they must not be trusted."[171] The Abstinence Clearinghouse promotes the undeniably incorrect idea that condoms are completely ineffective protection against both HPV and genital herpes.[172] Dr. Klein, who is also an educational agent under Martin's definition, counters these lies with facts,

> Their first strategy requires lying. Because condoms work, condoms work, condoms work. They work better today than they ever have. They work so well, hundreds of millions of people around the world use them to shape when and if they'll have children. They work so well, virtually every serodiscordant couple (one partner is HIV positive, the other HIV negative) who use condoms regularly prevent the HIV negative partner from contracting HIV. They work so well, they help prevent herpes, chlamydia, and the newest STD demon of the Right, HPV. In the 1980s, they helped dramatically stem the tide of HIV among gay men.[173]

The negligence and irresponsibility in the tactic of abstinence educational agents cannot be overstated. Teens are being mis-educated through a campaign of intentional misinformation from an institution they should be able to trust – much as women have been medically mis-educated for centuries by the medical institution. Abstinence-only "education" leaves teens completely uninformed about and unprepared to deal with the very real issues associated with responsible sexual relationships in the modern world.

Abstinence-only education presents a very specific viewpoint on relationships. It perpetuates a narrow and negative view of women by assigning value to a particular kind of lived experience over others. It isolates, ignores and, devalues the survivors of incest, rape, and domestic abuse and refuses to acknowledge that sexuality can be both

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[171] Klein, *America's War*, 14.
[172] Klein, *America's War.*
[173] Klein, *America's War*, 14.

healthy and enjoyable for women. It promotes the idea that anything that falls outside of heterosexual sex that happens inside of marriage for the purpose of procreation is wrong. The idea that "children should not be exposed to stories that portray immoral or unvirtuous behavior"[174] has been the rallying cry of the abstinence movement. Their theory is: if we teach children about safe sex, they'll have sex. "If children are not even aware of the existence of undesirable behavior…they will not be in a position to emulate it."[175] This plan has not exactly worked, however, as evidence shows. Educational agents do not teach children about safe sex, about the emotional aspects of sex, or about consent in sexual relations yet children are still having sex and experiencing sexual assault.

Klein argues that sex education has very little to do with "what's safe and healthy for the children." Rather, "It's about what's comfortable (and politically advantageous) for the adults."[176] Abstinence-only has been part of a long tradition in the U.S. of controlling sexuality. And, as with medical and legal actions to control sexuality, female bodies have been the main focus. Klein observes that federal funding of abstinence education transformed private morality into public policy. Of course, this version of "morality" is not the same for all families. Some would agree that it is immoral to withhold information about health. In fact, eighty-two percent of Americans support comprehensive sex education.[177] And after twenty-five years of abstinence-only programs' federal financial monopoly on sex education, President Barack Obama has

[174] Jane Roland Martin, *The Schoolhome: Rethinking Schools for Changing Families*, (Cambridge: Harvard University Press, 1992), 80.
[175] Martin, The *Schoolhome*, 80.
[176] Klein, *America's War*, 5.
[177] Valenti, *The Purity Myth*, 218.

cut its funding from the fiscal year 2017 federal budget. The new budget will instead increase funds going to programs that support teen sexual health.[178] This may give educational agents in schools who would otherwise engage students in thoughtful, accurate sexual and reproductive health education the chance to make positive changes to curriculum.

Circulating the Gifts

Finally, *circulating the gifts* speaks to the sharing of knowledge and ideas to contribute to individual and collective learning. This concept lies in stark contrast to the weaknesses of the "appropriation model" of education which Martin criticizes as such, "Appropriating for yourself the knowledge and skill you have attained by your own hard work makes perfect sense when there is nobody who can possibly want or need what you have acquired."[179] Appropriation has been the traditional model of Western medicine which has held itself apart from society, claiming elite status by cloaking itself in the intricacy and mystery of science. As medical men held proprietary claim to medical knowledge, the average person has come to believe themselves incapable of understanding the complexities of medicine. This act of mis-education has had profound mis-educational consequences, especially where women and women's health are concerned.

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[178] The Sexuality Information and Education Council of the U.S., "President's FY 2017 Budget applauded by the Sexuality Information and Education Council of the U.S. (SIECUS)." Last modified February 9, 2016. Accessed October 4, 2016. http://siecus.org/index.cfm?fuseaction=Feature.showFeature&featureid=2437&pageid=611

[179] Martin, *Cultural Miseducation*, page 132.

Clearly abstinence-only education does not exactly contribute to individual and collective learning in ways that result in positive outcomes – they are not circulating gifts. On the other hand, the BWHBC engages women's sexual and reproductive health in such a way that they not only share their own gifts, but they are able to learn from the gifts that others have shared with them. In *Our Bodies, Ourselves*, they share what they have learned about the informal curriculum of sex education in culture. The following passage makes evident the contrast between the BWHBC's approach to education and that of the abstinence movement. The thoughtful, frank, and honest approach to sharing knowledge is a hallmark of their book.

> We are simultaneously bombarded with two conflicting messages; one from our parents, churches and schools – that sex is dirty and therefore we must keep ourselves pure for the one love of our lives; and the other from Playboy, Newsweek, etc., almost all women's magazines, and especially television commercials – that we should be free, groovy chicks.
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> We're learning to resist this double message and realize that neither set of images fits us. What really has to be confronted is the deep, persistent assumption of sexual inequality between men and women in our society. "Frigidity" or "inadequacy" in bed in not divorced from the social realities we experience all the time. When we feel powerless and inferior in a relationship, it is not surprising that we feel humiliated and unsatisfied in bed. Similarly, a man must feel some contempt for a woman he believes is not his equal. This male-dominated culture imbues us with a sense of second-best status, and there is no reason to expect this sense of inferiority and inadequacy to go away between the sheets.
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> The illustrate that this concept which champions sharing, learning, and validating lived experience in educational spaces creates an environment that is conducive to true learning.[180]

As I begin focusing on the BWHBC in the coming chapters, their circulating of gifts will become evident.

[180] BWHBC, *Our Bodies*, 24.

Rethinking Sex Education

Educational philosopher Nel Noddings argues that "Part of caring for the self is gaining an understanding of life stages, birth, and death."[181] Presumably, this means that we should all be learning accurate, age-appropriate information about reproductive health and sexuality throughout our lives. It is important, as Carlson notes, to make space for progressive learning even in the face of oppressive standards. President Obama's change to funding abstinence programs may or may not come to pass under the incoming republican administration, house, and senate – republicans have been the strongest supporters of the so-called traditional family values espoused by these programs. But, should schools be allowed to reimagine a healthful and productive approach to sex education, what methods should they use? Whose work could serve as an example as they write a new curriculum? I believe that the BWHBC and their work on *Our Bodies, Ourselves* presents the perfect model upon which schools can build.

The following chapters will engage my OTIs with Joan Ditzion and Vilunya Diskin. I will also begin to describe the theoretical formulations of the problem and remedies that I have identified in the words and work of the BWHBC. The BWHBC, who have authored numerous editions of *Our Bodies, Ourselves*, have engaged in critical re-education of adult women concerning their sexual and reproductive health for more than four decades. Their work speaks to the need of women to be active participants in leading and learning in educational spaces, particularly where women's bodies are concerned. I will argue that schools can learn from their work how to

[181] Nel Noddings, *The Challenge to Care in School: An Alternative Approach to Education*, (New York: Teachers College Press, 1992), 80.

approach curricular and pedagogical reforms that the medical mis-education of women makes necessary in order to achieve Title IX's aim of gender equality.

Chapter Three:

"You don't have to worry your pretty little head about it.":

Naming the Problems

We would ask doctors questions and they would often not answer them and say 'you don't have to worry about that, I'm the doctor.' And sometimes they would say, 'Oh, you don't have to worry your pretty little head about it.'

- Vilunya Diskin

In the previous chapter, I framed the educational philosophy that guides the exploration of the medical mis-education of women. Martin's concept of cultural mis-education is the foundational work that shapes the medical mis-education of women. Martin clarifies that education is a cultural phenomenon that is experienced in daily living as well as in schools. Dewey's concept of experience in education makes clear that not all experience is equally educative. Dewey and Martin both point out that poor experiences can still result in learning, but those experiences are mid-educative in nature and will result in mis-education. Chomsky helps move cultural mis-education broadly and the medical mis-education of women specifically into the area of social justice. Chomsky's exploration of propaganda demonstrates what cultural mis-education can do on a large scale. The violence and hatred that Martin decries are fully exploited for the purposes of propaganda. And while Chomsky focuses much of his energies on the kind of political propaganda that results in wars, it is not difficult to make the leap from militarized war to the War on Women. Both are political situations,

and the War on Women relies heavily on educated medical men to serve as experts in framing women as incapable of managing their own lives. Through these educational and political philosophers, the full scope of the medical mis-education of women as a force of oppression can be understood.

I have also described a pressing case of the medical mis-education of women that takes place in within schools. Abstinence-only sex education, which has shaped sexual and reproductive health in schools in the United States for decades, has perpetuated the medical mis-education of women through curricular action that has resulted in widespread mis-education. The promotion of factually incorrect information has had a profoundly negative effect on the sexual and reproductive lives of a generation of Americans. The burden of this mis-education has the most prominent impact on the lives of girls and women who will have to physically endure pregnancies and bear the brunt of childrearing in a society that condemns female sexuality outside of heterosexual marriage. The stigma of the "ruined woman" taught in abstinence-only ensures that the social ramifications of teen pregnancy fall most definitely on the female. But the consequences reach much further than social stigma. Unintended pregnancies in teen girls too often result in women and women-led families entering into a cycle of poverty that is nearly impossible to escape. The medical mis-education of women that is endorsed through school curriculum disrupts women's capabilities which directly affects the abilities of women to live fully and autonomously.

This problem of medical mis-education that happens in schools has a chance of being reversed. President Obama's change to the 2017 federal budget which severs the abstinence-only requirement in order for schools to receive funding for sexual and

reproductive health programs gives educators the opportunity to reimagine what should be taught and how best to teach it. I propose using the BWHBC as a model. Their creative, inclusive, and interactive approach to education has changed the lives of women the world over. Their book *Our Bodies, Ourselves* is often credited as the beginning of the women's health movement in the American feminist movement of the 1960s to the early 1980s. To assist administrators and teachers in considering what kind of learning will best make relevant a subject necessary for a healthy life, I explore the words and work of the BWHBC for pedagogical clues to help make sexual and reproductive health education an educative experience that actively remedies the medical mis-education of women.

This chapter will be an exploration of the historical and analytic foundation of the problem of the medical mis-education of women. Utilizing interviews with founding members of the BWHBC Joan Ditzion and Vilunya Diskin and the 1973 edition of *Our Bodies, Ourselves* as primary sources, I will explore the thinking of the BWHBC regarding the medical mis-education of women at the historical period of the creation of their book. Diskin described the very beginnings of their project as seeking answers to their questions. She describes their very straightforward approach to learning, "…we have all these questions, let's make a list of everything we would like to know about." By seeking to answer the problems identified within the scope of their educational project, their work in fact points to larger, more profound questions.

My analysis of the words and work of the BWHBC has revealed educational and medical problems for which they created remedies. These problems overlap, interact, intersect, and depend on each other for their longevity and influence. These problems

are made explicit by the BWHBC as having a detrimental effect on the lives and health of women, and contribute to the medical mis-education of women. I name and define those educational problems as:

1. **The Deference Problem**: Women learn that they must defer to male authority and that they, their needs and goals are secondary to those of men. Women must focus their life's work on family and domesticity.

2. **The Isolation Problem**: Learning is typically done in isolation from and in competition with others. Sharing of knowledge is not a part of formal education.

3. **The Inferiority Problem**: Women are taught that they are incapable of learning the same level of complex information as men. This restricts women's participation in STEM and health fields. Women are either not allowed access to or given restricted access to topics that affect health and well-being of women.

I name and identify those medical problems as:

1. **The Knowledge Problem**: Medical learning is made intentionally difficult for laypeople through the professional hoarding of medical knowledge. Likewise, women's knowledge of their own bodies is not considered worthy of consideration by medical men as it does not originate from medical learning.

2. **The Experience Problem**: Women's experiences are devalued and thus not considered applicable or relevant to their own medical situations.

3. **The Control Problem**: Women's bodies and abilities have been defined by medical men which has allowed women's bodies to be controlled in medical and social contexts.

It is important to note that these problems, all bound to the educational problem of professions, rely heavily on what is called the *manufacture of consent*. Chomsky discusses how the concept of manufacturing consent grew out of the social experiments of the Creel Commission, something Bernays called engineering of consent. The manufacture of consent specifically referred to "bring[ing] about agreement on the part of the public for things they didn't want by the new techniques of propaganda."[182] This too was a function of the intellectual elites – members of "a "specialized class" of "responsible men" who are smart enough to figure things out."[183] It was implied, if not outright declared, that they were able to understand the world in ways that the common man, members of the "bewildered herd"[184] could not. The manufacture of consent was justified to keep society moving in a manner satisfactory to those in power. Chomsky describes a hierarchy that exists with the "political class and decision makers"[185] on top, followed by the specialized class of responsible men who serve those in the upper tier, and the bewildered herd at the bottom. The key is to have "an educational system directed to the responsible men, the specialized class"[186] and a way of keeping the bewildered herd, who are "guided just by emotion and impulse,"[187] distracted and give them a "tolerable sense of reality."[188] It is interesting to note how the bewildered herd is described in a feminized form – they are hysterical, emotional, and in need of leadership. It is easier to justify stripping agency from those who are constructed as lacking the means to exercise it.

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[182] Chomsky, *Media Control*, 14.
[183] Chomsky, *Media Control*, 14.
[184] Chomsky, *Media Control*, 15.
[185] Chomsky, *Media Control*, 15.
[186] Chomsky, *Media Control*, 19.
[187] Chomsky, *Media Control*, 19.
[188] Chomsky, *Media Control*, 17.

Successful manufacture of consent also requires certain other conditions. Chomsky states it is "necessary to completely falsify history"[189] if the bewildered herd are to overcome their aversion to the reality being presented to them. Using another wartime example, he elaborates, "If we're bombing South Vietnam, that's because we're defending South Vietnam against somebody, namely, the South Vietnamese, since nobody else was there." This level of manipulation, of mis-education, can easily be done "[w]hen you have total control over the media and the educational system and scholarship is conformist[.]"[190] Through institutions and institutionalized processes, it becomes easier to control the message and, as a result, to control people.

As Chomsky focuses on war as one of the most frequent beneficiaries of propaganda, Susan Faludi describes ways in which propaganda has benefited the men who wage the War on Women.[191] In her book *Backlash: The Undeclared War Against American Women* (1991), she opens by describing the ways that American women are told that have "made it" by marketers and magazines,

> Enroll at any university, join any law firm, apply for credit at any bank. Women have so many opportunities now, corporate leaders say, that we don't really need equal opportunity policies. Women are so equal now, lawmakers say, that we no longer need an Equal Rights Amendment. Women have "so much," former President Ronald Reagan says, that the White House no longer needs to appoint them to higher office. Even American Express ads are saluting woman's freedom to charge it. At last, women have received their full citizenship papers.
>
> And yet…
>
> Behind this celebration of the American woman's victory, behind the news, cheerfully and endlessly reported, that the struggle for women's rights is won, another message flashes. You may be free and equal now, it says to women, but you have never been more miserable.[192]

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[189] Chomsky, *Media Control*, 35.
[190] Chomsky, *Media Control*, 35.
[191] The War on Women is a term that has been used frequently in the media to describe the medical restrictions placed on women through legislators who claim to do so because they care about women who apparently must be protected from their own decisions.
[192] Susan Faludi, *Backlash: The Undeclared War against American Women*, (New York: Crown, 1991), ix.

Consent is largely manufactured in modern American women through the illusion of equality and advancement. And while it is hard to deny that women have a greater presence in public life than ever before, there are active institutionalized processes that work against women gaining full control of their bodies and, therefore, their lives.

Women are told that their personal and professional successes are in their own hands, that they have choices. This implication of choice without providing actual, attainable options can be thought of as a form of coercion. In her essay "In and Out of Harm's Way: Arrogance and Love," Marilyn Frye explores mechanisms of the patriarchal oppression of women. She describes the structure of coercion as such,

> to coerce someone into doing something, one has to manipulate the situation so that the world as perceived by the victim presents the victim with a range of options the least unattractive of which (or the most attractive of which) in the judgment of the victim is the act one wants the victim to do.[193]

Manufacture of consent is coercion, it is a restraining of capabilities, and does cause real harm to real people.

As the BWHBC explored these problems in the scope of their work – with an apparently clear understanding of how the manufacture of consent had influenced their reality – they did so with a focus on adult women who were living with the consequences of their medical mis-education in relation to the medical professions. The named problems I identified in their work are problems that permeate the whole lives of girls and women and are not isolated to any one age or life experience. Indeed the hierarchical patterns established in schools beget some of the problems experienced with other institutions like medicine throughout our lives. Because of pervasiveness of

[193] Marilyn Frye, *Politics of Reality: Essays in Feminist Theory*. (Freedom: The Crossing Press, 1983), 56.

these issues, the lessons found within their pedagogical approach to health education can be extrapolated to health education at any age and in any setting. This chapter is dedicated to gaining an understanding of the problems first and foremost, which is necessary to understand and implement remedies.

The Deference Problem

The Deference Problem is nothing new. Women's power, bodies, thoughts, intellect, ambitions, voices, their very existence have been devalued and discarded in deference to men. The BWHBC came to realize that although the Deference Problem had overshadowed their lives, it was not something unavoidable or inevitable, it was a problem that was created for them. Joan Ditzion described the epiphany that overcame the members of the BWHBC in the early stages of their work,

> So what was going on then in the second wave movement that really started primarily on college campuses was that women were learning we've been, reared in a sexist society that's patriarchal in its values – that of men dominating women and women feeling the inferior second sex … and this is all a social construction. You know, it's not really biologically determined, it's culturally determined and so if we live in a culture, we really need to call issue with that. And it was so profound because you know although I'd been involved in civil rights and other issues, I thought, wow, this really touches me at my core. You know I grew up feeling the whole sexist set of assumptions.[194]

This realization that Deference is not a failing of female character begins to breakdown the issues surrounding it. This educational problem of the professions identified by the BWHBC persists to this day.

In *The Second Sex* (1949/2011), Simone de Beauvoir famously wrote, "One is not born a woman, one becomes one."[195] The becoming to which de Beauvoir refers is

[194] Ditzion, interview with author, 2016.
[195] Simone de Beauvoir and Constance Borde, *The Second Sex*, (New York: Vintage Books, 2011), 283.

found in how we raise our differently sexed children to engage the world in vastly different ways. As educational agents, we bring girls up to be women who must exist in a culture of medical mis-education. The BWHBC were aware of how their socialization restrained their lives, goals, and physical freedoms. In *Our Bodies, Ourselves* they describe the group's observations of growing up female,

> It seems pretty clear to us that from the moment we are born we are treated differently from little boys. Our toys are different: dolls instead of chemistry sets. Our clothes are different: dresses to be kept clean instead of sloppy pants. Pocketbooks instead of pockets – something else to keep us from swinging our arms, using our bodies freely. Over the years the distinctions keep being made between boys and girls. We're emotional; they're intellectual. They're clumsy; we're graceful and dainty. They're athletic; we're domestic. They are going to go on to become doctors and businessmen. We are going to get married.[196]

Similarly, Martin references the two-sphere split which finds women associated with the perceived inferiority of the domestic realm, while men are associated with culture, intellect, and achievement. The disparate interpretations of the private versus the public worlds to which women and men are assigned is reflected in the values assigned to the lives of women and men. This is where the Deference Problem begins.

This control over women makes women's deference to men take on a particularly embodied form. Psychologist Miriam Greenspan's depiction of *Woman as Body* is particularly useful for illustrating this disparity. Greenspan argues,

> Since personhood is culturally defined in male terms, being feminine and being a person appear to be mutually exclusive. One aspect of this double-bind is the fact that to develop herself as a person, woman must develop herself as a body for men.[197]

Under this philosophy, a woman is not supposed to be mentally or physically superior to a man. It is a woman's job to make herself beautiful and desirable to accommodate

[196] BWHBC, *Our Bodies*, 26.
[197] Miriam Greenspan, *A New Approach to Women & Therapy*, (New York: McGraw-Hill, 1983), 163.

the gaze of men, to whom Sandra Bartky refers as the "panoptical male connoisseur,"[198] and women inherently understand that "they stand perpetually before his gaze and under his judgment."[199] Women must make themselves appealing to men as sex objects, as procreation vessels, as nurturers to meet all of the needs of men. "This production of 'docile bodies'[200] requires that an uninterrupted coercion be directed to the very processes of bodily activity, not just their result."[201] Women, in return for their mandatory efforts, are considered vain and shallow. Woman as Body traps women in a cycle of dependency for male approval and validation for which the ultimate reward is marriage and motherhood acquired within the confines of marriage. This is "the most powerful and prestigious position most women could hope to attain."[202] Indeed patriarchal culture never fails to remind us that women's bodies are there for the taking by men – by force if necessary, and domestic violence, rape, and rape culture exist to remind women that their bodies are not their own. Male privilege through institutions in a patriarchal culture is further reflected in "the legal power of the state and medical professions to control a woman's sexual and reproductive life"[203] and bodily control is reinforced through other male-dominated institutions like family, religion, and education. Women are tied to and control through their bodies in ways that men will never be.

Of course, Deference defines women's status in many ways. Martin has explored the relegation of women to what she calls the "ontological basement" of

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[198] Sandra Lee Bartky, *Femininity and Domination: Studies in the Phenomenology of Oppression*, (New York: Routledge, 1990), 110.
[199] Bartky, *Femininity and Domination*, 110.
[200] This term originated with Michele Foucault in Discipline and Punish, originally published in 1975.
[201] Bartky, *Femininity and Domination*, 103.
[202] Greenspan, *A New Approach*, 164.
[203] Greenspan, *A New Approach*, 166.

educational philosophy. Martin borrows the term from political philosopher Lorenne Clark who "has shown that from the standpoint of political theory the consignment of women, children, and the family to the ontological basement – that is, their apolitical status – is due not to historical accident or necessity but to arbitrary definition." [204] The domestic, reproductive work of mothers is not considered to be work in the same way that the public, productive processes of men are. Nurturing and caretaking are viewed as natural, instinctive processes that are done out of love of family and a sense of duty. These caring activities fall outside of the political, economic, social, cultural domain of "real work" that requires intellectual training and constructive purpose. Martin likens the educational realm to the political in that their aims are both productive – that is, production of things and laws is not that different from the role of schools to produce workers and citizens. Thus Martin notes that "the status of women and their family is every bit as "a-educational" as it is apolitical."[205]

The BWHBC were very much aware of the disparities in expectations of and for women. Their lives and the lives of women they knew were all restrained at least to some degree by the way that women and women's abilities had been defined in comparison to men. Contributors to the 1973 edition of *Our Bodies, Ourselves* indicated that they received mixed messages at home and in school about their worth. One woman recalled being told that she was important and capable by her family, but a college fund was established only for her brother, not her. Another woman felt that schools trained girls for domestic and family duties while boys were prepared for

[204] Jane Roland Martin, *Reclaiming a Conversation: The Ideal of the Educated Woman*, (New Haven: Yale University, 1985), 178.
[205] Martin, *Reclaiming*, 179.

important work in society. Even domestic spaces and leisure activities were given different meanings, indicating that the problems that Wollstonecraft, Woolf, de Beauvoir, and Martin also identified remain very much a part of the fabric of women's lives. They describe,

> Every time my husband has free time he sits down and reads a book. We both have a sense that that is really important. When I have free time I sit and crochet or read, and it feels as if I am doing nothing.[206]

> I look at the way we have divided up the space in our house. My husband has a little space that is considered his own, and I have no space that is mine. It is as if I exist everywhere and nowhere.[207]

They recognized that the power in their relationships with men was unequal both in and out of the home. Men's work was considered real work while women, who maintained the home and family, were not acknowledged as doing work at all. Even space was filled differently by men than by women. This teaches women that they lack value, that their contribution to family is unworthy, and by extension that their wants and needs are secondary to those of the men in their lives. The educational agents in social and institutional places had endorsed a curriculum in which women deferred to men in all matters.

In schools, we must be concerned that normalizing female deference to the wants and needs of men creates a consent problem and contributes to the medical mis-education of women. If Title IX is to be taken seriously, consent – something that assumed deference bypasses – should be incorporated into the curriculum of sexual and reproductive health classes as one way to prevent sexual harassment and assaults. The idea that consent must precede sexual interactions in all instances should be as

[206] BWHBC, *Our Bodies*, 7.
[207] BWHBC, *Our Bodies*, 7.

ingrained in children as is the importance of literacy or language skills. In *The Schoolhome* (1992), Martin distinguishes that girls face particular kinds of violence that are sexual in nature and reinforce the idea of female subservience. There is also evidence that school employees oftentimes ignore incidents of sexual harassment that they witness, leaving girls to fend for themselves in an environment that is supposed to be safe and supportive of their educational goals. In the essay "Still No Laughing Matter: Sexual Harassment in K-12 Schools," Nan Stein considers the environment of schools to be nothing short of a "training grounds for domestic violence."[208] She notes that sexual harassment often starts as general bullying as it allows children to perfect such abusive behavior early in their lives. As a result "girls learn that they are on their own" and find that adults will neither help them nor believe them when they report abuse. In addition, "harassers find that their conduct is treated with impunity, sometimes even glorified" while bystanders and witnesses "absorb the lesson that sexual harassment is a public performance which is normalized, expected, and tolerated." [209] Like Martin, Stein argues that the "sit-down-shut-up-and-do-your-work pedagogy"[210] that permeates our schools lends itself to a hostile environment that prevents children from feeling any sense of power to speak out against the injustices they witness and experience. Children begin to believe that they are merely passive beings, subject to whatever horrors the world throws at them.

Feminist author Andrea Dworkin discussed the larger rape culture in a speech entitled "I Want a Twenty-four Hour Truce during Which There Is No Rape." She

[208] Nan Stein, "Still No Laughing Matter: Sexual Harassment in K-12 Schools." In. *Transforming a Rape Culture*, Rev. ed., Edited by Emilie Buchwald, (Minneapolis: Milkweed Editions, 2005), 61.
[209] Stein, "Still No Laughing Matter," 61.
[210] Stein, "Still No Laughing Matter," 71.

suggests that true equality, freedom, and peace will not be possible until rape is eradicated. "…equality cannot coexist with rape. It cannot. And it cannot exist with pornography or with prostitution or with the economic degradation of women on any level, in any way. It cannot coexist, because implicit in all those things is the inferiority of women."[211] The Deference Problem allows mis-educational issues like rape culture to exist unchallenged. Indeed Deference is ingrained in girls and women at a very young age through educational agents in institutions like education and medicine.

The Isolation Problem

The Isolation Problem is a major part of female education in the U.S. This isolation has taken on many forms over the years. Wollstonecraft and Woolf discussed women's exclusion from schools and avenues of formal education. They saw women isolated to the home, without the means to engage in public life. But as schooling for girls became more acceptable, science and medicine were recruited to rationalize discriminatory education for girls in the 1800s in American schools. Dr. Edward Clarke, whom I discuss in greater detail later in this chapter, was a physician and educator who utilized his professional medical status to argue for limited or no education for girls. Preventing women from obtaining the same education as men ensured that women remained isolated in homes and men would continue to rule the public and professional realms. This perpetuated educational problems of generations found in society.

[211] Andrea Dworkin, "I Want a Twenty-four Hour Truce during Which There is No Rape," In. *Transforming a Rape Culture*, Rev. ed., Edited by Emilie Buchwald, (Minneapolis: Milkweed Editions, 2005), 19.

Women and their accomplishments have also been excluded from curriculum – an entire history of accomplishments isolated from public acknowledgment. Schools, which were designed by men, have focused on the achievements of white men in all subject areas. In "Excluding Women from the Educational Realm," Martin talks about exclusion – a form of isolation. She explains that this exclusion from education matters for several reasons,

> When the experience of women is neither reflected nor interpreted in the texts and anthologies of the history of educational philosophy, women are given no opportunity to understand and evaluate the range of ideals… which great thinkers of the past have held for them. When Wollstonecraft and [Maria] Montessori are ignored in these texts, students of both sexes are denied contact with great female minds of the past; indeed, they are denied the knowledge that women have ever thought seriously and systematically about education. What is more important is that, when the works of women are excluded from texts and anthologies, the message that women are not capable of significant philosophical reflection is transmitted.[212]

Just as excluding women from educational spaces became an excuse to exclude them from the public realm, isolating women from the accomplishments of women and disallowing them from critical thinking processes became ways to devalue women's intellectual abilities. The denial of space for women in education is the result of propaganda, mis-education, that allows cultural mis-education to flourish.

One of the hallmarks of propaganda is isolation. Chomsky's exploration of propaganda found that, "People have to be atomized and segregated and alone. They're not supposed to organize, because then they might be something beyond spectators of action."[213] This is important to the status quo as "organization just causes trouble."[214]

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[212] Jane Roland Martin. "Excluding Women from the Educational Realm." *Harvard Educational Review* 52, no. 2 (1982), 145.
[213] Chomsky, *Media Control*, 22.
[214] Chomsky, *Media Control*, 27.

Chomsky argues that isolation keeps individuals from sharing thoughts that are contrary to what we've been taught is true. In isolation, we have no way of knowing if others are thinking similar thoughts and "you never have a way of finding out whether you are crazy, and you just assume it, because it's the natural thing to assume."[215]

The BWHBC found that their isolation prior to working on their group project fed their mis-education. "For many of us it was the very first time we got together to with other women to talk and think about our lives and what we could do about them."[216] Women learn a sense of shame related to their bodies, which is undoubtedly a part of what kept women from sharing with each other. One of the contributors to the 1973 edition of *Our Bodies, Ourselves* reported, "We also learn that a woman's bodily functions are mysterious and slightly smutty. For instance, an ad for sanitary napkins says: 'When you have your period, you should be the only one who knows.'"[217] The BWHBC adds, "There is something shameful about our bodies. Our sexuality seems to shock and anger our parents; it scares us, and adds to the growing sense of alienation and mystery we have about our bodies." Shame is isolating. Shame halts future growth. Shame is both an act and consequence of mis-education.

But isolation can result from more than the exclusion of ideas, accomplishments, and sharing. Isolation can also result from competition. Schools do incite a sense of competition. The need to "win" the highest test score or write the best essay creates isolating hostility among students. This can become particularly contentious when girls beat out boys for the top honors. Contributors to *Our Bodies, Ourselves* described some

[215] Chomsky, *Media Control*, 27.
[216] BWHBC, *Our Bodies*, 1.
[217] BWHBC, *Our Bodies*, 27.

of their experiences. One said, "The few of us who did *not* stay out of "male" work suffered the consequences. We had to choose between being a "brain" or being a woman."[218] Another contributor added,

> For me the evidence of my mental competence was unavoidable, and I never had any trouble defending or voicing my opinion with men, because I beat them in all the tests. Consequently, none of them would come near me in my first seventeen years of life.[219]

Women learned that there was a very narrow definition of womanhood to which they had to adhere. Part of that meant that they would not be better than males in schools or at work. If they won in any competition, they paid a price: isolation. Isolation leads to self-doubt and self-criticism. Eventually girls and women learn to police themselves; they limit their own lives to avoid isolation. Indeed Isolation is ingrained in girls and women at a very young age through educational agents in institutions like education and medicine.

The Inferiority Problem

The Inferiority Problem keeps women from being able to excel in all areas of life. Women are taught that they are not capable of the same level of complex thought as men. This message is taught through socialization and in schools. Any ideas a girl might have that would lead her to a different conclusion was countered by shame. One of the *Our Bodies, Ourselves* contributors described, "I wanted to be a doctor, but I was told in direct and indirect ways that my ultimate ambition should be marrying a doctor and raising a family. I gave up my dream." [220] Once women were granted access to

[218] BWHBC, *Our Bodies*, 27. Emphasis in original.
[219] BWHBC, *Our Bodies*, 7.
[220] BWHBC, *Our Bodies*, 7.

formal education, they proved themselves more than capable of higher thought and academic engagement. This meant that other obstacles were placed in their path to convince society that educating woman was harmful to families and carried on the educational problem of generations.

Dr. Edward Clarke, a physician and professor at Harvard Medical School was one of the most vocal purveyors of this mis-education of and about women. Clarke understood his role as an educational agent and used it to his full advantage. He believed coeducation to be "a slippery slope leading to disaster"[221] and shaped his opposition to coeducation around women's reproductive health. Clarke suggested that education posed a risk not only to the immediate well-being of women, but also to their tradition roles as wives and mothers.

In his book *Sex in Education: Or, A Fair Chance for the Girls* (1873), Clarke wrote an argument against coeducation that featured his theory of physiological competition. In essence, he argued that a woman's body has a finite amount of nutrients available for proper growth and formation. If a woman uses those resources to develop her intellect, they cannot be used to develop her reproductive capacities. This results in weak women who are sterile or who would perpetuate this weakness by "giv[ing] birth to a feeble race, not of women only, but of men as well."[222] He contended that an educational system that treats girls the same as it treats boys is at the root of this problem and argued that American women were strong and robust prior to mass education. Schools and colleges were "to a large extent, the cause of "the thousand ills"

[221] David Tyack and Elisabeth Hansot, *Learning Together: A History of Coeducation in American Schools*, (New Haven: Yale University Press, 1990), 146.
[222] Edward H. Clarke, *Sex in Education; or, A Fair Chance for Girls*, (James R. Osgood and Company, Kindle Edition, 1873), 8.

that beset American women."[223] By neglecting a woman's "organization" – that is, the development of the reproductive organs marked by the onset of menarche – schools were setting women up to fail at their destiny: the proliferation of the human race. It is important to note that Clarke's concern about the continuation of humanity extended only to the American-born daughters of white, well-off men. Tyack and Hansot describe, "As his critics were fond of pointing out, he was not referring to the black women who labored in the fields or the daughters of immigrants who toiled in factories or as servants in prosperous homes."[224] The kinds of intellectual and physical labor that he argued were detrimental to the reproductive capabilities of middle- and upper-class white women did not seem to interfere with the hard physical work of those women who kept homes and societies running. Though Clarke would reference Darwin and the notion of survival of the fittest, his concerns were notably similar to those of the eugenics movement. Clarke's fear of elite whites being out-bred by undesirables was a part of his argument that no doubt resonated with whites who were equally anxious about losing their power position in the social hierarchy.[225]

Chomsky had noted the advantages of recruiting educated people like Clarke for the dissemination of propaganda, and Clarke's position as a physician and medical educator gave him solid credibility as an educational agent. Clarke used his knowledge of scientific and medical languages, along with a healthy dose of fear, to confound the public and gain support for his reasons for opposing coeducation. However, his book was not just about disrupting the education of girls. His book has a distinctly anti-

[223] Clarke, *Sex in Education*, 8.
[224] Tyack and Hansot, *Learning Together*, 150.
[225] Tyack and Hansot, *Learning Together*.

feminist tone to it. It was clear that he did not approve of independent women thinking and providing for themselves. He offered "evidence" of women's lack of fitness for the rigors of education or professions in the form of patients he had attended. In each instance, he describes how girls exposed to the public world had experienced a "slow suicide" whereby their bodies would malfunction and cause them to physically wither and die through any number of reproductive disorders.[226] Of one patient he wrote, "she persisted in the slow suicide of frequent hemorrhages, and encouraged them by her method of professional education, and later by her method of practicing her profession."[227] He further noted of this patient, "In spite of all her difficulties, however, she worked on courageously and steadily in a man's way and with a woman's will."[228] Of another patient, he wrote that she "believed in doing her work in a man's way, infected by the not uncommon notion that womanliness means manliness."[229] And concluded that "menorrhagia and its consequences are not the only punishments that girls receive for being educated and worked just like boys."[230] Ultimately, he endorsed the position that women who step out of line are deservedly punished for it.

Clarke's book received an unfortunate amount of positive attention. After its initial publication, demand for the book was high and it went on to be republished seventeen times in thirteen years.[231] The fact that this book was published just as women were beginning to make headway into education and professions was certainly not coincidental. His theories have since been entirely discredited but the effects were

[226] Clarke, *Sex in Education*, 36.
[227] Clarke, *Sex in Education*, 42.
[228] Clarke, *Sex in Education*, 42.
[229] Clarke, *Sex in Education*, 43.
[230] Clarke, *Sex in Education*, 45.
[231] Tyack and Hansot, page 151

deep and lingering, enshrining the medical mis-education of women for his intended audience.[232] To this day, many women still questioned whether "they could succeed in advanced schooling only at the expense of their health and their future prospects as full human beings."[233] Clarke's shift toward questioning the physical ability of women to handle studies and work was simply a new way to attack an old problem.

Though Clarke did not originate the idea of women as inferior, he certainly perpetuated it. The Inferiority Problem is the result of large-scale and timeless propaganda from many sources. Mis-educational actions like Clarke's help shape the public's perception of women and women's perception of themselves. Science education professor Nancy Brickhouse describes how gender and ethnic differences in science education have been used to limit the participation of marginalized people in STEM subjects. The "deficit model" endorsed the idea that "girls and minorities lack the cognitive abilities so that only the most exceptional members of those groups can be expected to learn science."[234] Brickhouse explains that IQ and ability tests have greatly influenced this thinking. This model supports the idea that these groups naturally lack ability in STEM and manifests itself as practices within schools that have limited participation. Brickhouse also points to actively discriminatory practices which play a role in the STEM discrepancy. Brickhouse describes,

> The discrimination takes the form of less encouragement from teachers and parents to pursue science, less encouragement from teachers and parents to pursue science, less attention and lower expectations from teachers, fewer out-

[232] As I searched for a copy of this book in the summer of 2016, I found many book reviews made by individual readers on a book seller's website remarking how enlightening the thought the book was and how it would shape the way the reader-reviewers would raise their daughters. The tragedy of this text is still apparently influencing its readers.
[233] Tyack and Hansot, *Learning Together,* 151.
[234] Nancy Brickhouse. "Bringing in the Outsiders: Reshaping the Sciences of the Future*." Journal of Curriculum Studies* 26, no. 4 (1994): 401.

> of-school science activities that are similar to school science activities, lack peer support and lack of good role models. [235]

Women and minorities were thus deemed scientifically incapable of learning science based on measures that have been highly criticized for being preferential toward white males. Then practices were put into place to ensure that these marginalized groups would struggle to be successful. So it is not that they are somehow incapable of learning science, it is that we have set them up to fail at it. A contributor to *Our Bodies, Ourselves* describes that the Inferiority Problem discouraged her from challenging the socially constructed mold,

> It was as if to be considered women we had to keep in our inferior place. If we challenged this we were treated badly and came to think of ourselves in negative ways. Our learned sense of inferiority affected the way we thought about our bodies – our physical selves.[236]

The Inferiority Problem is an mis-educational path to internalized sexism and a passive existence. It draws specific boundaries around women's lives and prescribes punishments for challenging those boundaries. In *Our Bodies, Ourselves*, the BWHBC described how this ingrained sense of inferiority shaped the life choices they would make,

> One thing that came out in talking together about growing up was that most of us felt we had spent a lot of time and energy in inner conflict during adolescence – trying to become selfless, sweet, passive, dependent children so that our princes would find us and we would live happily ever after. By the end of adolescence most of us had resolved the conflict by learning to conform to the feminine role, while suppressing qualities within us inappropriate to that role – independence, activity, anger and pride. These human qualities which would have got in the way of our "femininity" were, logically enough, labeled by our culture "male."[237]

[235] Brickhouse, Bringing in the Outsiders," 402.
[236] Brickhouse, Bringing in the Outsiders," 402.
[237] BWHBC, *Our Bodies*, 6.

Just as women are kept from subjects for which they are deemed unworthy, they are also kept from information that is imperative to their health and well-being. Since health topics fall into the scientific realm, it follows that girls and women would not have access to women's health information. Sex education in schools under abstinence-only assumes that students will not appropriately utilize knowledge about healthy sexuality. Though both girls and boys have been prevented from learning accurate sexual and reproductive health information, girls are more often than not suffer disproportionately from this knowledge deficit compared to boys. The physical and emotional responsibilities of unintended pregnancies and childrearing fall to the mother and, if the father chooses not to participate, the economic burden falls solely to her as well. Even the responsibility of social perception falls to the girl. A female's "virtue" is tied to yet another level of inferiority for women. A woman who does not maintain her purity is far more inferior than one who does. The potential for a life in poverty – one of social, financial, and opportunity inferiority – is a reality for girls and women who are denied accurate information about their reproductive health. The interference with sexual and reproductive health education in schools prevents women from flourishing and punishes them for failing to adhere to their socially prescribed roles.

Women have been excluded from STEM education and from appropriate sexual and reproductive health education based on mis-educational ideas that they lack the capacity to understand the information or even how to properly engage the information. Any learning experience that is founded on the basis that more than half of its students are incapable or unworthy recipients is not only mis-educational in its action, it results in profound mis-education that affects their lives in significant ways. From reduced

employment options to high-risk health issues, the Inferiority Problem discourages women from expecting more for themselves and experiencing their capabilities to their fullest. The Inferiority Problem is ingrained in girls and women at a very young age through educational agents in institutions like education and medicine.

The Knowledge Problem

From the perspective of medical professionals, it became important to hoard medical knowledge in order to maintain exclusivity. This is the embodiment of the appropriation model that Martin criticized as the hoarding of knowledge that could otherwise be shared to the benefit of others. The professional medical men of Western medicine embraced the appropriation model early in order to consolidate their own power and to ensure a customer base and further perpetuated the educational problem of generations. In direct opposition to the assumed altruistic motivations of medical men, the hoarding of medical knowledge was motivated by self-interest. This act of mis-education has had profound mis-educational consequences, especially where women and women's health are concerned.

The BWHBC described how the action and consequence of the medical mis-education of women worked to perpetuate the Knowledge Problem,

> One doctor in a community south of Boston, told a friend of mine he objected even to public-health nurses giving free Pap smears…. Another result of this imperialism of knowledge is that many women have not learned enough about their health needs to demand Pap smears as a public service. This kind of ignorance about our bodies, and particularly those parts related to reproduction and sexuality, is connected with alienation and shame and fear that have been imposed on us as women.[238]

[238] BWHBC, *Our Bodies*, 239.

Joan Ditzion spoke of her own experience with reproductive and sexual health education. From her early home life into adulthood, her body remained largely mysterious to her. She explained that, although she was raised in a progressive household, she does not recall any specific health education she received from her family. She explains, "I think my mom gave me a birds and the bees book or something when I started menstruating."[239] She also did not recall any sex education in schools and found learning on her own to be difficult because "what information was maybe available was always very technical."[240] This would suggest that her physicians also withheld this information from her. Of her adult life, she said, "I really knew very little about real sex even though I was married. You know, it was like sex is something that happens in the presence of a man, all that stuff."[241] – but that's where her practical knowledge ended. She also recognized that she lacked an understanding of larger issues in women's health ranging from pleasure to access to appropriate care. Ditzion explains,

> To learn about female sexual response, to realize that reproductive justice – there were many women who have had to have back alley abortions – that women really needed to have control over our reproductive lives, which still remains a huge issue.[242]

Vilunya Diskin described similar experiences. She explains how she learned about sex,

> When I was interested in sex, my mother gave me a book, it was called *Being Born*. To tell you how relevant that book was – I read the whole book and then I came to her and I said – she said I welcome any questions – I said, "so to make a baby, do you have your clothes on or do you have your clothes off?" You can tell how good that book was. She said to me, you know, maybe you should read it again… It was a terrible book.[243]

[239] Ditzion, interview with author, 2016.
[240] Ditzion, interview with author, 2016.
[241] Ditzion, interview with author, 2016.
[242] Ditzion, interview with author, 2016.
[243] Diskin, interview with author, 2016.

I would speculate that neither Diskin's nor Ditzion's mothers had been suitably educated about sex. It is probable that their mothers did not feel confident enough in their knowledge of the subject to speak with their daughters or even knew of appropriate resources to engage. The medical mis-education of women thus becomes generational as women could not pass on useful knowledge amongst themselves.

Because of Deference, Isolation, and Inferiority, women were unlikely to push their physicians to share their medical knowledge. As Sandra Morgan explains in *Into Our Own Hands* (2002),[244] "In 1969, a woman who placed herself under a doctor's care had the duty to do what she was told." There was no reciprocal duty for the doctor to inform, engage, or otherwise acknowledge the woman before him (in all likelihood at the time, the doctor was a male) was even a fully human being who should be valued as such. Diskin was familiar with this kind of dismissal at the hands of doctors. She illustrates, "We would ask doctors questions and they would often not answer them and say 'you don't have to worry about that, I'm the doctor.' And sometimes they would say, 'Oh, you don't have to worry your pretty little head about it.'"[245] As an educational agent, any physician who would answer a serious inquiry about health in such a manner is engaging in intentional and obstructive medical mis-education. A woman's well-being, health, intellect, and humanity are devalued in this kind of relationship that was perpetuated as an educational problem of generations.

However this was fairly commonplace. When women lacked information that helped them understand their bodies, they could not help but feel "discomfort with their

[244] Sandra Morgan, *Into Our Own Hands: The Women's Health Movement in the United States*, 1969-1990,
(New Brunswick: Rutgers University Press, 2002): 11.
[245] Diskin, interview with author, 2016.

bodies, feeling shame, feeling kind of at odds."[246] When women lacked knowledge, they were completely dependent on medical men to care for them in an open, honest, and humane way. Unfortunately, educational agents like Dr. Clarke had a prominent voice and ensured that women were barred from meaningful learning and respectful relationships with their physicians. One contributor to *Our Bodies, Ourselves* described how the doctor-patient relationship that exists in a state of unequal knowledge and power affected their care. She stated,

> I knew that my doctor had a reputation for being one of the best in the city, and it made me feel good when I said his name and other people would say, "Oh right, I've heard of him." I felt he was great and I was one of his lucky patients, even though I was rarely comfortable with him and always felt belittled when I went to him: I'd have to wait a very long time, or he wouldn't answer my questions, or I'd feel sometimes too timid to even ask any questions.[247]

Another described her experience at an annual gynecology appointment,

> One of the things I remembered really clearly is when he asked me how long my menstrual cycle was, and I told him, he looked surprised and just said, "That's interesting." I asked him if it was unusually long (I've since found out it is), if my hormones were out of whack, if he could even tell anything at all. I wouldn't have cared so much if he had said he couldn't tell, or didn't know, or even if he just wasn't interested in menstrual problems. But he talked to me as if I shouldn't know. It's my body, and I felt defeated in trying to learn about it.[248]

Ditzion's experiences and her self-directed learning led her to recognize how a lack of women in medicine contributed to medical mis-education of women. She argues that sexism could not help but exist in institutionalized medicine because,

> medical providers were also part of the larger sexist society. But that's so important, the medical institutions were not that different from other intuitions. My guess is because up until the 60s or 70s, there weren't many women physicians. It was because it was an almost exclusively male field in terms of both practice and research. I would imagine that it did shape [the culture of

[246] Diskin, interview with author, 2016.
[247] BWHBC, *Our Bodies*, 250.
[248] BWHBC, *Our Bodies*, 250.

> medicine] although women were always natural healers – it just wasn't necessarily validated.[249]

In *Our Bodies, Ourselves*, the BWHBC addressed this issue as well. They describe,

> Women have usually been excluded from the elite institution of medical school on the grounds that they were not strong enough to survive the rigors of training, or that they will drop out of the profession to marry and have families. Many women never even consider going to medical school because of the generally prevalent idea that they are not good at science and couldn't compete intellectually with men in male professions.[250]

As knowledge and the ability to learn was segregated to a particular gender, it became a struggle for women to be healthy in any true sense of the word. The Knowledge Problem became a defining factor in many aspects of women's lives.

The Experience Problem

Because professional medicine was considered a man's world, the only valid information anyone could contribute in a medical setting was scientific, learned information obtained in a man's way. That a woman's life experience and knowledge of her own body had no place in diagnosis or deciding treatment was an educational problem of generations. Diskin remarked on the lack of resources available to them that were presented from the perspective of a woman. She questioned, "What do men know about getting pregnant? At the time women's experiences were not valued, women's voices were not listened to."[251] The medical mis-education of women depends on trusting a man to interpret or assign value to women's lived experiences. The

[249] Ditzion, interview with author, 2016.
[250] BWHBC, *Our Bodies*, 240.
[251] Diskin, interview with author, 2016.

Experience Problem is one that devalues a woman's experience in favor of a man's learning.

Adrienne Rich explores motherhood in *A Woman Born* (1995). One of the themes she examines is the "Alienated Labor" of childbirth. Alienation describes the wedge in the relationship between a woman and her body, a woman and her baby, and a woman and her lived experience. This alienation is brought about at least in part because of professionalized medicine which endorses the patriarchal interpretations of childbirth. Unlike Ditzion and Diskin, Rich believed that she had been adequately educated by her mother regarding the sex and conception, and felt confident in her knowledge on those topics. But, actual labor was completely unknown to her besides what she could learn from novels and textbooks. In one textbook, written by the very obstetrician who had delivered Rich, she noticed a disturbing phenomenon within its pages: "Nowhere was the *face* of a laboring mother visible in its photographs; all was perineum, episiotomy, the nether parts I recognized as like and unlike my own, stretched beyond belief by the crowning infant head."[252] She realized that in a medical-obstetric context, women were not people but bodies whose sole purpose was to facilitate the delivery of other human life.

Rich's own experience with childbirth in the 1950s involved her being completely anesthetized during all three of her children's births so that she did not experience them at all. The first time was convincingly necessary to her, the other two appeared to be merely convenient for the doctor.[253] Discussing her birthing experiences

[252] Adrienne Rich, *Of Woman Born: Motherhood as Experience and Institution*. (New York: W.W. Norton & Company, Inc., 1995): 166. Emphasis in original.
[253] Rich, *Of Woman Born*.

with her friends left them all wondering if the others' experiences had been somehow more valid or had allowed them to be more of an active participant in the birth of their children. She writes, "None of us, I think, had much sense of being in any real command of the experience. Ignorant of our bodies, we were essentially nineteenth-century women as far as childbirth (and much else) was concerned."[254]

Professionalized medicine had in fact removed the Experience from the childbirth experience. It had become sterile, scientific, and disconnecting. The difference between childbirth under midwives compared with childbirth under medical men show a movement from a woman-centered experience to a male dominated one. Women have been conditioned over time to accept that their bodies and minds are not their own, and invalidating this uniquely woman's experience was part of the process.

It is not difficult to see how the medically established right of men to violate women's agency contributes to rape culture. Like medicine, rape culture undermines a woman's ownership of her experiences. Rape culture relies on women not being believed, and medical men have ensured that women's experiences and knowledge are suspect. The early establishment of hysteria as a woman's problem overshadows the credibility of women, especially when it is her word against the word of a man. This helps to perpetuate the false accusation myth that surrounds rape. In *The Politics of the Body* (2014), Alison Phipps points out that false reporting occurs no more frequently in instances of rape than for any other crime. The false accusation myth "relies on reactionary gender stereotypes about the vindictive woman and the victimized man, as well as resting on the assumption that 'real rape' involves a pathological stranger and a

[254] Rich, *Of Woman Born*, 176.

virginal victim."[255] This established criterion for rape creates doubt about women's reporting of their experiences. Everything about a woman's report is suspect and open to questioning.

In the case of director Roman Polanski's rape conviction,[256] actress Whoopi Goldberg "asserted that this crime was not 'rape-rape' because alcohol had been involved."[257] Even politicians set up criteria for determining under what circumstances a woman's reporting of her experiences is to be believed. Todd Akin, a Republican who ran for the Senate in Missouri in 2012 was well known for his opposition to abortion and had made a series of inflammatory remarks related to rape and abortion throughout his career. When asked to clarify his position on abortion in cases of rape, he responded that rape could not result in pregnancy with the now infamous remark, "If it's a legitimate rape, the female body has ways of trying to shut that whole thing down."[258] Factually incorrect science aside, he declared yet another way to "prove" that women cannot be trusted to relay their lived experience and justify controlling women's bodies. The Experience Problem delegitimizes women's lived experiences and declares women untrustworthy reporters of their lives. The Experience Problem became a defining factor in many aspects of women's lives.

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[255] Alison Phipps, *The Politics of the Body: Gender in a Neoliberal and Neoconservative Age*, (Malden: Polity Press, 2014), 31.
[256] In 1978, Roman Polanski was convicted of raping a thirteen year old girl whom he had provided alcohol. Polanski left the country before he could be sentenced and has been able to avoid extradition because he is not an American citizen.
[257] Phipps, *Politics of the Body*, 31.
[258] Chris Gentilviso, "Todd Akin on Abortion: 'Legitimate Rape' Victims Have 'Way to Try to Shut That Whole Thing Down,'" *Huffington Post*, August 19, 2012, http://www.huffingtonpost.com/2012/08/19/todd-akin-abortion-legitimate-rape_n_1807381.html.

The Control Problem

The Control Problem is the pinnacle of the medical mis-education of women. If women feel they must defer to men in all instances, if we do not educate women about their bodies, if we devalue their lived experiences, isolate them, and make women live in a state of assumed inferiority, it must by default mean that medical men have the right to control women's bodies. Marilyn Frye has described the effect of being under the gaze of the "arrogant eye" which views everything in reference to himself and his own interests. The arrogant eye sees that "everything is either "for me" or "against me""[259] In patriarchal societies man is above woman, there is a hierarchy that must be maintained. Women become the enemy to the arrogant perceiver who "falsifies… but he also coerces the objects of his perception into satisfying the conditions his perception imposes."[260] The arrogant eye is the eye of medicine. Medicine is mysterious, all-knowing, and unquestionably correct. Thus the medical eye sees from the perspective of dominance, of power. "If someone believes that the world is made for him to have dominion over and he is made to exploit it, he must believe that he and the world are so made that he can, at least in principle, achieve and maintain dominion over everything."[261] In exerting their power, professional medicine would like us to forget that women have always had a claim to health and health care, most obviously because of their roles as familial caretakers but also because of their historical roles as healers. This is another example of the educational problem of generations. The Control

[259] Frye, *Politics of Reality*, 67.
[260] Frye, *Politics of Reality*, 67.
[261] Frye, *Politics of Reality*, 71.

Problem removes any implication of sovereignty and puts power in the hands of medical men, for a woman's own good, of course.

The BWHBC understood that their mis-education resulted in a particular form of control of their bodies and lives. Many feminist theorists have noted that women who cannot control if and when they become pregnant cannot be independent or plan any kind of life at all. In *Our Bodies, Ourselves*, they describe how a lack of knowledge leads directly to external control,

> For women throughout the centuries, ignorance about our bodies has had one major consequence – pregnancy. Until very recently pregnancies were all but inevitable, biology *was* our destiny – that is, because our bodies are designed to get pregnant and give birth and lactate, that is what all or most of us did. [262]

Ditzion remarked on the importance of choice, "In the context of reproductive justice and rights, a woman who – and men, anyone who chooses to have kids – it's incredibly important work in society, but it needs to be chosen."[263] Men like Dr. Clarke would like to have removed any semblance of choice from women and have them focus on what he and many like him believed to be the sole purpose of a woman: motherhood.

In terms of medical control, physicians took on a paternalistic approach to women's health to justify controlling a woman's body. Chomsky's description of manufactured consent goes hand-in-hand with medical paternalism. From a bioethics perspective, "the basis of the decision must be the patient's well-being; thus, it is distinguished from actions the doctor might take out of self-interest."[264] The patient is considered to "frequently suffer from diminished reasoning capacity."[265] Thus the

[262] BWHBC, *Our Bodies*, 3. Emphasis in original.
[263] Ditzion, interview with author, 2016.
[264] Sherwin, *No Longer Patient*, 138.
[265] Sherwin, *No Longer Patient*, 140

patient, the woman, and the bewildered herd are all in need of guidance. This paternalistic approach is also employed by legislators who wish to limit access to abortion. There are three common themes that are generally written into laws that limit reproductive health. [266] One is that the decisions that women make are often misguided or incorrect. Another is that women will regret their decisions. And finally, women must be protected from their own decisions and their consequences. This kind of reasoning is used to rationalize the need for laws that require, for example, intravaginal ultrasounds or mandatory waiting periods before an abortion. Men in power claim that they are attempting to save a woman from herself.

The BWHBC made clear that they understood that roadblocks to abortion was about controlling their bodies. They describe,

> Abortion is our right – our right as women to control our bodies. In almost every community in this country a woman with an unwanted pregnancy is frustrated and obstructed by laws, hospitals, doctors, by high prices and poor communications. The same public whose sex-filled media urge her to be sexy turns on her with moralistic disapproval that isolates her and forces her to deal with her problem in secret.[267]

Despite any claims that women must be protected from themselves, the BWHBC could see the hypocrisy in their claims. Women are unable to effectively control pregnancy and yet unable to consistently access safe and legal abortion. The ability to control what happens to their bodies, their lives, belongs to men in positions of power. The Control Problem is aided by problems of Deference, Isolation, Inferiority, Knowledge, and Experience. The BWHBC explain,

> Why do unwanted pregnancies occur? Some of us become pregnant without thinking about it because we have been forced to believe that we are acceptable

[266] Abrams, Paula. "The Bad Mother: Stigma, Abortion and Surrogacy." *Journal Of Law, Medicine & Ethics* 43, no. 2 (2015): 179-191.
[267] BWHBC, *Our Bodies*, 138.

> only as sex objects or as mothers. Or we are taught that sex is not quite right (even though we are taught to be sexy and flirt) so we're scared to ask those who may know where to get birth control and which birth-control methods are most effective. Or even when we do ask, many of us can't get birth control – it's not easy for teen-agers anywhere, and it's hard for any of us who can't afford the medical fees and drug prices. And even if we can get the most effective method for pregnancy prevention, it may not be the nest method for all of us... And every method except the pill fails to work 2 percent of the time or more. Birth control is better than nothing, but there is no such thing as an ideal method, that is, one that is safe, simple, cheap and 100 percent effective. Birth control fails us because the methods are imperfect, not because we are irresponsible. Nevertheless the consequences fall to us.[268]

We place responsibility on women for their bodies, then refuse to give them agency, information, or resources, and blame them when things go wrong.

Of course, involuntary pregnancies were only one part of the abortion issue. Involuntary abortions and sterilizations were the realities of far too many women's experiences. In some communities there is a great and justified fear that women will not have the right to decide to have children. The BWHBC describes their understanding of the other side of this issue in 1973,

> When abortion laws are repealed, however, we have to make sure above all that abortions are voluntary as well as free and safe. Genocide of poor and black peoples to keep the most oppressed populations in check is a real fear; for instance, in some states laws have been proposed that would make women on welfare have abortions by threatening to stop their payments after a certain number of "illegitimate" pregnancies. We do not know from our own experiences – since we are white and middle-class – but we suspect that other women are forcibly made to abort or to be sterilized. Whether or not this is true, it is a fear that should be faced. For this reason it's crucial that whenever we talk about abortion we should talk about the implications for all women.[269]

Since this statement was written, substantial evidence has demonstrated that certain populations of women were in fact subjected to involuntary abortions and sterilization. The documentary film *No Más Bebés* (2016) tells the story of Latina women who were

[268] BWHBC, *Our Bodies*, 138.
[269] BWHBC, *Our Bodies*, 139.

sterilized against their will and often without their knowledge or "informed consent" in a hospital in Los Angeles in the 1960s and 1970s. The case *Madrigal v. Quilligan*[270] that is discussed throughout the film exposed the practices common at the Los Angeles County-USC Medical Center. Oftentimes the women did not speak or read English – and could not give truly informed consent to a procedure – and would be made to sign forms permitting tubal ligation before they would be taken to the delivery room or given appropriate medical care. The manufacture of consent that Chomsky spoke of is particularly important in medically-based oppression.

One example of how the Control Problem affects real lives can be found in Jenny, one of the founding members of Jane. Jane will be discussed in greater detail in the next chapter. Briefly, they were an underground abortion service that existed between 1969 and 1973 when *Roe v Wade* was decided. Around 1966, Jenny, a twenty-six year old mother of two young children, found herself with a significant health dilemma. She was in the midst of a two-year fight for her life against Hodgkin's disease, a form of lymphatic cancer. She had been diagnosed during her second pregnancy and her doctors had decided not to treat her cancer as the drugs and radiation could be harmful to the developing fetus. Her disease progressed very rapidly, spreading throughout her lymphatic system causing severe symptoms,

> By the time she went into labor she had chronic nosebleeds and was coughing up blood. During the birth she hemorrhaged so severely she barely survived… She had huge masses of visible tumors, the size of golf balls, from her neck to her armpits. Her prognosis was poor; she wasn't expected to survive.[271]

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[271] Laura Kaplan, *The Story of Jane: The Legendary Underground Feminist Abortion Service*, (Chicago: The University of Chicago Press, 1995), 3.

For the next two years, Jenny's cancer was aggressively treated. During that time, one of her biggest fears was becoming pregnant again while the disease was still active. She was afraid she could not survive another pregnancy with cancer. Though she pleaded with her doctor for a tubal ligation, he refused. He would not authorize what he thought of as an "elective" sterilization "for a woman as young as she."[272] The doctor put her on birth control pills but the experimental levels of hormones in contraceptive pills at the time made her feel worse than she already did on chemotherapy and radiation. She tried several brands, each with their own debilitating side effect profiles and ultimately ended up one that "was later discontinued because of its high failure rate."[273]

> A few months later she suspected she was pregnant. She went back to her doctor hysterical. He couldn't confirm her pregnancy but, fearing for her emotional stability, he agreed to schedule the tubal ligation. It was after that operation that the surgeon told her what she already knew: she was pregnant.[274]

Jenny was now worried not only for her own health, but for the health of the fetus that had been exposed to high doses of drugs and radiation over the course of Jenny's cancer treatment. "[B]oth she and the doctor recognized that there was little chance the child would be born normal." Because abortion was illegal in her home state of Illinois at the time (except to save the life of the mother), they had to turn their case over to the hospital board. The team of doctors treating Jenny including an oncologist, a radiologist, and a gynecologist all appealed to the board for permission to perform an abortion. The board however denied the request, noting that Jenny's life was not in

[272] Kaplan, *The Story of Jane*, 4.
[273] Kaplan, *The Story of Jane*, 4.
[274] Kaplan, *The Story of Jane*, 4.

immediate danger. “It was only after she convinced two psychiatrists she would commit suicide if she didn’t get an abortion that the board relented and agreed to it.”[275]

After her procedure, Jenny was justifiably furious. “It was one thing to be helpless in the face of a deadly illness; it was another to feel powerless before medical authorities.”[276] That the medical authorities who had ultimate control over Jenny’s life were all men was not lost on her. These men would never find themselves in Jenny’s predicament of having to beg for a safe medical procedure to save her life. This educational problem of generations prevented these physicians from seeing Jenny as an autonomous individual with the right to good health, the right to raise her existing children, and the right to her life.

In contrast to the experience of this white woman having to plead for a medically necessary sterilization procedure, women in Puerto Rico at the same time were experiencing forced sterilization as a form of population control. In 1965, an estimated one-third of women of childbearing age on the island had been sterilized.[277] These women had been coerced, misinformed, and paid to agree to the procedure as a routine practice of the U.S. government. In fact, many of the women who had voluntarily gotten the procedure did so because they believed it to be reversible.[278] There is no informed consent when a patient does not fully understand the ramifications of a procedure. It is also important to remember that poor and non-white women have experienced a much different relationship with medicine and other institutions in the

[275] Kaplan, *The Story of Jane*, 4.
[276] Kaplan, *The Story of Jane*, 5.
[277] Our Bodies Ourselves. “History of Forced Sterilization and Current U.S. Abuses.” Accessed April 20, 2017. http://www.ourbodiesourselves.org/health-info/forced-sterilization/
[278] Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico*, (Berkeley: University of California Press, 2002).

United States than have white women. In many cases, white women have been complicit in enforcing these differences. Margaret Sanger, who has been celebrated for her work to help American women gain access to contraception, was also instrumental in convincing researchers to test contraceptive pills on poor women in Puerto Rico in the 1950s. These experiments made many of the participants so sick they had to be hospitalized. Puerto Rican women found themselves as bodies to be controlled in the government's effort to control a population classified by many as undesirable. Though it manifests itself differently in different populations, this is how the Control Problem keeps women from living fully as independent, fully human beings.

What to Do With the Problems?

In this chapter, I have described the problems of education and medicine as identified through the works and words of the BWHBC. These problems demonstrate how insidious the medical mis-education of women is. Through the educational problem of generations that are perpetrated by educational agents of both medicine and education, women have learned that their lives do not have the same value as the lives of men. Fortunately the BWHBC does not only identify problems, they identify remedies through their work as well. In the next chapter, I will again utilize interviews with founding members of BWHBC and *Our Bodies, Ourselves* to explore the educational remedies to the medical mis-education of women that were developed by the BWHBC.

Chapter Four:

"We have to learn this for ourselves":

Naming the Remedies

We have to learn this for ourselves and we also have to figure out what information and what knowledge needs to be accumulated because there are lots of holes in what the professionals call women's health.

– Joan Ditzion

In the previous chapter, I named the educational and medical problems identified in the words and work of the BWHBC. These named problems demonstrate that the medical mis-education of women is both an action and consequence of institutional forces that have defined what it is to be a woman. The Deference Problem teaches women to defer to male authority and that their needs and goals are secondary to those of men. Women learn to focus their lives on the devalued work of caring for their families. The Isolation Problem excludes women from learning, isolates them from knowledge, and makes competition both necessary and isolating. Sharing is not part of formal education. The Inferiority Problem teaches women that they are incapable of learning the same level of complex information as men. This problem also restricts women's access to health information that is necessary for their well-being. The Knowledge Problem results from medical men hoarding medical knowledge which makes learning difficult. The Experience Problem devalues women's lived experiences which are not considered relevant or applicable to medical situations. This also gives unrestricted value to men's interpretations of women's experience. The Control

Problem has allowed women's bodies and abilities to be defined by medical men. This definition limits women in medical and social contexts and controls their bodies, opportunities, and ability to live fully and freely. These are all educational problems of generations that are perpetuated by educational agents of education and medicine.

The complex relationships between the various named problems is striking, with each being connected to and dependent upon each other to flourish. I presented them in a particular order as their complexity and interdependence builds as the list progresses with all problems leading to The Control Problem – the ultimate form of oppression found within the medical mis-education of women. As I examined the complex relationships between the problems, it was evident that remedies were also interdependent. Each item on the educational problems list finds its counterpart on the medical problems list, which lends itself to combined strategies for remedies. The BWHBC appear to have recognized this as they engaged in learning and teaching that actively remedied the medical mis-education of women. I name the educational remedies in which the BWHBC engaged as:[279]

1. **The Isolation-Knowledge Remedy**: Sharing knowledge counters isolation.
2. **The Inferiority-Experience Remedy**: Validating women's lived experience counters inferiority.
3. **The Deference-Control Remedy**: Sovereignty counters deference.

The medical mis-education of women is a problem that is typically addressed as solely a medical or political problem in need of medical or political efforts to address

[279] These names were constructed from scratch to represent their roots in educational and medical problems, how those problems interact, and how each remedy serves as a challenge to the mis-educational purpose of the set of problems. The names will be reconsidered in a future work to better represent their conceptual purpose as remedies.

their complexities for appropriate solutions. That very few people are viewing this as an educational question with educational remedies is part of what keeps an appropriate solution out of schools. The BWHBC recognized that the remedy that would improve women's sexual and reproductive health was much bigger than simply making contraception widely available to and easily accessible by women. The BWHBC applied a creative and unique educational approach that highlights the circulation of gifts to the educational and medical problems that the medical mis-education of women identifies. By identifying education-based remedies to the educational and medical problems they encountered, they in fact prove the existence of the medical mis-education of women as a problem grounded in education. This chapter will explore the educational remedies in which the BWHBC engaged to remedy the problems they identified with medical learning in adult women. Here too, primary sources will be interviews with founding members and the 1973 edition of *Our Bodies, Ourselves*. In addition, I engage the stories of activist Lillie Allen, Ntozake Shange's novel *Sassafrass, Cypress, and Indigo* (1982), and the abortion collective known as Jane. These narratives illustrate how circulating the gifts is inherent to women's work in education and caring. The diverse perspectives also help recognize gifts are shared in communities of women everywhere for the betterment of us all.

The Isolation-Knowledge Remedy

The Isolation Problem and the Knowledge Problem work in tandem to make women feel that they are inadequate and unworthy. They come from the same place in oppression. In a medical context, these problems work to keep women from an

understanding of their bodies, which is detrimental to their lives and their ability to live fully. Whether Isolation is brought about through educational means or Knowledge is hoarded as part of the medical professions, women have found themselves apart from truth, from themselves, and from each other. As previously noted, Chomsky understood the connection between exclusion and propaganda. Organizing leads to sharing and sharing allows people to understand that they are not crazy or alone. It would seem then that the most effective intervention for much mis-education is quite simply organizing. The key to the Isolation-Knowledge Remedy was thus shared learning experiences as the work of the BWHBC demonstrates.

Through organizing, the women of the BWHBC learned that they were not alone. The negative feelings that they had about themselves and their bodies had been isolating. In isolation, women learned to hide their talents, diminish their intelligence, and question their right to participate in the world outside of the home. Organizing allowed women to learn from and with each other and appreciate the unique gifts they each possessed. In the tradition of a true educational experience, the women all grew by engaging in the process. "Coming together with women was exciting. We were individual women coming together out of choice and strength."[280]

One of the ways women organized during the American feminist movement of the 1960s to the early 1980s was through consciousness-raising. Ditzion explains how important it was to the women's movement,

> So what women were doing, I mean there was the more traditional route was more like NOW and getting involved in political organizing, activist policy stuff which is great. But this started a whole new movement called consciousness-raising groups. And what it meant was that women would get together and we would just talk about our lives trying to figure out what were the internalized

[280] BWHBC, *Our Bodies*, 5.

> sexist attitudes we had and how has that impacted on us. We were feeling we all shared much more than we ever realized because of our socialization. You know, problems we thought were our own were really shared with many women.[281]

Consciousness-raising developed out of a deep sense of isolation and the need to feel connected. Feminist organizing brought about the realization that women needed to make connections between the realities of their lived experiences, to other women, and to the superficial societal expectations that restrained their capabilities. The consciousness-raising process brought women together and made them realize that they were not alone in their thinking or experiences. Most importantly, consciousness-raising made women realize that they could change things if they worked together.

Consciousness-raising was essentially an engagement in the scientific method to examine and validate their own feelings, assumptions, and experiences. It was not that they simply shared their feelings, they learned how to analyze them in the context of their lives, and put their concerns into action.

> The technique begins with a revelation of WHAT IS occurring in a woman's life, and goes on to probe the context and history of the issue or event. Group members go on to explore WHY the situation and conditions have come to be, a question that involves examining not only personal dilemmas and struggles but also patterns that evolve from individual stories that point to common concerns. Participation in a [consciousness-raising] group was, and is, a gateway that can lead women to explore WHAT should change and HOW, working together, these changes can be implemented.[282]

This was essentially a politicization of Martin's circulating the gifts. Consciousness-raising meant that women would learn not only how to implement changes on a personal level, but also how they could work together to create broader change.

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[281] Ditzion, interview with author, 2016.
[282] Janet L. Freedman, *Reclaiming the Feminist Vision: Consciousness-Raising and Small Group Practice*. (McFarland & Company, Inc, Kindle Edition, 2014), Loc 259.

Circulating the gifts and consciousness-raising depend on women being invested in teaching and learning, validating and inspiring, sharing and growing. "The goal of consciousness-raising was to utilize personal experiences to develop a political analysis leading to social change."[283] As medicine and education have become increasingly politicized, real change requires an honest examination of problems and a willingness to work together to remedy them.

Consciousness-raising gave them women of the BWHBC the confidence to know that they could take on their educational project. Diskin describes how they began to implement the Isolation-Knowledge Remedy,

> None of us had a medical background, that is absolutely right. But all of us were college educated. We were in our twenties, we were smart, we knew how to use libraries, we knew how to do research, and what we said was – look, it's not just information we want, if we want just straight medical information, we could go and get out medical books and read them. But, you know, the idea was to make… the medical language is so… you know, medical language is for doctors. I mean, it's deliberately obtuse, I think. Well, not deliberately. But, you know any discipline has got its own language… it's part of the monopoly of knowledge. So we said, okay, maybe we could decipher what those words meant and especially working together. But we can't expect most people to do this, you know they're not doctors. They have lives and jobs to live and so we said okay, we want to… we will go and do the research and we'll do it in pairs collectively because that was the whole point, it was a collective project and to go back and forth.[284]

They were learning for themselves about women's health and how to understand what had existed as protected, privileged information but, in the fashion of consciousness-raising and circulating the gifts, they were also learning in order to help other women.

Their planned work was definitely political but it was also very explicitly an educational project. Diskin in fact stated that "it's all about education."[285] The BWHBC

[283] Freedman, *Reclaiming the Feminist Vision*, loc 300.
[284] Diskin, interview with author, 2016.
[285] Diskin, interview with author, 2016.

set about to disrupt the monopoly of medical knowledge and in doing so created an approach to adult education that educational philosopher Susan Birden called coalition-engendered education. Birden describes coalition-engendered education as such,

> Consider for a moment a group of adults who are on the margins of an institution and who, for some reason, find it necessary to learn things that the dominant social or professional culture has withheld from them. If the dominant culture has withheld, silenced, denigrated, or trivialized information, there will be no ready-made curriculum. Furthermore, it is entirely likely that there may be no educator with either the expertise or interest to fill the role of leader, teacher, or facilitator. In such social contexts, if the learners are going to learn they must investigate and compile their own curriculum, develop their own activities, and become one another's teachers. The teaching role in coalition-engendered projects does not rest upon any one individual or group of individuals, but diffuses into the group as a whole.[286]

The BWHBC were breaking new ground on many fronts and they engaged in a logical approach to learning that best supported their group goals.[287]

In order to facilitate this project, they knew that they would have to be able to find reliable sources, understand and interpret what they found, and present it in such a way that it was clear to other women who did not have formal medical education. If they wanted to reach as many women as possible, they had to ensure that the topics were relevant and the material were accessible. They started their self-education quite simply – by making a list "of everything we would like to know about."[288]

> We needed to know about anatomy, we needed to know about sexuality… we wanted to know about abortion and post-partum depression, and we wanted a political chapter on the medical system, like how to navigate it. So those were our interests and what we said was, we're going to research these, we're going to write up our findings, and then we're going to share them with the community.[289]

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[286] Susan Birden. "Theorizing a Coalition-Engendered Education: The Case of the Boston Women's Health Book Collective's Body Education." *Adult Education Quarterly* 54, no. 4 (2004), 258.
[287] For more information about the history of adult learning in the United States, See: Jospeh Ketts, *The Pursuit of Knowledge under Difficulties: From Self-improvement to Adult Education in America, 1750-1990*, (Stanford: Stanford University Press, 1994).
[288] Diskin, interview with author, 2016.
[289] Diskin, interview with author, 2016.

In order to address the topics on their list, they decided on a democratic method of dividing the research: each woman would investigate a topic of great personal interest or significance to her and become an educational agent for the group. For example, Ditzion, who was contemplating motherhood at the time, worked on the chapter about deciding whether to have children, as well as the chapter on myths about women because of her interest in human development and psychology.[290] Further, "the abortion chapter was researched and written by women who had abortions, the post-partum chapter was written by women who either had their own post-partum depression or their mother had had post-partum depression. And so it went."[291]

Their next step was locating reliable sources of information. They started with the basics: "We went to the library… and we got information we needed." They consulted textbooks and journals, as well as physicians and people they knew in the medical field. They would then present their findings to the group. Diskin explains, "The two or three women who were working on an issue, they discussed it and collaborated on writing it up, and they taught it to the group and shared information with the rest of us."[292] However, they would go further than merely restating the information they found, they would incorporate consciousness-raising into their process to make it relevant to their lives.

The wonder of learning and sharing together was what made this educational experience unique in so many ways. Ditzion elaborated that

> in this case, women [were] getting together and defining our own agenda, learning for ourselves to answer burning questions that we didn't have the

[290] Ditzion, interview with author, 2016.
[291] Diskin, interview with author, 2016.
[292] Diskin, interview with author, 2016.

> answers to and needed, and also to figure out what knowledge was out there and what wasn't. And so to me, the educational piece, and I frankly don't think lots of the other founders necessarily resonated the same way but to me that was one of the most exciting parts of this project.[293]

The educational nature of this project started with the BWHBC learning together and learning together made the evolution of this project possible. Diskin stated,

> We didn't set out to write a book. That was never in our minds. But what was always in the front of our minds was informing ourselves through research and through talking with each other, and then educating other women to what we knew.[294]

Their goal at the beginning was to create a course as a way to disseminate this information to other women. The pamphlet they developed for the course, initially called *Women and Their Bodies*, was meant to make the course experience replicable. "The pamphlet idea was exciting because it was to generate a process but the process was women talking with one another, learning together, sharing experiences, broadening their knowledge base."[295] The consciousness-raising process had been so significant to their learning that they wanted to be sure that all women involved in the course could have the same deep and profound learning experience that the founders had had through their own learning. They in fact had hoped to reach as many women as possible,

> One of the things we said when we started was – we want this information to be available to all women. Now that's a very tall order, so we said look, and this is before you know any book idea came into our heads, we said we'll give a course, we'll Xerox these papers… and we'll give this course and we'll say to the people in the course, in the room, we'll say we're giving this course, it's going to be ten weeks, because there's ten chapters, and when this course is done you guys can have copies of these chapters or papers, we didn't call them chapters, and you go and give your own course. Anywhere and everywhere so in a church basement or in your living room in a center…and that will have a

[293] Ditzion interview with author, 2016.
[294] Diskin, interview with author, 2016.
[295] Ditzion, interview with author, 2016.

> snowball effect. Then we'll get more and more women to know this material. And you know the interesting thing, that's exactly what's happened.[296]

Soon the snowball effect that the BWHBC had desired had put them in a position to reach even more women. As the popularity of the course increased and more women became involved in teaching and learning, a small regional publishing house reached out to them. The New England Free Press sold 240,000 copies[297] of *Women and Their Bodies* which prompted interest from national publishers. The women ultimately chose Simon and Schuster and hired "a wonderful feminist lawyer who wrote us the best contract that has ever been written."[298] The BWHBC were able to secure an agreement with the publisher that would grant a seventy percent discount "for any group that teaches health education in whole or in part." This meant that clinics, hospitals, or community organizations could afford to purchase the book in bulk and "thousands and thousands of copies went out like that."[299] In fact, the discount is still a part of their publishing contract to this day and the BWHBC use it "all the time."[300] The BWHBC were also contacted by feminist organizations from other countries who would request permission to translate the book into other languages. Their contract included a provision that allowed them to sell the foreign rights to the text for one dollar.[301] The result is that "the book has been not only translated but adapted into thirty languages… it's sold over four million copies worldwide."[302]

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[296] Diskin, interview with author, 2016.
[297] Diskin, interview with author, 2016.
[298] Diskin, interview with author, 2016.
[299] Diskin, interview with author, 2016.
[300] Diskin, interview with author, 2016.
[301] Diskin, interview with author, 2016.
[302] Diskin, interview with author, 2016.

This form of outreach and learning together is a hallmark of women's health education by women. One of the educational legacies to come out of the reproductive justice movement is Lillie Allen's development of Self-Help. Allen is a health educator and one of the founders of the National Black Women's Health Project (NBWHP). The NBWHP "has played an important role in mobilizing African American women on the issues of health and reproductive rights and in bringing their perspectives, voices, and concerns to national and international attention."[303] Allen's work had been greatly informed by her experiences with internalized oppression and external forces of racism and sexism. Allen recognized the emotional trauma and self-doubt that results from living daily with these oppressions and set out to develop a process to work through it.

Allen started with Re-evaluation Counseling (RC), described as a "process of dialogue and active listening in which the participants work through difficult emotional issues so that they can effectively use their intelligence to address their problems."[304] RC sessions give participants a safe space in which to unload their emotional burdens and allow individual participants time to focus on their own personal issues. Allen observed a lack of black people involved in RC and thought it was problematic – and likely a result of the white participants who were uninterested in being confronted with the realities of racism. In order to create such a safe space for black people, and black women in particular, Allen would develop a similar process of self-disclosure that she initially called "Black and Female."[305] Allen describes the experience as "learning to act outside of my oppression, building a relationship with myself, and understanding how

[303] Jael Miriam Silliman et al., *Undivided Rights: Women of Color Organize for Reproductive Justice*, (Cambridge: South End Press, 2004), 63.
[304] Silliman, et al., *Undivided Rights,* 68.
[305] Silliman, et al., *Undivided Rights,* 69.

to maintain relationships with your own people first to understand what it means to be with people not coming from a place of oppression."[306] This change "successfully politicized"[307] RC and Allen named her approach Self-Help.

Allen's work was foundational in the formation of the NBWHP and Self-Help was a powerful tool used in the organization to create "a safe, validating environment"[308] in which black women could come together to explore their lived experiences. Through Self-Help, they could address their "physical, spiritual, emotional, and psychological health needs"[309] and work toward improved lives and health outcomes. Allen also integrated Self-Help into "Sisters and Allies," a multiracial program that brought together "white and black activists to build trust to enable them to work together to build an inclusive movement."[310] Allen's Self-Help was a learning tool that not only engaged individual women in a process of building their own self-worth, it also brought together women from different communities to realize what they could accomplish together.

Self-Help was later adopted by the National Latina Health Organization (NLHO) as "a tool for individual empowerment and social change."[311] The organizers of the NLHO understood that Latinas were particularly vulnerable to institutional exploitation in healthcare settings because they typically lacked "access to bilingual or culturally proficient health care information."[312] The NLHO was adamant that all women should have the health knowledge necessary to be able to care for and advocate

[306] Silliman, et al., *Undivided Rights*, 69.
[307] Silliman, et al., *Undivided Rights*, 69.
[308] Silliman, et al., *Undivided Rights*, 71.
[309] Silliman, et al., *Undivided Rights*, 71.
[310] Silliman, et al., *Undivided Rights*, 71.
[311] Silliman, et al., *Undivided Rights*, 243.
[312] Silliman, et al., *Undivided Rights*, 244.

on behalf of themselves and their families. Self-Help was integrated into the NLHO's educational programming as a way to give Latinas the health information they needed and also to give them "the opportunity to evaluate the information in terms of their own lives."[313] Self-Help allowed women to make vital connections between information and their experience. As with the NBWHP, women attending the community-tailored classes put on by the NLHO were able to share their stories "in a supportive, nonjudgmental group setting."[314] Many of the participants were empowered to share their personal stories for the first time. They could

> discharge their feelings and express their joy, pain, anger, sadness, or whatever emotions arise as they explore topics such as poverty, oppression, health, and family. This is critical, according to the NHLO, because Latinas are often so busy taking care of others and struggling to survive that they do not have the opportunity to express themselves and be heard.[315]

The "self-empowerment curricula" of the Self-Help sessions not only provided relevant health information to the participants, but also gave each woman in attendance a chance to share with the group how their new knowledge fit into her life. "[T]he NHLO believes that women will come to the best decisions for themselves when they have been listened to and supported, and realize their own power."[316] Self-Help served as an educational tool to help the women in attendance understand their own self-worth and "realize their agency in creating their life circumstances."[317] The feedback that the NLHO received about their educational sessions would be used to further customize learning experiences for the community. Thus, the knowledge generated from these

[313] Silliman, et al., *Undivided Rights*, 246.
[314] Silliman, et al., *Undivided Rights*, 246.
[315] Silliman, et al., *Undivided Rights*, 246.
[316] Silliman, et al., *Undivided Rights*, 246.
[317] Silliman, et al., *Undivided Rights*, 246.

experiences would come full-circle from the presenter to the individual woman to the organization and back to the community.

The circulating of gifts makes it possible for women to understand not only their bodies and health but also – and perhaps more importantly – the power they have to make a difference in the world. As Ditzion described they "wanted women to read and educate themselves about their own healthcare but also be part of this social justice, feminist movement in a way. It was a tool for the feminist movement as well as for health education."[318] That these women were able to successfully enact the Isolation-Knowledge Remedy through an curriculum of sharing and learning demonstrates how deeply rooted in education these oppressions really are. The experience of sharing knowledge to remedy mis-education, of organizing to counter propaganda, was one of the most important lessons the BWHBC learned through their process. "It's important to share this information but the intention was always and still today was just to get women getting together to learn and educate themselves and research issues that were really critically important. And that was the purpose of it really."

The Inferiority-Experience Remedy

The Inferiority Problem and the Experience Problem work in tandem to make women feel that they are inadequate and unworthy. They come from the same place in oppression. In a medical context, these problems work to keep women from understanding that they are capable of learning about their bodies and that the knowledge they have of their own bodies is invalid. This is detrimental to their lives and

[318] Ditzion, interview with author, 2016.

their ability to live fully. Whether Inferiority is brought about through educational means or Experience is devalued as part of the medical professions, women have found themselves apart from truth, from themselves, and from each other. The key to the Inferiority-Experience Remedy was thus shared empowering experiences as the work of the BWHBC demonstrates.

As the BWHBC embarked on their project, they were open to letting the process become what it needed to be a truly educational experience. They began with what they called professional sources – journals, medical textbooks, and healthcare professionals – to learn the facts that were necessary for a women's health project to truly address the gaps in their knowledge.

> Once we had learned what the "experts" had to tell us, we found that we still had a lot to teach and learn from one another. For instance, many of us had "learned" about the menstrual cycle in science or biology classes – we had perhaps even memorized the names of the menstrual hormones and what they did. But most of us did not remember much of what we had learned. This time when we read in a text that the onset of menstruation is a normal and universal occurrence in young girls from ages ten to eighteen, we started to talk about our first menstrual periods. We found that, for many of us, beginning to menstruate had not felt normal at all, but scary, embarrassing, mysterious.[319]

This process of sharing and making the information relevant to their own learning and lives was doing more than just letting them realize that they were not isolated in their thinking, that they were not crazy. This process was validating to their lived experiences and made their embodied experiences as women valid, too. This was learning that allowed them to live comfortably in their own bodies for perhaps the first time in their lives. "We realized that what we had not been told, even the tone of voice it had been told in – all had had an effect on our feelings about being female."[320] Rather than being

[319] BWHBC, *Our Bodies*, 2.
[320] BWHBC, *Our Bodies*, 2.

the "passive recipient[s] of information"[321] that school and medicine had taught them to be, they embraced their individual and collective talents and skills and gave their lives and intellectual abilities the respect they deserved. "We found that each individual's response to information is valid and useful, and that by sharing our responses we can develop a base on which to be critical of what experts tell us."[322] But this went beyond their relationships with their physicians and medical information. "Whatever we need to learn now, in whatever area of our life, we know more how to go about it."[323]

The BWHBC were creating a new approach to learning and it was an empowering process. It was centered around individual and group learning but, more importantly, allowed individuals to apply the health and medical information they were learning to their personal lived context to achieve relevance in learning. Further, it gave them the power to be critical of the medical institution – an institution that had previously been unquestionable. Using consciousness-raising as an educational foundation, the BWHBC was able to take their educational project to a new level,

> As we developed the course we realized more and more that we were really capable of collecting, understanding, and evaluating medical information. Together we evaluated our reading of books and journals, our talks with doctors and friends who were medical students. We found we could discuss, question and argue with each other in a new spirit of cooperation rather than competition. We were equally struck by how important it was for us to be able to open up with one another and share our feelings about our bodies. The process of talking was as critical as the facts themselves. Over time the facts and feelings melted together in ways that touched us very deeply, and that is reflected in the changing titles of the course and then the book – from *Women and Their Bodies* to *Women and Our Bodies* to, finally, *Our Bodies, Ourselves*.[324]

[321] BWHBC, *Our Bodies*, 3.
[322] BWHBC, *Our Bodies*, 3.
[323] BWHBC, *Our Bodies*, 3.
[324] BWHBC, *Our Bodies*, 1.

Diskin further elaborated on how the teaching that their member-researchers did changed the way they viewed and understood the information they found,

> what the rest of us did – and this is what was so unique about *Our Bodies, Ourselves* to this day – the rest of us gave them feedback about the information with our own experience. It was the integration of good medical information, accurate medical information, but it was integrated with our experiences. So you know it's one thing to read what a healthy pregnancy is, but it's another to talk about what happened to you… You can read about that but if you've experienced it, you have a whole different understanding.[325]

This process moved beyond fact-checking and reporting. They elevated personal medical knowledge gained through lived experience to the level of formal medical education. Women were acknowledged as the medical experts of their own lives and viewed as valid sources of knowledge about their bodies. Through this process, they reconceptualized biology in feminist terms "that privileged individual women's experiences over clinical research."[326]

The work that the BWHBC did to prepare the course pamphlet was not the only intellectual contribution responsible for the project. They in fact designed the course to evolve. Each group of women who participated in the course brought her own perspective and experience to the curriculum. "With each session, with each course, new information from women's life experience was being generated. Stuff that hadn't necessarily been discussed before or just broadening our whole way of thinking about things."[327] This was two-way, transformative, ongoing, democratic learning. Their class sessions echoed the process that the BWHBC used to assemble their course and pamphlet,

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[325] Diskin, interview with author, 2016.
[326] Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave*, (Chicago: University of Chicago Press, 2010), 11.
[327] Ditzion, interview with author, 2016.

> it was usually structured that there would be sharing of the information initially and then people in the large class group would divide up into small groups and talk personally how they resonated with these issues and then come back together and share what people learned. And often what was happening is that whoever was presenting, broadened their frame because there was always a few stories. It was always applying it to the personal – that was the other piece of it, the consciousness-raising. It was always the personal is the political… It was really validating every woman's real life experience as data or whatever knowledge is. So that's a pretty transforming experience and so each session generated new knowledge as well as the sharing of knowledge and a process. And then anyone who wanted to could either join the ongoing project as it were. And everyone was encouraged, if you want to [continue] the course, that was the good thing about the pamphlet… Once the pamphlet was developed, the idea was that people should use it as a basis for a class, a course.[328]

The BWHBC were learning as much from the women who took their course as the women learned from the BWHBC's research. The significance of the process also helped the women of the BWHBC and the women who took their course overcome the sense of inferiority that they had learned in their lives.

Though the path to *Our Bodies, Ourselves* created a modern approach to tackling what had become a very modern problem, the learning and teaching with and among women is how women had traditionally learned about health and caring. The tradition of midwifery is grounded in this style of teaching and learning. Women's health in the hands of women was a communal effort, requiring a commitment to sharing knowledge and life experience. This circulation of gifts is beautifully illustrated in the novel *Sassafrass, Cypress, and Indigo* (1982) by educational novelist[329] Ntozake Shange.

In this novel, Shange explores educational experiences and practices related to reproductive justice within a family of African-American women. The overall arc of the

[328] Ditzion, interview with author, 2016.
[329] Established by Susan Laird, See, Nel Noddings, *Philosophy of Education*. 3rd ed., (Westview Press, Kindle Edition, 2012).

story explores the lives and challenges of the three sisters named in the book's title. The widow Hilda Effania raises her daughters as a single mother in the South, Sassafrass deals with an abusive heterosexual relationship, Cypress dabbles in drug abuse and has an array of male and female lovers, and, of course, there is Indigo. Indigo whose entry into menarche opens the novel, is an icon of cultural wealth whose education in midwifery at the sides of other women exemplifies a kind of health care education that is rooted in the experiences of African women.

Indigo believes in the strength and wisdom inherent in womanhood. Shange opens her novel with the following passage,

> Where there is a woman there is magic. If there is a moon falling from her mouth, she is a woman who knows her magic, who can share or not share her powers. A woman with a moon falling from her mouth, roses between her legs and tiaras of Spanish moss, this woman is a consort of the spirits.[330]

Rather than seeing her lamenting the two-sphere split that was designed to make women feel inferior, Indigo embraces her womanhood and her own inner magic. She has two teachers in particular who make this learning possible: Sister Mary Louise and Aunt Haydee. From Sister Mary Louise Indigo learns about magic, the South, and of being a Southern woman. She is given connections to the past and the ability to honor her own body and the wonders that it can perform. Sister Mary Louise holds a celebration ritual upon Indigo's first menses during which she connects this life event to spirituality, the Earth, and to life. Indigo later describes "Marvelous Menstruating Moments" to the dolls that she created with her own hands and for each of which she made "a personal menstruation pad of velvet."[331] She declares, "When you first realize that your blood

[330] Ntozake Shange, *Sassafrass, Cypress & Indigo: A Novel*, (New York: Picador USA, 1996), 3.
[331] Shange, *Sassafrass*, 19.

has come, smile; an honest smile, for you are about to have an intense union with your magic. This is a private time, a special time, for thinking and dreaming."[332] Unlike the professional medical educational agents who had pathologized menses, Sister Mary Louise taught Indigo that the very thing that makes women different was meant to be celebrated.

Aunt Haydee is the community's informal medical provider, a healer. From her Indigo learns about midwifery. Aunt Haydee midwifery training was accomplished by allowing Indigo to attend births with her and increasing Indigo's responsibilities over time. In beautiful lyrical passages, Shange explores Indigo's transition into a healer,

> Indigo'd studied violin with the white woman Miz Fitzhugh sent every summer, but she concentrated more on learning what Aunt Haydee knew. Giving birth, curing women folks & their loved ones. At first Aunt Haydee only allowed Indigo to play her fiddle to sooth the women in labor, but soon their mothers, the children, sought Indigo for relief from elusive disquiet, hungers of the soul.[333]

Shange's celebration of black women, of the circulation of gifts that is common in women's communities and in women's health practices, is itself an expression of the kind of transformative learning in which the BWHBC engaged. Whereas the white medical professionals assume that the best source of knowledge about healing is their own, this novel shows that there are diverse sources of wisdom and means of transmitting it. It also gives back to black and brown girls who are sadly underrepresented in published novels. Indigo is a role model for girls to believe in their own magic and capabilities.

The learning experiences of Indigo and the BWHBC demonstrate that women model community in education that values history and experience – and honors the

[332] Shange, *Sassafrass*, 19.
[333] Shange, *Sassafrass*, 221-222.

history and experience of women. This is directly counter to the traditional models of education and medicine in which women as students and patients are told what and how to think about themselves and their potential to contribute to the world. Their exploration of being a woman in a woman's body in a male-centered world was profound to their work and to overcoming the sense of inferiority that cast a shadow over their lives. Even though men's health was considered the baseline of medical knowledge, they realized that men may share many of the anxieties that they had felt as women. However, they acknowledged that their life experience limited their ability to speak truthfully to being a man in a man's body,

> We have been asked why this is exclusively a book about women, why we have restricted our course to women. Our answer is that we are women and, as women, do not consider ourselves experts on men (as men through the centuries have presumed to be experts on us). We are not implying that we think most of twentieth-century men are much less alienated from their bodies than women are. But we know it is up to men to explore that for themselves, to come together and share their sense of themselves as we have done. We would like to read a book about men and their bodies.[334]

The pedagogical approach to medical and health education employed by the BWHBC would go a long way in countering the issues that Wollstonecraft and Woolf criticized regarding education and the professions. That the BWHBC found personal and professional empowerment through an educational approach that made room for women's characteristics is exactly what Wollstonecraft and Woolf would have anticipated. Ditzion explains that she experienced a personal epiphany of sorts,

> This was a breakthrough about women in that we could be very intelligent and creative and innovative thinkers. I did well in school and all but this work stimulated a real creativity in me and gave me a sense of my own – there were burning questions that I had and I can find the answers and that's what education's about. Because it was in this feminist context, like the men understood it or certainly people did, and now I as a woman could understand all

[334] BWHBC, *Our Bodies*, 2.

> this and generate questions and knowledge, you know? But the process, to me, that process was such a stimulating, self-affirming process in terms of women's competency and intelligence and creativity.[335]

This project was life-changing for the women of the BWHBC and for the women who attended their course. It was a true circulation of gifts from one woman to another.

This Inferiority-Experience Remedy countered the medical mis-education that had defined their lives. *Our Bodies, Ourselves* restored some measure of human dignity to women that is essential to life. Indeed, sharing this information and their personal stories with one another did what Chomsky had suggested it would do – they were able to disrupt the propaganda by coming together. Diskin explains that this "was our mission. We wanted to get this accurate information, we wanted to make it in language that all of us could understand and then relate our experiences with it so that it became much more relevant learning."[336] It was important that women reclaimed their bodies and this educational movement about women's health and bodies helped facilitate that. The BWHBC wanted to highlight "*our* experiences, *women's* experiences"[337] and, in doing so, validated the learning, teaching, healing, and caring that had always been a part of women's lives.

The Deference-Control Remedy

The Deference Problem and the Control Problem work in tandem to make women feel that they are inadequate and unworthy. They come from the same place in oppression. In a medical context, these problems work to keep women from

[335] Ditzion, interview with author, 2016.
[336] Diskin, interview with author, 2016.
[337] Diskin, interview with author, 2016.

understanding that they have a voice in their care and power over their own bodies. This is detrimental to their lives and their ability to live fully. Whether Deference is brought about through educational means or Control is enforced through the medical professions, women have found themselves apart from truth, from themselves, and from each other. The key to the Deference-Control Remedy was thus shared liberating experiences as the work of the BWHBC demonstrates.

The women's health issue most commonly associated with the American feminist movement of the 1960s to the early 1980s is access to abortion. The Supreme Court verdict in *Roe v. Wade* in 1973 was a significant moment in the lives of real women and for the women's movement. It gave women a right to control their bodies in a way that did not previously exist – at least not in a voluntary, legal, or safe way. Illegal and dangerous abortions will always occur when access is restricted and, for some women, involuntary abortion is always a threat. In the 1973 edition of *Our Bodies, Ourselves*, the BWHBC speak directly to the issue of abortion and its place in the agency of women. They begin their chapter on abortion with the simple statement: "Abortion is our right – our right as women to control our bodies."[338] Indeed they make their intent quite clear by stating, "We are demanding free, safe, and voluntary abortions for all women who want them, to be carried out in properly equipped hospitals or clinics by humane and qualified personnel, including trained and sympathetic counselors.[339] They draw attention to specific statistics that are important to understanding what legal and safe abortion means to women. Here are a few of notable facts related to abortion that they discuss:

[338] BWHBC, *Our Bodies*, 138.
[339] BWHBC, *Our Bodies*, 139.

- "the risk of death from an abortion done under proper medical supervision during the first twelve weeks is less than for a full-term pregnancy"[340]

- "until recently illegal abortion has been one of the most common causes of maternal death in this country"[341]

- "when legal abortions are hard to get, poor nonwhite women suffer most"[342]

Without an understanding of the risks of pregnancy and without the choice to terminate a pregnancy, women were at the mercy of medical, social, and economic factors that were historically not particularly sympathetic to the needs of women.

Prior to *Roe v Wade*, one underground women's health organization worked toward changing the narrative of illegal and necessary abortion. Jane was a feminist abortion service that was active from 1969 until 1973. Like the BWHBC, they believed that safe and affordable abortion should be available to any woman who wants one. Jane was formed by a group of women in Chicago and, for legal reasons, all members were known as "Jane" related to their activities on behalf of the group. At first Jane organized as a referral service, connecting women to physicians known to be willing to perform abortions. In addition, all of the women who came to Jane for help were also the recipients of education about the procedure itself, bodily care after the procedure, contraception, and self-care.[343] They would also accompany patients to the procedure to provide emotional support when the providers would allow their presence. And like other feminist organizations, they understood that the personal was political and educated women about the socio-political forces that put them in the position of having

[340] BWHBC, *Our Bodies*, 138.
[341] BWHBC, *Our Bodies*, 138.
[342] BWHBC, *Our Bodies*, 138.
[343] Kaplan, *The Story of Jane*.

to seek an illegal abortion. Despite their efforts at holistic education for the women who sought their help, Jane found that the societal forces that controlled women and forced them to defer to others was the most difficult part of their re-education approach to health.

> The most difficult task was to counteract the guilt and self-blame that women carried. Even if there was no way they could afford or care for a child, they still internalized society's judgements that women who sought abortions were selfish, immoral, denying their female duty, and stupid or careless for getting pregnant. Black women, as usual were under a double bind. They were not only burdened with society's attitudes, but also, by the criticism of black nationalists who identified abortion with genocide. Within those circles any woman seeking an abortion was considered a traitor to her race.[344]

The job of the Jane counselor to support the woman's decision and to alleviate her concerns by educating her on the systemic political and social issues that affected her ability to control her own body and health. Some women just wanted to get the procedure over with and get on with their lives, but in others Jane "could almost see a bulb light up."[345] By countering the mis-education to which women had been subjected their whole lives, their path to liberation had begun.

Their referral model soon became dissatisfying for Jane. Physicians were afraid of being arrested and prosecuted for performing abortions so Jane had limited referral sources. In fact, the physicians would often require the women receiving abortions to be blindfolded so they would be unable to identify the doctors should a legal situation arise. This fear also limited Jane's ability to attend to the women during procedures. There was also no way to control the cost of the abortions. Different providers charged different amounts, and the fees often exceed what many women could afford to pay.

[344] Kaplan, *The Story of Jane*, 37.
[345] Kaplan, *The Story of Jane*, 37.

Providers also had complete control over the appointment time and place, "From the moment a woman left home to meet the doctor until she safely returned, the group was out of it."[346] Jane were also disturbed that the medical staff often treated patients in a dehumanizing way, as passive recipients of the procedure. Though they knew they were providing a valuable service to the women who came to them for help, they also knew they could do better on their own.

Jane decided that they would take matters into their own hands. They convinced one of their providers to teach them to do the abortions themselves and were surprised at how easy it was for them to learn to safely perform the medical procedure. It also allowed them to provide services at little to no cost for women who could not afford to pay. Once Jane were in charge of the procedure, they were able to ensure that all of the women were treated with the care they deserved – in a caring environment where their agency, intelligence, and lives were valued and supported. All women who came to them for help were provided education on reproductive health topics. Each woman was required to receive counseling prior to the procedure which had to be done one-on-one with a Jane – no parents, husbands or boyfriends were allowed to be present to ensure that the woman was not being coerced into the procedure. Jane received as many as 300 requests per week and performed over 11,000 procedures without a single fatality while they were active.[347] Their overall message from their own educational evolution to the curriculum they delivered was a declaration of agency: "It's up to you to take charge of

[346] Kaplan, *The Story of Jane*, 37.
[347] Kaplan, *The Story of Jane*.

your life. You have to make your own decisions. You control your body, no one else does."[348]

This was also a message that the BWHBC endorsed. The more they learned about their own bodies and their prescribed relationship with the world, the more they felt like they could reclaim power in their relationship with the medical institution. One of the primary outcomes of their educational project was the development of agency and this was intentionally written in to their curriculum. Their self-education and the course they designed were meant to be liberating from the medical mis-education of women that affected so many aspects of their lives.

> I would say that the emphasis is really on women and health and a feminist perspective, which is you know we are equal to men in the sense of we deserve equal opportunity to health to the environment to wages, equal wages. We deserve to be liberated from the stereotypes and the sexism that we knew and the perspective really is if we want to live in a world that's much more equal, that's much more feminist, we have to be aware of where and what we're living and trying to make change. So we get this information, and we share this information, and we always say to people it's important to get active in your own life. And sometimes that action means you get a group of people together and you go demonstrate in front of the legislature, if you're wanting to change some laws?, sometimes it means sticking up for people in your community who are being discriminated against. It means different things in different situations but that the change aspect, the organizing for change is very much a part of this and its vision.[349]

Their contribution to women's health and women's health education was an act of activism, it was a subversive act that directly confronted centuries of medical, education, and political oppression. This education was a remedy to the problems of Deference and Control.

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[348] Kaplan, *The Story of Jane*, 36.
[349] Diskin, interview with author, 2016.

After they began their work, the members of the BWHBC felt the shift in their relationship with the medical profession. They had educated themselves and knew themselves capable of learning – and they knew, too, that they were unwilling to settle any longer for anything less than honesty, the best possible care they could get, and respect for their intelligence. Diskin describes the change she experienced,

> [My relationship with the medical institution] changed enormously. I felt that I was competent to ask good questions and also that I was competent enough and confident enough to know that I knew things about my body that nobody else knew about and that really to get the best healthcare, medical care, you have to share that knowledge that you know about yourself with your health provider. I knew if I had periods that were agonizing or the opposite, right? And if I was worried about something or if I had a symptom about something, I could describe it much more accurately – and the confidence was really important because I knew what I was talking about, and so when I got answers like 'oh, you don't have to worry about it' I would get very fussy and say 'yes, I do have to worry about it, it's my body, not your body and when it hurts or I need this information, I'm glad you have it in your head but you need to tell me for it to do me any good.' So it was that we had a footing, a sure footing of knowledge and also we knew that we had something to teach [doctors]. It's not a one-way street. Medicine, health is not a one-way street. I think you get the best care by accurately describing as accurately as possible your symptoms... And I do that now. When I go for my physicals, the day before, I sit down, I make a list of things, I make a list of symptoms, you know, I think about it. I think about what is it that I want to learn here.[350]

As the women of the BWHBC found themselves being liberated from the oppression they experienced at the hands of the medical professions, they were able to apply the lessons they learned to other institutional relationships. This change did not stop with the medical professions. The educational process that led to *Our Bodies, Ourselves* was "really raising my consciousness about being a woman in society today… I was aware that sexist attitudes was part of most institutional framework."[351] Just as they had

[350] Diskin, interview with author, 2016.
[351] Ditzion, interview with author, 2016.

learned to demand more of their doctors, they learned that they should demand more from society in general.

The BWHBC's educational project proved that women were capable of learning complex material. Their learning led them to realize that "The doctor is no longer a god-figure; that's the price we pay for our developing independence."[352] And this sense of independence was something they intended for all women in part because they knew that increased confidence in dealing with healthcare matters meant healthier communities. "We started out to make women informed consumers of their own healthcare… because we knew that would mean better healthcare for their families, for their communities. So that's how it works . When women have knowledge, it goes to the family and community."[353] If women are going to be the primary caretaker of their families, it is in everyone's best interests that they be informed and empowered.

> We want women to be liberated. What we mean by liberation is liberated to act in your own behalf. And we want women to be empowered, that is the other real kind of number one goal that we've always had because we felt that by getting the information, this accurate information, knowing what we were talking about and then bringing our experiences to that knowledge and seeing where points of contact, where points of not being in contact – that that was empowerment. And empowerment for us meant that you felt empowered to act and to have confidence in yourself. That you could be true to yourself, you could be more authentic.[354]

That empowerment was meant to lead women to feel the full weight of their humanity, to demand the dignity associated with that humanity, and to be acknowledged as being fully human. That piece was always foremost in their thoughts as they executed this project. Education was not just about learning a body of knowledge, it was about

[352] BWHBC, *Our Bodies*, 250.
[353] Diskin, interview with author, 2016.
[354] Diskin, interview with author, 2016.

realizing your own worth and power and to feel free to act on it in any way that best suits the individual woman.

> And that's what this book is all about, too – agency. I mean I say empowerment, but that's what agency is. If you feel you have agency, you're empowered. And that's exactly right. And we were. That's when we… you know, we as feminists think that choice is the most important part. So the choice to have a child, the choice not to have a child. There isn't a right way or a wrong way to do it, it's just what's right for you in your context and in your life and at the time. And not the have the government tell you what you should do or what you shouldn't do and of course it didn't bypass us, the enormous hypocrisy of some of our legislators who want the government out of business but want it in the bedrooms of women.[355]

Their enlightened understanding of the world was profound, even if it was initially mildly confusing. The BWHBC largely credit the change brought about in their perceptions of reality to the incorporation of consciousness-raising into their process. Consciousness-raising brought about their feminist mindset and as Sandra Bartky argues, this change is a process. She declares, "To be a feminist, one has to first become one."[356] The becoming part is made difficult through the realization of living in a world that devalues women. Bartky explains,

> Feminist consciousness is the consciousness of victimization. To apprehend oneself as victim is to be aware of an alien and hostile force outside of oneself which is responsible for the blatantly unjust treatment of women and which enforces a stifling and oppressive system of sex-role differentiation. … To see myself as a victim is to know that I have already sustained injury, that I have been at worst mutilated, at best diminished in my being. But at the same time, feminist consciousness is a joyous consciousness of one's own power, of the possibility of unprecedented personal growth and the release of energy long suppressed.[357]

The process for the BWHBC required that they had to relearn who they are and how to live within the new parameters of their being.

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[355] Diskin, interview with author, 2016.
[356] Bartky, *Femininity and Domination*, 11.
[357] Bartky, *Femininity and Domination*, 16.

> We all went through a time when we rejected our old selves and took on the new qualities exclusively. For a while we became distortions, angry all the time or fiercely independent. It was as though we had partly new selves and had to find out what they were like. But ultimately we came to realize that rejecting our "feminine" qualities was simply another way of going along with our culture's sexist values. So with our new energy came a desire to assert and reclaim that which is ours.[358]

Like Bartky, they had to realize the extent of their victimization in order to fight it. They had to understand that they had in fact been victimized and learn how to counter it. Their work was meant to do just that – and it worked. The educational project that they had devised proved an effective remedy to the mis-education that had colored their perceptions of themselves and their place in the world. For the BWHBC, their process began with their bodies. Their bodies had been a mystery to them, and the knowledge about their bodies had been kept from them. In order for them to regain control, to have agency, they had to start with their bodies.

> For us, body education is core education. Our bodies are the physical bases from which we move out into the world; ignorance, uncertainty – even, at worst, shame – about our physical selves create in us an alienation from ourselves that keeps us from being the whole people that we could be.[359]

By the time they were done with the first phases of their project, they had more than made peace with their bodies.

> Whatever view of our bodies we came in with in this group, we came out of it feeling so much more comfortable. Like, so much more appreciative and really good about our bodies, we felt good about them, what they could do, and how miraculous they really were.[360]

Indeed by the time they had completed their self-education, they had made the mental shift from victim to activist educators. They Deference-Control Remedy they had

[358] BWHBC, *Our Bodies*, 6.
[359] BWHBC, *Our Bodies*, 3.
[360] Diskin, interview with author, 2016.

employed had successfully countered the mis-educational problems that had restrained so much of their lives.

Envisioning the Possibilities

In this chapter, I have described the educational remedies identified within the work and words of the BWHBC. As the problems of Deference, Isolation, Inferiority, Knowledge, Experience, and Control were identified as mis-educational problems worthy of intervention, the development of *Our Bodies, Ourselves* as an educational resource demonstrate the link between medical oppression and mis-education. Each of the remedies identified further show that organizing – Chomsky's named remedy to propaganda and a traditionally women's approach to work – disrupts the traditional male model of education and medicine. Thus the work of the BWHBC proves the existence of the medical mis-education of women as a gendered medically based oppression rooted in mis-education.

In the next chapter, I will begin to explore ways in which the educational remedies identified in the words and work of the BWHBC can be adapted by schools. In particular, the applicability of their pedagogical approach to health education shows great potential to the development of a sex education curriculum that is sex, body, and agency positive. These remedies become even more crucial in the era of a Trump presidency. It is important to understand how the thinking of the BWHBC can contribute to remedying the medical mis-education of women but also how their creative remedies can be utilized to solve other problems of schooling.

Chapter Five:

"But you know they're not getting it in schools":

Theorizing School Curriculum for Young Women's Health

When women have knowledge, it goes to the family and community.

- Vilunya Diskin

In this inquiry thus far, I have explored the words and work of the BWHBC to clarify their contact with the medical mis-education of women and its influence on their lives. The BWHBC recognized that the educational agents of medicine attempted to define women and used the educational problem of generations to create ongoing restrictions on the ability of women to live fully. The BWHBC responded to this oppression by choosing to become educational agents of change and circulating their gifts – gifts that became *Our Bodies, Ourselves*, a significant contribution to women and feminism that started the women's health movement of the American feminist movement of the 1960s to the early 1980s. They shared the knowledge that had empowered and liberated them about women, women's bodies, and women's health. In doing so, they not only filled a knowledge gap that was detrimental to women's health, they also engaged in identifiable remedies that countered the medical mis-education of women.

I began in Chapter 3 by describing the educational and medical Problems that I identified within the work of the BWHBC. Those problems – Deference, Isolation, Inferiority, Knowledge, Experience, and Control – all contribute to the medically based

oppression that the BWHBC described as being an active force in their lives. In Chapter 4, I reviewed the remedies that they employed to counter those problems. I named them the Isolation-Knowledge Remedy, the Inferiority-Experience Remedy, and the Deference-Control Remedy. The complexity and interconnectedness of the problems of education and medicine lend to a combined educational approach to problem-solving. Their educational remedies were thus just as interdependent as the problems. The pedagogical approach employed by the BWHBC put Martin's circulating the gifts in action in a distinctive way. Their ability to utilize organization and consciousness-raising broke the mis-education that had cast a shadow over the lives of women.

As the earlier discussion of sexual and reproductive health education demonstrated, children in the U.S. are exposed to a curriculum that is mis-educative in both action and consequence. Title IX is the policy that is meant to establish an environment of fairness, safety, and equality in schools. Sadly, it does not yet appear to have been fully enforced or invoked routinely outside of athletics.

As Dewey argued, "Any experience is mis-educative that has the effect of arresting or distorting the growth of further experience."[361] This means that denying students a learning atmosphere that is conducive to learning – which includes not only academic merit but also physical, emotional, and mental safety – is not an appropriate condition for positive education. The description of sexual and reproductive health education given in Chapter 2 is clearly a mis-educational venture that stands in direct opposition to the intent of Title IX and a positive educational experience. Not only does abstinence-only education intentionally mis-educate students on facts related to safe and

[361] Dewey, *Experience and Education*, 25.

responsible sexual activity and behaviors, it relies on stereotypes that further oppress already marginalized people. In addition, the existing curriculum barely, if at all, recognizes the need for consent and in fact perpetuates the idea that females are solely responsible for preventing unwanted or unapproved sexual contact – all of which contributes to sexual violence and the silencing of victims. Under such circumstances, it is safe to say that students cannot feel safe in an environment that contributes more to rape culture in schools than it does an environment conducive to learning.

The problems that I identified in the work of the BWHBC are also clearly infused into sexual and reproductive health education at the hands of abstinence-only education that for decades has been the default curriculum for sexual and reproductive health in the U.S. The BWHBC aimed to correct educational deficits imparted by institutionalized education and medicine that served in the ongoing oppression of women. It is from this perspective that I see the potential for application of the BWHBC's educational remedies with regard to women's health education in American schools. Their approach to open, rational, engaging, empowering, and liberating women's health education can change the ways in which sexual and reproductive health education is envisioned and delivered. In this chapter, I propose that schools can learn from the BWHBC how to approach curricular and pedagogical reforms that the medical mis-education of women makes necessary in order to achieve Title IX's aim of gender equality. I will reimagine schools – and sexual and reproductive health education in particular – utilizing the educational remedies to the medical mis-education of women experienced by adult women and identified by the BWHBC. The applicability of *Our Bodies, Ourselves* to a sexual and reproductive health education curriculum that is sex,

body, and agency positive is an important lesson for educators, curriculum developers, educational administrators, librarians, etc. These remedies become particularly crucial in the current political climate in the United States. This only makes more urgent the need to explore not only the thinking of the BWHBC on the medical mis-education of women, but also how their creative remedies can be employed to solve other problems of schooling.

As I explore this connection, I will do so with the understanding that the learning and teaching in which the BWHBC engaged was vastly different from that which takes place in the public school setting. Besides the obvious age difference in learners, the BWHBC engaged in education that was voluntary for participants. In addition, the BWHBC as an organization were (and are) not publicly financed. It is also important to note that theirs was an educational body that was created predominately by white women. Regardless of their efforts to be inclusive of diverse voices and experiences and their acknowledgement of their own privilege, it is not the same as being led by a culturally diverse majority. This is similar to a problem that philosophers of education find in traditional curriculum where only the voice of a single group (white men) is represented in education. The comparisons I made between the work of the BWHBC and Allen and Shange suggest that it will be necessary to center more diverse voices to construct educational remedies to the problems found within the contemporary manifestation of the medical mis-education of women.

The BWHBC's Pedagogy in Schools

As Nel Noddings argued, "Part of caring for the self is gaining an understanding of life stages, birth, and death."[362] The traditional role of women as family caretakers, a role that continues to fall primarily on women, carries with it additional responsibilities that require additional understanding. Mary Wollstonecraft believed that because of this domestic burden, women and girls needed education that exceeded the education afforded to men in one area in particular: health education. Health education in Wollstonecraft's view surely encompassed a basic but comprehensive knowledge of caring for the health and well-being of husbands, children, elderly parents, along with self-care. This clarifies that the lack of health knowledge is not a contemporary problem that only just came to our consciousness in the American feminist movement of the 1960s to the early 1980s. Women have always been in need of and denied education that lends itself to liberation, and bodily education is of primary import to this level of agency. As the BWHBC remarked, "body education is core education."[363]

I believe that the remedies identifiable in the work of the BWHBC have applicability beyond adult education. School administrators and educators need to ask the questions: How are the problems of Deference, Isolation, Inferiority, Knowledge, Experience, and Control represented in their curricula and classrooms? How can the Isolation-Knowledge Remedy, the Inferiority-Experience Remedy, and the Deference-Control Remedy be deployed to improve learning and outcomes? The need for accurate and holistic sexual and reproductive health education is a necessity long before adulthood. Vilunya Diskin could not remember receiving any kind of education about

[362] Noddings, *The Challenge*, 80.
[363] BWHBC, *Our Bodies*, 3.

her body or sexuality in school herself. When asked about her children's exposure to sexual and reproductive health education she replied,

> My kids grew up with *Our Bodies, Ourselves* of course. And what I did was, I always left a copy of the book, the latest edition, in every bathroom in the house. I want you to know that they disappeared on a regular basis. They disappeared into their friends' homes which I knew and approved of obviously so I just kept doing that. So my kids were well-versed in feminism and health. But they didn't get it at school. And my grandkids, they haven't had any health education at school, I mean sex education not even any health education in school. I have a fourteen and a half year old [grandchild] and an eleven and a half year old [grandchild] and they know a lot of stuff because we have a lot of books and you know we do [talk] with them. But you know they're not getting it in schools.[364]

Diskin's need to circulate the gifts extended to the friends of her children to ensure that they were able to access accurate and relevant health information, realizing that schools were failing children in area. Indeed it is easy to argue that the earlier children are exposed to sex, body, and agency positive sexual and reproductive health education, the more likely it is that they will be able to enjoy healthy lives and sexual relations as adults.

In *The Schoolhome* (1992), Martin tackles the two-sphere split that exists in the school curriculum. The removal of domesticity as a valid subject worthy of intellectual engagement increases the state of cultural mis-education that exists as a result of a changing society. She re-envisions the school in the loving model of a home to counter the callousness of the real life of students outside of schools. Her model of education embraces what she called the "Three Cs" of care, concern, and connection – a way of engaging students in relevant, reflective, loving educative experiences. "The best answer I know is to turn the American schoolhouse into a moral equivalent of home in

[364] Diskin, interview with author, 2016.

which love transforms mundane activities, the three Cs take their rightful place in the curriculum of all, and joy is a daily accompaniment of learning."[365]

The interactive curriculum of the BWHBC did just this. Their combining of medical knowledge and sharing of lived experience infused the three Cs into their work. The women involved in the project felt themselves transformed as a result of it. From the BWHBC, we has seen that sharing knowledge counters isolation, validating women's lived experience counters inferiority, and sovereignty counters deference. These remedies identifiable in their work are fully applicable to a K-12 sexual and reproductive health classroom. The Isolation-Knowledge Remedy can be employed to encourage discussion among students. Students should never be shamed into silence, an experience that the BWHBC recalled as being detrimental to their medical care and self-esteem. Knowledge of their bodies, body parts, and function of those parts is not enough. Students need to be able to make the learning relevant to their lives. If shaming was not a part of a sexual and reproductive health classroom, students could openly share with one another – and realize that they are neither crazy or alone. The Inferiority-Experience Remedy can be engaged to help students understand that there is more than one way to experience healthy sexuality. That abstinence-only makes heterosexual sex inside of marriage the only acceptable way to express sexuality excludes a lot of students. An understanding that sexuality is a spectrum, not a right-wrong situation, is validating to lived and emotional experiences of students. The Deference-Control Remedy can be highlighted to enforce the necessity of consent in relationships, sexual or otherwise. Students must realize that they have ultimate control over what happens to

[365] Martin, *The Schoolhome*, 40.

their own body and that they are not beholden to anyone be they a boyfriend, girlfriend, teacher, or doctor. These remedies offer teachers and students the opportunity to turn the mis-educative curricula of abstinence-only into an educative event that validates and empowers students with the tools to protect and care for themselves. And while having school-aged students share their personal experiences with sexual and reproductive health may not always be appropriate, there are ways to ensure that they still receive validating educational experiences. Indeed there are people and organizations who actively work toward integrating the remedies to the medical mis-education of women identified in the work of the BWHBC into sexual and reproductive health for teenagers. Their work to helps to illustrate how the educational remedies of the BWHBC can be integrated into school sexual and reproductive health programs.

Ruth Alexander, one of the founding members of the BWHBC, helped to create the book *Changing Bodies, Changing Lives* (1998) to counter the negative narrative and mis-education found in abstinence-only education. Like the *Our Bodies, Ourselves* project, this book has been created to give teens a sex- and body-positive learning experience. In the preface, the concerns that parents may have about sex education are directly addressed,

> Many parents have an underlying feeling that sex information will shock or disturb their children, or, even worse, that it will interest them too much. Some fear that by giving teenagers information about sex we encourage them to rush out and "do it." This isn't what happens. Good sex education gives young people the tools to think before acting. It teaches them how to protect themselves; how to make good choices; how to evaluate whether a situation is dangerous to their well-being. Most significantly, it helps them to see the consequences of the actions they take. Good sex education teaches people how to be responsible and respectful.[366]

[366] Ruth Bell Alexander, *Changing Bodies, Changing Lives: A Book for Teens on Sex and Relationships*. Expanded 3rd ed. New York: Times Books, 1998), xvii.

This vision of sex education and of the agency of teens is starkly different from what is offered through abstinence-only. That teenagers can and will behave responsibly with appropriate information is an acknowledgment of their agency. Of course, the knowledge gained through this information may lead teens to have safe sex, it may convince them to wait until they are older to engage in sexual activities, or it may change nothing about the ways in which they experience their sexuality. We cannot be sure how individuals will respond to learning but we have an obligation to teach them the risks of unsafe sex and how to protect themselves. What we do know is that studies have shown time and again that when teens are given comprehensive information about "body functions, safer sex protection, sexually transmitted disease, and good relationship behavior," they are less likely to experience unintended pregnancy, spread STDs, or "engage in thoughtless, promiscuous, or exploitive sexual activity" than those who lack the knowledge.[367] This contributes to agency in a way that abstinence-only cannot and clearly does not intend to do. A book like *Changing Bodies, Changing Lives* serves as an educational agent that promotes critical thinking and engagement with the issue of sexual and reproductive health that is necessary for a healthful, safe, and hopefully satisfying sexual life.

Al Vernacchio has been a Human Sexuality educator for over twenty years. He teaches an elective course called "Sexuality and Society" to high school seniors at a private school. His course consists of factually correct, diverse, consent-oriented sexuality education. He has also published many articles and given many talks on the subject of sex, body, and agency positive sexuality that have all been received with

[367] Alexander, *Changing Bodies, Changing Lives*, xvii.

great approval by educators, parents, and teens who wish for a more thoughtful approach to sexual and reproductive health education. One of his more popular talks is concerned with creating a new metaphor for sex. In an article Vernacchio wrote for *The Wall Street Journal* entitled "What We Talk About When We Talk About Pizza," he challenges the old metaphor of sex as baseball. He illustrates the problem with thinking about sex in terms of rounding bases, scoring, and home runs,

> It's competitive, it makes sexual intercourse the goal, and it assigns strict and unyielding roles for 'the players.' It doesn't do anything to help young people develop healthy ideas about the place of sexuality in their lives.[368]

The baseball model forces us into predefined roles, set rules, fixed expectations, and "makes us less accountable for our own choices and actions."[369] Vernacchio instead proposes that we think of sex in terms of pizza. He explains,

> When you have pizza, you're not competing – you're in it to enjoy the experience together. There's no offense and defense in pizza. And when you share pizza with someone, you have to talk about what you want and what you like beforehand.[370]

He says that pizza makes room for negotiating terms where both parties can be satisfied. He argues that,

> the point of the pizza model isn't that 'anything goes.' It encourages us to take responsibility and exert self-control based on the values that we have learned at home and in the wider community…. We are the ones in charge of the pizza.[371]

This model assumes the intelligence, compassion, and agency of the people involved. It assumes sharing, consent, and mutual respect. It also assumes that people with comprehensive knowledge can make informed decisions *together*.

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[368] Al Vernacchio, "What We Talk About When We Talk About Pizza," *Wall Street Journal*, March 16, 2012. http://blogs.wsj.com/speakeasy/2012/03/16/what-we-talk-about-when-we-talk-about-pizza/
[369] Vernacchio, "What We Talk About."
[370] Vernacchio, "What We Talk About."
[371] Vernacchio, "What We Talk About."

Vernacchio's message, like that found in *Changing Bodies, Changing Lives*, is that we are capable of making good decisions when we have the information to make informed decisions. This form of education is inclusive – it does not shame sexualities, subscribe to stereotypes about people of color, or endorse gender roles. They name body parts using correct terminology, accurately explain biology and physiology, and understand that curiosity and questions are not wrong or shameful. Vernacchio and his peers are educational agents whose work corrects the medical mis-education of women that has become accepted as the standard of care in education and in medicine in this country. Educational agents like Vernacchio understand that the problem of the professions must be corrected. Educators like him recognize that the way to remedy this mis-education is through a coordinated curriculum that embraces the care, concern, and connection that transforms mis-education into educational experience.

Sociologist Lorena Garcia's book *Respect Yourself, Protect Yourself: Latina Girls and Sexual Identity* (2012) focuses on sexuality in second-generation Mexican and Puerto Rican girls and how they negotiate positive sexual identities for themselves in the face of negative stereotypes. Garcia's research points to the importance of student and community input into sexual and reproductive health curricula. She found that sex education was more beneficial when educators "take into account students' identities, experiences, and perspectives in developing sex education and to process in an informed manner, rather than operate on assumptions."[372] Like the BWHBC, Garcia recognized the importance of validating women's lives and their lived experiences to improve learning outcomes. This is particularly important where body education is

[372] Garcia, *Respect Yourself*, 156.

concerned. She argues that "the determination of what is most important to convey to students in sex education should not be made solely by school administrators, teachers, and sex educators."[373] Because communities were invested in the well-being of their youth, she endorsed the idea that "local players" like organizations that work with neighborhood youth, parents, and the students themselves should be involved in determining the appropriate sexual and reproductive health curriculum.[374] Garcia reports, "As I listened to the girls' stories about their sex education, I could not help wondering what their sex education experiences would have been like had they had been given an opportunity to share with the adults making sex education decisions for them what they felt the needed to learn."[375] Just as the BWHBC integrated the body and health concerns of adult women into their educational project, Garcia believed that giving young women a say in their sexual and reproductive health education planning was a necessary and empowering step toward agency. She argues, "If we want students to take their sex education seriously and to benefit from it, then we need to take the students seriously as sexual subjects."[376]

The BWHBC worked to create a curriculum to restore women's health for women. Likewise, there are educators who have been working both inside and outside of schools to ensure that teens have access to accurate and age-appropriate sexual and reproductive health education. And like the BWHBC, these health educator activists believe in the value of knowledge and have been diligently reinserting this information into the lives of young people. If we were to integrate the BWHBC's remedies into

[373] Garcia, *Respect Yourself*, 156.
[374] Garcia, *Respect Yourself*, 156.
[375] Garcia, *Respect Yourself*, 156.
[376] Garcia, *Respect Yourself*, 156.

sexual and reproductive health education curriculum, free from the influence of abstinence-only, what would that look like? I argue that it takes the form of *Changing Lives, Changing Bodies* or the findings of Lorena Garcia or the classroom of Al Vernacchio. Their work demonstrates that the remedies identified in the work of the BWHBC are transferable to a K-12 audience. This would not only improve learning outcomes, it would also improve the environment of schools. In this text I speak primarily of the importance of girls learning positive information about themselves. But, discussions about consent and broader discussions about reproductive health cannot help but positively affect boys as well. When girls are understood to be autonomous beings deserving of respect and everyone understands that consent is non-negotiable, attitudes will change. If Title IX's aim of gender equality in educational spaces is to be realized, this is a good place to start.

However, I am not unrealistic, and understand that implementing these remedies in formal school settings is unlikely in the current political environment. Indeed, I believe that the example set by the BWHBC becomes even more relevant under such circumstances. Just as the BWHBC had to create their own space and rules for learning and teaching, perhaps the best approach to an otherwise impenetrable curriculum is the establishment of ad hoc student learning groups to meet outside of the formal structure of education that would engage sexual and reproductive health in educative ways. This could mean that groups could be organized by students, parents, librarians, school social workers, or school nurses. Ideally, the agenda of these groups should be set by the students. As Garcia noted, empowering students with that role is important to their positions as sexual beings and also to their agency. Of course, for young learners, it

would be important that an educator, healthcare professional, or social worker with appropriate knowledge be present to direct the learning and re-direct mis-educative explorations that would perpetuate misinformation.

The process of researching, sharing, and making new knowledge relevant to young lives could be as transformative and positive as the learning experiences described by the BWHBC. Groups could be organized around specific topics or age-appropriate books that could be housed in the school library. Judy Blume's *Forever* (1975) is a perennial favorite of girls because of its respectful and responsible depiction of teenaged love and sex, and Blume's 1970 book *Are You There God? It's Me, Margaret.* depicts young girls coming of age and dealing with puberty, bras, periods, and sexual feelings. *The Care and Keeping of You* book series by American Girl – an organization perhaps best known for its dolls – provides age-appropriate and medically accurate body and health information for girls as young as eight years old. These books can be used to start a conversation that can serve as a foundation for building positive relationships with bodies, sexuality, and reproductive health. We must begin by acknowledging that young peoples' lives are as multifaceted as anyone's – they have responsibilities and expectations as children of parents and students in schools, and they have their own identities and agency to establish and protect. Whether these learning groups can organize on school grounds or meet in a home, public library, or community center, a safe space for learning and sharing should be established. This kind of ad hoc learning community could counter the medical mis-education of women that is supported by abstinence-only sex education. Whether the remedies are integrated into school curriculum or implented in an extracurricular group format, it is important to

explore how we can all take seriously our roles as educational agents and engage early in the lives of young people to remedy the problems of Deference, Isolation, Inferiority, Knowledge, Experience, and Control that would otherwise define and restrict their lives.

Implications for Future Research

This inquiry has focused on the work and words of the BWHBC and their work surrounding the creation of their book *Our Bodies, Ourselves*. Within their work, I identified problems of education and medicine that they were actively countering with their educational remedies. The Problems of Deference, Isolation, Inferiority, Knowledge, Experience, and Control can all be located within their work as real issues contributing to a pattern of oppression that defined and limited the lives of women. The educational agents of professional medicine perpetuated the educational problem of generations to create an atmosphere within medicine that was hostile toward women. This hostility made its way through other institutions that relied on unquestionable authority of medicine to further limit the lives of women. These problems, though most assuredly political in nature, are also grounded in mis-education. As such, the educational remedies enacted by the BWHBC were both innovative and effective. As they took on the mantle of educators, they engaged in restorative work that challenged medical authority and diverged from the medical mis-education of women that resulted from the professionalization of medicine. Those remedies – the Isolation-Knowledge Remedy, the Inferiority-Experience Remedy, and the Deference-Control Remedy – demonstrate that reintroducing the domestic love that is considered to be characteristic

of women into learning and care does make a difference to quality of life and well-being. The BWHBC circulated the gifts of learning and showed that sharing knowledge counters isolation, validating women's lived experience counters inferiority, and sovereignty counters deference. Their work was and remains intentionally political, however theirs is an educational project that restores dignity to women, to the ways in which women care, and the ways in which women educate and learn.

Though the work of the BWHBC focused on educating adult women about their bodies and health, I believe that their educational remedies can be equally applicable in schools. Educators like Bell, Garcia, and Vernacchio demonstrate that the issue of sexual and reproductive health education can be engaging, informative, effective, and respectful. Their examples allow us to imagine how holistic sexual and reproductive health education could be. Their methods reflect the educational remedies identifiable in the work and words of the BWHBC. If we ever truly desire to create a classroom environment that is conducive to learning, we must address the underlying issues that make classrooms hostile to girls in the first place.

The thinking of the BWHBC demonstrates that they were experiencing an intensely personal and social awareness of the medical mis-education of women as they worked on *Our Bodies, Ourselves*. It is evident that it was and remains a real and tangible concern to them that motivates them to continue their work to this day. Indeed their work did not end with the national publication of their book in 1973. They have built a legacy that continues to inform and educate. In 2011, the ninth edition was released and a newer update is already underway. By 2015, *Our Bodies, Ourselves* has

been printed in thirty languages and made available to women all over the world.[377] Their website, www.ourbodiesourselves.com, is continually updated, offering those seeking information on their bodies and health immediate access to reliable source of health information. Their efforts remain an urgent and ongoing necessity as the emboldened Religious Right of 2017 continue their legislative assault on women's reproductive rights with renewed vigor.

This is an important piece of remedying the medical mis-education of women. We must continue moving forward with educational remedies that speak to contemporary incarnations of the educational and medical problems that contribute to the ongoing oppression of women. Indeed this inquiry initiates a new field of curriculum inquiry to interpret, critique, and reimagine health education in schools and elsewhere, utilizing the OTI to build theory that can ground practice, As society becomes increasingly diverse, it will be necessary to centralize diverse voices and cultivate sensitivity to intersectionality to construct educational remedies to the problems found within the contemporary manifestations of the medical mis-education of women. The contemporary Reproductive Justice Movement (RJM), whose work is grounded similarly to the BWHBC, can serve such a purpose and would be ideal for future research.[378]

The term "reproductive justice" was conceptualized in the 1990s in the United States by women of color who felt that their needs were not being met within the agenda of the mainstream white feminist movement.

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[377] Our Bodies, Ourselves. "History," 2016. Accessed October 3, 2016.
[378] For more information on reproductive justice, see Joan C. Chrisler, *Reproductive Justice: A Global Concern*, (Santa Barbara: Praeger, 2012).; Loretta Ross and Rickie Solinger, Reproductive Justice: An Introduction, (Oakland: University of California Press, 2017).

> Women of color have had no trouble distinguishing between population control – externally imposed fertility control policies – and voluntary birth control – women making their own decision about fertility. For women of color, resisting population control while simultaneously claiming their right to bodily self-determination, including the right to contraception and abortion or the right to have children, is the heart of their struggle for reproductive control.[379]

Too many examples can be drawn from American history of the medical oppression of women of color – from slave women being subjected to experimental gynecological surgery in the age prior to anesthesia, to Puerto Rican woman being used as guinea pigs for research on birth control pills, to women of any race or ethnicity in this country being sterilized without their knowledge, understanding, or consent. Thus their fight for reproductive control intersects with social justice concerns, creating a movement for reproductive justice.

The RJM would be a logical next step for this project. It would be equally enlightening to explore what educational and medical problems are identifiable in the work of the RJM and learn the thinking of women in the RJM surrounding the medical mis-education of women. From there, we can learn how their educational remedies can be utilized within schools to the benefit of girls and women. It would also be valuable to understand how the medical mis-education of women has changed since 1973. And though the BWHBC did indeed include diverse voices in their project, it was at its core a project borne of white women whose work predated feminist theorizing of intersectionality. Engaging the RJM would center the voices of women of color and would allow a more intimate exploration of how the medical mis-education of women has differently impacted their lives.

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[379] Silliman, et al., *Undivided Rights*, 7.

As long as medicine abets in the devaluation of women, cases of teen HIV are rising, and women's health services are being restricted, we must take seriously the effects of the medical mis-education of women. Whether in the classroom or in the delivery room, educational agents in professional medicine have a responsibility for their educational and mis-educational actions and consequences. By circulating the gifts of knowledge, the BWHBC have no doubt created healthier women and, by extension, healthier families. The power of the women's health movement as demonstrated by the BWHBC lies in democratizing knowledge and making relevant connections of that information to the lives of women. The BWHBC has reclaimed a piece of women's history for women and honored the intellectual integrity of women. They have joined women healers and women educators, and rejuvenated and relegitimized the work of women caring in a mainstream forum in the contemporary era. The work of the BWHBC should put formal educational agents of professionalized medicine on notice. Women will no longer blindly accept the unquestioned authority of the medical establishment. Women have the tools, resources, and ability to seek appropriate answers to their questions. Women can be their own educational agents and have been empowered to advocate for themselves and for each other.

My goal with this inquiry has not been to frame the relationship between women and the medical establishment as irreparably broken. Indeed as more women have entered the medical professions, the relationship has begun to mend in many ways – new perspectives and insights have a way of bringing clarity to old problems. My primary criticism is that the medical establishment remains insulated from outside influences. That is not to say that new ideas and innovations are rejected. Medical

journals are filled with new approaches, techniques, technologies, and medications that promise to improve the lives of patients the world over. The problem, I believe, lies in that medicine does not go outside of itself to see what works. Women's health activists have found approaches that improve the health of women, their families, and communities – approaches that work. The BWHBC demonstrate how effective circulating the gifts can be. Medical knowledge works most efficiently when an individual's lived experience is acknowledged as an integral part of their health and integrated into their healthcare plan. The pedagogical techniques and the curriculum that the BWHBC have devised comes from a non-medical sphere and have not been vetted by medical professionals, and are therefore, unfortunately, considered unworthy of integration into medical thought. It would be beneficial for all parties involved – patients, healthcare professionals, caretakers, students – if the medical community could reach out to community educators and create more collaborative relationships. The future of community health lies in community solutions. No one group or institution can have ownership over or sole responsibility for the health of every individual or population, nor should they. The key may lie in institutional acceptance of the unification of formal and informal medical educational sources.

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Interviews

Vilunya Diskin, interview with author, April 2016.

Joan Ditzion, interview with author, April 2016.