

AT: Welcome to the Infinite Women podcast. I'm your host, Allison Tyra, and today I'm joined by writer Kayla Branstetter, a professor of English at Crowder College, to discuss her book *Don't Be an Athena* and her research on narrative medicine and the ways women's pain is often minimized or dismissed by systems meant to help them. So anyone who's listened to my episode with Dida Sundet about rape myths might have an idea of what you mean by "don't be an Athena," but could you clarify that for us?

[Listen to Dida Sundet on rape myths](#) or [read the transcript](#).

KB: I was doing my blog and I come across writing about ancient women. So if you go to my blog, you'll see there's one about Isis and Mary Magdalene, and then I include Athena. And the inspiration behind this came after I read the book *Off With Her Head*, because it talks about this history of women and how history got it wrong. So I researched Athena and the Medusa legend. And to my surprise, Athena isn't necessarily favorable. She is the reason why Medusa is this gorgon or this villainous woman that has lasted for thousands of years. And depending on which version you hear, I went with the Roman poet Ovid, Athena transformed Medusa into this gorgon after Poseidon sexually assaulted her in Athena's temple. And I felt like it's just this great opportunity to play on something that women go through even in the 21st century of victimizing and turning the victim into a monster instead of empowering her to become a survivor and going after men of power who created this situation to begin with. And I wanted to use that to address what women are going through with their reproductive choices, specifically in the United States. So each chapter is tied to "don't be an Athena." Instead of taking a woman's trauma and using it against her and making her into this "monster" who can go on and create more victims, let's find a way to empower women, make them survivors, have their voices heard.

AT: I feel like I need to point out that it wasn't just Athena. You see this a lot with the Greek goddesses, Hera in particular. (KB: Oh, absolutely. Yes, it wasn't just her. They were horrible. And Zeus.) So that's something that I get more into in the conversation with Dida. If you want to know more about the mythology aspect of it, it wasn't just Athena. A lot of these goddesses were horrible people to other women.

KB: The gods and goddesses, they were power hungry. They were greedy. They were jealous. And they had no problem attacking each other.

AT: What I find striking both about that as a metaphor and a sort of origin point for a lot of these attitudes is that it's very much about power imbalance and not just that you are attacking women for things that they often had no control over, which I feel like you can also apply that to things like disability, for example, or racial inequality, class inequality. Anything where you are blaming the victim and making it their fault in your head when that doesn't make any sense. But so much of this comes from power imbalances where someone who has more power and privilege is adding on to whatever that victim is already experiencing.

KB: Yeah. Athena and a lot of the goddesses are in this position of power. And when you're in a position of power, how can you empathize with someone from a marginalized group if you've never been in a similar situation?

AT: And so for anyone who's not familiar, because it's come up a couple of times before on other episodes, the empathy gap is essentially difficulty people have relating to experiences that they don't understand because they have not experienced it themselves. And they have not necessarily consumed a lot of stories, whether that's fiction or nonfiction, about those different stories. So it might be someone who has a lot of wealth privilege has difficulty understanding what it's like to be poor because they've never experienced it. And that's not a narrative that they've consumed a lot of. And so tying this into your work, you're currently getting your doctorate at Rockhurst University. And it's a doctorate of education with a specialization in healthcare, which feels like a combination that I haven't seen very often.

KB: Yes. When I tell people, because I have a master's degree in the humanities from University of Denver in Art, Literature and Culture. And now I'm studying a doctorate in education and healthcare. And to some people, it seems like my career is diverting some. And it honestly is not. I'm right on track. With my book, I interviewed 25 women from across the United States of various backgrounds, whether socioeconomic, racial, ethnicity, religion, location. I accidentally found narrative medicine. I didn't know what I was writing. I didn't know what I was writing was narrative medicine. I just wanted to have these women's stories heard. And I admit my own experiences influenced this decision to have this book formed. And when I found out I was in narrative medicine and the impact that these women's stories can have in the medical field, I decided to pursue a doctorate in education with an emphasis of healthcare, because what I'm working on right now with my institution is establishing some form of a narrative medicine certificate for healthcare students. And this narrative medicine certificate is forcing future healthcare professionals to understand that every patient has a story. So having these healthcare professionals read fiction and nonfiction and study art and theater and creative writing courses with a purpose to become better healthcare professionals in the future. So it does make sense. I'm advocating that we need more humanities, not less humanities, so we can improve empathy. Empathy can be taught. And I think we're in this place in society with the advancement of AI that we need to remind ourselves about the humanity.

AT: And this is also something that came up in an episode that I previously did about Riva Lehrer, who is a disabled activist, artist, educator. And she actually has an empathy exercise that she does with medical students where they have to essentially profile a specific disabled person. And only, I believe, 30% of their presentation can be about that person's condition. So the rest of it has to be about them as a person. And so she is, like you said, teaching empathy. She is forcing them to see these people as human beings and to tell their stories in that way.

But when we're talking about, don't be an Athena as a question of power and victimization, we can look at a lot of people's experiences with medical institutions and individuals as people who have been victimized by the system. So for example, whether that's fatphobia, whether that's class bias, there are all these biases that doctors bring into an exam room that they don't necessarily want to acknowledge, that they may not be aware of, but that are actively impacting how they are treating the people who come to them for help.

[Listen to Sharrona Pearl on Riva Lehrer, disability, humanity and autonomy or read the transcript.](#)

KB: Yes. And part of the narrative medicine is to help challenge a future physician or even a nurse. They may not say that they're biased, but until you start exposing them to certain ethical dilemmas and situations, do these biases start surfacing? And I have these conversations even with my students now, and I don't have the narrative medicine, but I do have a lot of nursing students in my courses. For example, a homeless person, if a homeless person who is seeking healthcare, did you already create that individual story before they even entered the exam room, let's say from an emergency room? And if you already have this pre-assumption of what this individual's story is, is that going to dictate the type of care you're planning on giving this individual when you've already created the individual's narrative? You already made an assumption about this person. And how many of those biases or assumptions are already living in your psyche before you even enter an exam room? So for women, are you already assuming what the woman's story is before they entered the exam room? So that's what I'm also challenging is you can't create a narrative of this patient before even understanding the patient, if that makes sense. Because I know, I've had students that, I would put on the board, I'm like, "okay, give me these stereotypes of a homeless person." And some had no problem giving the stereotypes. And then some people, some of my nursing students said, "this feels wrong." I'm like, "I'm glad you're saying that, because it is wrong."

AT: But I feel like the students who are open about, "no, here are the stereotypes." This could be my personal bias, because I am that kind of very straightforward person. But I feel like those are the ones who are at least

aware and willing to talk about it. (KB: Yes) And I actually feel like that's a better starting point.

KB: It can be, but some of them, it was the ones who were afraid to do it. They were thinking like, "I can't do that. I'm not giving this person this story." And then I had some students, they realized, "oh, I'm falling into this." And you're right, it makes them more aware of their own biases, so they can correct themselves later on. But even with my education students, who, you can't create your student's narrative. We all want that perfect student who's not going to fight back. But parents are sending the students that they have to us. And so we can't create their narratives. And you can be a part of their narrative, but you can't assume a student's narrative any more than you can assume a patient's narrative.

AT: Well, since you're framing it through this narrative lens, it kind of feels like a lot of people, including medical professionals, have a stronger affinity, shall we say, for the fiction in their head, than they do for the nonfiction of the person in front of them, and what that person may be telling them.

KB: No, I agree. And I don't know how many women, and as a woman, I've gone through this, of I have this pain. I went through this a few years ago, I had this pain. So of course, they're running tests. And when I get the test back, physically, according to the test results, there's nothing wrong with my body. So then you're dismissed. Because according to the evidence, there is nothing wrong with my body. But I'm telling them there is something wrong with my body. I know my body, something is wrong. But they're telling me that, "well, we ran this test, we ran this test, we're telling you like, there's nothing wrong." That narrative of, "I'm telling you something doesn't feel right." But the evidence of the test that you ordered are confirming **your** assumption about my body.

AT: It also really makes me question just medical professionals expertise when they say things like that. Because fundamentally, doctors should know that there are things that tests cannot catch, especially if you're running a limited number of specific tests, like the idea that, "well, we ran three tests, and they didn't find anything. So you must be fine," is deeply questionable in terms of how much of a professional are you? You went to school for years. Surely you must know that this is not the be all, end all solution.

KBL Yeah. And in a doctor's defense, because I have written this in my literature review, the time spent with patients have drastically reduced. We're talking, they have what, 7 to 10 minutes, a lot of the times are spent charting. So I think they're trying, some doctors are trying the best with the finite amount of time they have. But at the end of the day, at least in the United States, we're not getting any better. Infant mortality rate is on the rise. Maternal mortality rate is on the rise. We're not getting any healthier. And the community is starting to distrust the medical community. And I feel like stories bring people together. So with narrative medicine, this idea of using narrative to bring people back together, with the finite amount of time that we do have, and actually listening to a patient's story, to get to the bottom of the source of their pain.

AT: So once again, capitalism is the root of the problem. (KB: Yeah, it's for profit.) Well, and I will say even here in Australia, because I live in a more rural area, our medical system is overtaxed in the sense that we don't have the resources in a more regional, rural area to meet the needs of the community. By which I mean that it can be really hard getting in to see a doctor, like just a GP for something that's not urgent, because we don't have enough GPs for the number of people here.

KB: Yes, we have a physician shortage here as well. And I'm in a rural area. I'm in rural southwest Missouri. And a couple of years ago, a local hospital spent millions of dollars rebuilding this hospital. And in it was this state of art labor and delivery unit. And they had to shut down the labor and delivery unit. And in the state of Missouri, you have several counties that don't have a labor and delivery unit. So what does that say about rural

women in their health care? Because now they're traveling on average an hour to three hours to seek prenatal care. And that's if the woman has the resources to even go to their prenatal appointment.

AT: So I think part of it also comes down to a lack of curiosity, which, again, like you said, it is limited by the available resources. They are time strapped. And the resources available to them in terms of medical facilities, in terms of the tests that they can run, are often limited. But I remember when I was in my mid-20s, I had my cholesterol checked, I have high cholesterol. And I was talking to the male American doctor, and said, "Okay, so what do I do about this?" He said, "Okay, eat less dairy and less red meat." I already don't eat that much. "Okay, don't smoke and drink less alcohol." I have never smoked, and I don't drink alcohol at all. "Exercise more." Okay, what kind of exercise and how much? He didn't know either. And then finally, he looked at me and said, "you could lose weight." And again, this comes back to my question of, "you went to medical school, and they didn't teach you the difference between correlation and causation. Which, for anyone who's not familiar, it basically means that just because two things coincide, it doesn't mean that one causes the other. It didn't occur to him that if you were smoking, drinking alcohol, eating a lot of red meat and dairy, and not exercising, and you change those lifestyle habits, there's a good chance you would lose weight. But just saying "lose weight" is not actually healthy when you already can't really give me any information on exercise, and you've given me fairly little information on diet. In my opinion, that was an example of fatphobia. He was looking at a woman in her mid-20s, who's otherwise healthy, who's not showing any of these risk factors that he's talking about in terms of lifestyle. And I don't think it occurred to him to look deeper. And so a few years later, I was diagnosed with polycystic ovary syndrome, which messes with a lot of levels in my body, (KB: I address that condition) including likely my cholesterol. And so if this male doctor had stopped to say, "gee, this otherwise healthy, young woman doesn't have any of these risk factors. I wonder why she has high cholesterol?" And instead, he just looked at me and said, "oh, you should lose weight."

KB: Well, with PCOS, it's not easy.

AT: Well, here's the thing. A few years later, the way I got diagnosed was I had a weird skin discoloration that was connected to my insulin deficiency because my PCOS also messes with my insulin. And a female doctor here in Australia took one look at that and said, "we need to get you in for a transvaginal ultrasound," which is just as much fun as it sounds. So she looked at that and immediately knew what was going on. But if that's just tied to insulin resistance, any doctor could have also looked at that and just said, "oh, well, the woman that I see as overweight has issues with insulin. It's probably her own fault."

KB: Lifestyle. Yeah, it's a lifestyle choice. You chose this. I interviewed, I believe I have four women in my book that have PCOS. And I remember interviewing them and they felt like they were going crazy, that they weren't being heard. Like what you were saying, this fat shaming of "I can't lose weight." And then come to find out, they did go to female doctors and they were able to identify, they went to their gynecologist and they were able to finally say, "hey, this is the issue." And I think one woman I interviewed, she almost self-diagnosed through Google, like going to Google, putting in her symptoms and realize, "oh, I'm not going crazy. I legitimately am struggling to lose weight."

AT: Yeah, because difficulty losing weight is one of the common symptoms of PCOS. (laughs)

KB: Yes, it is. It is. (AT: That's the irony.) Yes. And so you can't body shame a person. You can't sit here and say, well, you deserve to go through this suffering because you're choosing to do this without looking at the underlying condition such as PCOS.

AT: And so it's that incuriosity that I think is stemming from the combination of capitalism ruins everything and

those internalized biases. And I do have a separate episode with Alexis Pedrick on medical racism, if anyone's interested in that aspect specifically. [Listen to Alexis Pedrick on medical racism](#) or [read the transcript](#). But all of this means that doctors think they know more than they do, which is incredibly dangerous. And I think part of it might also be people don't like admitting when they don't know the answer. And so in situations like yours, it feels like part of why they're saying, "well, there must be nothing wrong with you because I can't find the answer" because they don't want to admit that they don't know the answer. The only options are either "I can't figure this out" or there's nothing actually wrong with you. And the gaslighting of saying, "actually, there's nothing wrong with you" feels like a response to them just not wanting to acknowledge that they don't know.

KB: Yes. And then we're not having those conversations. Again, I had to go to my gynecologist. My body's going through perimenopause right now. I didn't even know that term existed. And I'm going over my symptoms and they're like, "oh, yeah, it's perimenopause." And we're just now I feel like starting to study more perimenopause and menopause and understanding the side effects and how to treat those conditions. But so much of perimenopause is tied to, there's nothing medically wrong with you except your body's getting ready to go through a change.

AT: Generally speaking, a lot of people are aware of this, but just in case the listener isn't, there is a drastic gender gap in funding and resources for research that primarily focuses on conditions that impact people who have female biology, shall we say, rather than male biology. Conditions like endometriosis, for example, is a huge one. But another barrier that you have with conditions like perimenopause and menopause is that, as I understand it, a lot of the medico-industrial complex, if you will, views perimenopause and menopause as not medical conditions because they are a natural part of the life cycle. And similar to a lot of aspects of pregnancy, so much of this pain and genuine problems that primarily women are facing just get treated as normal and therefore not something that medicine has to address.

KB: Yes, I address endometriosis in my book as well. And it's mainly reproductive. Perimenopause, that might be my next book. We'll talk about that next because I feel like it's a worthy topic. But some of the conditions related to even pregnancy, one of my good friends, and she's in the book, she had HELP syndrome. We didn't know what HELP syndrome was. And it's an extreme form of preeclampsia. And what's interesting is growing up and being around pregnant women, I never heard of preeclampsia or HELP. It wasn't something that I felt it was discussed a lot. It doesn't mean it didn't exist. But my friend had preeclampsia and it's a spike in blood pressure, blood pressure issues. There's protein in the urine. You start retaining fluid. And if it's not caught, the woman can essentially die of a stroke and have a seizure. So it is life-threatening if it's not treated. And one of the treatments to preeclampsia, depending on the severity of the preeclampsia is delivery, you need to deliver the baby. So this woman, she had preeclampsia first pregnancy, had PCOS, decided to get pregnant again. And it was a high risk pregnancy, literally from conception on. And she developed HELP. And it's an extreme form of preeclampsia, you still have high blood pressure, you still have the swelling, you have the protein in the urine, but it starts attacking your liver and your kidneys. You start going into organ failure. And that's what my friend was starting to do. She was going into organ failure and delivery is the only way to treat HELP syndrome. And so the baby was delivered at 32 weeks, I believe. And it became an emergency situation, but the doctor studied her symptoms and noticed that something significant was going wrong.

Later, I ran into another woman last year who also developed HELP syndrome. And I asked the medical team, I said, "how often do you see this?" Because they keep saying "this is a rare condition. It's rare." I'm like, is it rare? Because you're telling me that it affects like one out of, I think every thousand women, but two very close people have developed HELP syndrome in my life. And they said they're starting to see more of it. Are we really starting to see more of it? Or we finally are listening to women and their bodies and the severity of it? But if you watch the documentary *Aftershock* on Hulu, it talks about HELP syndrome and the racism attached to it

of, it can be cured if it's caught in time, but you have to listen to women because it's also a postnatal. So even after delivery, you still have to monitor the woman from her blood pressure because she can still have a stroke and seizures. So she can still pass away even after the baby has been delivered. If you're just going to say, okay, here's the baby and you don't take care of the mother postpartum. And with the *Aftershock* documentary, it talks about the postnatal care. These women had HELLP syndrome and their symptoms were being dismissed. And both women were Black mothers. And it does talk about dismissing symptoms due to racism. And both women had HELLP syndrome and they died postnatally. So after the baby was born and they kept saying they didn't feel right, something was not okay. And their blood pressure was not stabilized and then it became too late. So that monitoring of, "okay, you had the baby, that should be enough" and dismissing patient symptoms that ultimately left a newborn baby without her mother.

AT: I feel like, especially if there is a C-section involved, the relative lack of post-care monitoring should be a concern. And again, we come back to the question of race, because Black women are more likely to be told to have C-sections than white women are. And particularly with what I would consider very concerning laws restricting women's reproductive rights in the US, there were actually two cases in Florida where women who had actively been in labor for hours. And this was two Black women in separate instances were basically taken to court via Zoom or whatever while in labor, because their doctors wanted them to have C-sections. And these women did not want to have C-sections. And one of the two women was forced, a judge ordered her to undergo surgery, which is absolutely insane and dystopian. And the other woman was a doula. She was a birth professional. And the state's attorneys still felt justified and righteous, taking this woman who had actively been in labor for hours to court and forced her to spend, I think it was something like three hours defending her own medical decision **while actively in labor**. That is something that if you wrote it in a sci-fi book, you would be told it was too heavy-handed.

KB: Yes, I interviewed a woman for my book, a Black woman around the New York City area, not even Missouri, where the maternal mortality rate among Black women in Missouri is alarming, as is the infant mortality rate. But this woman is from New York. She got pregnant at 20 and had a C-section. And I remember when I interviewed her, I asked her, "did you want a C-section?" Because I knew the statistics of, they are usually bullied into having a C-section. And then afterwards, the pain is being diminished. We're not even taking care of them postnatally. And she reflected back. She goes, I don't know because I was 20 and naive. I just automatically trusted my medical team. Because now that you say it, I don't know if it was necessary to have a C-section or not."

AT: Well, it comes back to that issue of time and resources, because my understanding is that for doctors, a lot of times, sending the patient into surgery to have a C-section not only means that you can bill them for all the surgical things, but it also means that you don't have someone occupying a bed for what might be a 12-hour or more labor.

KB: Oh, C-sections benefit insurance companies and hospitals more than it benefits the woman. Because you can go in, have this surgery real quick and be discharged. But it's not what's good for the woman. If she's a low-income woman and she needs to get back to work, a recovery for a C-section, at least in the United States, eight to 12 weeks, if you're a low income woman and you need to get back to work, you don't have eight to 12 weeks to recover. You have maybe a week.

AT: Especially because I would assume statistically, you're more likely to have a physical job that requires you at the very least standing for long periods of time, if not more physical labor.

KB: Yes. And again, we need to listen to women's bodies. Having women take control of their narrative in being

able to make their own decisions, just like the women in Florida.

AT: And even someone like Serena Williams has been very candid about her birth experience where she knows she has a condition that means that she is more prone to blood clots. And she knew what it felt like. She knew exactly what tests needed to be done to confirm it. And she knew that she needed, I believe it was warfarin. And even someone as famous as Serena Williams, who is a professional athlete, which when we're talking about how well someone knows their own body, I'm going to go ahead and give professional athletes and dancers and the like the benefit of the doubt that they probably know more about their bodies than I know about mine. And she is explicitly saying, this is exactly what is happening. This is exactly what you need to do. And she still had to fight the medical professionals that were supposed to be taking care of her to actually do it.

KB: Yes. And my goal and hope is through the narrative medicine and through my book is to have these conversations of, in hindsight, back to my book's theme of Athenas, we have a bunch of Athenas positions of power who are dictating our stories. And they're victimizing these women. And that's not what we need. So I'm trying to build empathy with my narrative medicine certificate and with my book, to invite people to the table to read these stories and at least recognize the issues. That empathy gap we've been talking about, can you recognize that it's an issue if you've never experienced it?

AT: In my mind, I keep coming back to the question of authority and arrogance because I find a lot of people who seek positions of power over others, particularly others who are vulnerable. And often these are professions that are lauded like teachers, police officers, and medical professionals. I find that there are often people who seek those positions of authority over vulnerable individuals because they want the power. Like it's not altruistic. It is because it is putting them in that position where they are in charge. And that's not great.

KB: No, no, it's not. I've been in education for 16 years, and my teaching style has drastically shifted. And it comes from being scared that I'm in the classroom with these teenagers. But after a few years of teaching narratives, reading students' story, and getting to the story behind the student behavior, my teaching style drastically shifted.

AT: I often say that the people who would benefit most from reading my books are the ones who will never read my books, meaning those whose biases are so deeply entrenched that they have no interest in having those biases challenged. So assuming that your most likely audience is those who already have a degree of empathy for the topic, what do you hope they will get out of it?

KB: I worked hard at offering diversity in my book. And I want the majority of women, when they read my book, to find themselves in this book. This is a survivor's guide, is what I really want. These women survived. They were vulnerable enough to come forward with their stories. And stories are supposed to connect us and humanize us. So that's what I'm hoping that this book will do. I cover a wide range of issues, whether it's teen pregnancy, abortion, IVF, surrogacy, adopting through the foster care system, women who the stigma behind women who don't want to be moms. So I interviewed women who are like, I don't want to be a mom. I'm not going to be a mom. But I'm still a woman. And I still love children. I just don't want children. And women who desperately wanted a child, but life chose differently. And women who have been sexually assaulted and molestation and domestic violence. I cover a lot of issues, but these are survivor stories. And I want women to be able to do what we need to be doing. That's connect, connect as women and understand that you may be going through hell right now. But you can get through it. You're going to survive it.

AT: Join us next time on the Infinite Women Podcast. And remember, well-behaved women rarely make history.