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Teja Kosi

"DRAMATIC", "CRAZY", AND "UNWORTHY" WOMEN: ENDOMETRIOSIS AND THE (MEDICAL) PERCEPTIONS OF FEMALE PAIN

ABSTRACT

Taking a critical feminist cultural studies approach, this article describes, analyses, reflects and theorises women's pain in the case of endometriosis. Western historical discourses on endometriosis over the last 2,500 years offer a basis for analysing the position the disease holds in contemporary society. Using locally limited digital ethnography (the stories of 33 women published on the website of Endozavest – Society for Raising Awareness for Endometriosis between 16 January 2017 and 24 April 2023), supported by secondary sources, three ways in which women's pain is perceived and managed are presented and contextualised: dramatised pain, mental illness, and "female deficit". The article reveals how patriarchal violence within the medical system perpetuates aspects of physical pain that directly/indirectly discipline women's bodies and push them into a variety of unwanted sexual and reproductive roles.

KEY WORDS: endometriosis, female pain, medical violence, contemporary perceptions of femininity, unwanted patriarchal roles

»Dramatične«, »nore« in »problematične« ženske: Endometrioza in (medicinske) percepcije ženske bolečine

IZVLEČEK

Članek s feministično-kulturološke kritične pozicije opisuje, analizira, reflektira in teoretizira žensko bolečino na primeru endometrioze. Zgodovinski diskurzi o endometriozi, ki so (bili) prisotni na zahodu zadnjih 2500 let, ponujajo podstat za analizo endometrioze v sodobnih družbah. Z lokalno zamejeno digitalno etnografijo (33 ženskih pripovedi, objavljenih na spletni strani Društva za

ozaveščanje o endometriozi – Endozavest med 16. 1. 2017 in 21. 4. 2023), ki jo podpirajo sekundarni viri, se predstavi in kontekstualizira tri načine dojemanja in upravljanja z žensko bolečino: dramatizirane bolečine, duševne bolezeni in »ženskega primanjkljaja«. Članek osvetljuje vlogo fizične bolečine znotraj medicinskega sistema, ki s tem, ko ohranja telesa v bolečini, ženske potiska v nezaželjene seksualne in reproduktivne patriarhalne vloge.

KLJUČNE BESEDE: endometrioza, ženska bolečina, medicinsko nasilje, sodobne percepcije ženskosti, nezaželene patriarhalne vloge

1 Introduction[1]

This paper attempts to make a feminist cultural studies contribution to the field of (social) medicine by analysing and reflecting on endometriosis – a disease in which the presence of endometrial tissue outside the uterus (Chapron et al. 2019: 666) often manifests through horrific pain, infertility and sexual difficulties (Cole et al. 2021: 172). Endometriosis is characterised by an unusually high degree of uncertainty, ambiguity and conflicting information about its most basic features, which affects how it is managed and treated – or, rather, often untreated – taking an average of 7.5 years to reach diagnosis (Hogg and Vyas 2015: 134), with some studies presenting even higher numbers of up to 10 years or more (Seear 2014: 8; Ghai et al. 2020). Grogan et al. (2018) pointed out that suspiciously unusual (non-)treatments are recorded even after diagnosis. In recent years, critical social science research has drawn attention to these characteristics of the medical management of endometriosis. Since the 1990s, the disease has also been given more space in the medical and self-help literature, traditional media and social media. However, it has persistently been constructed as an enigma, rightly earning the "disease of theories" moniker (Seear 2014), as it is surrounded by layers of myths, stereotypes, patriarchal norms and coercion.

Establishing the premise that beneath the surface of constructing endometriosis as an enigma, chaos or something messy and mystical hides a melding of various aspects of (neo)patriarchy,[2] I proceed to offer a slightly different cultural studies

1. This work was supported by the Slovenian Research and Innovation Agency (ARIS) within the "Young Researchers" programme and by the ARIS research and infrastructure programme "The Production of Meaning and Knowledge in a Time of Crisis: Cultural, Religious and Scientific-Developmental Aspects of Societies in Slovenia, the Balkans, and Europe".

2. Neopatriarchy is the continuation of patriarchy, "a structure and culture of male domination over women, manifested in everyday life in both the public and private spheres" (Zaviršek 2018: 176). Neopatriarchy, one of the forms of patriarchy, emerges or is renewed after apparent historical victories of feminist and other equality movements. It acts as a dark shadow that reminds us of how the post-feminist conjuncture is often "more of the same", which calls for new feminist interventions.

analysis that proposes and tests a scheme of understanding of this "mysterious" disease, which takes into account the existing literature on endometriosis and its medical management as well as personal testimonies captured by digital ethnography. As existing conceptualisations inadequately capture cultural realities and meanings, I attempt a new articulation of happenings that will shift the debate around treating endometriosis within the medical system and situate it on the spectrum of the politics of female pain. I argue for it to be conceptualised and understood as a form of patriarchal medical violence.

In deploying the term patriarchal medical violence, I am first of all referring to the structural violence in the medical system that arises as a consequence of omnipresent patriarchal forces. In 1969, Johan Galtung introduced the term structural violence to describe violence that "is built into the structure and shows up as unequal power and consequently as unequal life chances" (Galtung 1969: 171). In recent decades, certain flaws of the term have been recognised (Herrick and Bell 2020; Macassa et al. 2021; Raguz 2021), however, it still offers a potent ground for highlighting the ubiquitousness of hegemony and analysing the complex interactions between institutions and other powerful social, political and economic forces guiding our everyday life (e.g. hierarchies of race, gender, economic position, language, ethnicity, etc.), which harm individuals or groups (Stonington et al. 2018: 1959–1960). Such modes of functioning are usually not recognised as violent, since they are perceived as "given", "natural" or "just the way things are" (Galtung 1969: 173; Shapiro 2018: 3; Macassa et al. 2021: 8). Thus, even though some voices call for the abandonment of such terminology, it is vital to use the word violence to translate actions into words as precisely as possible and enable problems to attain visibility and recognition (Chadwick 2021). In this study, I argue that the female body is a site where structural and direct violence meet, which is heard in the voices of those who suffer.

This article features a short historical overview of the discourses on endometriosis in the last 2,500 years, which can help reflect on how past ideas on women's health and pain persist in the present with minor variations. What follows is an analysis of the contemporary perceptions of female pain in the context of endometriosis. By examining the politics of pain and the relationships of power in medical discourses and systems, I try to reveal how patriarchal violence more or less secretly perpetuates aspects of physical pain that directly or indirectly discipline women's bodies and push them into a variety of unwanted sexual and reproductive roles.

In line with the general need to disrupt patriarchal language and formalised academic and medical forms, I occasionally combine my observations with more personal and directly political tones, aware that biased political knowledge is not only legitimate within cultural and gender studies but also a cherished tradition.

2 The burden of the past: (gendered) histories of endometriosis

We are the stronger, and they the weaker. They are obliged to believe all that we tell them. They are not in a position to dispute anything we say to them, and we, therefore, may be said to have them at our mercy. We, being men, have our patients, who are women, at our mercy.

(Seymour Haden, British Medical Journal 1867: 396, in King 1998: 247)

As an extension of the introduction, this chapter offers a short historical overview of Western discourses on endometriosis in the last 2,500 years – from antiquity to the present. The overview is schematic: it does not strive to be comprehensive, detailed or perfect but seeks to create the basis for understanding the perceptions and treatments of endometriosis in the past. The stroll through the labyrinths of the past and the readings of history are highly subjective and porous. In the generalised historical discourses of endometriosis as a totality of statements and experiences of a certain time, I highlight certain myths, stories and sayings that act as "atoms of discourse" (Foucault 2001: 86); I create historical collages and compose a story – almost a historical fiction – based on historical testimonies and insights.[3]

The written history of endometriosis usually starts in 1860 when Karl von Rokitansky provided the first pathological description (Chaichian 2019), although Nezhat et al. (2012: 1–2) convincingly showed that signs of endometriosis corresponding with contemporary clinical interpretations of the disease could be found much earlier. Therefore, it is worth pointing to classical and late antiquity when one of the most well-known medical documents was created – The Hippocratic Corpus – in which Hippocrates and other Greco-Roman authors described the *hysterikos–hysterike* family of disorders based on the assumption that the uterus was not an ordinary organ and was more akin to a living animal hungry for motherhood. This gave rise to one of the most deeply held dogmas of ancient medicine: the idea that if a woman did not fulfil her socially desirable roles – first and foremost, marriage and motherhood – her womb would not fulfil its purpose and would begin to wander around, contributing to the development of various diseases (Laqueur 1990: 110; Nezhat et al. 2012: 2–3; Dean-Jones 1992: 61–62; Veith 1965: 9–39).

In the Middle Ages, theological influences and supernatural explanations of phenomena began competing and interfering with as well as actively destroying

3. Due to space constraints, the historical part remains incomplete and invites readers to explore the topic through additional sources.

scientific heritage (Nezhat et al. 2012: 11). Explanations reached a new peak around the 17th century when endometriosis pain, perceived as the so-called "suffocation or strangulation of the womb", was increasingly read as a sign of demonic possession (Maines 1999: 28; Veith 1965: 57), madness or witchcraft (Nezhat et al. 2012: 15; Veith 1965: 56–73).

Until the mid-19th century, most physicians did not treat endometriosis surgically despite the availability of anaesthesia and aseptic techniques. Instead, they opted for either lighter techniques (e.g. hot douches and morphine to treat pain) or more invasive techniques, such as bloodletting or applying leeches to the cervix. As doctors believed that the patients were in pain because of their displaced wombs, they invented other unusual forms of treatment.[4] The more dangerous methods included attempts to puncture nodules, which had a 70% mortality rate. Electric shock treatment was also used (Nezhat et al. 2012: 42–44, 46).

Even though hysteria could already be found in The Hippocratic Corpus and that its everchanging symptoms resembling endometriosis had since been present, in the 19th century, the period of "the great confinement" (Foucault 1988: 38) when people were exiled to various institutions (Foucault 1988), hysteria was deemed a pandemic (Maines 1999: 5). Furthermore, since it was perceived as a form of madness, it was treated as such (Nezhat et al. 2012: 35). It had sufficiently broad definitions and symptoms, which were frequently updated for application to non-standard expressions of femininity; for this reason, some contemporary researchers call it the "dumpster diagnosis" (Jones 2015: 1095–1096). Meanwhile, in 1860, clitoridectomy, the removal of the clitoris, briefly became popular (Ehrenreich and English 2005: 136), and then towards the beginning of the 20th century, physicians expanded the definition of hysteria to its limits, making it so all-encompassing that, around 1900, it was bereft of all meaning[5] (Jones 2015: 1096).

By the 20th century, advances were made in a variety of "scientific arenas", with significant impacts on endometriosis (Nezhat et al. 2012: 37). Despite surgical developments, the idea of endometriosis as a mental illness remained intact. Some physicians described the womb as the "controlling organ" that affects the entire female body and thoughts, while others believed the same about the

4. One such treatment included the physician manually manipulating the uterus to try and move it into its "natural" place, while another aimed to achieve the same goal by riding in a carriage or during a rough horseback riding session (Nezhat et al. 2012: 42–46).
5. Until the American Psychiatric Association officially removed it from the canon of contemporary diseases in 1952, hysteria was the most often diagnosed disease in history (Maines, 1999: 2; Jones, 2015: 1090).

ovaries. As these two organs were the main culprits of all female diseases, female sexual and reproductive organs became the main targets for medical treatments[6] (Ehrenreich and English 2005: 132, 134–135).

In 1927, John Sampson – considered the father of endometriosis, whose research and findings were internationally recognised – proposed the name endometriosis in a study. In the 20 years following his high-profile publications, endometriosis was found throughout the body, including in adolescents (Nezhat et al. 2012: 49). As presented above, based on historical traces and mutations, endometriosis can be considered old; however, it is not insignificant that it only took on its name and classification at the time of the decline of hysteria about a century ago. Thus, it can be concluded that the ashes of hysteria moulded the terrain for endometriosis to grow.

Since the 1960s, endometriosis has often been called "the career woman's disease" and has remained associated with women who decide against having children (Shohat 1992: 65). Such conceptions strongly influence treatment type. According to Nezhat et al. (2012: 51), "Perhaps most remarkably, some treatments have remained the same for hundreds of years with only minor variations". In recent years, there have been some notable developments in the medical treatment of endometriosis mapped in the medical literature; nevertheless, as I discuss later, the idea of the wandering womb as a patriarchal fantasy, a prescription for traditional gender roles and sexualities, still echoes in the medical management of the disease today.

3 Endometriosis and female pain: an ethnographic study

To the woman, God said, "I will greatly multiply your pain in child bearing; in pain you shall bring forth children, yet your desire shall be for your husband, and he shall rule over you".
(Genesis 3:16)

According to the widespread definition created by the International Association for the Study of Pain (IASP 2020), pain can be understood as "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage". Despite generalised understandings identifying pain as an unpleasant bodily sensation or disorder that can be

6. For example, in the second half of the 19th century, surgery became more focused on controlling what were called "female personality disorders". The most common surgical intervention "in the female personality" was the removal of ovaries, also called "female castration" (Laqueur 1990: 176–177; Ehrenreich and English 2005: 136).

accompanied or replaced by emotional distress and suffering (Kumar and Elavarasi 2016: 88), as a cultural studies scholar, I understand pain as a phenomenon in which bodily (some may say natural) factors intermesh with cultural layers (Morris 1991), as people and cultures do not narrate, represent and understand pain in the same way (Patterson 2021: 315). "General cultural beliefs" and the "dominant medical culture" influence pain, and besides the impact of space and time, pain is also gendered (ibid.), being common knowledge that there is, indeed, a "gender pain gap" (Bimpong et al. 2021). Several evidence of gender pain bias in the medical system can be found in the literature (some of it presented below), still reflecting the acute need for practical changes and additional empirical data and theorisation with the help of different disciplines that can offer diverse methodological and theoretical bases with their own passions and concerns.

This research is based on digital ethnography. I analyse 33 stories (personal confessions of women with endometriosis in Slovenia) published on the website of Endozavest – Society for Raising Awareness for Endometriosis[7] between 16 January 2017 and 24 April 2023. The main method – locally, culturally and geographically limited digital ethnography – was partly supported by secondary sources in digital and print forms (academic and other productions, such as articles, comments, platforms, etc.), which were publicly available and accessible between 2020 and 2023. Additional sources confirmed the presence and persistence of some of the trends and tendencies presented in the study. In one part of the article, ethnography and autoethnography[8] were also carefully embedded. I used a "flexible cultural studies methodology" (Pužar 2011: 82) to summarise stories that were read (*digital ethnography*), observed (*classical ethnography*) and lived/embodied (*auto-ethnography*) into a new model based on the perception of women's pain. This strictly qualitative approach uses personal experiences as evidence[9] (Berry 2011: 166) and prioritises complexity (Haggis

7. Endozavest – Society for Raising Awareness for Endometriosis was founded in 2016 by women who had endometriosis themselves and wanted to discuss it, raise public awareness and help each other. During almost a decade of existence, it became known as a strong, persistent and professional force that offers a space for education, support and efforts to improve patient care (Endozavest 2025). My position here is not that of an insider or community member.
8. The autoethnographic method reports on the researcher's personal and emotional life and analyses social science concepts and perspectives through introspection (Bloor and Wood 2006: 18).
9. There has been a recognised need for such qualitative evidence that produces insight that can guide healthcare services and improve structures of care (Cunnington et al. 2024: 1–2).

2008: 165), contextuality (Denzin 2003; Saukko 2003) and reflexivity (Berry 2011: 166–167) over "the usual axes of individualization and generalization" (Pužar 2011: 83). I sought to understand lived experiences, recognise recurring cultural patterns and varying interactions of multiple factors integrated into a system (Berry 2011: 169–170; Haggis 2008: 161), a process that demanded sensitivity to the experiences of others, a certain level of vulnerability and accountability for the findings and interpretations herein.

Extensive ethnographic and autoethnographic material stored in the author's cultural archive showcases that pain bias extends beyond the medical system and unveils the persistent normalisation of female pain in everyday life. The gendered normalisation of pain occurs by routinely ignoring pain in girls and women and through culturalisation. The process starts during childhood, where women are told to bear a little pain. When they begin menstruating, the general advice is to accept any sort of pain to get used to it over time and live with it. Women's pain is often trivialised, thus disqualifying their experience: they are told that they are "whining for nothing", that "that's just the way it is" and that, according to the Slovenian proverb, "all will be well after marriage". Women's pain is normalised to the point that it is sometimes described as part of women's nature or fate.[10]

The gendered normalisation of pain is grounded in social and political motives, where pain can be understood as a disciplining tool if a woman transgresses the desired perceptions of femininity and social roles, which in patriarchal and prevalently heteronormative environments, still often act as a patchwork of motherhood, heteronormative partnerships and panoptical homemaking.

Reflecting on the previous chapter, when it comes to the relationship between female pain and motherhood, childbirth has historically been privileged over women's pain (Virdi 2019). This is similar to genital pain, which many women experience outside of sexuality; however, in the medical system, penetration

10. Katarina's (Endozavest 2022) testimony on the Endozavest website reflects this: "I thought that this is how it should be, that this is part of a woman's life". Many similar examples can be found in popular culture. In the second season of the TV series Fleabag, one of the conversations in the third episode went like this:
Women are born with pain built in. It's our physical destiny: period pains, sore boobs, childbirth, you know. We carry it within ourselves throughout our lives, men don't. /.../ We have it all going on in here inside, we have pain on a cycle for years and years and years and then just when you feel you are making peace with it all, what happens? The menopause comes, the fucking menopause comes, and it is the most wonderful fucking thing in the world. And yes, your entire pelvic floor crumbles and you get fucking hot and no one cares, but then you're free. No longer a slave, no longer a machine with parts. You're just a person.

appears as a criterion for measuring genital pain and, consequently, treatment success (Farrell and Cacchioni 2012: 331). Even if a woman does not participate in a heteronormative partnership and/or motherhood, the politics of pain, with its ideological structures and mechanisms, often results in women staying at home, away from the public sphere, where they and their voice are relegated to controlled niches (Pužar 2019: 72). Thus, the normalisation of pain can be seen as a form of gendered systemic violence that ensures that women's autonomy and agency remain limited.

When an individual tries to break out of the described social order by claiming the right to manage her own body and pain – which could fall outside the categories of givenness, unchangeability and normativity – there are various "defence mechanisms" to ensure that any such attempted "attack" is nipped in the bud. These include the more or less indirect methods of silencing women and pushing them back or trying to push them into the frame of patriarchal norms. To support this thesis, this chapter offers three ways in which female pain in the context of endometriosis is perceived and managed: 1) when women are not believed and their pain is labelled a lie or its milder form – dramatisation; 2) when pain is (mostly) acknowledged but its symptoms are understood to be of psychological origin and 3) when women are believed – "even" the fact that the symptoms are of physical, not psychological, origin – but various reasons transfer responsibility to the one who inhabits the body, the one who causes all these ailments.

These three perceptions of female pain (dramatised pain, mental illness and "female deficit") reflect three figurations of women with endometriosis (endo women): the "dramatic woman", the "crazy woman" and the "problematic" or "unworthy" woman, which are often interlaced in everyday life, as shown in the testimonies herein. They can also be seen as an updated version of the historical femininities described in the previous chapter. Thus, the following section can also be read as a reproduction of patriarchal power structures through the ages, an illustration of "how the form and position of femininity hardly changes, how they usually only assume the appearance of change and how the forms that do change give the impression of constancy" (Pužar 2019: 67).

3.1 Dramatised pain

In the medical system, doctors' qualifications make them the ultimate actors in deciding and socially legitimising pain and suffering (Johansson et al. 1999: 1800). In the case of endometriosis, pain can sometimes not be proven with material evidence, but merely by the words of a woman (de Souza São Bento and Nunes Moreira 2017: 3030), whom doctors can decide whether to believe.

Often, women's pain is not recognised as real and/or serious, which can be seen in two things. To diagnose endometriosis, surgery is needed to determine the bodily signs of the disease and pain. It is the organic, bodily state that must prove the legitimacy of the "really painful" pain. Furthermore, women have testified that physicians have advised battling pain with "psychological solutions" – relaxation – often disregarding their symptoms or mockingly telling them to their face that no one has ever listed so many symptoms before (Manica, Endozavest 2022). This is a form of humiliation and insult: even if a doctor does not tell her directly that she is lying, their words and actions convey the same message.

The fact that women are not believed and that their self-reports of pain are classified as exaggeration, dramatisation, hysteria or half-truths can be explained through Miranda Fricker's (2007:[11] 33, in Barnes 2020) concept of the "credibility deficit": as gender stereotypes portray women as untrustworthy and irrational, they are perceived and treated as a less reliable source of information. As women are perceived as more emotional and sensitive, their pain is tied to psychological issues despite physical characteristics or the physical origin of the disease (Hoffman and Tarzian 2001). Endo women are often labelled overly sensitive, fragile and weak, as illustrated by the following story[12] (Saša, Endozavest 2022):

> *I call my gyno to tell her my problems. She says that it's normal, that menstruation hurts, that I'm just weak because I can't bear the pain. My next period, the story with pain repeats, and then the next one and the next one and the next one. Pain is becoming unbearable. I felt like my body is constantly in pain, even in the days without my period. One day, pain was simply too much for me to get up. My partner carried me to the ER. I had an ultrasound. They saw nothing. I was given a painkilling injection and sent home. I was only diagnosed with endometriosis at an infertility clinic. Before that, my pain was just painful menstruation, and I was "weak" because I couldn't stand the pain.*

The "credibility deficit" that attributes women lacking credibility points to how untrustworthy or biased the medical system is. Gender bias and stereotypes within the medical system are well documented in the empirical literature (e.g. Hoffman and Tarzian 2001: 13; Chang et al. 2008; Billock 2018; Samulowitz et al. 2018: 8–9; Barnes 2020). Such actions are, of course, neither neutral nor

11. Fricker, Miranda (2007): Epidemic Injustice: Power and the Ethics of Knowledge. Oxford: Oxford University Press.
12. In many stories, the medical professionals involved were themselves women. In order to better understand the main sources for their involvement in the creation and reproduction of certain patriarchal patterns, additional analysis is needed.

coincidental, with their presence evident especially when it comes to women's sexual and reproductive health.

The questioning of the existence and reality of a woman's pain in performing her sexual and reproductive roles is certainly not a contemporary invention. In the past, scientists often posed the question of whether female pain was really horrible or whether it even existed. In 1949, the Journal of Clinical Investigation published a groundbreaking study on labour pain, which seems rather inappropriate from a contemporary perspective: the focus was on whether women actually felt pain during labour or whether it was simply a hysterical response to a stressful situation (Hardy and Javert 1949). To confirm that childbirth was indeed painful, we would have to wait until it was possible to measure pain on men (Barnes 2020). This "proof" of labour pain fuelled the belief that it was influenced by the proximity of the husband during labour (Norr et al. 1977) and the woman's emotional stability during pregnancy (Nettelbladt et al. 1976). Until the 1970s, scientists assured women "that little or no pain should be possible – in fact, birth should be positively enjoyable – if only they could just *calm down*" (Barnes 2020).

Women's pain was not treated as a serious issue worthy of medical attention in the past, and this persists today. In the case of endometriosis, this shows in the fact that during consultations, women begin by apologising to their doctors for wasting their time with something as unimportant and trivial as their pain. In the medical system, a woman's pain is perceived and treated as something redundant, unnecessary and distracting. Physicians and other health professionals react accordingly. Women are sometimes sent away by nurses and do not even make it to their physician or a specialist (Karmen, Endozavest 2022):

> *Ten years ago, I wanted to speak to my gyno about how I think I have endometriosis, and the nurse sent me away saying: "You're too young for that!" I doubt that she even knew in that moment how old I was. My only regret is that I was afraid to insist, despite my age. I was actually ashamed because she said that in front of other patients, and I almost sank into the ground.*

If the physician believes that her pain is not real, the woman is often not referred to a specialist or sent for further testing, or she must "fight" for it, as pointed out by Patricija (Endozavest 2022):

> *I was diagnosed when I was 34. Ever since I was 20, I suffered chronic pain and painful period, painful ovulation and painful intercourse. [...] After years of unsuccessful debates with my gynaecologist, she finally sent me into tertiary care. Endometriosis was found in my ovaries, my bowels and my bladder.*

In cases when the door to a GP, gynaecologist or other specialist remains closed to women, they often turn to self-funding services:

> *I got diagnosed by coincidence. My mom read an article on endo. She encouraged me to self-fund a check-up with a specialist. In October last year, it was confirmed that I have endo. I waited for a diagnosis for at least six years* (Laura, Endozavest 2022).

Notably, self-funded services are often (financially) inaccessible, and in general, such medical "management" of female pain and disease reveals structural discrimination. Therefore, it is not surprising that in 2017, the first published guidelines on the management of endometriosis by the National Institute for Health and Care Excellence in the United Kingdom succinctly stated, "Listen to women" (Boseley 2017).[13]

Before moving to the next section, which deals with the perception of female pain as a mental illness, two things need to be further emphasised. First, neither this nor the next section argues that "real" or "serious" pain is necessarily physical or bodily in origin. Pain hurts the same, whether it is predominantly of a physical or mental origin, but its origin is important in light of treatment (Barnes 2020). Second, an occurrence that is often forgotten or deliberately omitted from the discussion of believing endo women is that a doctor's inability to locate the physical origin of female pain does not necessarily mean the absence of it.

3.2 Mental illness

When physicians fail to check or cannot locate the physical origin of female pain, it is often ascribed to a psychological origin, falling into the mental illness category. Diagnoses and treatments taken from the pool of mental illnesses often depend on whether physicians believe their patients. If physicians believe that women feel pain, they can be diagnosed with a somatisation disorder, in which emotional and psychosocial issues are expressed through physical symptoms (Jones 2015: 1102). If they believe that a woman's symptoms are imagined, they can give a hypochondria diagnosis, which is perceived as an imaginary disorder that exists only "in her head". Endo women can also be diagnosed with other mental illnesses, such as bipolar disorder (Turner 2022). Some doctors still believe that endometriosis is a mental illness or that the poor mental health of

13. The debate on the problem of disbelief in women is much wider than the scope of this article. For example, it was an important part of the #MeToo movement, the notorious Harvey Weinstein case and the recently concluded trial of Amber Heard and Johnny Depp. It features in various online spaces, for example, on Twitter, with the #BelieveWomen hashtag (Barnes 2020).

women causes it (Freedman 2017), which supports women's well-founded claim that some GPs lack knowledge, awareness and compassion – instead filling the void with personal opinions that support myths about endometriosis (Jones et al. 2015). As shown in the above historical overview of the disease, female pain, especially pain in the region of the reproductive organs, has always been subject to fantasies (Shohat 1992: 60), often meandering through the mental landscape of women. The next part of this paper presents several cases depicting how the updated historical project is carried out in contemporary Slovenia, often under the guise of care, kindness, and good intentions.

After the appointment (or an examination that reveals nothing remarkable), doctors often kindly enquire whether women are feeling alright or are experiencing difficulties in life. Laura's (Endozavest 2022) situation is typical:

> *The last time, my doctor told me that she can't help me and asked me if I was otherwise feeling fine. She wanted to know if I had any trouble at home or in school. She hinted that my issues were psychological. After three years of constant examinations, they decided that I was making my pain up.*

Adolescents and women are generally assumed to be buzzing with too much emotion, with hypersensitivity and overload as the basic building blocks:

> *My GP also began ascribing my issues to emotional teenage problems, but I knew this was not true. [...] When I insisted that the issue lies elsewhere, she showed her scepticism, but with a lack of other ideas, she sent me to see a gyno and check if perhaps this is where my troubles originate* (Branka, Endozavest 2017).

Many stories revealed that to help overcome the burdens and distresses of everyday life on women, psychiatric treatment is conveniently and well-meaningly offered to heal pain. This advice – a "break" that will "heal" the woman – is presented as something that may replenish her's energy to functionally (and "voluntarily") continue to participate in the patriarchal regime, with all its burdens, although such "well-meaning care" acts as a "form of political rationalisation of violence" (Zaviršek 2018: 13).

If a woman declines an offer of psychological treatment, this is another reason for the blame to be put on her. If she accepts psychological help and is then labelled mentally ill, she is further oppressed by the system of regulation and subjugation; she is subjected to further stigmatisation and, in some cases, new forms of humiliation, submittal and theft of her dignity. The common denominator of the listed options is the creation of new reasons to cease the search for information regarding the physical origins of pain or to stop or neglect the physiological treatment of endometriosis, regardless of a confirmed diagnosis. This can be seen in

Urška's (Endozavest 2017) story "IT'S ALL PSYCHOLOGICAL": "Ever since my first period, I battled pain in my abdomen, cramps, vomiting, dizzy spells, extremely strong bleeding; seeing my GP and gyno, I was quickly sent away, saying that this is normal and that it's all psychological". Along with an extremely long period of not being diagnosed despite seeing her GP and gynaecologist, what stands out are the effects of hormonal medication, especially what her gynaecologist told her during a check-up: "First go to a psychiatrist to cure depression, then we'll treat endometriosis" (ibid.). Disappointed, she turned to a self-pay gynaecological clinic; she wrote her story while waiting for an operation (ibid.).

As Slavoj Žižek (2018) poignantly summarised, the most effective lies are those that include truth. Notably, it has been proven that endo women experience more mental distress than other women. In a synthesis of 42 studies, Culley et al. (2013: 634) demonstrated changes in the mental health of endo women and that compared with the control groups and the general population, endo women averaged a higher level of depression, anxiety and other psychological issues. This is unsurprising, given that these women describe their lives as an endless battle with pain (Grogan et al. 2018), briefly summarised by Urša (Endozavest, 2022) here: "I can no longer live in a body that is constantly in pain".

Pain is always connected to psychological and emotional distress (Guidone 2020: 274) and has negative effects on mental health. However, other factors can cause patients to suffer mentally, for example, misdiagnoses of physical states that cause "iatrogenic" symptoms and diagnoses that develop as a consequence of systemic and human–ethical deficits or result from "wrong and harmful treatment" (Ule 2003: 225).

For example, Manca's (Endozavest 2022) testimony draws attention to the consequences of medical descriptions and understandings of female pain in endometriosis as "psychological flaws":

> *My story is no better. I have also been plagued by symptoms from A to Z for years, and I had a HORRENDOUS pain that I can't describe with words. Nobody would listen to me either. My doctor didn't believe me [...] She asked me if I had any other issues, mental. She sent me home with a referral to a psychiatrist. I cried for hours and hours. I told myself I wasn't crazy ... but I knew I'll go mad if I'd have to continue living with this pain.*

In the second part of Manca's story, the reader also learns that it took her 11 years to be diagnosed – a period that she describes as "a struggle" (ibid.). In some situations, women feel the pressure to accept the identity of a "crazy hypochondriac woman" (Cole et al. 2021: 182) and see themselves through the eyes of others.

3.3 "Female deficit"

What happens when endometriosis symptoms, especially pain, show in ways that cannot easily be dismissed as a lie, exaggeration or madness? Today, unlike in the past, we know that the belief that the wandering uterus causes mental illnesses or endometriosis is wrong, but the logic behind it has survived, albeit with slight modifications or corrections. Nowadays, hormones, among other things, are blamed for causing these states. Female hormones – oestrogen and progesterone – are often blamed for endometriosis. There is also the "theory of estrogen dominance" that supposedly "proves" that "all women are potentially endometriotic" (Jones 2015: 1101), that is, that endometriosis comes with the female gender, just like pain. Alongside hormones, numerous psychological and physical characteristics are linked to endometriosis, such as being underweight, egocentric, having above-average intelligence, higher levels of anxiety and a need for perfection (Shohat 1992: 62). With that, certain characteristics are pathologised and, thus, situated as problems within the woman's body or mental state.

An example is Simona (Endozavest 2022): "During my gynaecological examination, I mustered the courage to mention my difficulties. A few short questions and useless advice later, she sent me home saying that nothing was wrong apart from my lack of confidence". In the case of endometriosis, as in other cultural phenomena, norms and pressures are adapted to current ideological updates, and in this particular case, the notion of confidence culture (Orgad and Gill 2022) can easily be identified. Female confidence is "frequently framed in terms of overcoming deeply rooted internal obstacles and correcting a psychological deficit" (ibid.: 6), while lack of confidence is considered "individual toxic baggage" (ibid.: 144) that treats women as isolated and excluded from the culture that normalises the pathologisation, objectification, control, guilt and hate speech against them (ibid.). Again, this puts the cultural focus on individuals; the problem is turned inwards, depoliticised and refigured as work that women need to do on themselves.

Finally, in a range of discourses, endo women are constructed and perceived as unsuccessful women. As reflected in the ethnographic material and secondary sources, there are two important aspects of the attributed failure: the first one being that these women might not be ideal sexual partners. In a 1997 self-help book by Valerie Worwood and Julie Stonehouse (2007: 48, in Jones 2015: 1096), *The Endometriosis Natural Treatment Program*, the authors concluded that "When sexual intercourse is painful, she cannot always be the willing, relaxed lover she would like to be". This concise phrasing offers two insights: first, women

must always be available to offer pleasure to the man; second, they must perform this role willingly and smilingly and must internalise it regardless of pain.

Similarly, the contemporary medical literature still features theories on how a lesser degree of procreation leads to a higher risk of endometriosis, hinting that the body punishes the childless woman. Such ideas are also showcased in Slovenian ethnography: "The kind lady interviewed me on a multitude of things and also concluded that all my troubles will disappear when I give birth" (Patricija, Endozavest 2022).

> *I started taking pills every day in the morning and at night. After six months, the situation was not good. I was still in pain. Every time I saw them, they answered: you are not well, it would be best for you to get pregnant...* (Urška, Endozavest 2017).

Returning to Worwood and Stonehouse (2007: 48, in Jones 2015: 1096), the authors continue their account of endo woman: "And finally, the ultimate cruelty, she may be unable to conceive /.../ For many sufferers, endometriosis is an affront to the female experience on all levels". In such discourses, the endo woman is subject to pity and contempt because she cannot (or does not want to) conceive and bear children (Jones 2015: 1097), which points to the fact that even today, childbearing and motherhood are still part of the irreplaceable "aura of femininity".

4 Conclusion

In the field of pain studies, it is well known fact that "pain exposes deep problems of meaning" (Charon 2021: 33) on both individual and societal levels. In cultural studies, pain is one of many examples of the misleading dichotomy between nature and culture, both of which contribute to the discursive, affective, material and social textures of everyday lives.

This cultural studies account looked into (medical) perceptions of female pain in the context of endometriosis, with three main hypotheses regarding 1) the bare existence of patriarchal medical violence, 2) structural and direct violence, (ab)using female physical pain as a disciplining tool and pushing women into particular sexual and reproductive roles and 3), by doing so, producing many dehumanising effects.

My goal in investigating patriarchal medical violence was not to discredit the medical system, but quite the opposite: to advocate that medicine matters and that different disciplines can support and learn from each other, perhaps even when their contributions are (or seem to be) in conflict. Despite some opinions claiming that my work is overly critical and negative towards the medical system, I try to engage with the topic in a productive and meaningful way, using "intellectual

empathy" (Chadwick 2021: 343) and effort to unveil the work of culture, its power and consequences – which, through the research process, present many paradoxes and ethical dilemmas – with the hope that this can contribute to "useful knowledge" production (Grossberg 2010: 24).

The material, which was gathered by combining ethnography and secondary sources, demonstrates the persistent desire for static femininity, as endo women with aching bodies, perceived as "dramatic", "crazy" or "unworthy", usually cannot wriggle out of the panopticon of home. While motherhood once chained the traditional woman to her home, for the endo woman, it is her physical pain.

It can be argued that although, in principle, care is reserved for women (Zaviršek 2018: 176), as it is associated with femininity (Snitow 1983: 249), contemporary societies are always "concerned" about the position of women, they show a certain "care", and in the case of endometriosis, instead of concern for the health status of women, the primary concern is what women lose to the disease. The politics of female pain in endometriosis unveils how the cultural (patriarchal) mourning of the roles of mother, homemaker and ideal heterosexual partner is felt on individual bodies. Despite the illusion of post-patriarchy, at least partly, there is a notable loyalty to seemingly outdated patriarchal patterns. However, cultural analysis of discourses and meanings also offers a reversal in meaning-making. Thus, what is regrettable and can be mourned is what endo women in current structures of everydayness actually lose – their dignity, security and the possibility of making decisions about their own lives. The loss of possibility is the loss of autonomy.

References

Barnes, Elizabeth (2020): The hysteria accusation. Aeon. Available from: https://aeon.co/essays/womens-pain-it-seems-is-hysterical-until-proven-otherwise (3. 11. 2024).

Berry, Keith (2011): The ethnographic choice: why ethnographers do ethnography. Cultural Studies ↔ Critical Methodologies, 11 (2): 165–177. DOI: https://doi.org/10.1177/1532708611401335.

Billock, Jennifer (2018): Pain bias: the health inequality rarely discussed. BBC, 22. 5. 2018. Available from: https://www.bbc.com/future/article/20180518-the-inequality-in-how-women-are-treated-for-pain (3. 11. 2024).

Bimpong, Kweku, Thomson, Katie, Mcnamara, Courtney L., Balaj, Mirza, Akhter, Nasima, Bamrea, Clare, and Todd, Adam (2021): The gender pain gap: gender inequalities in pain across 19 European countries. Scandinavian Journal of Public Health, 50 (2): 287–294. DOI: https://doi.org/10.1177/1403494820987466.

Bloor, Michael, and Wood, Fiona (2006): Keywords in Qualitative Methods: A Vocabulary of Research Concepts. London, Thousand Oaks and New Delhi: SAGE Publishing.

Boseley, Sarah. (2017): "Listen to women": UK doctors issued with first guidance on endometriosis. Guardian, 6. 9. 2017. Available from: https://www.theguardian.com/society/2017/sep/06/listen-to- women-uk-doctors-issued-with-first-guidance-on-endometriosis (3. 11. 2024).

Branka (2017). Endozavest, 16. 1. 2017. Available from: https://endozavest.si/2017/01/16/branka/ (1. 12. 2022).

Chadwick, Rachelle (2021): The dangers of minimizing obstetric violence. Violence Against Women, 29 (9): 1899–1908. DOI: https://doi.org/10.1177/10778012211037379.

Chaichian, Shahla (2019): It is the time to treat endometriosis based on pathophysiology. Journal of Reproduction and Infertility, 20 (1): 1–2.

Chang, Anna, et al. (2008): Bias in cardiovascular testing persists after adjustment for presenting characteristics and cardiac risk. Academic Emergency Medicine, 14 (7): 599–605. DOI: https://doi.org/10.1111/j.1553-2712.2007.tb01842.x.

Chapron, Charles, Marcellin, Louis, Borghese, Bruno, and Santulli, Pietro (2019): Rethinking mechanisms, diagnosis and management of endometriosis. Nature Reviews Endocrinology, 15: 666–682. DOI: https://doi.org/10.1038/s41574-019-0245-z.

Charon, R. (2021). How to listen for the talk of pain. In In D. Padfield, and J. M. Zakrzewska (eds.): Encountering Pain: Hearing, seeing, speaking: 33–46. London: UCL Press.

Cole, M. Jennifer, Grogan, Sarah, and Turley, Emma (2021): "The most lonely condition I can imagine": psychosocial impacts of endometriosis on women's identity. Feminism & Psychology, 31 (2). DOI: https://doi.org/10.1177%2F0959353520930602.

Culley, Lorraine, et al. (2013): The social and psychological impact of endometriosis on critical review. Human Reproduction, 19 (6): 625–639. DOI: https://doi.org/10.1093/humupd/dmt027.

Cunnington, Sophie, Cunnington, Amy, and Hirose, Atsumi (2024): Disregarded, devalued and lacking diversity: an exploration into women's experiences with endometriosis. A systematic review and narrative synthesis of qualitative data. Journal of Endometriosis and Uterine Disorders, 8. DOI: https://doi.org/10.1016/j.jeud.2024.100087.

de Beauvoir, Simone (2010): The Second Sex. New York: Random House.

de Souza São Bento, Paulo Alexandre, and Nunes Moreira, Martha Christina (2017): The experience of illness of women with endometriosis: narratives about institutional violence. Cien Saude Colet, 22 (9): 3023–3032. DOI: https://doi.org/10.1590/1413-81232017229.03472017.

Dean-Jones, Lesley (1992): The politics of pleasure: female sexual appetite in the Hippocratic Corpus. Domna C. Stanton (ed.): Discourses of Sexuality: From Aristotle to AIDS. Michigan: The University of Michigan Press.

Denzin, Norman K. (2003): Performing (auto) ethnography politically. Review of Education, Pedagogy, and Cultural Studies, 25 (3): 257–278. DOI: https://doi.org/10.1080/10714410390225894.

Dixon, Laurinda S. (1995): Perilous Chastity: Women and Illness in pre-Enlightenment Art and Medicine. New York: Cornell University Press.

Ehrenreich, Barvara, and English, Deirdre (2005): For Her Own Good: Two Centuries of the Experts Advice to Women. New York: Knopf Doubleday Publishing Group.

Endozavest. Available from: https://endozavest.si/o-nas/kdo-smo/ (19. 3. 2025).

Farrell, Janine, and Cacchioni, Thea (2012): The medicalization of women's sexual pain. The Journal of Sex Research, 49 (4): 328–336. DOI: https://doi.org/10.1080/00224499.2012.688227.

Firestone, Shulamith (2019): Dialektika spola. Zagovor feministične revolucije. Ljubljana: *cf.

Foucault, M. (1988): Madness and Civilization: A History of Insanity in the Age of Reason. New York: Random House.

Foucault, Michel (2001): Arheologija vednosti. Ljubljana: Studia Humanitatis.

Freedman, Sylvia (2017): 'Do mad people get endometriosis or does endo make you mad?'. Guardian, 21. 3. 2017. Available from: https://www.theguardian.com/commentisfree/2017/mar/22/do-mad-people-get-endometriosis-or-does-endo-make-you-mad (1. 12. 2022).

Galtung, Johan (1969): Violence, peace, and peace research. Journal of Peace Research, 6 (3): 167–191. DOI: https://doi.org/10.1177/002234336900600301.

Ghai, Viscalli, Jan, Haider, Shakir, Fevzi, Haines, Pat, and Kent, Andrew (2020): Diagnostic delay for superficial and deep endometriosis in the United Kingdom. Journal of Obstetrics and Gynaecology, 40 (1): 83–89. DOI: https://doi.org/10.1080/01443615.2019.1603217.

Grogan, Sarah, Turley, Emma, and Cole, Jennifer (2018): "So many women suffer in silence": a thematic analysis of women's written accounts of coping with endometriosis. Psychology & Health, 33 (11): 1364–1378. DOI: https://doi.org/10.1080/08870446.2018.1496252.

Grossberg, Lawrence. (2010): Cultural Studies in the Future Tense. Durham: Duke University Oress.

Guidone, C. Heather (2020): The womb wanders not: enhancing endometriosis education in a culture of menstrual misinformation. Chris Bobel, et al. (eds.): The Palgrave Handbook of Critical Menstruation Studies: 269–286. Singapore: Palgrave Macmillan.

Haggis, Tamsin (2008): "Knowledge must be contextual": some possible implications of complexity and dynamic systems theories for educational research. M. Mason (ed.), Complexity Theory and the Philosophy of Education: 150–168. Oxford: Wiley-Blackwell.

Hammer, Allison K. (2023): Masculinity in Transition. Minneapolis and London: University of Minnesota Press.

Hardy, James D., and Javert, Carl T. (1949): Studies on pain: measurements of pain intensity in childbirth. The Journal of Clinical Investigation, 281 (1): 153–162. DOI: https://doi.org/10.1172/JCI102044.

Herrick, Clare, and Bell, Kirsten (2020): Concepts, disciplines and politics: on "structural violence" and the "social determinants of health". Critical Public Health, 32 (23): 295–308. DOI: https://doi.org/10.1080/09581596.2020.1810637.

Hoffman, E. Diane, and Tarzian, J. Anita (2001): The girl who cried pain: a bias against women in the treatment of pain. Journal of Law and Medical Ethics, 29 (1): 13–27. DOI: https://doi.org/10.1111/j.1748-720X.2001.tb00037.x.

Hogg, Susannah, and Vyas, Sanjay (2015): Endometriosis. Obstetrics, Gynaecology & Reproductive Medicine, 25 (5): 133–141. Available from: https://www-sciencedirect-com.nukweb.nuk.uni- lj.si/science/article/pii/S1751721415000457?ref=cra_js_challenge&fr=RR-1 (2. 11. 2020).

IASP Announces Revised Definition of Pain. International Association for the Study of Pain, 17. 7. 2020. Available from: https://www.iasp-pain.org/publications/iasp-news/iasp-announces-revised-definition-of-pain/ (9. 4. 2025).

Johansson, Eva, Hamberg, Katarina, Westman, Goran, and Lindgren, Gerd (1999): The meanings of pain: an exploration of women's descriptions of symptoms. Social Science & Medicine, 48 (12): 1791–1802. DOI: https://doi.org/10.1016/s0277-9536(99)00080-5.

Jones, E. Cara (2015): Wandering wombs and "female troubles": the hysterical origins, symptoms, and treatments of endometriosis. Women's Studies, 44: 1083–1113. DOI: https://doi.org/10.1080/00497878.2015.1078212.

Karmen (2022). Endozavest, 18. 3. 2022. Available from: https://endozavest.si/2022/03/18/karmen/ (5. 6. 2022).

Katarina (2022). Endozavest, 10. 4. 2022. Available from: https://endozavest.si/2022/04/10/katarina/ (5. 6. 2022).

King, Helen (1998): Hippocrates's Woman: Reading the Female Body in Ancient Greece. London: Routledge.

Kumar, Ka, Elavarasi, Prabakaran, and David, Chaya M. (2016): Definition of pain and classification of pain disorders. Journal of Advanced Clinical and Research Insights, 3 (3): 87–90.

Laqueur, Thomas (1990): Making Sex: Body and Gender from the Greeks to Freud. Cambridge: Harvard University Press.

Laura (2022). Endozavest, 11. 4. 2022. Available from: https://endozavest.si/2022/04/11/laura/ (5. 6. 2022).

Macassa, Gloria, McGrath, Cormac, Rashid, Mamunur, and Soares, Joaquim (2021): Structural violence and health-related outcomes in Europe: a descriptive systemic review. International Journal of Environmental Research and Public Health, 18 (13). DOI: https://doi.org/10.3390/ijerph18136998.

Maines, P. Rachel (1999): The Technology of Orgasm: "Hysteria", the Vibrator, and Women's Sexual Satisfaction. Baltimore and London: Johns Hopkins University Press.

Manica (2022). Endozavest, 4. 4. 2022. Available from: https://endozavest.si/2022/04/04/manica/ (5. 6. 2022).

Morris, David B. (1991): The Culture of Pain. Berkeley: University of California Press.

National Institute for Health and Care Excellence (2017): Endometriosis: diagnosis and management. Available from: https://www.nice.org.uk/guidance/ng73/resources/endometriosis-diagnosis- and-management-pdf-1837632548293 (4. 11. 2024).

Nettelbladt, Per, Fagerström, Carl-Fredrik, and Uddenberg, Nils (1976): The significance of reported childbirth pain. Journal of Psychosomatic Research, 20 (3): 215–221. DOI: https://doi.org/10.1016/0022-3999(76)90024-6.

Nezhat, Camran, Nezhat, Farr, and Nezhat, Ceana (2012): Endometriosis: ancient disease, ancient treatments. Fertility and Sterility, 98 (6): 1–62. DOI: https://doi.org/10.1016/j.fertnstert.2012.08.001.

Norr, Kathleen L., Block, Carolyn R., Charles, Allan, Meyering, Suzanne, and Meyers, Ellen (1977): Explaining pain and enjoyment in childbirth. Journal of Health and Social Behavior, 18 (3): 260–275. DOI: https://doi.org/10.2307/2136353.

Orgad, Shani, and Gill, Rosalind (2022): Confidence Culture. Durham: Duke University Press.

Padfield, Deborah, and Zakrzewska, Joanna M. (eds.) (2021): Encountering Pain: Hearing, Seeing, Speaking. London: UCL Press.

Patricija (2022). Endozavest, 4. 4. 2022. Available from: https://endozavest.si/2022/04/04/patricija/ (5. 6. 2022).

Patterson, J. (2021). Acute pain is sexy and chronic pain is not: Language, communication and transformation. In D. Padfield, and J. M. Zakrzewska (eds.): Encountering Pain: Hearing, seeing, speaking: 315–332. London: UCL Press.

Pužar, Aljoša (2011): Asian dolls and the Westernized gaze: notes on the female dollification in South Korea. Asian Women, 27 (2): 81–111. DOI: https://doi.org/10.14431/aw.2011.06.27.2.81.

Pužar, Aljoša (2019): Odraščanje v Južni Koreji: feministične etnografije transgresije. Ljubljana: Založba ZRC.

Raguz, Maria (2021): Structural violence: its many faces and challenges in research, policies, prevention, and intervention. Journal of Prevention & Intervention in the Community, 49 (4): 303–310. DOI: https://doi.org/10.1080/10852352.2019.1664716.

Samulowitz, Anke, Gremyr, Ida, Eriksson, Erik, and Hensing, Gunnel (2018): "Brave men" and "emotional women": a theory-guided literature review on gender bias in health care and gendered norms towards patients with chronic pain. Hindawi: 1–18. DOI: https://doi.org/10.1155/2018/6358624.

Saša (2022): Endozavest, 11. 4. 2022. Available from: https://endozavest.si/2022/04/11/sasa/ (5. 6. 2022).

Saukko, Paula (2003): Doing Research in Cultural Studies. London: SAGE Publications Ltd. DOI: https://doi.org/10.4135/9781849209021.

Seear, Kate (2014): The Making of a Modern Epidemic. Endometriosis, Gender and Politics. London and New York: Routledge.

Shapiro, Johanna (2018): "Violence" in medicine: necessary and unnecessary, intentional and unintentional. Philosophy, Ethics, and Humanities in Medicine, 13 (7). https://doi.org/10.1186/s13010-018-0059-y

Shohat, Ella (1992): Lasers for ladies: endo discourse and the inscriptions of science. Camera Obscura: Feminism, Culture, and Media Studies, 29: 56–89. DOI: https://doi.org/10.1215/02705346-10-2_29-57.

Simona (2022). Endozavest, 10. 4. 2022. Available from: https://endozavest.si/2022/04/10/simona-3/ (5. 6. 2022).

Snitow, Ann Barr (1983): Mass market romance: pornography for women is different. Ann Snitow, Christine Stansell, and Sharon Thompson (eds.): Powers of Desire: The Politics of Sexuality: 245–263. New York: Monthly Review Press.

Stonington, Scott D. et al.(2018): Case studies in social medicine – attending to structural forces in clinical practice. The New England Journal of Medicine, 379 (20): 1958–1961. DOI: https://doi.org/10.1056/nejmms1814262.

Turner, Hannah (2022): My endometriosis was misdiagnosed as bipolar disorder. Refinery29, 21. 3. 2022. Available from: https://www.refinery29.com/en-us/endometriosis-diagnosis-mental-health (2. 5. 2022).

Ule, Mirjana. (2003). Spregledana razmerja: o družbenih vidikih sodobne medicine. Maribor: Aristej.

Urša (2022). Endozavest, 17. 4. 2022. Available from: https://endozavest.si/2022/04/17/ursa/ (2. 5. 2022).

Urška (2017). Endozavest, 21. 11. 2017. Available from: https://endozavest.si/2017/11/21/urska/ (2. 3. 2020).

Ussher, M. Jane (2013): Diagnosing difficult women and pathologizing femininity: Gender bias in psychiatric nosology. Feminism & Psychology, 23 (1): 63–69. DOI: https://doi.org/10.1177/0959353512467968.

Veith, Ilza (1965): Hysteria: The History of a Disease. Chicago and London. The University of Chicago Press.

Virdi, Jaipreet (2019): Demanding a diagnosis for invisible pain. Wellcome Collection, 22. 8. 2019. Available from: https://wellcomecollection.org/articles/XTg6VBAAACQAP5hQ (2. 3. 2020).

Worwood, A. Valerie, and Stonehouse, Julia (2007): The Endometriosis Natural Treatment Program: A Complete Self-help Plan for Improving Your Health and Well-being. California. New World Library.

Zaviršek, Darja (2018): Skrb kot nasilje. Ljubljana: *cf.

Žižek, Slavoj (2018): Slavoj Žižek: The function of ideology today is to kill hope. YouTube, 24. 8. 2018. Available from: https://www.youtube.com/watch?v=TkPNgw2VUbU&t=812s (3. 11. 2024).

Author's data

asist. **Teja Kosi**
University of Ljubljana, Faculty of Social Sciences
Kardeljeva pl. 5, 1000 Ljubljana, Slovenija
E-mail: teja.kosi@fdv.uni-lj.si