

From beneath the rainbow: lesbian and bisexual women's perspectives on health and disease

Por debaixo do arco-íris: perspectivas de mulheres lésbicas e bissexuais sobre saúde e doença

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Abstract

This study aimed to understand the meanings that homosexual and bisexual women give to the state of health and illness and the way they evaluate their own state of well-being. It is a qualitative research study consisting of the accounts of 14 women from the municipality of Imperatriz, Maranhão, Brazil. Medical anthropology and gender studies contributed to analyzing the categories “Dimensions of health and disease” and “Looking at one’s own health”. These sections discuss the dualistic mind-body perspectives that etiologically characterized the health-disease process in these interlocutors’ view. In addition, the sociocultural context was understood as shaping the way they translated and evaluated their own health condition, a context crossed by their bisexual and lesbian experience. Therefore, the interviewees’ sexual identities and behaviors challenge the rigid way the health-disease process is interpreted by biomedical knowledge, questioning practices that marginalize these women in health care services.

Keywords: Women’s Health; Sexual and Gender Minorities; Health; Disease.

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Resumo

Este estudo teve como objetivo compreender os sentidos que mulheres homossexuais e bissexuais dão ao estado de saúde e doença e a forma como avaliam o seu próprio quadro de bem-estar. Tratou-se de uma pesquisa qualitativa constituída pelos relatos de 14 mulheres do município de Imperatriz, Maranhão, Brasil. A antropologia médica e os estudos sobre gênero contribuíram para analisar as categorias “Dimensões da saúde e da doença” e “O olhar sobre a própria saúde”. Nessas seções, são discutidas as perspectivas dualistas mente-corpo que caracterizavam etiologicamente o processo saúde-doença na visão dessas interlocutoras. Ademais, o contexto sociocultural foi compreendido como formatador da maneira como traduziam e avaliavam a sua própria condição de saúde, contexto esse atravessado pela vivência bissexual e lésbica. Portanto, as identidades e os comportamentos sexuais das entrevistadas friccionam a rigidez como o processo saúde-doença é interpretado pelo saber biomédico, questionando práticas que marginalizam essas mulheres nos serviços de assistência à saúde.

Palavras-chave: Saúde da Mulher; Minorias Sexuais e de Gênero; Saúde; Doença.

Introduction

*Under the soft sheet, a world pulses,
and my hand slides, whole
over her, naked girl, missing link
between what I am and what floats
(Borges, 2014).*

The excerpt from the poem *Allegory* (2014) by Bahian writer and journalist Kátia Borges presents the sexual encounter of two women. In this excerpt, the author proposes to the readers' imagination a particular perspective on a moment fetishized by the eyes of others, but which, in her writing, constitutes a metaphorical space regarding the discovery of herself, situated between what it really is and what it may be - what floats. Using this epigraph, this study begins its dialogue by pointing to what is found here: the senses and meanings attributed to health and disease through the eyes of lesbian and bisexual women, observing, therefore, this reality through the eyes of whoever experiences it, that is, from beneath the rainbow.¹

The study of population health conditions, when using gender as an analytical category, makes it possible to understand that women's and men's socialization processes are different, especially in Western societies that are marked by patriarchy (Sagot, 1995; Scott, 1995; Urra; Pechtoll, 2016).

Women are related to household activities, of motherhood, the feminine and fragile figure; these activities work as starting points, at the same time as they impart limits of their identities and bodies. These discrepancies in the roles socially attributed to men and women constitute a system that grants power to men based on patriarchal and phallogocentric views, legitimizing a context of inequalities and inferiority of women over men, deprivileging the uniqueness of the female experience (Sagot, 1995; Urra; Pechtoll, 2016).

This model of control finds a contrary response as lesbian and bisexual women break with the normative standard of heterosexuality.

¹ The expression “rainbow” refers to the symbology of LGBTQIA+ social movements, in use since the 1970s. As this is a study that uses the perspective of women who belong to this community, the dialogue is built from the “native” vision, thinking about health from the way it is interpreted by the social actors of this reality, that is, from beneath that rainbow.

Not only their bodies, but the way they think about themselves, the way they relate to other people, and the social limits they recognize are crossed by the typifications given to their sexual identities. Thus, this castrating environment acts directly on the way they produce their subjectivities in health, given that the sociocultural context surrounding individuals influences the way they understand the health-disease process (Helman, 2009).

In Brazil, some authors addressed the homo-affective behavior of women, using social vulnerabilities and aspects of marital relationships as their analytical approach (Andrade et al., 2020; Valadão; Gomes, 2011). This research, inspired by the work of these authors, emerges from the following concerns: 1) what are the meanings given to states of health and disease from the perspective of lesbian and bisexual women? 2) How do lesbian and bisexual women evaluate their own health?

It is assumed that the meanings attributed by lesbian and bisexual women to health and disease are crossed by the sociocultural context they are in, that is, heteronormativity and the constant control of their bodies and identities reflect on the way they interpret the health-disease process. Therefore, the objective of this study is to understand lesbian and bisexual women's perspectives on health and disease states, as well as the way they evaluate their own health.

Methodology

This is a qualitative study carried out in the city of Imperatriz, Maranhão, Brazil, in 2020.

The city is an important commercial-political hub in southern Maranhão and has a rigid Catholic and Protestant religious base in its history (Sousa, 2014). In the city, there is a rise in political groups that adopt discourses about essentially heteronormative standards of morality. The social appeal of these speeches led to the occupation of decision-making positions by political figures who are opposed to public policies aimed at sexual and gender diversity (Carvalho, 2020).

For this reason, this geographical-political space was thought to be useful for understanding how the sociocultural dynamics of this situation shape the

subjectivity of lesbian and bisexual women who live in the city, resulting in specific interpretations about health and illness.

The interviews were carried out from January to March 2020. The snowball technique was used to get to know the potential interviewees and made it possible to build a network of nominated participants (Vinuto, 2014). This network was based on proximity and, particularly, on the credibility present in the previous relationships between the key informant, the interviewees and their nominees. This key informant, a lesbian woman, was part of the personal contacts of one of the researchers and was engaged in LGBTQIA+ sociability networks in spaces such as universities and social movements and, for this reason, favored this study with a range of interview possibilities.

These methodological choices positively encouraged fieldwork. The recommendations and the proximity between the participants produced a relationship of minimal trust between the interviewees, their referrals and the researchers. This happened, firstly, because potential participants were initially contacted by the interviewee who nominated them. Thus, due to the credibility present in the previous contacts between these women, the approach and acceptability on the part of those nominated for the research was facilitated.

All 14 participating women were nominated according to the following inclusion criteria: women who self-identify as lesbian or bisexual and who are 18 years of age or older. After the referral and prior acceptance - informed by the participant who referred her, the potential interlocutor was contacted via messaging app, in which the research proposals were presented. The potential participant was then asked if she was interested in taking part. If yes, the individual interview was scheduled.

The conversations began after the presentation and signing of the Free and Informed Consent Form (TCLE) and were conducted in a private environment on the premises of the "Autores, 2021" Center at the Universidade Federal "Autores, 2021".

The interviews were carried out in the presence of the two researchers responsible for the fieldwork, a man and a woman. The first researcher, a man, more experienced in qualitative research, conducted

the interviews. The second researcher, a woman, made records in the field notebook and asked questions that were prompted by the interviewees' answers. The conversations were recorded and then transcribed in full by the two researchers.

The data was analyzed using Bardin's (2011) thematic content analysis. The author lists three necessary steps to capture and apprehend the meanings expressed in the speeches: pre-analysis, which consisted of organizing the material and systematizing the ideas presented by the interlocutors; exploration of the material, consistent with coding, definition of standards for speech excerpts and classification of exposed ideas; and interpretation, capturing all the content that was expressed in the speeches, which were categorized according to the meanings they transmitted.

The analysis also continued with the choice of the theoretical perspective to be used. Thus, the framework of social sciences, especially medical anthropology and gender and sexuality studies, were used to discuss the categories that emerged in the previously mentioned thematic categorization process. The field diary was also used, which accurately combined with this theoretical perspective and allowed us to discuss the meanings of the speeches in a way that is close to the sociocultural and sexual identity contexts in which they are produced, also allowing non-verbal records to corroborate the process of grasping these meanings.

The interlocutors were named in a fictional way, using species of flowers, without any mention of their real identity, an effort that was necessary to maintain their privacy. In this regard, this research complies with the principles of ethics in research with human beings, and was approved by the Research Ethics Committee (CEP) of the Federal Universidade Federal do Maranhão, according to certificate of presentation of ethical assessment (CAEE) 28248620.5.0000.5087.

Results and discussion

Fourteen (14) women participated in the study - Table 1 presents a summary of the participants' profile.

Most of the participants were between 20 and 30 years old and were academics at one of the higher education institutions in the city of the study. Half of these interlocutors were students and/or health professionals, which produced a certain alignment in understanding the health-disease process and, on the other hand, enabled an understanding of the differentiation of perspectives in relation to women who study-work in other areas, even if vulnerabilities due to sexual orientation are present.

This proximity of profiles resulted from the fact that the study's key informant was a nursing academic. However, as the snowball network of referrals grew, other profiles were added, such as teachers and students from the social sciences and humanities, as well as the exact sciences.

Table 1 – Characteristics of study participants, 2021.

Names*	Age	Sexual Orientation	Occupation
Tulipa	22	Bisexual	Social Communication Student
Rosa	25	Lesbian	English Teacher
Hortênci	20	Lesbian	Social Communication Student
Margarida	24	Bisexual	Nursing Student
Jasmim	25	Bisexual	Nursing Student
Amarílis	28	Lesbian	Forest Engineer
Lírio	24	Lesbian	Nurse
Gardênia	23	Bisexual	Biology Student

continues...

Table 1 – Continuation

Names*	Age	Sexual Orientation	Occupation
Violeta	22	Bisexual	Law Student
Azaleia	26	Lesbian	Nursing Student
Girassol	30	Bisexual	Medicine Student
Begônia	24	Lesbian	English Literature Student
Lavanda	25	Bisexual	Portuguese Teacher
Magnólia	23	Lesbian	Nursing Student

*Fictitious name, unrelated to the interlocutors' real identity
 Source: Information from the field diary, 2020.

When asked what they thought a healthy person would be like, these women talked from a perspective related to the health-disease process.

Therefore, two categories emerged: 1) “Dimensions of health and disease”, which concerns the dimensions given to what they believe health is, enumerating characteristics and, consequently, allowing an understanding of the logic they attribute to the state of complete well-being and illness; 2) “The look at one’s own health”, which deals with how the interlocutors assess their own health status, taking into account the way they perceive their body and its insertion in a sociocultural context crossed by their experience as a lesbian or bisexual woman.

Dimensions of health and disease

This category has as a substantial element the understanding of how the participants in this study dimension the health-disease process. These interpretations showed an influence of social and cultural contexts in this dimensioning, since causes from different domains can be attributed to health and disease: natural, psychosocial, socioeconomic and supernatural (Minayo, 1988).

Furthermore, a crossover between homosexuality and bisexuality was noted in these perceptions. However, especially the interlocutors who study and work with/in the health area composed their perceptions with physical and psychological elements of illness.

Interviewees Margarida and Rosa express their perspectives, focusing on the elements expressed in the body and in mental experience:

Physically, for me, I think you have to have a good lifestyle. It’s not because you have a thin physical pattern or a fat physical pattern, but that you are healthy in terms of habits. You have a good diet, practice physical exercise, consider your activities and leisure. For me, this means being physically healthy. Now in terms of psychological health, it varies a lot, because I think that, for you to have psychological health, currently, you have to free yourself from many triggers [problematic situations and people]. (Margarida)

Being healthy means... not getting tired quickly when I exercise. For example: climbing a staircase, a flight of stairs, and getting tired. For me, I’m not healthy. But... and psychologically, today, as a person who in therapy, [...] it’s being at peace with your mind, which is a very difficult thing. We struggle every day, but just the fact of reflecting on the things you do, the things you say, I think, I already consider it a... a healthy step for your mental health. (Rosa)

Some interlocutors focused on analyzing the perspective of health and disease according to the space their bodies occupy in the social world. As Lírio argues, the state of good physical health is characterized by the absence of disease, while good mental health depends on the balance of multiple factors:

We bring to the complete idea of absence of disease by talking about the physical and, when it’s about the mental, then we will list well-being, right?

I have to be okay with myself, I have to be okay with others, with society, with the environment. (Lírio)

In Jasmim's speech, health appears intrinsically crossed by her existence as a bisexual woman and by the current stigmatization that LGBTQIA+ people experience:

Starting from the principle of gay men, lesbians and bisexuals, I think that the first factor in recognizing yourself as healthy and feeling healthy is acceptance. Being psychologically stable to understand what is going on, because within the social context we are very stigmatized, very repressed. (Jasmim)

Begônia, from a very early age, was educated based on the dogmas of her very traditional evangelical parents' religion. The interviewee went through an extensive and traumatic process of understanding and accepting her bisexuality, especially by her family.² For this reason, feeling good about herself is essential for her to think about health status: "*Look, from what we see today, being healthy is being that fit person, right, with those muscles and everything. But it's not, right, it's broader [...] it's about feeling good about yourself*" (Begonia).

The narratives present a duality: physical health and psychological health. This division becomes clearer as they begin to list physical conditions that make up the profile of someone healthy, as in the elements listed in Margarida's speech. Furthermore, it is notable that the physical aspects are more often described by her, due to the palpable concreteness of reasoning and exemplification arising from her training as a Nursing student.

In the words of Rosa, an English teacher, a description is presented that results from her recent interest in establishing a psychological monitoring routine and, concomitantly, from her findings in individual research and informative materials from the office she attends.³ Therefore, the aforementioned interviewee has a more reflective behavior about

herself as an agent of her health status, especially with regard to the psychological dimension.

The categorization reflects the interviewees' approach to the "body-mind" duality, found in biomedical knowledge, demonstrating a division between problems of the body and problems of the mind (Helman, 2009).

There is a more numerous description of elements with regard to the physical dimension, illustrating a greater ease of translating situations in which the bodily representation of the illness is concrete.

In these terms, physical symptoms, as expressed by Rosa in "climbing a flight of stairs and getting tired", are an individual bodily experience that defines the health condition, supported by a personal sense of identity about the health-disease process. This way of thinking about illness emerges from a functional self-perception of the health status, which is linked to the aspect of medical rationality (Helman, 2009; Pinheiro, 2006), which is based on the organic functionality of bodies.

The consequent understanding of Margarida and Rosa's testimonies therefore allows us to identify that the "healthy" status and the "ill" status are the result of the interaction between medical rationality and subjective experiences of their bodies. Pinheiro (2006, p. 7) argues that "the problem of illness, life and death can only be qualified when each living being's organic individuality is taken into account". The organic individuality that the author deals with, on the one hand, emphasizes each individual's specificity, from an organic perspective and, on the other hand, focuses on one's insertion in the world, which evokes factors such as economy, social relations, affectivity, etc.

However, it is observed that Margarida and Rosa locate the elements of health and disease in themselves, without connection to broader issues, which is similar to what Jurca (2021) calls social individualism. According to the author, people perceive themselves and are constrained to perceive themselves as producers of themselves, responsible for unraveling and resolving the

² Information given in an interview and recorded in the research field diary on February 12, 2020.

³ Information given in an interview and recorded in the research field diary on February 6, 2020.

complexities of life, that is, the individual becomes the entrepreneur of themselves.

This view assumes that Margarida and Rosa recognize their health status as something controlled in the training of their own habits and in their autonomy as the only ones responsible for their own care, that is, that they seek to improve their physical fitness and avoid “triggers”, in order to achieve a body-mind balance.

It is worth noting that all the interlocutors are inserted in the higher education environment or have been there at some point. A priori, it was imagined that health students would present a more pluralistic and detailed perception in assessing the health-disease process, since they come into contact with the conceptual and ideological basis of Collective Health in their undergraduate courses. However, only Lírío, a nurse, worked out elements about health and illness in a more diverse way.

Even with this prior contact, as can be seen in Margarida’s speech, the health students outlined perspectives linked to a dichotomous linearity between mind and body, with short developments on the dimension of the mind. This result may contribute to the problematization of the health model that prevails in higher education institutions, especially those that work with health sciences.

Rosa, Lírío, Jasmim and Begônia, on the other hand, describe the elements that make up health and disease in a more plural way, citing the social and family context, the relationships between the subjects and the environment. The interviewees lead us to think that the perceptions they provided are intrinsically linked to existence in time and space, even when there is a greater or lesser proximity to biomedical medicine (Minayo, 1988).

In Margarida’s and Lírío’s speeches, it is possible to understand how, for them, the state of health is configured as a notion of weighting/balance. Margarida highlights the balance between a healthy mind and a body with full functional capacity, while Lírío adds the balance between multiple factors, which exceed the mind-body dimension.

A similar perspective is analyzed by Minayo (1998). The author demonstrates that residents of shanty towns in Rio de Janeiro point to the

imbalance between food and alcoholic beverages as possible causes of illness, that is, they understand that there must be a balance between “light” and “heavy” foods and alcohol consumption. Just as the interlocutors of this study think, the imbalance in specific dimensions of life is used to attribute an etiology to illness, focusing on the need for the individual to maintain a linearity between what is good and bad for health.

The recognition of health and disease status by Lírío is crossed by an interpretation of the insertion of one’s body in the world, an aspect theorized by Helman (2009) when he stated that the presentation of the disease and the responses of others to this condition are related to a sociocultural context. Therefore, physical and psychological experiences were not the only ones mobilized in the definition of what health is, but, taken together, these aspects gained more concrete parameters when the interviewees positioned their body-mind - female and lesbian - in the social situation in which they find themselves.

The decriminalization of homosexuality in some societies did not mean a full legitimization of sexual diversity, nor the decoupling of their identities from pathologization, immorality and criminal practices (Gama, 2019). This hostile social gaze and its persuasion in the construction of notions about health and disease are evidenced when Jasmim understands herself to be healthy as she also feels accepted, hence deriving her concern and fear of being discriminated against. Begônia, on the other hand, emphasizes feeling good in her own skin, the result of a traumatic process of acceptance of her sexual orientation by her family.

In this dialogue, the contributions of Monique Wittig (1992) are fitting, when she argues that a lesbian woman is not considered a woman if she is not included within heterosexual parameters (Wittig, 1992), highlighting a process of historical erasure. This non-recognition is used as a “discourse of non-difference” (Paulino; Rasera; Teixeira, 2019, p. 6), especially in healthcare environments, in which the existence of these women can be denied.

This “denial of the other” (Paulino; Rasera; Teixeira, 2019, p. 6) can be understood through Jasmim’s speech. For the interviewee, being healthy is the result of the obligation to think about

her health condition according to the risks of a stigmatizing context, which is beyond her power to control. Thus, she deals with a sociocultural problem individually and takes responsibility, without understanding that this context is also responsible for the construction of political environments to promote and protect her health status.

In Begonia's experience, there is a denial of the other in the family dimension and, thus, the health-disease process is taken with intense interiority. This contributes to the reflection that, in addition to elements of the body and mind, the cultural-family context produces an important crossing in the way the interlocutor interprets the health-disease binomial. Furthermore, it contributes to raising a question about how subordinate identities are denied the ability to feel comfortable with themselves.

Non-recognition has impacts on different dimensions of life. Thinking about institutional environments such as health services, barriers are created in accessing the assistance provided to these women, through arguments that promote a false "equality" in health needs between the LGBT population and other population groups (Paulino; Rasera; Teixeira, 2019). Consequently, they can contribute to the denial of the singularities in the perception of health and, more broadly, of the lesbian and bisexual women's peculiarities of existence.

The interpretations constructed here culminate in contributing to the inclusion of gender relations in the health field, in order to provide other horizons in understanding health and disease states. The singularities of female living and the way the lesbian and bisexual existence can (re)organize the perception of the health-disease binomial (Heilborn, 2003) must be taken into account in this process.

Looking at one's own health

This category is focused on the self-perceived assessment that the women participating in this study produced regarding their current health situation. This perspective was found through the guidance of questions that sought to encourage, in the interviewees,

a reflection on their own health status at the time of dialogue with the researchers. Therefore, as a result, concepts of health and disease applied to their own bodies and experiences emerged.

Interviewee Gardênia, when asked about considering herself a healthy person, presents a self-assessment mediated by purchasing power. This relationship is reflected in the way Gardênia and many other lesbian and bisexual women from popular classes manage their health, since income is a fundamental element of the lack of contact with the gynecologist:

I think... I think so. Despite being a person who still cares a lot about taking these tests, even more so due to lack of money, right? So, for example, a gynecologist, the last time I had an appointment was over a year ago. It's been a year and a half and a few months since then. So, I think it's something I should do more often, for example. But as I often do blood tests, I say: "Ah, nothing was found in the blood test so I'm going to put it aside!". I don't have very good contact, very often like this. (Gardênia)

Due to her father's employment, *Gardenia* used the services of a health plan for many years, including during the period in which she underwent cancer treatment. Her entire care path took place mostly in private health units until her recent disconnection from the health plan, essentially becoming dependent on the Brazilian Unified Health System (SUS). With very religious parents, her bisexuality became a marker of her bad relationship with them, culminating in her moving out. Recently, *Gardenia* started living with her boyfriend, after serious family disagreements.

Her therapeutic journey since leaving the health plan and leaving home is seen by her as a state of constant "survival". Providing for herself, basically, with the amount coming from a research support grant from the university where she graduated and from freelance work, Gardênia has been struggling to monitor her health status to the detriment of the constant basic life needs, such as housing and food.⁴

⁴ Information given in an interview and recorded in the research field diary on February 19, 2020.

Contributing to the understanding of health from the perspective of those who experience the particularities of the sexual identities discussed here, Jasmim presents the professional dimension as a determinant of her health status self-assessment:

I don't feel good because I can't solve it. I see myself leaving college without a perspective, without knowing what I'm going to do. So, the fact that I feel a little lost professionally doesn't make me feel healthy. (Jasmim)

When inquired about considering herself a healthy person, the interlocutor Lírio reports vulnerabilities that are motivating for a negative assessment of her health status. Her speech reflects a social context of punishment that emerges from within the family and produces a need to “make up for” her unaccepted sexual identity:

Unfortunately, I haven't yet reached the last point I touched, which, for me, would be the point where I can prove that I can be someone, even if I'm homosexual. Because, from my own experience, I lost a lot of the vision that people had of me, right? And in this regard, I talk about my family, in particular. I lost a lot of people's vision of me from the moment they discovered me as a homosexual woman. There was that concept of: “Lírio, who goes to college, who was always a good student and who was this, who was that”, which people deified, right? From the moment they found out I was a lesbian, it seemed like everything I had achieved until then fell apart, right? And it doesn't exist anymore, but I'm fine with myself and I accept it and everything, but I still have this need to: “I'm going to prove to everyone that just because I'm a dyke it doesn't mean I don't deserve their recognition and, also, that it's not because I am a lesbian woman that everything I have achieved to date has become invisible.” I'm still the same person I've always been. (Lírio)

Gardênia presents two important elements: income and blood tests. Income as an element that determines the paths and care alternatives adopted. It is healthy to understand that Gardênia was part

of a family with greater purchasing power and who remained close during the most fragile moments of cancer treatment. The interlocutor therefore had her monetary support base and emotional-family support weakened.

The material conditions of existence are also motivators of the etiological perception of health and disease in Minayo (1988). Issues such as lack of food, housing conditions and basic sanitation are highlighted by the author as shaping the interpretation of the causes of illness among popular community residents. In Gardênia's life, after disclosing her bisexuality to her family, socioeconomic conditions allowed her to obtain only blood tests as a form of more specialized health care.

On the other hand, it is possible to think that Gardênia's situation could be alleviated with the use of SUS health services. However, lesbian and bisexual women face non-recognition of needs and discrimination in the Brazilian health system, which makes access difficult and reduces the quality of care received (Paulino; Rasera; Teixeira, 2019).

These women are not encouraged by health professionals to verbalize their social orientations when they seek health care, when they do, they are treated with hostility (Valadão; Gomes, 2011; Andrade et al., 2021). Therefore, for Gardênia, the obstacle is twofold: she does not have the financial resources to cover her health needs and, also, possibly, her specificities as a bisexual woman will not be recognized.

Jasmim's speech refers to a personal demand, but which is mirrored in a social requirement, with greater ideological and political dimensions. According to Viana and Silva (2018), in an analysis of the findings of Curran and Hill (2017), neoliberal meritocracy and its mode of production cause society to seek perfection, through a series of unrealistic expectations of personal and professional success, which affects multiple life domains, including health. As a result, mental illness epidemics have become recurrent (Viana; Silva, 2018).

By reporting that she was “lost” professionally and holding herself accountable to the point of not feeling healthy, Jasmim also punishes herself. This pressure-punishment opens space for overly watchful and anxious behavior about the future

and the social framing of her sexuality in a health context of vulnerabilities.

In Lírio's speech, many aspects are of interest in understanding why she made a negative assessment of her health status. The first of these concerns the social invalidation of the homosexual person, in which her body and its qualities become dispensable and, therefore, the lesbian woman finds herself pressured to achieve privileged social and economic conditions to validate her existence. It is important to highlight that LírioShe is a nurse, economically stable, that is, achieving higher education training and financial independence had little influence on her family's appreciation of her person.

In her studies on the limits of the body and sex, Judith Butler (2000) legitimizes the indispensable character of the homosexual person as a participant in the materialization of sexual identities. It is possible to understand that, even though they are necessary in the social context of heterosexual identity formation, lesbian and bisexual women - like other dissident identities - are hierarchized, classified, dominated and excluded by binary logic (heterosexuality-homosexuality) (Louro, 2001).

In Lírio's speech, it is clear that the family has a bearing on her self-assessment of health, particularly since, after disclosing she is a lesbian, the prestige of being a good daughter and a good student has waned and, therefore, there is a need to prove to herself and others that she is still the same person. As already analyzed by Dias (2016), the family context of homosexuality raises it to a level of greater stigmatization, due to the entire social construction that privileges heterosexuality and the marginalization of homosexuality. Thus, Lírio finds herself isolated and undervalued in her family, due to the binary-homophobic pattern.

In this way, living in a community, especially for Lírio, provides an ambiguous feeling of belonging, but also an exercise in constant search to regain the affection and value lost due to her sexual identity. The journey in search of a healthy life, which would generally be less tortuous if she were a heterosexual woman, is decisive in the way she attributed meaning and self-assessed her health. In this case, the social perspective on signs of the body and behavior, as articulated by Helman (2009),

not only determined illness, but also legitimized the way Lírio thinks about her body, her identity and the meanings that she attributed to her well-being.

Final considerations

This study strives to understand the meanings that lesbian and bisexual women from a city in the interior of the state of Maranhão give to health and disease and how they evaluate their own health status.

The approach to medical anthropology, sexual identity and the way this identity is seen by society opened space for the interlocutors' testimonies to be discussed close to the reality in which their meanings are produced. It was thereby observed that biomedical knowledge and the political-social-cultural context exert a great influence on the way the female interlocutors interpret the health-disease process and evaluate their own well-being.

Health and disease perceptions (re)organized themselves in a challenging way: sometimes close to biomedical medicine, sometimes close to a more plural etiological dimension. This was expressed in the mind-body dichotomy cited by most interviewees and also in the way life experiences and existence as lesbian and bisexual women allowed them to reflect on issues such as family, social and environmental context. In this way, the participants expressed particularities in the meanings they attribute to the health-disease process which, concomitantly, also reflect the experience of illness as a social construct.

The understanding undertaken here presents a fragment of reality, one which exposes the worldview of a specific group who, when reporting their perceptions about the health-disease process, demonstrate the crossings that produce barriers in everyday life and, consequently, in the search for health. The idea here is not to make generalizations, but to make it clear that lesbian and bisexual women have specific health needs.

In this framework, the "native's perspective", in this study, made it possible to elucidate that subordinated discourses must often occupy space in health training and practice environments. Therefore, studies that use the vision of social actors from marginalized contexts are encouraged to interpret the ways their existence is crossed by (de)legitimizing norms of identities.

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Authors' contribution

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