The Nurse Becoming Podcast #107 - Becoming a Sex-Positive Pr...

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SPEAKERS

Featherstone, Amanda Guarniere

A Amanda Guarniere

Hello Featherstone! Welcome to the show!

F Featherstone 00:09

Thank you for having me, Amanda, it's so exciting to be here.

A Amanda Guarniere

I am really excited to talk to you. We've been, I guess, internet friends for a little bit, mainly over on LinkedIn. So I was really excited when I reached out and you said yes, about coming on the show and sharing your expertise with us. So thank you.

F Featherstone 00:27

Absolutely. It's, it's so funny, because I stumbled upon you, when I was doing some research when I was transitioning from one nurse practitioner thing to another. And I was like, "Oh, my gosh, I think this is the only nurse practitioner specific like resource that I've found! I've gotta follow this woman!"

A Amanda Guarniere

Well, I'm happy to be that person for you!

F Featherstone 00:49

It's mutua. Yeah, I've been really excited. And so I was very surprised when you reached out because I was like, Oh, my goodness, it's so funny when like someone that you're like, oh, this person like is doing these amazing things. It's like, Hey, want to come talk with me? And I was like, "absolutely!"

A Amanda Guarniere

Well, it just goes to show that people are watching wherever you are putting yourself out there in thought leadership in whatever form other other people are watching. So I think you were a really good example of that, you know, we were connected on LinkedIn, and you would come across my feed, and I would see and read about all the wonderful things you were talking about and doing. And so it just goes to show you that that people are watching even if you don't realize you are and even, you know, if you have one friend or one follower, you are a influencer, quote unquote.

F Featherstone 01:39

Yes, we all influence those around us, even if it's not a high number or to a high degree. So I'm really excited you let me come and talk about sex, because that's like one of my favorite, favorite things to talk about. And everybody who knows me will laugh when they hear that.

A Amanda Guarniere

Well, I am excited to dive into it. I'm excited to share with my listeners. I've already introduced you in the intro to the episode, but I would love to hear in your own words, who you are, what you do. Tell us all those things.

F Featherstone 02:12

Okay, well, I'm Featherstone, and I'm a non binary nurse practitioner I originally trained in sexual and reproductive health. And then I went and got immediately cross trained in psychiatry, because I realized that there just weren't a lot of great mental health resources for women and queer folks. And so many mental health meds impacts sexuality that a lot of people don't seek care or are reluctant to adhere to care. Because no one's fully explained to them how it interacts with like their hormones and their sexuality and their arousal. And so, I originally started by focusing on parents, I originally started my graduate training as a midwife, but I was like, Oh, my goodness, I do horrible with sleep deprivation. And I'm a single parent. So this isn't a great fit. And I eventually, you know, had a really interesting career path that led me to where I am now, which is where I focus on mental health and sexuality of parents and queer folks. And so, I'm really passionate about sexuality. I'm also passionate about mental health being the base rock of that, because if you can't be like healthy and happy on your own, how are you going to have a fantastic sex life? Let's just like incompatible. So that's sort of where I'm at now.

A Amanda Guarniere

I love to hear that because it sounds like what you're saying and I'm sure we'll get into this a little bit more is that sexuality and having a wonderful sex life isn't just physiological. Am I hearing that correctly?

F Featherstone 03:38

It is only partially physiological. I wouldn't even give it the "mostly". If you're friends with me on LinkedIn, you know, I love love, love books. I have this giant bookshelf behind me. And that's not even a third of the books I have. It's kind of a problem. But I recently read an incredible book by Justin Lane Miller called, Tell Me What You Want. And he did this incredible large research study over the internet, all kinds of people. And he was asking them about their fantasies. And a lot of us would say like, this shouldn't be a part of like academia like this isn't relevant. But I would argue that it really is because discrepant libido or discrepant interest is a big part of like marital satisfaction and like long term relationship negotiation. And so I have a friend, Melissa Bentley at PSI who talks about normalizing and colonizing and it's not that something is normal or abnormal, like that's really judgy but talking about if it's super common, it has to be normal. Like if the most common category of fantasies is multiple people, then you're not weird. If you fantasize about threesomes like that's not weird and but there's so much like social messaging about like, what's good and normal about sex and sexuality and relationships, that I love diving into books like that. And so have all these books. And I feel like I bring that in to like my patient visits when I'm like, when I have somebody who on their like, third or fourth or seventh visit is like, oh my god, I have to tell you this thing. I'm so ashamed. And I'm like, Oh, that's really common. And they're like, what? And I'm like, Yeah, that's really normal. You're not the only one who's told me that today. Much less in my career, and you just see like people's posture change and their bodies change. And like, because we don't usually get permission in our society to talk about those things openly. Like we are, we were originally like, agnostic in terms of government, but the majority of the settlers here in the US were Christian. And like, you know, there's a lot of melting pot mixing bowl stuff going on. But there's a lot of areas that are super conservative, and it's really not conducive to open, compassionate dialogue about sex, especially for queer folks.

A Amanda Guarniere

Yes, for sure. And I think that that's part of that's part of, you know, the purpose of the episode today is to really talk about how can we, as healthcare providers, create a more comfortable environment to really have appropriate dialogue with our patients so that we can give them the best care so they can live their best lives, et cetera, et cetera, right. So before we get deeper into that, I want to kind of backtrack a little bit to you and your story and your your nursing journey. I'm wondering like, did your interest in this field come about, like as part of your nursing journey or adjacent to it, if you wouldn't mind telling us a little bit more about how you got interested in this kind of intersection of fields?

F Featherstone 06:57

Okay. To start my nursing journey, I have to take you across the Atlantic Ocean, to West Africa. I was an exchange student when I was 16, to Mali, and when I was there, you could have never

told me that 20 years later, I'd be a healthcare person, I was convinced I was going to be a writer, or a massage therapist or an actor. I'm just very much in the humanities into people watching and talking to people and sort of figuring out what made people tick. And I stayed with this amazing family in Mali, and had just like this, this thing happened, where I was like, oh, people don't all have the same access to health information. Health literacy is not. Not for other people, not for other countries. Not like it was for me in my middle class, white privileged upbringing with a very educated mom. And I was like, oh, maybe I'd have fun doing something in in medical stuff, like something exciting. And so I came back home and at 17 became an EMT. And so I was running on an ambulance crew with the local volunteer EMS and seeing all these crazy things and hearing, like, it totally expanded my view of the world because I was exposed to so many things that like, I just didn't know they existed. Like, I didn't really know about drugs, like I but like, I'm learning about, like, how to take care of somebody after they get Narcan, you know, and it was just wild, it was wild. But at five foot four, and like 100 pounds, dripping wet at 18, like, I had a rough go, I got pushed around really bad. And I just felt really like frustrated that I didn't have more authority. So I got impulsive, and I was like, I'm gonna go be the person that like goes and saves people in a different way. So I signed up for the army to be a military police officer. And I did that for three years. And while I was in the army, I got pregnant and had my first son, and had a very complicated birth with a very wonderful set of midwives. And I walked away from that, and I was like, oh, man, this is how I want to help people. I want to be a midwife. This is where it's at, like they can make such a difference. And so when I got out of the Army, went straight to nursing school, I had a one year old baby, my BSN program first semester. And looking back, I'm like, Oh, my God, I was so ambitious. It was hard with a baby. And then I decided to grow my family more while I was in nursing school. And so I had my second son at the end of my junior year and had a pregnancy loss in the middle. And so like, I'm going through all these reproductive life events, and I'm having these own challenges, you know, within my marriage because of these reproductive life events, and I feel like You know, sex is so taboo. And I was only 23. And I didn't really talk about it to anybody and I wasn't seeking mental health care. So it was just all all me and and it was a very isolating experience. You know, I didn't come from a family where you talk about that stuff with your parents and, and I've always identified as queer. And I was just like, man, if one of my health care providers at that point in my life had been like, how was your intimate relationship with your husband going? When you have a miscarriage? It's really hard. Like, how are you feeling about your body? Never once did anyone ever asked me how I felt about my body. And I feel like it could have made such an impact to even open that dialogue. So I graduated nursing school and my first job, it was so rough, it was in a neuro ICU. It was so so hard. That is like a brutal nursing environment like busy large Ward, like 27 beds. So multidisciplinary, like people got good care, but it was stressful as a first nursing job, especially when I knew that I wanted to be a midwife. So I did, I did my mandatory six months, excuse me, and I got onto a labor and delivery ward. And that's basically where I stayed until I graduated from my women's health and PE program because 14 babies into my midwifery clinicals. I said, Nope, I need sleep. This is not negotiable. And I pivoted to women's health, NP, but my plan was always to go back for Psych. I was like, yeah, it's great doing prenatal care. I love educating patients. But I really love talking to them through like how their birth went and how they're feeling about it, and how breastfeeding is going and how they're managing like resuming intimacy with their partner. And that's like, I want to do more of that. But if you only get one postpartum visit, as a midwife, that's not the bread and butter of what you're doing. And I was like, I think I think that's where I want to go, I think I've seen enough moms come into that six week apartment, feeling like a wreck, feeling discouraged, feeling depressed, feeling anxious, just feeling like they're failing that I want to do more of that. And I graduated with my Women's Health Program. And it just so happened that I live in a really big city, but there were no Women's Health jobs. And I got one call back about a job and realize which physicians were

there. And I was just like, I don't, I don't want to work there. I'd rather take more of an RN position than taking an NP job where I think I'm gonna be miserable. Because I know quality of life for me is just so important as a single parent, because it trickles down to everybody. If if mom's unhappy, everybody's unhappy. So I ended up taking a job. It was originally marketed as an RN job, but I was like, Can I just like sort of carve out my own spot like this is this is a brand new company, it's me and the physician owner. I want to do this, this and this, in addition to like our enrolls and he was like, Sure. I was doing like case management. I was doing a lot of like liaison work with other clinics and like networking and a lot of business things that I've never done before. And I loved it. I loved it. And then COVID hit. And in person interventional psychiatry was just not the future of mental health during COVID. And I've been organizing for the perinatal Mental Health Coalition here in my city for like, over a year at this point when COVID hits, and I'm hearing from all these perinatal therapists that like, oh my god, there's not enough providers. There's not enough providers, people are waiting to get seen. I'm all full. Everyone I know is full. Parents are just through the roof with anxiety and OCD. We can't vaccinate children. We can't vaccinate anybody. It's terrifying. And I was like, I feel like I'm not fulfilling my calling right now. Like this has been great. But now I need to pivot. And I did a bunch of research and my program where I went was frontier nursing University, and they were really research heavy. And I instantly was just like, I need to pull data, like where can I work and I carved out a niche doing like women's specific like perinatal mental health. And I found that the top three states in the US that had autonomous practice, and the worst maternal mortality, morbidity outcomes, overlapped with one state and it was Idaho. And so I did a bunch of digging into Idaho and I was like, okay, never been to the West Coast. Never been to the Pacific Northwest. But 100% of their counties are low resource for mental health. Wow. And so I reached out to some of the Postpartum Support organizers out there who do like Postpartum Support groups for moms and stuff. And I got one on the phone this lovely lovely doula. And I was like if I were to open a perinatal mental health practice, how many people do you think you would refer like per month? She was like, maybe four. And I was like, okay, four people a month and bad. I was like, Where do you what part of the state are you in? She's like, Oh, I'm in CDA, it's really rural. I was like, Well, if I can get four people a month from a rural area, like I think this is sustainable. And I happen to look up in the PSI directory, like how many prescribers in Idaho were perinatal mental health certified, and there were three. I was like, if there's only three people who are specializing in this, and one of them is a full practice midwife who's catching babies, she's not doing even primarily mental health. Like there's, if we're having 20,000 babies a year there, and it's one in five birthing people who have a perinatal mood or anxiety disorder, that's 1000s of people that probably need care and way, way, not enough providers. I said, Yep, I'll just start my practice there. And so I started seeing patients in early 2021, via telehealth, and I've been networking with therapists and midwives, and doulas, and support group facilitators, and obs and sex therapists and just like anybody out there who might interface with patients that I might be a good fit for. And so I just am word of mouth. That's how I grew my patients.

A Amanda Guarniere

That's amazing.

F Featherstone 16:33

It's been so interesting. And I always get people confused. They're like, do you live in Idaho? And I was like, no, no, no, I'm born and raised in Richmond, Virginia. But like, with COVID, it just

opened up everything for telehealth,

A Amanda Guarniere

Right? Yeah, I think that's like, we could have a whole separate episode all about how to how to do how to start up a telehealth practice. Because like, that's such an awesome accomplishment and such a huge, a huge part of your story, obviously, because it's really brought you to where you are today for sure. So thank you for for sharing all of that. And I'm trying to like field out all the questions I have, like starting a practice and starting a business because I want to keep on task to.

F Featherstone 17:26

We can always do a two part-er.

A Amanda Guarniere

Well, we'll have to have a part two to this episode. So okay, so topic of this episode that we really wanted to dive into is sex positive care for all patients, especially the queer community. So I kind of want to kick off by asking, like, why, why is this important for us to talk about as nurses and providers?

F Featherstone 17:54

Okay, so before we started recording, I told you, I was going to be really vulnerable today. So I am. At a certain point in my life, I just decided that Monogamy was not really working out for me. And as a women's health provider, I was like, but I can't do this with a good conscience, knowing that I'm not taking care of myself. So I really was like, I'm going to be a responsible adult, I'm gonna get sexually transmitted infection tested regularly. I'm gonna, you know, always use barriers, blah, blah. And I remember going and asking for an STI panel on a patient first and getting looked at like, I had three heads and like getting grilled about what I had done, or what kind of symptoms I was having. And I was like, whoa, I'm a nurse, like this, this could be done better guys. And I think that's really been like sort of my experience over and over is like having my own care experiences where I was just like, Man, this provider left a lot to be desired, they were either rude or judgmental, or just didn't know what they were talking about. And like, and I have all the benefit of now a graduate education and sexual reproductive health. But like, you shouldn't have to be an expert in those things to get good quality care, like the level of knowledge of your provider should be higher than your own. And so I had joined the polyamorous community and was sort of educating my peers there, and helping people know the basics of like CDC guidelines about STI testing, and knowing what to say to advocate for themselves so they could get the STI testing that they wanted. Like lots of folks I knew were going and being refused things like HSV, one and two testing. And I was like, I know it's really uncomfortable to tell a doctor that you're having sex with one more than one person, but that's also you being honest and vulnerable and telling them why you need this care. And so Some of it was like, you know, helping people feel empowered, giving them the knowledge of like, Yes, this is best practice in medicine, you don't have to have symptoms to have this test, explaining

that you have sex with multiple people, or you have sex with men who have sex with men, like this should be able, that should be enough to prove that you need this test. And so some of it was like advocating within my community. And during this portion of my life, I became more aware that like, my gender was not static, sis, gender female. I always joke that my revelation was from Brienne of Tarth, from Game of Thrones. The image of this, like very androgynous female warrior, resonated with me in a way that like, no other TV character had. And so like, there was a point where I was like, oh, okay, my gender isn't static. Got it? How do I? How do I deal with this? How do I come out? Like, there were so many questions that were difficult for me, even as a nurse and health care provider. And like, trying to talk about it with my own healthcare, people, because I get care at the VA was a very interesting experience. And I'll never forget, like, a time when I was like, You know what, I think I don't need a breast exam. I think I'm good enough at examining my own chest, that it's just so uncomfortable to have a provider do it, I think I'm just gonna say, Nah, I'm good. And I did, and this nurse practitioner, just was aghast that I would come in for an annual and decline a breast exam. And it was such an uncomfortable like interaction. And like, I had kept my bra and like a sort of, like, visual cue of like, right, right, this ain't where I need you to go. And, and it was just like me and her and the nurse. And I was like, no, but really, you're not gonna, you're not gonna do that. And so it was just like, man, if I'm having all these uncomfortable things happen. And I feel like I'm having a hard time like advocating, I'm not the only one, I can't be the only one. Like, there's so many parts of the human experience that are just so much more universal than we ever know. So I had that. And I think the icing on the cake that made me feel like sexuality, education for providers needed to be better, was I had an exam, because I was considering being a surrogate. I love being pregnant. It's, it's just, it feels good to me, I feel good about how my body looks. And you know, that's not for everybody. But I went in for this assessment, who happened to be a colleague, andand she asked me in what a lot of like teenagers or young people would say is like your body count. She asked me about my lifetime sexual partners. And I had a moment and I like, cocked my head. And I was thinking, and I was like, Is this really relevant? I was like, Do you want to know how many partners I've had in the last year? And she's like, Do you not know. And it was like, there were these levels to the situation. Like, this is a midwife I worked with. This was a midwife I had liked. So we were kind of like, friends. And just like, was so uncomfortable, and so judgmental, and I was just like, oh, oh, no, I don't know, off the top of my head, how many people I've been with in my lifetime? Because it's not relevant to me today.

A Amanda Guarniere

Which is amazing, like that asking that question, like, is

F Featherstone 23:50

Asking the question once, and then getting pushed back and doubling down that I think is what killed me. Yeah. And, and like, I was just, like, so mad, not just for myself, but like, for anybody else that's been treated that way. And I was just like, I am never gonna do that. Not in any of my days of being a nurse practitioner. I'm never going to ask for somebody's body count. I'm never going to ask their lifetime partners. Because it's not relevant. It's irrelevant. If you're having unprotected sex recently. It's irrelevant if you haven't had a sexual, you know, transmitted infection into Heston a long time. You know, those are relevant things, but not your lifetime. That's just like, let's bring all this sexual shame into this equation and make this very

vulnerable appointment the worst it can possibly be. So think that was sort of like, my moment where I was like, this is just not good. And I had Queer friends who went in and would like ask for tests and they would be, you know, grilled or shamed. And then prep came out and became more prevalent, which was great. But then there were all these roadblocks and people would like have to come in like in person, or they would have to do like a bunch of questionnaires and be in person. And I'm absolutely about like, meeting the requirements for giving a drug responsibly. But also, there has to be an element of understanding of the community that you're working with. And in a lot of communities, if you're not focused on having a baby like, and if you're comfortable with the risk of having an STI, and like partying and hooking up, like, that's your choice, like, and obviously, we want to encourage people to be as safe as possible. But if they understand the risks, and they're comfortable with them, it's not up to us to like, shame that they're not going to seek care anymore, ever. Like, they're just not going to come back to you if you alienate it like that. Right. And a lot of the queer community is having sex, that's not going to result in having a baby accidentally, so they're not seeking contraception. So any opportunity, you have to do an STI test or education, or you know, screening for things, you need to be aware of that, like, you have a lot of influence on their future care seeking behaviors.

A Amanda Guarniere

Yeah, for sure. So I guess my question is, like, how do we, you know, how do we kind of embody being more sex positive as providers? And in terms of the conversations that we're having, like, are we and I'm going to, you know, refer to, you know, the health care provider community as we are we I see kind of two potential issues that were not asking any questions. And also, we're asking the wrong questions. In some scenarios, so I guess, like, where do we start navigating? If we know that we want to be sex positive, inclusive providers? And maybe we're not aware of our own biases or our own issues in this conversation? Where do we start?

F Featherstone 27:07

I think there's a couple of things. I love the PLISSIT model. If you haven't heard of it, to anyone who's listening, please look it up. And it starts with P, which is permission to have a conversation about the topic. And so just charging right into questions without sort of evaluating someone's comfort or permission is obviously problematic, because you want to sort of have an intro of like, I usually ask my patients some questions about their sex life, because I feel like it can really impact other things. And it's a part of quality of life, would you be comfortable with me asking you some of those questions? No big deal if you don't. And the second step after that is your poker face. And I talk about your poker face a lot, because nobody has had all the experiences out there. And so there's going to be a day somewhere in your career, maybe more often than not where something surprises you. But you cannot show that to a patient. Because they are probably feeling all sorts of trepidation and discomfort about disclosure. And they're looking for any little sign any microexpression of shaming or judgment. And so you want to be as stone faced and nonchalant as possible? Because then they'll be like, Oh, I can tell them that. And they were okay. So maybe I can tell them a little bit more of the story and ask the questions, I really want to ask because this is a safe person. But our lizard brain is on the lookout for any sign that it's not safe to disclose to this person. And that clams up so fast. I joke about sphincter law, because I'm from the midwifery world, and like people want to have babies when there's an audience, they don't want to feel like the physician

or the health care provider is an audience. That feels bad. And so before you ask a patient, anything, I want you to think about, what's the utility of this question? Am I asking this? Because I want to know, or am I asking it because it's going to inform a decision? And is this patient going to perceive it as being a like toxic invasive curiosity? Because so many trans folks in particular, get real uncomfortable talking about their sexuality because they're acutely aware of how different they are? And this provider might be like, Oh, this is the only trans person I've seen in like, six months, I should ask everything I can. It's just so fascinating. And it feels awful. To be viewed like a curiosity. Yeah. And so if you feel like you're asking something, and you see like any subtle sign that a patient might be uncomfortable, you can say, No, you don't have to answer that. The only reason I ask is because and you give your rationale. Every time you give, like a scientific or logic based rationale to something, people usually feel less like on the spot. It's more like this is business as usual, I asked people this because, you know, how much alcohol do you drink? Not because I'm judging you, but because it can impact your liver function. And I want to interpret your liver values correctly. That feels a lot less judgmental.

A Amanda Guarniere

Absolutely. Yeah, I think, you know, when we use the conversation, the you know, the patient provider conversation that's like a sacred space. And whenever we can explain our rationale, justify our questions, and, and also involve the other person in the conversation so that it doesn't feel like an interrogation, I think that that's really patient empowering. So I'm taking notes over here. I'm gonna link to the plist model in the show notes. But I think the two actually, three things that are take homes for me right now that I want to kind of reiterate, for our listeners is permission, you know, asking permission, or you can view it as consent permission or consent, to have a conversation and to ask a certain category of questions. I think that is a phenomenal approach that we should do more often in kind of all aspects of everything. All aspects of everything, like I'm even thinking about, you know, like on the on the business side of things. Like if someone writes and asks me a question about something like, I often will ask permission to share a link with them that will give them more information, you know, just kind of like those micro permissions. But yeah, asking permission, I think is a great habit to start practicing if we're not doing so already. And and the poker face, which may or may not be easier with many of us still wearing masks and healthcare settings. I don't know, I kind of felt that that was, that was helpful. But yes, just in general. If you are not someone who has a good poker face, it's a good thing to practice.

F Featherstone 32:27

As a health care provider, if you have kids, it's good for you as a parent...

A Amanda Guarniere

100%.

F Featherstone 32:34

I think some of it is like thinking about how you ask things in a sexual history, if you do get that

I think some of it is like thinking about how you ask things in a sexual history, if you do get that consent to sort of go down that line of questioning. And it's funny because we ask people things like, how do you identify your sexuality? Okay, let's say let's say I have a female patient, and she says lesbian. That doesn't necessarily mean that she's not ever having sex with anybody with a penis. You asked about gender, what you really meant to ask about was body parts, because you want to ask if she needs help with contraception. So asking, you know, a woman who's married, what are you doing for birth control? She might not think of her husband's vasectomy as the birth control. But it is, and it's not something she's doing. So you know, we have to really think about, it might sound really bizarre at first, if this is not how you're used to speaking to patients, but are you having sex with anybody who produces sperm? Or if there's someone who has a penis and produces sperm, are you having sex with anybody who has ovaries? Because if they don't have ovaries, we're not worried about pregnancy. And you don't need to continue down that line of questioning.

A Amanda Guarniere

Right. And it sounds like those questions that could even be prefaced with you know, I'm going to ask you some questions about your need for birth control. Are you having sex with anyone who produces sperm? Or anyone who has ovaries? You know, I think that's a good way to also weave in the thing that you said about, you know, that the only reason I ask is because so yeah, sounds like we could either use that on the end of the question, or even as a precursor to the question, too.

F Featherstone 34:19

Because I can offer birth control, I always ask people, are you having sex with anybody who could help you have an accidental pregnancy? Right? You know, there are ways to ask these questions that don't necessarily talk about gender, because gender is something that is complicated, and someone might not necessarily want to either disclose a transgender identity or out their partner is transgender. Yeah. You know, I have non binary patients who were assigned female at birth, who are dating women who are transgender. So there is potential for pregnancy but bringing gender into that is just like, really strange when we come from a gender binary and we don't have have, you know, we have one person who's not binary. So it's just like the gender, talk about what you're actually worried about, which is accidental pregnancy. And they can tell you, you know, if they've had something done, or their partners had something done and in terms of like sterilization, or long term birth control, and so it's not an issue and you just move on, right? But you're gonna put yourself in a real awkward position. If you're like, Well, do you have sex with men? And then you see them, like, kind of squirm and be like doing this mental calculation of are you going to consider their partner a man because they have a penis? Or, you know, are? Am I going to have this uncomfortable conversation about my partner? Or, you know, the fact that I have multiple partners? Can you just ask blanket questions about what you need? Right?

A Amanda Guarniere

Yeah, it goes back to considering the utility of the question, you know, making sure you, you, as the provider, know, why you're asking the question, what's the what's the utility? What's the information that you're seeking? You know, and in terms of, of gender identity, if you're going

down that path, like, you probably need to know, you know, gender assigned, or sex assigned at birth, for screening purposes, maybe, you know, current anatomy questions, but like, beyond that, I'm not sure where there's relevance to the question.

F Featherstone 36:21

Absolutely. A lot of it's just like, being aware of your assumptions. So we talked about bias, the, like, the best definition I've ever heard of bias is like systematic misconceptions that cause errors. So like, making these assumptions that are wrong. And so if you are always assuming that someone is only having sex with one person, you might not be getting the full picture, especially if you hone in those questions about their partner. Because there might be more people at play. You know, I talked earlier about Justin Lee Miller's book and the categories of fantasies that people are interested in, and the number one category was multi partner sex. So if that is the number one category of fantasies, we can assume that more people are probably engaging in some form of at least sexual non monogamy. Especially younger, folks, we see it a lot more with younger folks. But it's not a guarantee that it's just younger folks, just because someone's in their 40s doesn't mean they're not having sex with more than one person. And so you've got to really check your assumptions, and have an open mind. And that's where that poker face comes in. Because you will be amazed about the things that you hear people talk about doing once they feel safe with you.

A Amanda Guarniere

And isn't that such a nice thing, you know, when when our patients feel safe with us, like, that's, that's what it's all, you know, what it's all about, right? That's when we get to really do the good work. And provide the care that is not only in their best interest, but also helps them feel good and helps them feel like a good participant in their care. Because, you know, from the example that you shared earlier, like you've been on the receiving end of care that didn't make you feel like a empowered participant, I think that we probably can all think of examples that have made us feel a certain way. And, and so many of us go into healthcare, to improve that, right. But we may not be comfortable with, with certain conversations that are necessary to have in order to create those safe spaces. So I think that this is an excellent, excellent place to start. And I know that we could talk about this forever and ever. And I think it's really good to like give our listeners, you know, some some small things that they can implement, you know, immediately, which is that permission, the poker face, and providing that context to the questions that you're asking. So that you make sure that you as the provider are asking things that are that have utility and also so that the person on the receiving end of your question knows why you're asking.

F Featherstone 39:21

The last thing that I want people to take away from is that the more you can assure people that what they're going through is common. So like that they fantasize about something or that their marriages sex life is a lot less, less frequent than it used to be before having kids. Or you know, one person started getting mental health care, and now they're not initiating sex as much these things are all really common. And discrepant, libido like one person wanting to have sex more than the other is one of the most common reasons that people seek sex

therapy. And so if we can just tell people that not only does that happen a lot, but that there's help out there for it. And we can, you know, recommend books that they can read that can help change how they think about it or just educate them more about how their medicines work and serotonin. I feel like they can walk away feeling a lot more hopeful before we've actually done any interventions. Yeah, just assuring people that they're not alone. For sure.

A Amanda Guarniere

We talked a little bit at the beginning of the episode about your specific work as a provider, but I'd love for you to share anything that you'd like to share in terms of where folks can learn from you connect with you. Where can they find you in the online world?

F Featherstone 40:40

Okay, so my, my online private practice that serves Idaho is eucalyptus health. And Eucalyptus is a nod to my beginnings in midwifery. But I put a lot of good stuff on my Instagram, as well as my LinkedIn. Because I feel like I'm not necessarily the right provider for every patient. But I love educating fellow providers and talking about stuff. And I've had people I've had a lot of my colleagues come to me and they're like, I have this trans patient and they don't want to fuck it up. I don't want to alienate them. What do I do? And so we have a lot of like LGBTQ or trans one on one conversations with folks who know that I love helping providers do better with those populations. So LinkedIn is a great place to find me as well.

A Amanda Guarniere

And on Instagram, you're@eucalyptushealthcare. I'll put these links in the show notes. But for anyone listening who may want to remember, and what should people search to find you on LinkedIn?

F Featherstone 41:43

R. Featherstone.

A Amanda Guarniere

My final question, do you have any big dreams, big goals? Anything that you want to kind of put out into the universe because when we speak it out loud, it's much more likely to happen.

F Featherstone 42:02

I don't know if I'm gonna go for my PhD. But I think my next educational endeavor, I've already promised my older son that it won't be until he moves out. But I think sex therapy is the next credentials. I want to add because just I've heard so many amazing things about the trainings,

and I work with the board of Idaho sexual health professionals. And I just love like all the stuff that we work on and talk about. So I think that's probably the next tools I want to add to my toolkit, besides sexual reproductive health and psychiatry.

A Amanda Guarniere

Awesome. That sounds like it'll be a good, a good stack to add to your credentials.

F Featherstone 42:42

Thank you so much for having me, Amanda.

A Amanda Guarniere

My pleasure. Thank you so much for your time. This has been wonderful!