

# The Menstrual Cycle: A Feminist Lifespan Perspective

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## I. Introduction

### A. Why Menstruation Matters

The Menstrual Cycle is one of *the* most important biological differences between females and males, one that has been used – in many contexts — to justify discrimination against women and girls. Thus, the more clearly we understand the biological and social significance of the menstrual cycle for both women and men, the better we understand the fundamental arrangements of human society. Challenging the shame and secrecy surrounding the menstrual cycle, encourages *embodied consciousness*, or a more meaningful and complex appreciation of bodies across the lifespan. Interdisciplinary menstrual cycle research, especially studies that explore the psychosocial dimensions of menstruation in diverse cultural settings, is an emerging subfield.

Some menstrual activists and menstrual cycle researchers refer to “menstruators” instead of women when referring to those who menstruate. This linguistic choice locates menstruation beyond the confines of gender as socially constructed and expresses solidarity with women who do not menstruate (due to illness, age or some aspect of their physiology) and transgender men and genderqueer individuals who do in spite of their gender identity. Refusing to assume who does and does not menstruate is one way of challenging the rigid gender binary that perpetuates privilege and oppression (Bobel, 2010).

### B. How the Menstrual Cycle Works

Most menstrual cycles are 21-35 days long but variability is common after menarche (the first period) and also before menopause. Each menstrual cycle is created by a unique egg and its surrounding cells; these produce hormones under careful feedback control by brain and pituitary hormones. A usual menstrual cycle begins with 2-6 days of vaginal blood loss (called a “period” or “flow”) as the uterine lining is shed. Whole period blood loss averages 8 soaked regular menstrual products (40 ml) (Hallberg, Hogdahl, Nillson, & Rybo, 1966). Despite cultural concepts of regularity, a third of women, once a year have a period two weeks early or late (Munster, Schmidt and Helm, 1992). From low levels during flow, estrogen rises to a midcycle peak over 9-20 days. Next, a pituitary Luteinizing Hormone (LH) peak triggers the release of an egg (ovulation). Following ovulation, progesterone production rises steeply while estrogen decreases minimally (Nielsen, Brixen, Bouillon, & Mosekilde, 1990) until both decrease at the next flow. The luteal (post-ovulation) phase normally lasts 10-14 days (Vollman, 1977) but ovulatory disturbances are common (Bedford 2010).

### C. Menstrual Attitudes & Representations

Though menstruation is a biological reality, culture-bound values shape its meaning and management. Though there is not a comprehensive cross-cultural comparison of menstruation, anthropologists have reported extensively on various cultural practices surrounding menstruation ranging from severe social restriction to special respect and privilege for menstruating women (Mead, 1949; Shuttle & Redgrove, 2005; Knight, 1991). In most cultures, menarche (the onset of menstruation) is viewed as differentiating males and females. Though uncommon, artistic and cultural menstrual references exist, such as bleeding wounds (in crucifixion or Dracula) (Mulvey-Roberts, 1998) or wolf bites in fairy tales (Bettelheim, 1976). In cinema, as early as 1966, *To Sir with Love* used a menstrual detail to test the protagonist’s manhood, and more recently *Superbad* (2007) and *No Strings Attached* (2011) offered more subtle explorations of male responses to menstrual encounters. Meanwhile, novelists such as William Faulkner, Joyce Carol Oates, Erica Jong and Philip Roth and Stephen King (who exploited menstruation in the horror genre), included menstrual content. Artists such as Vanessa Tiegs and Judy Chicago used menstrual blood and menstrual products, respectively, to challenge menstrual silence and secrecy.

In contemporary advertising venues, menstruation is most often coupled with dominant and recurring themes of secrecy and concern for restrictions on physical and social activity. In advertisements for drugs marketed for menstrual discomfort, the menstrual cycle is treated as a “hygienic crisis” (Brumberg, 1997), a medical condition, and a “problem” or malady requiring treatment (Tavris, 1992; Angier, 1999; Ussher, 2006; Vostral, 2008). One recent study, however, suggests that teen girls use their menstrual experiences as a “source of power” in their interactions with other girls as well as boys (Fingerson, 2006).

Menstrual taboos shape many religious and secular practices across the globe (Delaney, et al, 1988; Knight, 1991; Laws, 1990; Van de Walle & Renne, 2001). For example, certain religious traditions regard menstrual fluid as ritually impure and thus, the menstruating woman is banned from religious rites, sex, and/or food preparation (Delaney, et al, 1988; Douglas, 1966; Houppert, 1999; Knight, 1991, Mendlinger & Cwikel, 2006; Stein & Kim, 2009). Theorists, including psychoanalysts Freud (1962) and Horney (1967) tried to account for the existence of menstrual taboos; the former claimed that menstrual taboos were an attempt to control women while the latter contended that male fear of menstruation had roots in castration anxiety. Some feminists critique the uses of taboo to disenfranchise women (Bobel, 2010; Delaney, et al, 1988) but not all menstrual prohibitions are equally disadvantageous and women assert their agency in the particular cultural and religious contexts in which various menstrual practices are embedded (Buckley & Gottlieb, 1988; Shuttle and Redgrove, 2005). For example, In *Genesis* Rachel manipulated a menstrual taboo to defeat her hated father Laban when she claimed to have her period (“the way of women is upon me”) so that he would not search her belongings. Menstrual myths endure, such as the fear that menstruating women attract bears, in spite of research to the contrary (Rogers, et al, 1991).

## II. *Early Experiences of Menstruation*

Menarche, or first menstruation, is one of the last pubertal changes, occurring after breast bud and pubic hair development. Menarche can occur as early as age 8 and as late as 17 (Hilliard, 2002). The development of full reproductive maturity, however, takes several years. With respect to girls in western culture, early menstruation can be challenging for girls; some experience negative outcomes regarding sexuality and body image (e.g., Mendle, Turkheimer, & Emery, 2007; Posner, 2006). Whether girls are experiencing early puberty related to early menarche is a controversial issue (Dorn & Rotenstein, 2004). The average age of menarche in both the United States and Europe is 12.5 years, and has not changed in 50 years; African American girls menstruate about six months earlier than European American girls (Steingraber, 2007). A trend of earlier menarche is evident in newly industrialized countries (Steingraber, 2007). In Western culture, girls have mixed, but mostly negative feelings about menstruation: they see it as a sign of growing up but are also embarrassed about it (Stubbs, 2008). Preparation leads to more positive attitudes and experiences (e.g., McPherson & Korfine, 2004). For example, supportive, engaged mothers who react in a matter-of-fact way can buffer widespread negative cultural messages about menstruation (Lee, 2008). However, most educational materials and menstrual product advertising focus exclusively on keeping clean and hiding menstruation (Erchull, Chrisler, Gorman, & Johnston-Robledo, 2002; Simes & Berg, 2001). Girls who see menstruation as a barrier to a sexualized self-presentation, highly valued in Western culture, are likely to see these products as especially attractive (Stubbs & Johnston-Robledo, in press).

## III. *Menstrual Management*

### A. **Menstrual Care**

Mainstream menstrual products – commercial pads and tampons typically made of a blend of pesticide-treated cotton and rayon (wood pulp)— raise both environmental and health concerns (Bobel, 2010). The average menstruator uses approximately 11,000 menstrual products (pads, tampons) over the lifespan and thus produces 250-300 lbs of garbage (Stein and Kim, 2009). Tampon use is linked to Toxic Shock Syndrome (Berkley, Hightower, Broome and Reingold, 1987, Kehrberg, et al, 1981, Tierno and Hanna, 1989 and Vostral, forthcoming). TSS develops when the bacteria *Staph. Aureus* produces a toxin that rapidly overwhelms the immune system sending the woman into acute circulatory collapse (CDC, 2005). Half of all known cases of Toxic Shock are in women using tampons (FDA, 2009). The FDA recommends using the lowest absorbency for one’s flow, changing tampons at least every 4 to 8 hours and alternating pads with tampons to reduce TSS risk. Though rumors do circulate about the biohazardous contents of tampons, there is no evidence of asbestos in tampons and it has been estimated that dioxin (a byproduct of tampon and pad bleaching processes) exposure is negligible. (FDA, 2009). Concerns about conventional products lead some menstruators to opt instead for reusable cloth pads, menstrual cups, sponges and/or tampons made only of organic cotton.

### B. **Cycle-stopping Contraception (“menstrual suppression”)**

Hormonal contraceptives (“the Pill”), traditionally taken 21 of 28 days, stop ovarian cycling and alter endometrial and cervical changes needed for fertility. Marketing the “choice” of no periods, pharmaceutical companies have touted continuous hormonal contraception (Johnston-Robledo, Barnack, Wares, 2006, Hitchcock, 2008, Gunson, 2010, Mamo and Fosket, 2009). Hormonal contraceptives are promoted as more “natural” by pharmaceutical companies, citing that hunter-gatherer women had fewer menstruations (Jones, 2011). However, in the populations referred to, hormone exposure was low due to nursing and/or under nutrition, both of which can cause menstruation to temporarily halt, rather than high, as

is the case with modern drugs (Hitchcock & Prior, 2004). These products have high rates of unpredictable spotting and flow, especially with initial use. Furthermore, cycle stopping contraception exploits menstrual-related stigma and promotes menstrual concealment norms, and may be particularly attractive to young women who have not yet developed comfort with menstrual management and are socialized to see their flow as merely a nuisance. Cycle-stopping contraceptive products medicalize menstruation, are likely to lead to earlier initiation and prolonged use of hormonal contraception, and normalize replacing a biological function with a pharmaceutical product to meet social expectations of menstrual concealment. Long-term safety data, especially for the breast and in adolescents, are lacking (Hitchcock, 2004).

#### IV. Problems attributed to the Menstrual Cycle

**A. Premenstrual Syndrome (PMS)** is the repeated occurrence of behavioral, physical, and mood symptoms severe enough to impact a woman's social and work-related functioning during the premenstrual/post-ovulatory phase of the menstrual cycle (Taylor, 2005). Evidence-based treatment for moderately severe PMS includes a combination of personal and environmental stress management, dietary awareness, nutritional supplements, and exercise (Taylor & Colino, 2002; Taylor, 2005).

**B. Premenstrual Dysphoric Disorder (PMDD)** is a severe form of PMS affecting less than 8% of menstruating women, and may be a cyclic form of depression (Huo et al, 2007; Klatzkin et al, 2010); Taylor, 2006). PMDD is an accepted diagnosis by the U.S. Food & Drug Administration that has approved newer antidepressants for its treatment--it is not accepted by the International Classification of Diseases (Mintzes 2006; European Agency 2004). Critics argue that labeling women with PMS and PMDD individualizes problems as merely psychological. Ultimately, they assert, these labels hide the external sources of symptom expression that arise from a host of situations, such as stressful work environments, social relationships, poverty, or living in unsafe neighborhoods (Caplan, 1995, 2004; Offman & Kleinplatz, 2004).

**C. Other Menstrual Cycle Concerns** include heavy flow, cramps, anovulatory androgen excess (polycystic ovary syndrome or PCOS) and irregular, absent or long cycles. **Heavy menstruation** is flow more than 6 days and/or more than 16 soaked "regular" size menstrual products (80 ml blood loss] per period). Heavy flow is more common in adolescence, perimenopause and in those of any age with higher estrogen levels and ovulatory disturbances (Seltzer, Benjamin, & Deutsch, 1990; Moen, Kahn, Bjerve, & Halvorsen, 2004). **Cramps** occur normally in teenagers and can improve following childbirth. They are most often effectively treated with short-term, high dose over-the-counter ibuprofen. **Anovulatory androgen excess (AAE/PCOS)** occurs in about 4-10% of women (Talbot, Wild, Remsberg, Gibson, & Casoglos, 1999). It is defined by clinical evidence of high male hormones (testosterone) that presents as acne, facial hair, oily skin and hair and head hair loss), lack of regular egg release, and long or absent cycles (Pedersen, Brar, Faris, & Corenblum, 2007). It runs in families, causes a marked increased risk for insulin resistance, type 2 diabetes and fertility problems, and is associated with obesity and depression. **Far apart cycles** (cycles 36-180 days apart), irregular or absent menstruation (no flow for 6 months) are relatively rare—less than 6% of women ages 16-35 experience these in a year (Munster, Helm, & Schmidt, 1992); younger women, those under emotional or nutritional stress, and/or who over-exercise are more at risk (Bedford 2010).

#### V. Rethinking Menstruation

##### A. Menstrual Activism

Activists from across the feminist spectrum have challenged the menstrual status quo of shame, secrecy and silence, through visual and performance art, ritual, humor, direct action, informational workshops, the production and dissemination of zines (independent, small scale publishing), the use of websites, blogs and other social media, as well as research which normalizes the menstrual cycle as a healthy bodily process (Bobel, 2010; Kissling, 2006). Some menstrual activists celebrate the menstrual cycle as a source of feminine power and connection while others resist an essentialist framing of menstruation in which a biological process is conflated with a socially constructed category. Instead, such activists target the global menstrual care industry while promoting the use of environmentally-sustainable, safer and less costly alternatives (Bobel, 2010). This activism has not gone unnoticed; the *Vital Sign* campaign from the American Academy of Pediatrics (2006) reframes menstruation as a key indicator of girls' and women's overall health.

##### B. Fertility Awareness and the Menstrual Cycle

A woman who monitors and charts her menstrual cycle events to determine her phases of fertility and infertility is practicing fertility awareness (FA). Women can use FA to prevent or achieve pregnancy and/or to monitor gynecological

and general health. Technical and contextual differences exist between the many variants of FA based methods of birth control (sexualityanduc.ca). Methods vary in their focus on signs of fertility. FA methods, which do not prevent STI's, are gaining credibility and attention in comprehensive discussions of contraceptive choices for women (Eldridge, 2010).

### **C. Body Literacy and Informed Choice Making**

Body literacy is the self-knowledge acquired by women who learn to observe, chart and interpret scientifically proven signs of fertility and infertility - their individual menstrual cycle events - together with other health and wellness observations. Body literacy helps a woman to understand how her health is connected to her menstrual cycle, and thus make informed decisions about her health care (Wershler, 2005) and resist institutional control of her body, for example, vis a vis pharmaceutical companies (Bobel, 2010).

## *VI. Perimenopause and Menopause*

### **A. Definitions and “Symptoms”**

Female reproductive hormones have a unique lifecycle—they are low in childhood, rapidly increase during puberty and maintain mean high levels throughout young-mid adulthood. In perimenopause, estrogen levels become erratic, their mean is higher than in young adulthood, and progesterone levels become lower (Prior 1998). Perimenopause refers to the whole, highly variable transition to menopause that begins one year following final flow (Prior and Hitchcock 2011). During both perimenopause and menopause, some women experience night sweats and/or hot flashes (vasomotor symptoms), sleep problems, decreased interest in sex and/or migraines.

### **B. Social Constructions and Dimensions of Peri/Menopause**

Because biomedical discourse regards menopause as a “deficiency disease,” women in the United States can find it difficult to resist the power of pervasive negative definitions of this normal transition (Lyons and Griffin 2003). Feminist scholars counter that menopause is a broad, biosocial transition that individual women may see as positive or neutral (Dillaway 2005a, 2005b). While some women view menopause as the dawn of a better and more carefree life-stage, free from the burdens of pregnancy, menstruation, and contraception, others may find the transition fairly inconsequential (Ballard, Elston, & Gabe, 2005; Trethewey 2001). Others may still define menopause negatively when negotiating symptoms (e.g., hot flashes/flushes). The negative view of menopause is linked to gender norms (about women’s physical attractiveness and youthfulness) and certain reproductive experiences and choices, such as delayed childbearing or infertility (Dillaway 2005b; Lyons and Griffin 2003). Nonetheless, when social class, racial, and other cultural differences are studied, great variation exists across groups of women as they think about menopause (Avis & Crawford, 2008). For instance, while African American and lower-income women report higher rates of menopausal symptoms and/or more intense symptoms when surveyed, research also suggests that they report more positive (or at least more neutral) attitudes towards menopause than their European American counterparts (Green & Santoro, 2009; Nixon, Mansfield, Kittell, & Faulkner, 2001). The reasons for these variations are only partially understood.

### **C. A Woman-Centered, Critical Approach to Perimenopause and Menopause Therapy**

Perimenopause and menopause are hormonally very different, thus menopause therapies may not be suitable/safe for perimenopause, and no study in perimenopause has shown that menopausal type hormone therapy (HT) or the Pill improve symptoms (Casper, Dodin, Reid, & Study Investigators, 1997). Knowing the course and variability of perimenopause, having social support, maintaining exercise and a good diet are helpful. Use of hormone therapy (HT) for menopause (aka “postmenopause”) by women without vasomotor symptoms does not prevent but actually increases risks for heart attacks, stroke, blood clots, breast cancer and memory problems. HT does reduce osteoporosis/fractures (WHI 2002; Anderson et al., 2004) and vasomotor symptoms (MacLennan, Broadbent, Lester, & Moore, 2004). Vitamin D, regular exercise, community involvement and maintaining a healthy weight likely prevents osteoporosis, memory problems and heart disease. Vaginal dryness, due to menopause, can be treated with regular, gentle sex and vaginal non-hormonal or, if still necessary, very low dose, vaginal estrogen therapy (Speroff, 2003).

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