

MENSTRUAL SUPPRESSION IN CONTEXT:
OBJECTIFICATION, GENDER, AND CHOICE

By

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Menstrual suppression, the practice of reducing or eliminating occurrences of menstrual bleeding, has been widely advertised and discussed but not extensively researched. The purpose of this project was to establish a theoretical base characterizing the possible sociocultural pressures at play in a narrative of menstrual choice, and gather data to strengthen or weaken one side of the theoretical argument. I consider the work of feminist scholars criticizing or engaging with menstrual suppression as contraceptive technology. Three hundred and nineteen women completed surveys about their experiences with contraceptives, menstrual suppression, interpersonal and internal objectification, sexual subjectivity, gender role, and neoliberal beliefs. I explore relationships between these constructs and find that body surveillance partially predict suppression decisions, whereas different types of suppression are associated with dissimilar aspects of sexual or gendered experience. The findings are significant for future work in feminist healthcare. The findings are all partial, however; I end the project by cautioning against essentialist perspectives that remove nuance from choice entirely.

CHAPTER 1 INTRODUCTION

Selling Menstrual Suppression

In 2009, two advertisements aired on television for Seasonique, a contraceptive pill designed to reduce periods (or “withdrawal bleeding”) to 4 occurrences per year. The first of these depicted a woman’s “logical side” and “emotional side”; Emotional attempted to persuade Logical that she could stop having so many periods, while Logical protested with uncertainty about new and different things. Eventually, Logical concedes: “Ask someone logical, like your healthcare provider!” and Emotional twirls happily in a new dress, period-free ([The Well-Timed Period, 2007](#)). The second ad urged women to “repunctuate” their lives by demanding: “Who says you have to have 12 periods a year on the pill?” ([MLCip, 2009](#)). Though only two examples, these commercials reflect the marketing tactics that have permeated discourse about menstrual suppression. Periods are devalued much the same way women’s issues are often devalued: in this case, reproductive and menstrual decision-making processes are portrayed as a tension between dichotomous emotion and logic. Menstrual suppression, on the other hand, is characterized with neoliberal language; women are “empowered” to opt out of periods.

These commercials provide some insight into the way that advertisers constructed a narrative of menstrual suppression, but questions remain about how this narrative and others may have been internalized by consumers. Who chooses to suppress menstruation, how do they do it, and why? Do the people who engage in this practice reflect the cultural values that dominate advertisements, or do their choices represent the culmination of health advancements in pursuit of freedom from biological

constraints? As a feminist psychologist in pursuit of interdisciplinary answers, I believe that these questions speak to a complex problem of agency, and they may be best considered through multiple avenues. Thus, the current research will first explore relevant literature in Feminist and Gender Studies (Chapter 2), resulting in two potential theories about the cultural context of menstrual suppression. I will then ground my perspective in psychological literature (Chapter 3), enabling me to conduct a study (Chapters 4 – 5) that will put pressure on one of these contextual theories in order to facilitate a critical analysis of its validity (Chapter 6).

Suppression: How, Who, and Why?

How do People Suppress Periods?

Studies of menstrual suppression are not always clear, partially because neither the term “menstrual suppression” nor the colloquialism “skipping periods” have stable or consistent definitions across context. Many of the top Internet search results are do-it-yourself recommendations: forums where women advise one another how to suppress their periods by skipping the placebo week on their hormonal contraceptive pills. Often, these conversations are framed around occasional or frequent but not total cessation. Total menstrual suppression can be achieved medically in several ways. Thus, we must be very clear what we mean when we use the term.

First, it is important to note that the periods experienced while using hormonal contraceptives are different than periods experienced otherwise. The bleeding that takes place during cycles of hormonal contraceptives is typically called “withdrawal bleeding” because it occurs when estrogen levels change as a result of, for example, the absence of a daily pill (Marcovitch, 2010). This often figures prominently in “how-to” guides: “...physiologically this isn’t a real period at all. And it isn’t necessary” (Doucleff,

[2016](#), para. 5). Thus, when I refer to “menstrual suppression” or “skipping a period,” this technically refers to methods that avoid monthly withdrawal bleeding.

Some contraceptives are developed, marketed, and prescribed with this purpose in mind. Vaginal rings such as NuvaRing, intrauterine devices such as Mirena, and contraceptive shots such as Depo-Provera can all lessen or eliminate periods, but none can guarantee full regulation. In fact, breakthrough bleeding (or “spotting”) is common with all methods, and most come with other potential disadvantages, including fertility issues, uterine perforation, and menstrual irregularity ([Douceff, 2016](#)).

The menstrual cycle is also commonly regulated using contraceptive pills. Extended use regimens are designed and packaged in such a way that periods of withdrawal bleeding occur infrequently, and continuous use regimens eliminate withdrawal bleeding entirely. For instance, the aforementioned drug Seasonique regulates one’s cycle with 84 days of active combination (estrogen/progestin) pills followed by seven days of low-dose estrogen pills, resulting in a roughly three-day period of withdrawal bleeding every three months ([Birth Control News, n.d.](#)). In either case, it can take months or even years for the body to adjust without breakthrough bleeding or full unscheduled bleeding episodes ([Association of Reproductive Health Professionals, 2008a](#)). People also sometimes alter their own pill regimens using 21- or 28-day packs, allowing for menstrual suppression on demand without a medical consultation; this is particularly noteworthy in the current research because “the pill” is consistently the most popular method of contraception in the United States ([Jones, Mosher, & Daniels, 2012](#)), but this type of do-it-yourself menstrual suppression remains vastly understudied.

Regardless of which method is used, most clinical studies conclude that contraception regimens designed to reduce or eliminate periods are likely just as safe as comparable contraception regimens that include withdrawal bleeding (for reviews, see: [Jacobson, Likis, & Murphy, 2012](#); [Mendoza et al., 2014](#)). That is, they appear to have the same short-term side-effects as typical regimens (e.g., blood clot risk) but there have been no long-term studies. Some menstrual health authorities endorse the practice as a result ([Planned Parenthood, n.d.](#)), while others caution against sustained use until long-term investigations are conducted, particularly with young women or teenagers ([Society for Menstrual Cycle Research, 2007](#)).

Who Suppresses Periods?

The idea of skipping periods seems popular: a Google search for “how to skip period” returns 64.9 million results, including how-to guides and media speculation. However, it is unclear how many women actually engage in this behavior. Part of the reason for this is the murky definition of menstrual suppression, as discussed above – to my knowledge, no comprehensive large scale data has been gathered estimating rates for all of the different regulatory methods. Medical researchers are most interested in evaluating and promoting menstrual suppression through extended pill regimens, like Seasonique, or through injections/IUDs. Therefore, estimates of menstrual suppression in contraceptive journals are low (20% in a previous sample; [Andrist et al., 2004](#)) but typically only assess patients who seek long-term or continuous use methods from their doctors, not people who occasionally skip a period on their own. In a previous sample of college students, most women who suppressed their menstruation did so using regular contraceptive pills ([Johnston-Robredo et al., 2003](#)). In that same sample, only 12% of women had suppressed their periods, but less than half of the women had ever used

contraception methods that could be used to suppress periods. Women who were on the pill were also significantly more likely to have heard of menstrual suppression. Presumably, then, many women in their very young sample (17-22 years old) had never skipped a period because they did not have the opportunity or means. In all cases, many more women were interested in suppression or willing to suppress than actually had suppressed. Both of the above studies are now outdated and limited, but specific data about suppression is difficult to pin down. According to recent statistics about contraceptives in general, four out of five women who have had sex with a man have used the pill, so it is likely that this is the most common way to skip periods.

It is important to note that, in addition to the discussed measurement issues with estimating “who suppresses,” the bulk of data collected also unsatisfactorily assesses “who menstruates.” Most cisgender women do menstruate, but many do not, because of infertility, hormonal imbalance, age, or disorder (such as polycystic ovarian syndrome). Transgender people of all identities may experience menstruation but are rarely included in large-scale studies. Though my project is primarily concerned with cisgender women who menstruate, I will sometimes use gender neutral terms like “menstruators” or “people who menstruate” instead of specifically referring to cisgender women. In accordance with the Society for Menstrual Cycle Research’s feminist lifespan perspective on the menstrual cycle (2011), I do this avoid linking gender inherently to menstruation, thus expressing solidarity with cisgender and transgender women who do not menstruate as well as transgender men who do. Feminist scholars have a duty to acknowledge and challenge normative boundaries where they exist and deconstruct

them where possible; therefore, I will consider the complexities of gender identity in the available literature, limited though the avenue may be.

Why do People Suppress Periods?

Online articles and other media representations of menstrual suppression construct a set of reasons for suppressing one's menstrual cycle, but—as mentioned previously—they are often outweighed by the assertion that choice, regardless of justification, is most important. Few studies have been conducted to ascertain just how accurate this is to real healthcare decision-making processes.

In terms of studies specific to suppression, a survey of college students found that the most commonly cited factors were convenience/scheduling and personal preference ([Lakehomer et al., 2013](#)). In a study of young adult transgender patients, 53 of 123 trans men used oral contraceptives specifically to regulate menstruation in order to manage gender dysphoria and facilitate transition ([Kanj, Conard, & Trotman, 2016](#)). In a very limited sample, Repta and Clarke ([2013](#)) used qualitative data to contextualize suppression decisions, suggesting that convenience, manageability, and appearance concerns were among the most relevant factors.

Looking to online articles for possible suggestions, what are some more concrete and specific reasons? First and foremost, contraceptives are often prescribed to treat menstruators who endure physical pain in the form of endometriosis or other serious dysmenorrhea; complete menstrual suppression may provide additional relief ([National Institute of Child Health and Human Development, n.d.](#)). Do-it-yourself guides cite other premenstrual symptoms, special occasions/travel plans, or athletic/military careers ([Association of Reproductive Health Professionals, 2008b](#)). Some guides invoke normative appeals to sexuality:

Sheer panic ensues because this is literally the worst thing to happen to any woman. What will you do? You haven't seen your boyfriend in weeks and you're accumulating cobwebs down there. There's no way your white bikini will hold up against the waves of the crimson tide. And all of that bloating will make you look like a balloon in your bandage dress. There's only one solution: skip your period. ([LaFata, 2014](#), para. 7)

Other guides simply claim that menstruators eschew periods because they are seen as unnecessary in today's society (e.g., [Doupleff, 2016](#)).

Taken together, we can begin constructing a more complete picture of decision-making factors related to menstrual suppression, but caution is warranted. It is unlikely that the reasons can all act independently of one another, particularly given the proliferation of the choice narrative. Differences in complex decision-making presumably exist across context, length of suppression, and contraceptive method.

Given these gaps in the literature, the first goal of this study will be to gather enough information about my sample to paint a somewhat accurate picture – how? Who? Why? In the next chapter, I will move from these basic descriptive boundaries to explorations of a contested feminist space: is the menstrual choice a successful application of technological empowerment and autonomy free from biology, or is it the micro-level enactment of a disempowering and narrow cultural ideology?

CHAPTER 2 FEMINIST PERSPECTIVES ON MENSTRUAL SUPPRESSION

“Since the dawn of hormonal contraception, women have debated the wisdom of suppressing their periods. Crunchy feminists think it's unnatural; techno-feminists think it's liberating” (Saletan, 2007, para. 3). Though perhaps too succinct, the Washington Post reporter above still manages to capture the essence of a dichotomy in feminist perspectives on menstrual suppression. Put simply, some feminists – in this case, stereotypically imagined as hippies who define womanhood through its supposed biological distance from manhood – reject the rhetoric of menstrual suppression outright. Other feminists – often third wave feminists, characterized by tech savvy and subversion of gender roles – embrace cycle-stopping technologies. These two feminist generalizations are destined to be placed firmly at either end of a binary issue; after all, the first group emphasizes naturalness and biological essentialism, whereas the second group emphasizes technology's power to overcome biological limitations and further equalize divides on sex/gender lines. The missions, when constructed with simplified feminist stereotypes, seem diametrically opposed.

However, there is certainly more to the story. No feminist issue should be constructed in dichotomy because it necessarily flattens the nuance of each perspective and precludes the establishment of a middle ground. In this chapter, I will attempt to flesh out these two perspectives in order to give them adequate consideration. As a result, I will be able to use the current study to investigate some core tenets of one perspective, hopefully shedding some light on the issue as a whole.

Why is Menstruation an Important Issue for Feminists?

Scholars have long discussed the role of menstrual discourse in controlling women's bodies. For some feminists, menstrual taboos reaching back to antiquity represent one of the most central foundations of patriarchy. Simone de Beauvoir (1952) postulated that women's inferiority was linked to the social constraints placed on their bodies as mothers. Fertility reflected nature, chaos, and disorder, rather than civilized impartiality, effectively "othering" women while trapping them in a relational position to men. To this day, rhetorics of bodily repulsion can be weaponized to reify female inferiority; as Breanne Fahs (2014) writes, "the disgust directed toward women's bodies serves as a powerful regulatory force to direct, contain, control, and denigrate women's bodies" (para. 3).

In the 1970s, the convergence of a feminist health consciousness and rejection of societally imposed shame narratives led to menstrual activism (Bobel, 2008). Pharmaceutical companies and product manufacturers had repeatedly taken advantage of menstruators by selling unsafe or toxic tampons and napkins, building distrust that would eventually culminate in a critical, alternative conceptualization of menstrual health needs. In order to force the Food and Drug Administration to regulate dangerous chemicals in "femcare," menstruators had to protest – in addition to letter-writing campaigns and petitions advocating for safe standards, women were able to reclaim their periods, staging "Bleed-Ins" and embracing their cycles as natural and spiritual (Bobel, 2008). These ideals reflected cultural feminism, which emphasized "women's culture" with feminine values (see Henley et al., 1998), but this type of feminism has largely fallen out of favor with the public. Though menstrual activism persists in some forms among (mostly white, privileged) third wave feminists (Bobel, 2010),

contemporary casual discourse about women's health is dominated by the notion of choice. We have increasing variety when it comes to menstrual hygiene, menstrual regulation, and even menstrual suppression. With modern technology, menstruators can now choose how, when, and if they bleed.

Feminist Perspectives on the Menstrual Suppression Narrative

In this section, I will be discussing feminist analyses of menstrual suppression as a cultural narrative and as a practical technology. This will clarify the aforementioned divide between feminist groups, both of whom criticize the gendered construction of the issue, but arrive at different conclusions. Radical/cultural feminists primarily reject the technology in favor of performing womanhood in a "natural" way, while technofeminists will enter a reciprocal process of co-construction with the technology while using it to their benefit.

Gender and Technology

According to Judy Wajcman (2007), a pioneer of feminist technoscience, feminist approaches to science and technology begin with roughly the same critique. Because the fields of science and technology had been dominated by men, women had insufficient access to technological/scientific resources, and the advancements created by men were therefore unavoidably gendered to the detriment of women (Wajcman, 2007). From this point in the 1970s, Wajcman writes, different branches of feminism arrived at different "solutions" based on their ideological orientations – for instance, liberal feminists focused on equality of access, advocating for more women to enter the field and leaving it at that. Radical and cultural feminists soundly rejected man-made technology, which led to an emphasis on gender differences and a return to "feminine methods" as they distanced themselves from masculine technology (specifically,

reproductive technology). Beginning in the 1990s, postmodern cyberfeminism emerged; these feminists believed that the contemporary technology offered opportunities to erase gender lines completely, particularly in a supposedly anonymous Internet age.

“Feminist technoscience,” on the other hand, refers to the field that materialized somewhere between the gender-divided “pessimism” of radical feminists and the overzealous “optimism” of the cyberfeminists ([Wajcman, 2007](#)). Instead, technofeminists acknowledge the dynamic and inseparable nature of gender, technology, and science. They adopt a critical stance, but they also negotiate technological spaces because they believe that technologies and gender relations are simultaneously and cooperatively constructed on the levels of design, production, and use. Put another way, technofeminism calls for critical reflection on technological advancements, but also active engagement with gendered advancements that have the potential to equalize the socially constructed boundaries between sexes.

Therefore, menstrual health is an area that lends itself well to this sort of active consumption. As an example: technofeminists asserted that the original design of the pill served masculine needs more than it equitably served women’s fertility needs. Because men were generating the science and designing the technology, they created a version of the pill that was gendered based on their cultural understanding of menstruators ([Oudshoorn, 1994](#)). Imagining all menstruators to be basically the same, they created a rigid and universal regimen wherein the pattern of withdrawal bleeding mimicked a “typical” menstrual cycle instead of a more gender-equitable situation. In effect, male scientists standardized the cycles of countless women based on an

abstract ideal of womanhood, proving that the social realities of menstruators and menstrual technology are indeed co-constructed ([Oudshoorn, 1994](#)).

Given this example, it is clear how technofeminists might endorse total or partial menstrual suppression. With only 21- or 28-day cycles at one's disposal, the most immediately viable way to effect change in the design is to reschedule the monthly withdrawal bleeding through pill manipulation. Similarly, complete suppression may represent even greater freedom from the disproportionately gendered original regimen. Though technofeminists would likely still critically analyze the social construction of the technological rhetoric, they would also occupy a relatively optimistic position in which their choices result in shifting technoscience.

Choice and the Sociocultural Context

The radical feminists who largely rejected masculine-skewed technology focused much more acutely on bodies and choice. This is not necessarily surprising; the notion of choice – and, in particular, informed choice in a bioethical context – has always been a prominent feature in the women's health movement ([Gunson, 2012](#)). However, this is significant in that it represents an ontological shift in the choice paradigm as compared to technoscience; whereas technofeminists attempt to critically engage choice on a one-on-one level, this perspective maintains that menstruators as a whole are being misled by a co-opted version of true "choice." For example, Carly S. Woods ([2013](#)) asserts that because choice is so central to feminism and to American life as a whole, "it presents a rhetorical paradox. It holds the promise of individual agency but can also be co-opted to promote controversial choices that reinforce sexist stereotypes" (p. 267). As Woods ([2013](#)) observes, choice in the realm of healthcare has the potential to empower patients, but it is also inevitably commercialized. It is no coincidence that, for instance,

greater concern for premenstrual symptoms (in the form of PMS and PMDD) shortly preceded greater demand for medications regulating moods and periods. In an effort to popularize Yaz, a contraceptive pill that simultaneously regulated the menstrual cycle and premenstrual moods, Bayer Healthcare Pharmaceuticals launched a marketing campaign using “girl power” ideology to encourage young women to take control of their bodies. Creating a self-reliant, confident, individualistic ideal juxtaposed with the specter of a debilitating condition like PMDD allowed the company to manipulate the choice narrative. After all, would an empowered girl let menstruation get in her way when instead she could choose to better herself physically, mentally, and emotionally? Similarly: by constructing a situation wherein “to bleed or not to bleed” is a simple, individual, binary choice, marketing campaigns have camouflaged their own complicity in the perpetuation of harmful narratives by setting the responsibility solely on the shoulders of the consumer.

One such harmful narrative perpetuated is in fact the very idea on which menstrual suppression is built. The controversial book *Is Menstruation Obsolete?* (Coutinho & Segal, 1999) first brought this narrative to the forefront by framing menstruation as wholly unnecessary, unhealthy, and avoidable. In Coutinho’s view, menstruators keep menstruating only because we are holding onto tradition and unwilling to advance into a new age where the supposedly unbiased march forward of biomedical progress has left us with periods that are not even real. According to Katie Ann Hasson, this redefinition of menstruation reflects a rhetorical shift designed to preclude the necessity for healthcare decision-making – if the “realness” of a period is defined by the presence or lack of ovulation rather than the experience of bleeding, then

all hormonal contraceptives already suppress the menstrual cycle (2016). In this case, if the patient has already made the choice to suppress their cycle, then the social meanings of their withdrawal bleeding periods are diminished whether or not they feel and behave like “normal” menstrual periods. This functionally removes the central choice from concerns about naturalness or safety by implicating the consumer in a choice they had already made and taken responsibility for; at this point, hanging onto a fake period can seem silly and counterproductive, particularly when accompanied by advertising tactics that insinuate that menstruators are inhibited competitively by monthly menstruation. As Woods summarizes, “when posited as a needless reminder of biological difference, the decision to suppress menstruation may seem like an uncontroversial personal choice” (2013, p. 268).

When the choice narrative enters such rigidly defined territory, it becomes necessary to discuss the neoliberal context that facilitates framing healthcare decisions as consumerism. A neoliberal healthcare narrative is not an uncommon one. Neoliberalism, a political ideology emphasizing free market, limited government regulation, meritocracy, and an ethic of personal responsibility (Bockman, 2013; Steger & Roy, 2010), cohabitates well with the United States’ brand of capitalism. In the neoliberal healthcare narrative, individual choice is important – reaching one’s best and healthiest self is a moral mandate of sorts. Patients are faced with these choices even if they are not equipped or inclined to make them (Glasdam, Oeye, & Thrysoee, 2015). Phrased another way, we have the healthcare choices available to us, and so it is a matter of personal responsibility to take advantage of the choices that better enable us to succeed. In a supposed meritocracy, successful may mean more self-regulated and

consistently productive. Given this cultural milieu, strictly controlling one's menstrual cycle as per the image put forth by pharmaceutical companies can become a mandate as well. This is particularly true if one has negative connotations about periods (Gunson, 2016). Several feminist criticisms of menstrual suppression specifically link the rhetoric of choice to neoliberal values (see Gunson, 2010 & 2012; Hasson, 2012; and Kissling, 2013). Though neoliberal values may not be deployed consciously by the medical establishment, "the neoliberal values of individual choice and self-surveillance come to be axioms through their continual reiteration such that their value is no longer questioned" (Gunson, 2010, p. 1331).

Similarly, menstruators are likely unaware of the ideologies whose values they are accepting if they make uncritical menstrual suppression decisions. The neoliberal context serves to obscure the gendered issues at play – framing the issue as one of "freedom" may prevent menstruators from seeing the aforementioned menstrual disgust narratives that may be reified. I will discuss this at greater length in the next chapter, but for now suffice it to say that feminist critiques that are skeptical of menstrual suppression may also call into question the objectifying narratives present in the social construction of menstruation as a problem to be "fixed" and a stigma from which to distance oneself (Johnston-Robledo et al., 2003; Roberts & Waters, 2004).

Next Steps

Given the two feminist perspectives that I have described, I want to move on to build the psychological framework which will contextualize the discussion with actual menstruators' responses. Since there is more literature to support the perspective that implicates internalized gendered and neoliberal values, I will create a research paradigm to test whether the theory can be substantiated. I also think it is the

theory more likely to reflect suppression motivations, as a result of my own feminist journey unpacking the internalized oppressive narratives that once led me to decreased well-being and poor healthcare decision-making. However, it is likely, if not definite, that the final conceptualization of menstrual suppression will not fit exactly into either theory. As explored by Gunson (2012), experiences of decision-making and menstrual suppression are multi-faceted:

The narratives of the women who were participants in this study demonstrated accommodation as well as uncertainty and skepticism. In so doing, they constructed a range of health identities that both appropriated and contested dominant understandings of “choice,” reflecting the complex intersections of social, cultural and embodied constraints when taking up medical technologies. (p. 8)

Thus, though I expect to see the aforementioned themes figure prominently in my data, I also want to be careful not to overstate the degree to which participants will present with specifically technofeminist or neoliberal/gender-normative reasoning. The data that I gather will serve to contextualize and, hopefully, lend validity to some of the discussed themes.

CHAPTER 3 PSYCHOLOGICAL FRAMEWORKS

Psychology of Menstruation

Feminist psychologists have posited that menstruation is a source of social stigma with negative consequences for well-being and mental health (e.g., [Chrisler, 2011](#); [Johnston-Robledo & Chrisler, 2013](#)). In an experiment exemplifying this stigma, Roberts et al. (2002) found that participants evaluated a woman as less competent and less likable after she dropped a tampon from her handbag; interestingly, participants also evaluated women in general with more objectifying standards after watching the tampon fall, particularly in the case of participants who adhered more strongly to typical gender roles. Thus, the mere sight of menstrual hygiene products may be enough to elicit stigma. Relevant to the previous chapter, advertisement is an important vehicle through which this stigma travels, but it is also internalized via dominant cultural attitudes that seep into media, education, socialization, jokes, and shame-based social interactions ([Johnston-Robledo & Chrisler, 2013](#)). Menstruators who internalize the stigma of menstruation may have lower self-esteem and engage in more frequent self-monitoring, which is likely related to objectification theory (explored below). Negative attitudes toward menstruation are prevalent, but they are especially negative for menstruators who have high levels of shame and self-objectification ([Johnston-Robledo et al., 2007](#)). Some feminist researchers have suggested that this affects menstrual health decision-making, including menstrual suppression (e.g., [Johnston-Robledo & Chrisler, 2013](#)); however, insufficient research exists to test that claim.

Attitudes Toward Menstruation

Several studies have found evidence that menstrual attitudes are related to body image and related constructs. In a recent small sample, for example, Chrisler and colleagues (2015) found that greater body appreciation predicted positive menstrual attitudes, although they did not extend this link to interest in menstrual suppression. Schooler and colleagues (2005) found that menstrual shame was indirectly related to women's sexual decision-making and risks through body comfort levels.

Premenstrual syndrome, commonly understood as the experience of emotional and physical symptoms preceding the onset of menstruation, has also been studied by feminist researchers. Cosgrove and Riddle (2003) found that traditional femininity was correlated with certain premenstrual symptoms, including negative affect and impaired concentration. The authors suggest through qualitative analyses that women cope with failures to live up to idealized images by distancing themselves from menstrual or premenstrual versions of themselves (Cosgrove & Riddle, 2003).

Diversity

As with many areas of psychological research, much of our knowledge about menstrual attitudes is based in convenience samples: mostly White, young, heterosexual, cisgender, middle or upper class women enrolled in college. As a result, we have limited knowledge about the menstrual attitudes of people of color and queer people, among others. Though I do not select for specific identity groups in my study, it was my hope that using an online participant pool instead of the typical college sample would give me some diversity in race/ethnicity, age, and sexuality.

On the topic of race, it is possible that menstruators differ, but little research is available. In a small qualitative study, Fahs (2011) observed that White women more

often expressed positive emotions about menstrual sex than did women of color. However, Deuster and colleagues (2011) collected data from a sample of deployed military women and found that African American women reported lower menstrual concerns than did White women, Asian women, or Latinas. In a comparison of a predominantly Black sample in Georgia and a predominantly White sample in Oregon, Edelman et al. (2007) found no racial differences in period enjoyment, but significantly fewer Black women expressed willingness to engage in period suppression. Overall, the literature about menstrual attitudes is lacking in sufficient racial diversity and thus few comparisons between racial groups can be made.

Some transgender people menstruate, and their unique social positions indicate that their relationships with menstruation are likely very different from that of cisgender women. Nuanced issues like dysphoria, gender presentation, and safety in public restrooms could complicate the matter. Unfortunately, transgender people are almost never considered in menstrual cycle research. Some feminist academics are trying to rectify this erasure, but progress is slow. Transgender issues are rapidly evolving, and feminists sometimes lag behind, breeding distrust (Vasquez, 2016). It is certainly not helpful that there is a history of radical feminist scholars characterizing menstruation as an issue of gender essentialism—as an example, consider Germaine Greer’s recent comment that “if you didn’t find your pants full of blood when you were thirteen there’s something important about being a woman you don’t know” (Morris, 2015, para. 5). As a result, rectifying the dearth of research about the menstrual cycles of transmasculine individuals requires careful and purposeful work on the part of feminist psychologists, who must navigate relatively uncharted waters while mending existing feuds among

trans people, feminists, and academic researchers. In fact, as suggested in an opinion piece by transgender neuroscientist Kale Edmiston, the best way to move forward is perhaps to make room for trans people in academia so that they can be treated seriously as experts in their own experience ([Edmiston, 2016](#)).

Based on the scant amount of research available, the trans community appears to have a complex relationship with menstruation. In one of the very few studies of masculine of center people, Chrisler et al. ([2016](#)) found that participants had mixed attitudes about menstruation but anticipated negative opinions from others; perhaps as a result, most hid their menstruation by avoiding public restrooms or products that require frequent changing in public. In terms of menstrual suppression, the participants exhibited more positive attitudes toward menstrual suppression than did cisgender women in previous studies, and 40% had suppressed their periods in some way ([Chrisler et al., 2016](#)). The researchers note, however, that participants were often hesitant to discuss menstruation with medical professionals ([Chrisler et al., 2016](#)). Given the variability in trans experience, it is likely that further study would reveal even greater complexity; perhaps the study's inclusion of masculine people who did not identify as trans men resulted in less negativity toward menstruation as a result of decreased concerns about dysphoria and passing as male.

Similarly, it is possible that sexual orientation complicates menstrual attitudes, but there is too little research on the specific experiences of lesbians and bisexual or queer women to say for sure. Fahs ([2011](#)) spoke to this issue in a small qualitative study wherein thematic analyses revealed that lesbians and bisexual women expressed more positive emotions related to menstrual sex. However, contrary to predictions,

another study found no significant difference in menstrual attitudes by sexual orientation (Morrison et al., 2010).

Objectification Theory

Objectification Theory, proposed by Fredrickson and Roberts (1997), attends to the ways that women adopt the perspective of an outside observer when they evaluate their own bodies. The widespread sexualization of women and girls forcibly reduces their value to physical attractiveness. Through objectification, their bodies may be separated into parts inscribed with sexual meaning; in this way, their bodies can be detached from their personhood, minimizing all other characteristics in favor of a physicality that exists only to please heterosexual men. Thus, the male gaze functions as a way of policing women, whether women are literally gazed at in interpersonal interactions or are more abstractly the object of male gaze in media representations (Fredrickson & Roberts, 1997). Since sexualization seems unavoidable to most women, objectification happens without the consent of the objectified. From birth, anyone inhabiting a “feminine” body is surrounded by these normative forces, facilitating their internalization (Smolak & Murnen, 2011). Seeing that her value is dictated by her appearance, an individual is likely to build her self-concept around it, and so she may evaluate herself as an object in much the same way that an outside observer would (Fredrickson & Roberts, 1997).

Self-Objectification

Self-objectification is associated with body surveillance and feelings of shame, and, as explained by Roberts and Waters (2004), “women ... often participate willingly in the cultural flight away from the corporeal body, engaging in a great variety of body-altering practices designed to transform the physical body into the idealized body” (p.

10). When self-objectification distances women from their bodies, they have lower awareness of internal bodily states ([Fredrickson & Roberts, 1997](#)). This cycle of shame and detachment may be related to how the individual evaluates and prioritizes their menstrual cycle. Andrist ([2008](#)) proposed a similar function: objectification, as a way of devaluing women, causes women to frame their bodies as cultural symbols, and menstrual suppression allows one to distance oneself from animalistic embodiment.

Self-objectification has been operationalized in a variety of ways and, as a result, measured differently by psychologists. In this study, I take my cue from Moradi ([2010](#)) by noting that self-objectification may be conceptualized as a process that dynamically links several constructs within Objectification Theory. As a result, I decided to seek answers using three constructs to speak to the complex process of self-objectification: experienced sexual objectification, an external component working in tandem with internalization; internalization of bodily standards; Objectified Body Consciousness ([McKinley & Hyde, 1996](#)), which incorporates body surveillance and body shame. Each component I have chosen draws on Objectification Theory, but due to a lack of relevant research I do not know which pieces of the puzzle will fit in with menstrual suppression.

Objectification and Menstruation: What do We Know?

Previous samples have shown a relationship between self-objectification and negative attitudes and emotions about menstruation ([Roberts & Waters, 2004](#); [Schooler et al., 2005](#)). Grose and Grabe ([2014](#)) found that self-objectification predicted negative menstrual attitudes which in turn predicted attitudes about alternative menstrual products. Though one previous study has attempted to link self-objectification to aspects of menstrual suppression and failed to do so ([Johnston-Robredo et al., 2003](#)), that study is outdated and limited in its scope and sensitivity. As discussed above, the

researchers failed to access a large population of menstrual suppressors in a young sample of women with little variability in contraceptive methods.

In the aforementioned experiment by Roberts and colleagues, participants with high levels of gender conformity who saw the woman drop a tampon from her bag exhibited a generalizable increase in objectification attitudes. That is, gender-normative people evaluated women as a whole with more objectifying standards after watching the tampon drop (Roberts et al., 2002). I will be employing the ideas of gender conformity and objectification in my own study, albeit in a different context.

Relatedly, Erchull (2013) linked objectification and menstruation using a terror management framework. Terror Management Theory, originally proposed by Greenberg, Pyszczynski, and Solomon (1986), is a psychological context for understanding the existential crisis of mortality. While this seems complicated and abstract, the theory's importance for my purposes lies in the human tendency to use cultural constructs to tame life's chaos when faced with the reality of death. As Erchull (2013) elaborates, reminders of our natural or animal nature can trigger mortality salience, and as a result we often distance ourselves from aspects of ourselves that seem animalistic. If menstruation is a reminder of corporeality, then people will generally want to distance themselves from menstrual signifiers, and objectification is an efficient way to do so (Erchull, 2013). In a content analysis of menstrual product advertisements, Erchull (2013) found that only roughly half of the images depicted women at all, and of those, most depicted idealized but largely nonsexual bodies, which "provide needed distance from realities of women's corporeal nature that are inherent in an advertisement for a product to manage menstruation" (Erchull, 2013, p. 37). The author

suggests that this objectification strategy could extend to menstrual suppression, although no suppression advertisements were analyzed.

Research Goals

Taken together, the existing research suggests that menstruation is stigmatized and that women may respond through objectification theory, but the body of work is still limited and often mixed. As a result, asking questions about menstrual suppression is complicated, but I specifically targeted a sample of women who had used hormonal contraceptives in order to gather data related to the themes outlined in Chapter 2: is the degree to which someone internalizes a neoliberal, self-objectifying narrative related to their engagement in menstrual suppression? Conceptually, I am interested in the power of this internalization to affect the subjectivity of women. Specifically, I expected that the degree to which someone experiences self-objectification may be related to disregarding bodily needs in favor of minimizing shame, controlling the body, and using the body as an object. This is my primary interest. However, because I think that previous menstrual suppression studies have fallen short in part because they did not differentiate between varying levels of menstrual suppression, I expected a secondary model to emerge. Menstruators who suppress occasionally will likely have different specific motivations that menstruators who suppress continuously.

My hypotheses are as follows:

1. Among people who engage in menstrual suppression, the most common method will be personal manipulation of 28-day oral contraceptive regimens.
2. Greater levels of self-objectification will be related to higher menstrual suppression.
3. Greater internalization of neoliberal beliefs will be related to higher menstrual suppression.
4. Different methods of suppression will reflect different motivations for suppression: Suppressing occasionally (i.e., using do-it-yourself cycle manipulation) will be associated with sexuality (specifically, sexual subjectivity and sexual motivation),

and suppressing continuously (i.e., using prescribed methods like continuous oral contraceptives or IUDs) will be associated with normative gendered values and low collective self-esteem.

CHAPTER 4 METHOD

Participants and Procedure

This study was approved by the University of Florida Institutional Review Board. I recruited participants through Prolific Academic (prolific.ac), a crowdsourcing website dedicated specifically to academic research. I used the prescreening tools on the Prolific Academic website in order to verify that the women in the sample had at least some experience using hormonal contraceptives so as to maximize the likelihood of recruiting participants who had faced a menstrual suppression choice. Volunteers who met the criteria were directed to an online survey hosted on Qualtrics software and were compensated approximately \$2.50 upon completion. At the time of analyses, data were collected from 336 adult women. As part of the data cleaning process, I eliminated responses from participants in nations other than the U.S., Canada, and the United Kingdom because of language barriers and possibly confounding differences in cultural influence (though there were not enough participants from any one of these English-speaking nations to select from a single location). I also eliminated responses from participants whose stated gender identity was listed as “genderqueer” or “agender.” Though these participants met the contraceptive use prescreening criteria, I did not have the means to accommodate the complex motivations that may influence their suppression behaviors, including but not limited to dysphoria and gender presentation.

The final sample (n=319) ranged in age between 18 and 49, and the mean age of the sample was about 31 years old (SD=6.7). Participants were primarily White (93.4%), followed by Latina (3.8%), Native American (2.2%), Black (2.5%), Asian/Pacific Islander (1.9%), and other (2.2%). Participants lived primarily in the United Kingdom (66.1%),

followed by the United States (29.5%), and then Canada (3.1%). Most participants identified as heterosexual (78.7%), followed by bisexual (15.4%), lesbian/gay (2.5%), queer, (1.3%), or other (2.2%). Most participants were also highly educated, with the vast majority (72.7%) holding a college degree or greater.

Measures

Suppression behavior. After providing informed consent (Appendix A), participants completed a questionnaire (Appendix B), developed for this study, about their contraception use and menstruation experiences. This first section of the survey assessed the outcome variables: menstrual suppression overall, long-term menstrual suppression, short-term menstrual suppression, and likelihood of future suppression. Participants also provided open-ended responses about their reasons for suppressing and rated the pain, symptomology, and inconvenience of their menstrual cycles.

Menstrual attitudes. Participants completed the Menstrual Attitude Questionnaire (Brooks-Gunn & Ruble, 1980). The scale is designed to measure several different attitudes about menstruation, and is therefore divided into five subscales. The debilitation subscale (study reliability throughout, $\alpha=0.87$) consists of 12 items, including “I don’t allow the fact that I’m menstruating to interfere with my usual activities.” The bothersome subscale ($\alpha=0.63$) consists of six items, including “Menstruation is just something I have to put up with.” The natural subscale ($\alpha=0.82$) consists of four items, including “The recurrent flow of menstruation is an external indication of general good health.” The predictable subscale ($\alpha=0.73$) consists of four items, including “I have learnt to anticipate my menstrual period by the mood changes which precede it.” The denial subscale ($\alpha=0.82$) consists of seven items, including “A woman who attributes her irritability to her approaching menstrual period is neurotic.” Response options

ranged from 1 (*strongly agree*) to 7 (*strongly disagree*). I averaged the items in each dimension but did not create a single score for total menstrual attitudes because of the disparate nature of some of the subscales; for example, the items on the “menstruation as bothersome” subscale may be interpreted as negative, while the “menstruation as predictable” items may not.

Sexual subjectivity. I used the Female Sexual Subjectivity Inventory ([Horne & Zimmer-Gembeck, 2006](#)) to assess participants’ sexual self-concepts. The instrument contains 20 items divided into five subscales. The sexual body-esteem subscale ($\alpha=0.87$) consists of five items, including “I am confident that a romantic partner would find me sexually attractive.” The second subscale ($\alpha=0.83$), which measures respondents’ sense of entitlement to sexual pleasure from the self, consists of three items, including “It is okay for me to meet my own sexual needs through self-masturbation.” The third subscale ($\alpha=0.77$), which measures respondents’ sense of entitlement to sexual pleasure from partners, consists of four items, including “I would expect a sexual partner to be responsive to my sexual needs and feelings.” The fourth subscale ($\alpha=0.82$), which assesses respondents’ self-efficacy in achieving sexual pleasure, consists of three items, including “I am able to ask a partner to provide the sexual stimulation I need.” The sexual self-reflection subscale ($\alpha=0.89$) contains five items, including “My sexual behavior and experiences are not something I spend time thinking about.” Response options ranged from 1 (*not at all true for me*) to 5 (*very true for me*). I averaged the items in each subscale and also in the inventory overall to create a total sexual subjectivity score ($\alpha=0.87$).

Locus of causality for sex. In order to assess participants' external or internal motivations for engaging in sexual activity, I used seven statements from the Perceived Locus of Causality for Sex scale (Jenkins, 2003). Participants responded to the prompt "The last few times I had sex, I engaged in sexual activity..." by checking any number of the seven statements, such as: "...because I wanted to enjoy the physical sensation"; "...because I thought my partner would be happier with me afterwards"; and "...because I felt pressured."

Gender conformity. I measured gender conformity using the Conformity to Feminine Norms Inventory-45 (Parent & Moradi, 2010). The measure consists of 45 items divided into nine subscales of five items each. The thinness subscale ($\alpha=0.89$) contains items such as: "I am terrified of gaining weight." The domestic subscale ($\alpha=0.83$) contains items such as: "It is important to keep your living space clean." The investment in appearance subscale ($\alpha=0.84$) contains items such as: "I feel attractive without makeup." The modesty subscale ($\alpha=0.85$) contains items such as: "I hate telling people about my accomplishments." The relational subscale ($\alpha=0.77$) contains items such as: "I believe that my friendships should be maintained at all costs." The involvement with children subscale ($\alpha=0.95$) contains items such as: "I find children annoying." The sexual fidelity subscale ($\alpha=0.88$) contains items such as: "It is not necessary to be in a committed relationship to have sex." The romantic relationships subscale ($\alpha=0.82$) contains items such as: "My life plans do not rely on my having a romantic relationship." The sweet and nice subscale ($\alpha=0.74$) contains items such as: "I rarely go out of my way to act nice." Responses range from 1 (*strongly disagree*) to 4

(*strongly agree*). I averaged the items in each subscale and separately averaged all 45 items to create a total conformity score ($\alpha=0.84$).

Neoliberal beliefs. Participants completed the Neoliberal Beliefs Inventory (Bay-Cheng et al., 2015). The measure consists of 25 items divided into four subscales. The system inequality subscale ($\alpha=0.89$) contains seven items, including “Discrimination does not exist today to such a degree that affirmative action policies are necessary.” The competition subscale ($\alpha=0.82$) contains five items, including “Fairness means letting people have equal opportunity, not guaranteeing equal outcome.” The personal wherewithal subscale ($\alpha=0.91$) contains eight items, including “A person’s success in life is determined more by his or her personal efforts than by society.” The government interference subscale ($\alpha=0.88$) contains five items, including “The government often hurts individual ambition when it interferes.” Response options range from 1 (*strongly disagree*) to 5 (*strongly agree*). I averaged all 25 items to create a total neoliberal beliefs score ($\alpha=0.94$) in addition to the subscales.

Collective self-esteem. Participants completed the Collective Self-Esteem Scale (Luhtanen & Crocker, 1992), which I altered slightly to specifically target esteem related to collective womanhood. The measure consists of 16 items divided into four subscales of four items each. The membership self-esteem subscale ($\alpha=0.81$) includes items such as: “I am a worthy member of the social group (womanhood) I belong to.” The private collective self-esteem subscale ($\alpha=0.84$) includes items such as: “I often regret that I belong to the social group (womanhood) I do.” The public collective self-esteem subscale ($\alpha=0.83$) includes items such as: “Overall, my social group (womanhood) is considered good by others.” The importance to identity subscale ($\alpha=0.88$) includes

items such as: “Overall, my group membership (womanhood) has very little to do with how I feel about myself.” Response options range from 1 (*strongly disagree*) to 7 (*strongly agree*). I averaged all 16 items to create a total collective self-esteem scale ($\alpha=0.87$) in addition to subscales.

Sexual objectification. In order to assess participants’ experiences with sexual objectification, I administered the Interpersonal Sexual Objectification Scale (Kozee et al., 2007). The scale consists of 15 items in two dimensions. The body evaluation dimension ($\alpha=0.93$) contains 11 questions, including “How often have you noticed that someone was not listening to what you were saying, but instead gazing at your body or a body part?” The second dimension ($\alpha=0.84$) measures unwanted explicit sexual advances using four questions, such as: “How often have you been touched or fondled against your will?” Response options include “never,” “rarely,” “occasionally,” “frequently,” and “almost always.” I averaged all items into a total interpersonal objectification score ($\alpha=0.93$) in addition to averaging within the two dimensions.

Objectified body consciousness. In order to assess components of participants’ self-objectification, I used the Objectified Body Consciousness Scale (McKinley & Hyde, 1996). The scale consists of 24 items divided into three subscales with eight items each. The surveillance subscale ($\alpha=0.89$) includes items such as: “I think more about how my body feels than how my body looks” (reversed). The body shame subscale ($\alpha=0.87$) contains items such as: “I feel ashamed of myself when I haven’t made the effort to look my best.” The control subscale ($\alpha=0.82$) includes items such as: “I really don’t think I have much control over how my body looks.” Response

options ranged from 1 (strongly agree) to 7 (strongly disagree). In addition to these subscales, I averaged all 24 items to create a total score ($\alpha=0.85$).

Sociocultural attitudes toward appearance. Participants completed the Sociocultural Attitudes Towards Appearance Questionnaire-3 ([Thompson et al., 2004](#)). The measure consists of 30 items divided into four subscales. The general internalization subscale ($\alpha=0.94$) contains 9 items, including “I do not care if my body looks like the body of people who are on TV” (reversed). The athlete internalization subscale ($\alpha=0.81$) contains five items, including “I compare my body to that of people who are athletic.” The pressures subscale ($\alpha=0.95$) consists of seven items, such as “I’ve felt pressure from TV and magazines to be thin.” The information subscale ($\alpha=0.91$) contains nine items, including “Movies are an important source of information about fashion and ‘being attractive.’” Response options range from 1 (definitely disagree) to 5 (definitely agree). I averaged all 30 items to create a total internalization score ($\alpha=0.95$) in addition to the four subscales.

CHAPTER 5 RESULTS

Preliminary Analyses

Though I only collected responses from 336 women (319 after data cleaning), over 1000 people responded to the prescreening item on the Prolific Academic website. Over 70% of those respondents reported that they had in fact used hormonal contraceptives at some point. However, since Prolific Academic does not require its participants to respond to every demographic screening question, I cannot say for sure how accurate this representation is of the participant pool as a whole. Additionally, though Prolific Academic's participants are primarily British and American, there are no restrictions on nationality or country of origin. I restricted my study to participants from the U.S., the United Kingdom, and Canada, but the prescreened pool may draw from any country.

The vast majority of participants had experience using contraceptive pills (88.7%). Some participants reported having used hormone injections (12.9%), intrauterine devices (11.9%), and implants (14.4%). On the whole, participants reported moderate menstrual discomfort; on scales from one to ten, participants rated their menstrual pain ($M = 4.96$, $SD = 2.4$), menstrual inconvenience ($M = 5.67$, $SD = 2.48$), and premenstrual syndrome symptoms ($M = 5.44$, $SD = 2.45$). About a third of the total sample had ever consulted with a doctor about menstrual suppression (36.7%), but over half (61.5%) thought that menstrual suppression was "a little," "somewhat," or "very" safe.

More than half of the sample reported having ever suppressed their menstrual cycles (58%). As predicted, the majority (75.1%, or 43.6% of the total sample) of

suppressors had done so using short-term methods (i.e., skipping a period manually by manipulating pill regimens), whereas only 31.4% (18.2% of the total sample) had used long-term methods. About half (51.1%) of the total sample responded that they were “a little,” “somewhat,” or “very” likely to consider menstrual suppression in the future, but the responses were somewhat polarized, with “very likely” (21.6%) and “very unlikely” (21.9%) being the two most common responses.

As a preliminary step, I first ran correlations between the indicator variables and the outcomes of interest. The results of select correlations are reported in Table 5-1 (Menstrual Attitudes Questionnaire subscales), Table 5-2 (objectification theory-related scales), Table 5-3 (sexuality subscales), and Table 5-4 (gender subscales). I removed several subscales that did not yield any significant correlations (i.e., Female Sexual Subjectivity Inventory: pleasure from self, efficacy, and total scales; Collective Self-Esteem: public and identity scales; Objectified body Consciousness: control scale; Sociocultural Attitudes Toward Appearance Questionnaire: athlete and pressure scales; Conformity to Feminine Norms Inventory-45: domesticity, modesty, relational, romance, and niceness scales; the Neoliberal Beliefs Inventory; and the Interpersonal Sexual Objectification Scale).

Hypothesis Testing

Hypothesis 1. I predicted that, of those participants who engaged in menstrual suppression, the majority would do so short-term by manipulating their own contraceptive regimens. As stated in the previous section, this hypothesis was supported: 75.1% of suppressors used short-term methods as compared to 31.4% of suppressors who used long-term methods.

Hypothesis 2. I hypothesized that greater levels of self-objectification would be related to higher levels of menstrual suppression. In order to test this relationship, I ran a logistic regression with the outcome variable menstrual suppression (of any kind), predicted by the Objectified Body Consciousness Scale (total score), the Interpersonal Sexual Objectification Scale (total score), and the Sociocultural Attitudes Toward Appearance Questionnaire (total score). The model tested against a constant only model was statistically significant ($\chi^2 = 9.749$, $p = .021$, $df = 3$), but I rejected the model because the results were driven only by the Objectified Body Consciousness Scale, while the other scales were nonsignificant. Instead, a model using the Objectified Body Consciousness Scale as the only predictor was significant ($\chi^2 = 6.732$, $p = .002$, $df = 8$). The odds ratio of the statistic was $\exp(B) = 1.592$, indicating that for every unit increase in the Objectified Body Consciousness Scale, the odds of the outcome occurring increased by roughly one and a half times, or 159%. However, as indicated by the Nagelkerke's R^2 statistic (.04), the model explained very little of the variance (4%). This was not entirely surprising, given that I was only testing using a single predictor.

It is noteworthy that, upon further examination, the subscale driving this effect seemed to be the surveillance scale. When the model was run with the subscales separated, the surveillance score was the only one to reach significance ($p = .001$). Thus, a regression with this subscale as the only predictor ($\chi^2 = 10.119$, $p = .001$, $df = 1$) explains about 4.2% of the variance according to the Nagelkerke's R^2 statistic (.042). For every unit increase in surveillance, the odds of suppression increased by 137% ($\exp(B) = 1.374$).

Hypothesis 3. I hypothesized that greater internalization of neoliberal beliefs would be related to higher levels of menstrual suppression. I again ran a logistic regression with the outcome variable menstrual suppression (of any kind), but this time using the total Neoliberal Beliefs Inventory as a predictor. The model was not statistically significant ($\chi^2 = 2.034, p = .154, df = 1$), indicating that neoliberal beliefs were not are not a good predictor for menstrual suppression. I investigated further by running a model using the four subscales of the Neoliberal Beliefs Inventory; however, none of the scales reached significance.

Hypothesis 4. I hypothesized that different types of suppression (short-term or long-term) would reflect different motivations for suppression. Specifically, I suspected that long-term suppression would be related to gendered predictors and short-term suppression would be related to sexual predictors. In order to test this hypothesis, I ran several logistic regression models.

I first attempted to predict long-term suppression with gendered predictors (collective self-esteem and gender conformity); this model did not reach significance ($\chi^2 = 4.125, p = .127, df = 2$). However, a model of long-term suppression predicted by collective self-esteem alone was statistically significant ($\chi^2 = 4.118, p = .042, df = 1$). The odds ratio of the model was $\exp(B) = .665$, indicating that for every unit increase in collective self-esteem the odds of the outcome occurring decreased by 33.5%. However, as indicated by the Nagelkerke's R^2 statistic (.031), the model explained very little of the variance (3%). Thus, I decided to run a third model for long-term suppression using the subscales of the Collective Self-Esteem Scale that appeared most relevant according to the correlation matrix. This model, using the private self-esteem and

importance to identity subscales, was statistically significant at the .039 level ($\chi^2 = 6.464$, $df = 2$). The odds ratios ($\exp(b) = .789$ and $\exp(b) = .845$, respectively) indicated relatively small changes per unit, but the Nagelkerke's R^2 statistic (.048) was slightly improved, explaining about 5%.

I then moved to short-term suppression. In this model, I used the five subscales of the Female Sexual Subjectivity Inventory as predictors. The model was statistically significant ($\chi^2 = 12.921$, $p = .024$, $df = 5$). Looking at the variables individually, the only subscale that reached statistical significance was the partner subscale ($p = .006$). In a model containing only this subscale ($\chi^2 = 7.631$, $p = .006$, $df = 1$), we see that for one unit increase in the predictor, the odds of short-term menstrual suppression increase by about two and a half times ($\exp(B) = 2.515$). Again, as indicated by the Nagelkerke's R^2 statistic (.06), the model explained little of the variance (6%).

Table 5-1. Correlations between indicator variables and Menstrual Attitudes Questionnaire subscales.

Variable	Suppression (any)	Suppression (long-term)	Suppression (short-term)	Future likelihood
MAQ: debilitation	-.08	-.02	.18*	.10
MAQ: bothersome	-.05	-.03	-.02	.33**
MAQ: natural	-.09	-.01	-.09	.33**
MAQ: predictable	.06	.10	.04	-.04
MAQ: denial of symptoms	.00	-.09	-.16*	-.06

* $p \leq .01$. ** $p \leq .001$.

Note: The Menstrual Attitudes Questionnaire is denoted here as "MAQ."

Table 5-2. Correlations between indicator variables and select scales related to objectification theory.

Variable	Suppression (any)	Suppression (long-term)	Suppression (short-term)	Future likelihood
OBCS: surveillance	-.18**	.05	.11	.18**
OBCS: shame	-.08	-.13	.14	.18**
OBCS: total	-.17**	-.06	.11	.19**
SATAQ-3: internalization	-.12*	-.01	.17*	.13*
SATAQ-3: information	-.12*	-.02	.06	.05
SATAQ-3: total	-.12*	-.04	.14	.09

* $p \leq .01$. ** $p \leq .001$.

Note: The Objectified Body Consciousness Scale is denoted here as “OBCS.” The Sociocultural Attitudes Toward Appearance Questionnaire-3 is denoted here as “SATAQ-3.”

Table 5-3. Correlations between indicator variables and select sexuality variables.

Variable	Suppression (any)	Suppression (long-term)	Suppression (short-term)	Future likelihood
FSSI: body-esteem	.00	.03	-.16*	-.10
FSSI: entitlement to pleasure from partner	-.07	.05	-.21**	.07
FSSI: sexual self- reflection	-.10	-.07	-.02	.13*
Motivation: sensation	-.08	.04	-.07	.15**
Motivation: partner happiness	-.03	-.18*	.10	.03
Motivation: feeling attractive	-.03	-.26**	.00	.14*

* $p \leq .01$. ** $p \leq .001$.

Note: The Female Sexual Subjectivity Inventory is denoted here as "FSSI."

Table 5-4. Correlations between indicator variables and select gender variables.

Variable	Suppression (any)	Suppression (long-term)	Suppression (short-term)	Future likelihood
CFNI: thinness	-.05	.00	.07	.12*
CFNI: appearance	-.11*	.06	-.08	.17**
CFNI: children	.16**	-.02	.22**	-.21**
CFNI: fidelity	.08	.12	.01	-.14**
CSE: membership	.11	.07	.00	-.14*
CSE: private self- esteem	.03	.16*	.07	-.02
CSE: total	.07	.15*	.05	-.11*

* $p \leq .01$. ** $p \leq .001$.

Note: The Conformity to Feminine Norms Inventory-45 is denoted here as "CFNI." The Collective Self-Esteem Inventory is denoted here as "CSE."

CHAPTER 6 DISCUSSION

Three out of four of my hypotheses were at least partially supported. I found that: more women engaged in short-term, manual suppression rather than long-term suppression; objectification (specifically, body surveillance) partially predicted suppression; and different suppression types were associated with different factors (namely, long-term suppression was partially predicted by private collective self-esteem tied to womanhood and short-term suppression was partially predicted by the dimension of sexual subjectivity that assessed participants' senses of entitlement to pleasure from their partners). Unfortunately, I found no support for my hypothesis that neoliberal beliefs would be associated with suppression.

Limitations

My study has several limitations, the first and foremost of which is a lack of diversity. Though I had hoped that an online sample would provide more diversity than a convenience sample of college students, and though I did have a wide range of ages, most participants were White. This not only limits the study's generalizability; it also inadvertently contributes to a trend of feminist menstruation research as an area dominated by Whiteness. In terms of sexuality and gender identity, I was unable to assess nuance in any meaningful way; in fact, as pointed out by one asexual participant, many of the measures assumed sexual activity or desire, heterosexual or otherwise. Transgender participants were similarly excluded from the study, because the measures often assessed feminine norms or identity.

I specifically sought out a sample with experience using hormonal contraceptives, and despite the benefits of doing so, this may also be a limitation.

Again, my results are not generalizable; I cannot say what percentage of menstruators suppress, only what percentage of hormonal contraceptive-using menstruators suppress. Additionally, although the nationality of participants did not appear to complicate the results, it is certainly possible that a U.S.-specific study would have yielded different findings.

Future Directions

Now that I have shown that menstrual suppression is a widespread issue warranting study, I am hopeful that future researchers will expand on my methods. Efforts to bridge my limitations – particularly in terms of racial, sexual, and gender diversity – would provide a fuller picture of the nuance at play in menstrual decision-making. Future research should also work towards characterizing the middle ground that I have begun to explore here. In a way, the low explanatory power of my results supports a model of menstrual suppression that is far more complex and multifaceted than those suggested by previous theoretical and empirical work. Thus, researchers can combine aspects of the two seemingly disparate theories described in Chapter 2 in order to explore agentic yet culturally situated motivations for menstrual suppression. As a beginning step, a mixed methods study contrasting participants' objectification levels with their qualitative descriptions of decision-making processes may provide some enlightenment as to the breadth of a possible model.

Contributions

Although these results do not fully contextualize menstrual suppression, they represent several steps forward for the literature. First and foremost, the clear majority of women in my sample who favored short-term suppression are relevant to future research about menstruation, contraceptives, and reproductive healthcare decisions.

Limited research has assessed short-term manipulation in the past (for example, see [Lakehomer et al., 2013](#)), but none have found high proportions of suppressors and most do not delineate between different types of suppression. Because I was able to access a targeted sample of women who had used hormonal contraceptives, I obtained a more accurate portrayal of menstrual suppression tendencies for those women who had access to the means, knowledge, and potential pressure to make the choice. Additionally, by clearly defining suppression and asking separately about suppression methods, I allowed for more women to admit to skipping periods occasionally and casually. Thus, my study assessed the issue with a novel, multi-pronged strategy while adding to the scant literature pointing to growing prevalence.

Secondly, my findings indicate a link between self-objectification and menstrual suppression. In 2003, psychologists failed to find any correlation between Objectified Body Consciousness or other self-objectification measures and women's potential interest in menstrual suppression ([Johnston-Robledo et al., 2003](#)), and in the intervening years this remained largely unchallenged. My results reveal a potential for this link to be meaningful, especially as young women's familiarity with suppression grows, but more work must be done to establish a solid knowledge base. Though I attempted to measure the process of self-objectification using three separate measures, the Interpersonal Sexual Objectification Scale was uncorrelated with any of my indicators and the Sociocultural Attitudes Towards Appearance Questionnaire-3 did not contribute significantly to regression models. Only the Objectified Body Consciousness Scale predicted suppression, and within that scale only the body surveillance portion was particularly important. While I originally hypothesized that self-objectification as a

larger process would be more relevant, it makes sense that body surveillance would stand out as a predictor. Surveillance emphasizes the importance of appearance to the point of ignoring or disregarding its function; presumably, if one is vigilant about presentation but distanced from internal experiences, then menstruation could represent a nagging reminder of the messier, uglier side of gendered embodiment. Interestingly, Johnston-Robledo and colleagues (2003) found correlations between surveillance and the sentiment: “If my period disappeared, I wouldn’t miss it.” Though not strong evidence for an objectification link (certainly many people would not miss their periods without having internalized objectifying menstrual rhetoric), it does speak to some kind of a consistent correlation across the years.

Lastly, the associations between long- and short-term suppression and individual subscales is intriguing. Because of the small effects and the lack of cross-construct scale significance, the topic needs refinement before I can claim confident explanations. However, the findings imply that my original hypotheses are based in some truth. If long-term menstrual suppression is related to lower levels of collective self-esteem, it stands to reason that the choice to suppress in a semi-permanent way can function as an avenue for distancing oneself from womanhood. On the other hand, if short-term/manual suppression is related to the degree to which one feels entitled to sexual pleasure from a partner, it could be that occasional suppression is practiced in order to have sex on one’s partner’s terms, not one’s own.

What remains is the question of feminist theory. Which scholars are correct? Are reproductive technologies a malleable feminist tool, or are they laden with cultural meanings and pressures that undermine consumer choice? Although my hypotheses

leaned on the side of the latter, my findings were so partial that I only feel it is correct to land somewhere in the middle. The measure of neoliberalism was not correlated with anything, and I found evidence for the importance of components of Objectification Theory and gender roles but not for constructs in their entirety. Additionally, because so little variance could be implicated, I do not have strong explanatory power. It seems likely that these societal forces matter, but they do not overwhelmingly dictate choice. I believe it is important to continue studying these themes so that feminist researchers and healthcare providers can make room for as much agency as possible in healthcare decision-making. Still, motivations are varied, and as Gunson asserts: “When nature is simplistically defined as static and singular, as having only one authentic truth, there is little space to articulate identity other than in dualistic terms” (2016, p 322). Though feminists should make room for menstruators to make an informed choice about their nature, nature can be individual, constructed, and contested.

APPENDIX A INFORMED CONSENT

Informed Consent

This study is being conducted by Alexandra Weis, a graduate student at the University of Florida, working with the research lab of Dr. Alyssa Zucker (Center for Gender, Sexualities, and Women's Studies Research). In this research study, we are interested in your behavior, beliefs, and attitudes related to contraceptives, menstruation, and menstrual regulation. We will also ask you to fill out questionnaires about your experience of gender and the social environment. This study will take about 20 minutes of your time and it will be conducted entirely online. You will be compensated about £2.00 (~\$2.50) for your time. Your participation in this study will be confidential to the fullest extent provided by the law. No identifying information such as your name will be collected. Your Prolific ID will be used for only to compensate you for your work. It will not be shared with anyone outside the research team and will be deleted from the data after collection is complete. There is a minimal risk that security of any online data may be breached, but since (1) no identifying information will be collected, (2) both the crowdsourcing website (Prolific Academic) and the survey host (Qualtrics) use several layers of encryption, and (3) your data will be removed from the server soon after you complete the study, it is highly unlikely that a security breach of the online data will result in any adverse consequence for you. Only the researchers will have access to your information on the Qualtrics server. Researchers will not have access to identifying information (such as your name and email address) that you have provided to Prolific Academic. If you are interested, you may read about Prolific Academic's privacy policy [here](#), and Qualtrics's privacy policy [here](#). There are no anticipated risks or benefits associated with participation in this study. Participating in this study is voluntary and there is no penalty for not participating. You do not have to answer any question that you do not want to answer. You have the right to withdraw from the study at any time by closing the window. If you have questions about the study, you may contact Alexandra Weis (a.weis@ufl.edu), Graduate Research Assistant in the Center for Gender, Sexualities, and Women's Studies Research at the University of Florida. Who to contact about your rights as a research participant in the study IRB02 office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone 352-392-0433. By clicking the button below you are indicating that you have read the informed consent statements above and agree to participate.

APPENDIX B
BEHAVIOR QUESTIONNAIRE

We are interested in how you use birth control in your everyday life and whether it affects your menstrual cycle. As a result, we will ask you some questions in this section about your sexual behavior and your experiences using different kinds of contraceptives. Choose the answer that applies to you best.

BQ1 Do you currently use any of the following contraceptives? (Check all that apply)

- Birth control pills (1)
- Hormone shot (2)
- IUD (3)
- Arm Implant (4)
- Condoms (5)
- Other (6) _____

BQ2 Have you ever used any of the following contraceptives? (Check all that apply)

- Birth control pills (1)
- Hormone shot (2)
- IUD (3)
- Arm implant (4)
- Condoms (5)
- Other (6) _____

BQ3 In an average month, about how many times do you have sexual contact with a partner?

BQ4 On a scale of 1 to 10 (1 being no pain and 10 being extreme pain), how much pain do you typically experience during menstruation?

_____ (1)

BQ5 On a scale of 1 to 10 (1 being no symptoms and 10 being extreme symptoms), how much are you typically affected by PMS (for example, moodiness)?

_____ (1)

BQ6 On a scale of 1 to 10 (1 being no inconvenience and 10 being extreme inconvenience), how much are you typically affected by the “inconvenience” or having your period?

_____ (1)

BQT2 Menstrual suppression, sometimes called “skipping your period,” is a way of using certain types of birth control to avoid having monthly bleeding.

BQ7 Have you ever consulted with a doctor about suppressing your menstrual cycle?

- Yes (1)
- No (2)

BQ7 Have you ever suppressed your menstrual cycle?

- Yes (1)
- No (2)

Condition: No Is Selected. Skip To: If you have never suppressed your men....

BQ8 If you have suppressed your menstrual cycle, what method or methods did you use to do so?

BQ9 Have you ever suppressed your menstruation long-term (for example, by eliminating monthly periods with injections such as Depo-Provera or reducing monthly periods to 4 per year with hormonal pill cycles such as Seasonale)?

- Yes (1)
- No (2)

Display This Question:

If Have you ever suppressed your menstruation long-term (for example, by eliminating monthly periods with injections such as Depo-Provera or reducing monthly periods to 4 per year with hormonal pill c... Yes Is Selected

BQ10 How long did you suppress your menstruation in this way?

- Less than six months (1)
- Six months to a year (2)
- One year to two years (3)
- Two years to three years (4)
- Longer than three years (5) _____
- Did not suppress my cycle long-term (6)

Display This Question:

If Have you ever suppressed your menstruation long-term (for example, by eliminating monthly periods with injections such as Depo-Provera or reducing monthly periods to 4 per year with hormonal pill c... Yes Is Selected

BQ10 Why did you make the decision to suppress your periods? (Feel free to type as much as you need.)

BQ11 Have you ever “skipped a period” on your own (for example, by skipping the placebo week on your birth control pills in order to plan when your next period would be)?

- Yes (1)
- No (2)

Display This Question:

If Have you ever “skipped a period” on your own (for example, by skipping the placebo week on your b... Yes Is Selected

Q251 How many times would you say you skipped your period in this way?

- One time (1)
- Two to four times (2)
- Five to seven times (3)
- Eight to ten times (4)
- More than ten times (5) _____
- Did not skip my period on my own (6)

Display This Question:

If Have you ever “skipped a period” on your own (for example, by skipping the placebo week on your b... Yes Is Selected

BQ12 What caused you to skip your period? (Feel free to type as much as you need.)

BQ13 How likely are you to consider menstrual suppression or “skipping a period” in the future?

- Very unlikely (1)
- Somewhat unlikely (2)
- A little unlikely (3)
- A little likely (4)
- Somewhat likely (5)
- Very likely (6)

BQ14 What reasons would lead you to consider menstrual suppression or “skipping a period” in the future? (Feel free to type as much as you need.)

BQ15 How safe do you think menstrual suppression is?

- Very unsafe (1)
- Somewhat unsafe (2)
- A little unsafe (3)
- A little safe (4)
- Somewhat safe (5)
- Very safe (6)

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BIOGRAPHICAL SKETCH

Alexandra Weis will receive her Master of Arts in Women's Studies from the Center for Gender, Sexualities, and Women's Studies Research at the University of Florida in 2017. She will move on to pursue a PhD in the field of psychology, where she hopes to continue integrating feminist thought with social science practice.