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“Just because I don’t bleed, doesn’t mean I don’t go through it”: Expanding knowledge on trans and non-binary menstruators

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ABSTRACT
Objectives: Critical menstruation studies is a field in its nascence, marginalized within the broader area of reproductive health research. Menstruation-related research is virtually absent from trans studies, itself a marginalized field of inquiry. This article focuses on the experiences of trans and non-binary menstruators, to contribute to this burgeoning area of study.

Methods: This article involves secondary data analysis of a qualitative dissertation research study on trans people’s reproductive lives, health, and decision-making processes. Of the fourteen participants in the broader study, eleven discussed their perceptions of and experiences with menstruation and menstrual health. Those experiences where subjected to thematic narrative analysis, with a focus on themes that were substantively significant.

Results: Participants describe experiences with amenorrhea associated with the use of testosterone, menstrual resumption following the cessation of testosterone and for other reasons, menstruation-related dysphoria management strategies beyond medical interventions, as well as barriers to menstruation-related health care. One participant describes bloodless periods as a trans woman, a phenomenon altogether absent from the clinical and experiential literature in this field. The article explores how cisnormativity, repronormativity and transnormativity informed the participants experiences of menstruation and reproductive health care.

Conclusions: Contributing novel stories to the literature, this article illustrates how clinically focused research fails to attend to the experiential components of menstruation for trans and non-binary people. Expanded knowledge is beneficial to the development of gender-inclusive menstruation research, clinical interventions, healthcare environments, and activist efforts.

KEYWORDS
Transgender; non-binary; menstruation; reproductive health; secondary analysis

Introduction

In December 2019, a group of menstrual health researchers and activists gathered in Hermance, Switzerland. A self-proclaimed “bloody think-tank,” the goal of the event was to consider the needs of populations who are marginalized both within the burgeoning field of critical menstruation studies and the broader menstrual activist movement. Along with Equality North Carolina’s Policy Director Ames Simmons, I was invited to speak to the needs of trans and non-binary menstruators. We presented on a range of topics, including: the efforts by some companies to ensure their menstrual products and marketing strategies are gender-inclusive (Gonsalves, 2020; Landsverk, 2019), the importance of gender-inclusive language in both menstruation research and period activism (Carnes, 2018); and, recognizing the gaps in knowledge, a description of what little is known about trans and non-binary people’s experiences with and perceptions of menstruation. At the end of the gathering, we were asked to share our take-aways and preliminary ideas on how to mobilize what we had learned. Knowing that a secondary analysis of my dissertation data could contribute to the limited literature on this topic, I shared my plan – to write an article. This article aims to address this knowledge gap by contributing to the field empirical evidence about trans and non-binary people’s experiences with menstruation.
Researcher positionality

I am a non-binary person who menstruates and who struggles to navigate the gendered landscapes of reproductive health. While this article centers the experiences of people who participated in my dissertation research, I am inevitably also a subject of this inquiry, an in-between who is both researcher and researched (Milligan, 2016). Whereas at least two formidable thinkers in this field have struggled with whether and how to conduct research on this topic as cisgender people and trans allies (Bobel, 2010; Rydström, 2020), I have no such qualms. That is not to say that being a trans person in the field of trans studies exempts me from engaging in harmful (mis)representations of the trans and non-binary people who have trusted me with their stories. My liminal position does not remedy the power imbalance that inevitably exists between research participants and myself, nor does acknowledging my positionality eliminate my biases. Rather, I highlight my stakes in this conversation in order to expose how who I am has necessarily informed my research interests, the opportunities available to me to share these findings, and undoubtedly every other element of this data generation, analysis and writing. There is power and magic in the betwixt and between, as well as great vulnerability – I pull back the curtain on the researcher-as-impartial-ventriloquist (Allen & Cloyes, 2005) and expose how I bleed, quite literally, for my scholarship (Lowik, 2020).

Literature review

Menstruation and dysphoria

Much of the research, whether clinical/medical, experiential, or based in critical theory, explores the link between menstruation and dysphoria. While recognizing that not all trans and non-binary people experience a sense of distress or anxiety associated with their menses, that there is a possibility for dysphoria is often framed as the impetus for clinical interventions such as menstrual suppression (Akgul et al., 2019; Krempasky et al., 2020). This possibility of distress and dysphoria is particularly salient in the literature on trans and non-binary youth, where menarche as a component of puberty is understood as being associated with significant and worsening dysphoria (Frank, 2020; Raynor, 2020). It is acknowledged that ongoing menstrual cycles later in life may also be distressing, especially insofar as they are conventionally gendered and ascribed with deeply engrained social meaning about what it is to be feminine and a woman (Ahmad & Leinung, 2017; Frank, 2020; Guss, 2019; Kanj et al., 2019). Framed as an experience (cisnormatively) incongruent with their gender identities as not-women, menarche and ongoing menstruation prompt concerns over mental health and self-harming behaviors (Carswell & Roberts, 2017).

More than just the experience of cyclical menstrual bleeding, however, dysphoria may also be associated with: menstrual management and suppression techniques that require the vaginal/front hole insertion of tampons, menstrual cups or intrauterine devices (Akgul et al., 2019; Chrisler et al., 2016); the associated symptoms of cramping and breast/chest swelling, where these symptoms are made increasingly complicated for those who bind their chests (Bliss, 2018; Krempasky et al., 2020); taking medications associated with cisgender women such as combined hormonal contraceptives as well as estrogen-containing hormonal options (Krempasky et al., 2020; Pradhan & Gomez-Lobo, 2019) and purchasing and using feminized menstrual products (Bliss, 2018; Frank, 2020; Rydström, 2020). Managing menstruation in gendered public restrooms may also be triggering of gender dysphoria and distress, as these spaces can be characterized as sites of surveillance and gender policing, both in terms of their architecture and due to the watchful gaze of other users (Bliss, 2018; Chrisler et al., 2016; Fahs, 2016; Grace & Wellington, 2020; Pfeffer, 2017). From a lack of garbage cans and other disposal receptables in men’s bathrooms (Bliss, 2018; Frank, 2020), to the tell-tale sound of a pad or tampon wrapper (Carnes, 2018; Frank, 2020), to a lack of gender-neutral facilities generally, the use of gendered public bathrooms may be associated with increased dysphoria in and of itself, but concerns over personal safety are amplified when a person is menstruating.
**Menstrual suppression**

The available research focuses on the use of hormonal contraception technologies including depot medroxyprogesterone acetate and levonorgestrel intrauterine devices as effective menstrual suppression techniques, utilized to achieve therapeutic amenorrhea and therefore alleviate any associated gender dysphoria (Akgul et al., 2019; Chrisler et al., 2016; Kanj et al., 2019; Schwartz et al., 2019). Gonadotropin-releasing hormone agonists, commonly called puberty blockers, are also discussed in the literature as a tool to suppress puberty, menarche and alleviate gender dysphoria associated with its onset (Pradhan & Gomez-Lobo, 2019; Schwartz et al., 2019). Often menstrual suppression is discontinued upon initiation of gender-affirming hormone therapy regimens, specifically testosterone, which can be used to achieve amenorrhea on its own (Akgul et al., 2019). Those with incomplete menstrual suppression on testosterone may continue to use these, or try progesterone therapies, to achieve and maintain amenorrhea (Boudreau & Mukerjee, 2019; Schwartz et al., 2019).

Preventing menstrual bleeding and other menstrual symptoms is often not the main reason for initiating testosterone use, which has numerous other effects. Further, in many parts of the world, access to testosterone outside of the diagnostic framework of “gender identity disorder” is not possible (Rydström, 2020). However, the impact of testosterone on menstruation has been well-documented, with the literature indicating that cessation of menses most often occurs within 4-6 months of dose-dependent, continuous, bimonthly, intramuscular injections (Ahmad & Leinung, 2017; Carswell & Roberts, 2017; Nakamura et al., 2013; Schwartz et al., 2019). Amenorrhea is thought to occur as the result of endometrial atrophy and ovulation suppression, both of which may be incomplete (Boudreau & Mukerjee, 2019; Pradhan & Gomez-Lobo, 2019; Schwartz et al., 2019).

**Contraception**

Due to the potential for incomplete ovulation suppression, or ovulation breakthrough, there may be a need for contraceptive use among those on testosterone who are having certain kinds of sex (Kanj et al., 2019; Pradhan & Gomez-Lobo, 2019; Schwartz et al., 2019). However, there is evidence that some trans people and some clinicians alike have been confusing testosterone for a contraceptive (Gomez et al., 2016; Krempasky et al., 2020), likely due to a misunderstanding of the relationship between pregnancy risk and amenorrhea. To address the risk of unintended pregnancy, trans-competent contraceptive counseling and abortion care are therefore paramount (Krempasky et al., 2020; Lowik, 2018). Although no contraceptive methods are contraindicated when used alongside hormone replacement therapy regimens (Pradhan & Gomez-Lobo, 2019), some contraceptive methods may serve as unwelcome reminders of the person’s sex assignment and be triggering of gender dysphoria, especially those that cannot easily be concealed or which are self-administered periodically (Krempasky et al., 2020). Some opt for menstrual management strategies which do or may negatively impact fertility, such as hysterectomy, endometrial ablation, or aromatase inhibitors (Krempasky et al., 2020; Schwartz et al., 2019). As such, trans-competent fertility and family planning counseling are ultimately important considerations for those accessing these procedures and medications (Krempasky et al., 2020).

**Gender-inclusive gynecologic care**

Whether delivered by obstetricians and gynecologists (OBGYNs), primary care providers or specialists, trans and non-binary people have menstruation-related health care needs that must be met. However, trans and non-binary people are less likely to seek gynecologic care than cisgender people (Boudreau & Mukerjee, 2019; Chrisler et al., 2016). They may delay or altogether avoid this care due to numerous actual and perceived barriers. Despite being recognized as important by trans and non-binary people, how gynecologic care has been cisnormatively gendered is at the root of these barriers (Obedin-Maliver, 2015). Particularly, OBGYNs are having to reconcile their historical and ongoing exclusive and exclusionary focus on the health care needs of cisgender women, with the reality of trans and non-binary people’s identities and bodies (Obedin-Maliver, 2015). Many OBGYNs indicate
that they have received no training on how to serve trans patients and thus would not be comfortable doing so, especially in light of the lack of comprehensive guidelines to inform that care (Boudreau & Mukerjee, 2019; Krempasky et al., 2020; Obedin-Maliver, 2015).

When it comes to providing gynecologic and menstruation-related care to trans people, many recognize that OBGYNs are well-positioned in terms of their skills and competencies, and understand that the inclusion of trans people is not a threat to the cisgender women who also receive care at their hands (Obedin-Maliver, 2015). Instead, the health and social inequities that trans and non-binary experience are rooted in gender-based discrimination, violence, and systemic oppression. Therefore, commitments to alleviating these gender-based inequities by health care providers can be extended to include trans patients (Stroumsa & Wu, 2018). Ultimately, making room for trans and non-binary people who menstruate, and/or who need other kinds of care offered within traditionally gendered health spaces and other health care settings more broadly, is imperative.

Methods

Theoretical frameworks and concepts

The informational erasure which characterizes existent knowledge of trans and non-binary people and menstruation is the result of pervasive and often unquestioned norms in research generally, and within so-called women’s health research more specifically. Cisnormativity, repronormativity and transnormativity are the foundations on which the landscape of menstrual life and health research is built. Cisnormativity describes how sex and gender are assumed to be causally connected binaries, and where people are assumed to be cisgender (Bauer et al., 2009). Repronormativity describes both the maternalization of female-assigned bodies and women-identified people (Franke, 2001) and the paradigm that legitimizes only certain (cisgender, heterosexual, marital) acts of reproduction (Weissman, 2017). Finally, transnormativity describes a set of standards against which trans people are held accountable, including that trans people will identify in binary ways, and will access (or ought to desire access) to gender-affirming medical interventions (Johnson, 2016). One specific transnormative standard involves the expectation that trans people will completely renounce the sexed, gendered, and reproductive capacities associated with their sex assignment, where this renunciation is demanded as evidence of their authentic gender identities. Taken together, cis-, reproto- and transnormativities provide a useful framework for considering how, for example, menstruation has been understood as a uniquely and quintessentially cisgender women’s experience, why menstrual health care has been frequently delivered under the umbrella of women’s health, why trans men are expected to deplore their menstruation as demonstrative of their authentic identities as men, etc.

Recruitment, ethics and analysis

This study employed a convenience sample and snowball recruitment techniques. Initial recruitment involved circulating a recruitment postcard seeking trans and non-binary participants for a study about reproductive life. The postcard was circulated by mail to approximately 50 organizations and individuals who serve trans and non-binary people in both the Greater Vancouver Area and the West Kootenays in British Columbia, Canada. Each received a letter explaining the nature of the study, and 2-3 recruitment postcards to circulate among their clients, patients, or customers. A small minority of these recipients requested electronic versions to circulate via their listservs more easily. Beyond that, it is otherwise unclear if and where the recruitment postcards were distributed by these recipients. In both locations, I attended relevant community events and added recruitment postcards to community bulletin boards. In the West Kootenays, I made myself known at Trans Connect, a support program run out of ANKORS HIV/AIDS resource center, and I attended trans and non-binary drop-in hours at the Nelson and District Women’s Center. A Facebook page was also created for this project, which proved to be an advantageous component of the recruiting strategy.
The Facebook page was shared by community members of their own volition, including circulation within both open and closed queer and trans parenting, pregnancy and chest-feeding groups and the Vancouver Queer Spoon Share. Participants were encouraged to share the recruitment postcard or Facebook page with their peers.

The eligibility criteria for the study included: being at least 19 years old (the age of majority in BC), being able to communicate in English, being trans or non-binary, living in either the Greater Vancouver Area or the West Kootenays at the time of their initial interview, and having discussed at least one facet of reproductive life or health with a health care provider. In total, 14 people participated in the research, eight from the Greater Vancouver Area and six from the West Kootenays. This dissertation research was interested in unpacking the relationship between gender identity and reproductive life generally, and where the participants discussed a wide range of reproductive experiences. This article involves secondary analysis of the existing data, focusing specifically on the discussions of menstruation which occurred within the context of the interviews. Menstruation and menstrual health, in this case, were not the sole foci of the original work; however, the topics of menstruation and menstrual health were discussed by 11 of the 14 participants, where indicative but not exhaustive extracts are included in this analysis.

Approval for this research was sought from the Office of Research Ethics’ Ethical Review Board at the University of British Columbia. Once approval was granted, the recruitment of participants began. Each participant was required to sign a consent form and all interviews were conducted at various quiet locations at their discretion that offered privacy from onlookers. In field notes, interview transcripts and digital photograph files, participants are identified only by a pseudonym. The method for this study involved an initial interview, a participatory photography process where each was invited to create or collect existing photographs on the topics of gender, reproduction and health care, and a follow-up interview where the photographs served as elicitation tools to prompt further discussion (Harper, 2002). Participants were asked to rate each photograph that they selected for inclusion in the study on a scale from 1-3 (Holtby et al., 2015), where images rated at 3 could be shared broadly, including in publications. All the images included in this article were rated as 3s by the participants.

All interviews were audio-recorded, transcribed and all references to and discussions of menstruation or menstrual health were extracted. These extracts and relevant photographs were analyzed using a thematic narrative analysis approach (Parcell & Baker, 2017). Each of the interview excerpts and photographs were clustered in noteworthy and meaningful themes. Themes were generated based on their substantive significance, where significance is determined not based on frequency, but rather on how the participants’ stories expanded knowledge and deepened understanding of this nascent subject of inquiry (Floersch et al., 2010). Thematic analysis is combined here with narrative analysis, which focuses on how participants engaged in meaning making via the telling of their stories, where their stories and photographs are laden with affect, interpersonal relations, temporality, and the strategic use of language (Floersch et al., 2010). The aim was to consider how the study participants made sense of and experienced their menstruation, with special attention paid to how their stories expand our knowledge beyond that which has been written about trans and non-binary people and menstruation thus far.

**Sample**

The 11 participants in this secondary analysis ranged in age from early 20s to early 60s, with the majority being in their 30s at the time of the study. Six participants were born in British Columbia, one in Manitoba, one in Quebec, two in the United States (one East Coast, one West Coast) and one in Eastern Europe. All were living in either the Greater Vancouver Area or the West Kootenays at the time of our initial interview, some being new to each area and others having lived in that area of British Columbia for years.

The majority of the participants (n = 9) described themselves as unemployed, under-employed, precariously employed, on disability/
government assistance or working class (including artists, front-line workers, administrators, people working in service, hospitality and transportation industries, students and those in career training programs). Some of these participants indicated that while they personally were working class, they came from middle to upper-class families, and saw themselves benefitting from some of the privileges associated with their upbringing. The remaining two participants described themselves as middle-class (one was a graduate student and the other a registered massage therapist in training). Ten of the participants were white, and one was mixed-race.

Only two participants indicated having no disabilities, medical or mental health issues. The remaining nine described a variety of disabilities, medical conditions, and mental health challenges, including some discussed within the context of menstrual health, namely polycystic ovarian syndrome, endometriosis, post-traumatic stress disorder and dysmenorrhea.

The sample was relatively heterogenous in terms of sex assignment, with 10 participants who were assigned female at birth (AFAB) and only 1 participant who was assigned male at birth (AMAB). Both gender identity and sexuality varied substantially for the participants, each of whom was asked to describe their gender identity and sexuality in their own words. Many participants indicated that they used multiple terms to describe these facets of their identities. In terms of gender, reported identities included: trans, non-binary, femme, genderfluid, gender-queer, agender, masculine of center, trans man and trans woman. One participant described their gender simply as ‘infinity,’ and spiritually tied to the number eight. In this article, I use the pronouns participants explicitly told me to use, recognizing that these may have changed since the time of their involvement in the study and making note of when participants use more than one set of pronouns interchangeably. In terms of sexuality, reported identities included: gay, lesbian, bisexual, pansexual, demisexual, panromantic, queer and kinky. Three participants described their relationships as monogamous, seven described their relationships as non-monogamous (using terms such as non-monogamous, polyamorous, and relationship anarchy) and one participant did not mention whether they were monogamous or non-monogamous.

Results and discussion

The bloodless period

An increasingly common refrain among menstruation researchers and activists is not all women menstruate and not all people who menstruate are women (Bobel, 2010). The intention behind this statement is to untether this embodied reproductive phenomenon from gender. Meant to draw our attention not only to the menstrual experiences of AFAB trans and non-binary folks, this mantra also reminds us that there are many girls and women who do not menstruate and are no less women as a result. The non-menstruating women are often enumerated as: premenarchal girls, postmenopausal and post-hysterectomy women, intersex women, women experiencing cancer treatment-induced amenorrhea, women who do not bleed for any number of other reasons, and trans women (Bobel, 2010). It is true that trans women and other AMAB trans folks do not bleed. This lack of menstrual bleeding may even be distressing, insofar as it is a gendered phenomenon in and of itself, but also because it is cis- and repronormatively understood as a sign of potential motherhood (Richard, 2017). However, some AMAB trans folks who access gender-affirming hormone therapy do report period-like symptoms (Kailyn, 2016; Riedel, 2016). AMAB trans people on estrogen-based hormones report everything from nausea, bloating, mood swings and food cravings, and some use period-tracking apps to chart the cyclical pattern of these symptoms (Kailyn, 2016).

Sophia is a trans woman in her early 60s, who started her medical transition in her late 50s – she had had bottom/genital surgery and been on gender-affirming hormone therapy for a few years at the time of her participation in this research. She explained,

As a trans girl, I hope for that time of the month. I have my week, you know, just because I don’t bleed doesn’t mean I don’t go through it, because I have
the issues and everything else to do with it… I don’t think having a period would be a bad thing, to me, okay? I would deal with it, because the woman in me would love to have had to do that, and it sounds disgusting as fuck, but… my own feeling is that I’m a woman, I would have loved to have experienced that on a regular basis, and I do, on a monthly basis – I don’t do the bleed, but I do have the other issues, and I can deal with that.

Here, we see Sophia describing her desire for menstrual bleeding in a way that recognizes its gendered connotations, where menstruating would be affirming of her identity as a woman. Despite imagining menstruation as distasteful, Sophia nonetheless indicates that she would love to have had the experience of cyclical bleeding. Beyond menstruation-as-bleeding, however, Sophia indicates that she does experience other menstrual symptoms. When asked whether she knew that these symptoms could occur, Sophia said, “When I started hormones, no… it’s something that I’ve talked to other trans women about, but I know my cycle. I am right back on, the week of the 15th, and it just comes on and I know.” When asked to describe what kinds of symptoms she experiences, Sophia said she, “Gets bitchy. I get cramps. I’m coming up to it starting… I get little things like that… It’s like they say, like, when I started the hormones and as soon as that patch went on, and it started to kick into my body… it was like a lightbulb went off and suddenly… I was right.” Sophia attributes these menstrual symptoms to her hormone regimen, and as one component of her being right about and in her gender. Is it possible that our fixation on the bleeding element of menstruation has resulted in the invisibility of other components of hormonal, menstrual cycles, such that the menstrual experiences of AMAB trans people are dismissed and invisibilized? Indeed, a single scientific study has been conducted on this topic, and it is unclear whether these symptoms are psychosomatic or physiological (Riedel, 2016). Sophia’s experience of a bloodless period, alongside the experiences shared by other AMAB trans people on blogs and in editorials, prompts important questions about the limits of research that focuses exclusively on the bleeding element of menstruation, and/or exclusively on the experiences of people who were assigned female at birth.

Adding complexity to the narrative of menstruation as dysphoria, suppression as relief

The experiences described herein add complexity to the dominant narrative that suggests that menstruation is always triggering of gender dysphoria for trans people, and that menstrual suppression is also the remedy to that distress. Jamie, a trans man in his early 30s, described how testosterone-induced amenorrhea alleviated his menstruation-related gender dysphoria. He indicates that, …after I went on T, after the first couple of months until I stopped bleeding… it was like super dysphoric to have my period. Like, I was like compartmentalizing so hard. And also, for some reason, it got more painful. Like I felt it was more painful, like there was also like emotional pain… And then it like, after like… 3 or 4 months on T, it stopped and it never like happened again and I’m honestly so glad. Just like not to have to think about any of it anymore.

For Jamie, painkillers could alleviate some of the physical pain he endured during those first months on testosterone, and while he acknowledged that “there was never anybody who was or is a woman who liked having their period,” amenorrhea was the ultimate relief of his menstruation-related gender dysphoria. This unification of body and identity is similarly described by participants in other qualitative research (Raynor, 2020), although what Jamie’s stories provides, is insight into how physical and emotional period pain and the resulting dysphoria may become worse on testosterone before it gets better.

For Elliott, a trans non-binary person, femme, and gestational parent of a toddler, their first few months of testosterone were characterized by physical and emotional extremes. Due to an error in calculating the correct dosage, Elliott was incorrectly administered 400 mg of testosterone for their first injection – they credit the “trans underground,” both online and in-person peers, with helping them adjust their dosage to a more reasonable level. However, they quickly realized that a two-week injection cycle, even at the correct dosage, was untenable for them – they describe “having PMS symptoms every 9 days… it turns out that like, my body just metabolizes everything quicker than most, so like, I can’t
handle a two-week injection cycle... luckily by that point, I had comprehensive care and was able to be like ‘let’s half you and put you on weekly,’ and that kind of solved the problem.” Years later, Elliott decided to stop using testosterone, allowing their menstruation and ovulation cycles to return so that they could gestate, birth, and tit-feed (their terminology) a child. During this process, they experienced some of the most intense periods of their life, which caused them to reconsider whether being a breeding parent (their terminology) was something they could achieve. They also experienced a first-trimester miscarriage, which their doctor insensitively celebrated as evidence of their restored fertility following cessation of testosterone, but which Elliott described as a “hard, emotional scab” that they would need to overcome.

Despite steadily increasing their dose of testosterone to achieve amenorrhea, Riley, a non-binary trans person in their early 30s, never stopped menstruating, an experience that is not uncommon (Pfeffer, 2017). Due to their facial hair growth, Riley describe how women’s bathrooms were no longer safe for them, and that men’s bathrooms were challenging to navigate while bleeding. Ultimately, Riley developed severe and painful acne and had to stop using testosterone. All the while, they were unsure as to whether their fertility would return alongside their menstruation, having signed a consent waiver when they initiated their testosterone regimen which they sarcastically describe as reading, “you may have loss of reproduction capabilities. Sign your life away here.”

For Will (he/him, she/her, and they/them), relief from menstruation-related gender-dysphoria occurred through a two-pronged process and did not involve the use of menstrual suppression. First, Will reimagined their gender outside of the conventional language of trans identity and began to describe their gender using descriptors of her own making – infinity or eight. Second, Will’s participation in sweat lodges and other spiritual practices facilitated their ability to reframe their moon-time (her terminology) as “time of purification, a cleansing, letting things go, um... that it is a sacred time for the self.” Photograph 1 depicts an infinity symbol or sideways eight held over Will’s abdominal and pelvic region, the source of his cramps and bloating, and illustrative of his efforts to reframe not only his periods but his entire reproductive system in his own terms. Nash, a client in Fahs’ therapeutic practice and a subject in her 2016 chapter “The Menstruating Male Body”, was similarly able to reframe his periods as masculine to alleviate the dysphoria associated with their arrival. Clearly, reimagining menstruation beyond its cisnormatively gendered conventions is an effective strategy undertaken by trans and non-binary people, and Will’s Photograph 1 is an artistic depiction of those efforts.

Finally, Deacon is a genderfluid person who was amenorrhoeic for four years due to polycystic ovarian syndrome (PCOS). When their period returned, they had to manage their conflicting feelings. On the one hand, they were relieved because its return meant that they had successfully managed their PCOS. On the other, they describe their period as a bodily reminder of “Hey! Yeah! We can have babies! Hey! Yeah! When are you having babies? Babies?!” where they had no interest in having children.

From these five participants’ experiences, we see that merely documenting when amenorrhea occurs as is the focus of much of the clinical literature, is insufficient. For Jamie, Elliott and Riley, the multi-month process of (un)successfully achieving menstrual suppression had qualitative components that are lost by focusing exclusively on the temporality of these processes. Elliott and Riley’s experiences of menstrual resumption following the cessation of testosterone are also largely absent from the existing literature. In Will’s case, relief from
menstruation-related gender dysphoria did not involve menstrual suppression and for Deacon, the return of their menstrual cycle was indicative of their returning health, even if the state of PCOS-induced amenorrhea had been gender-affirming. Taken together, their experiences add complexity to the dominant narrative which positions menstruation as dysphoria-inducing and menstrual suppression as the remedy.

**Cis-, repro- and transnormativities**

Huxley (they/them and she/her) is a genderqueer person in their early 30s with post-traumatic stress disorder resulting from a sexual assault. She described how, because of that violent experience, the prospect of pregnancy was so deeply distressing that she would rather die by suicide than be pregnant even with pregnancy termination options available. Although the cramps are “a drag,” they described their period as empowering, affirming, and a cyclical sigh of relief that they are not pregnant. For Huxley, the act of bleeding was not dysphoria-induced but empowering. It was the potential for pregnancy which was triggering of their post-traumatic stress disorder. At the time of their initial interview, Huxley had decided that a tubal ligation was their best option for ostensibly eliminating their risk of pregnancy, all the while allowing them to continue ovulating and menstruating.

In **Photograph 2**, we see an exchange between Huxley and their partner, when Huxley was preparing to ask for a tubal ligation procedure. Elicited by this first photograph, Huxley described at length how the doctor tried to dissuade her from a tubal ligation, and how she went about convincing them that she “deserved to be sterilized.” Huxley itemized some of the reasons why the doctor was reluctant to provide her with a tubal ligation, including that she might regret the decision later especially because she was currently childless, and considering that her future hypothetical partners (presumed to be cisgender men) might desire children that she would thereafter be unable to provide. This gatekeeping of voluntarily undertaken medical interventions which foreclose fertility and procreative possibilities has been well-documented among cisgender women and critiqued for being patronizing, patriarchal and an impediment to reproductive freedom (Denbow, 2015). Gatekeeping these surgical interventions is emblematic of pervasive repnormativity in medical establishments. Huxley navigated these concerns, and the repnormative logics which underpin them, by reassuring the doctor of their certainty and demonstrating their awareness of and comfort with the potential risk of regret.

What makes Huxley’s experience unique is her deployment of an inventive pragmatism technique, which Pfeffer describes as “active strategies and actions that might be considered clever manipulation of existing social structure in order to access social and material resources on behalf of oneself or one’s family” (2012, p. 578). Huxley intentionally elected to conceal their genderqueer identity, for fear that her access to the procedure would be denied or delayed on that basis. Huxley worried that the doctor would incorrectly assume that their request for such a surgical intervention was a step in their gender-related medical transition - that is, Huxley did not want the doctor to think that she was experiencing gender-related dysphoria associated with her uterus and
reproductive capacity, and as such, was seeking tubal ligation as a ‘treatment’ for that dysphoria. Huxley describes how she strategically allowed herself to be misgendered as a “poor traumatized lady,” where she imagined that the doctor’s reasoning was,

she’s just fucked up and stuff and so she just wants to like, reclaim her body so, you know, I can help her out with this, she’s of a certain age where, you know, we stop caring about women having children because they’re not, you know, performing well in that way, [laughing] so you know, no harm, no foul.

Huxley was ultimately able to leverage her post-traumatic stress, her increasing age, and in an act of inventive pragmatism, her ability to pass as a cisgender woman, all to her advantage and she was ultimately approved for the procedure.

Eli, a non-binary person in their early 30s, also experienced medical gatekeeping. After years of having gynecologists condescendingly dismiss their pain because “periods are painful,” they were able to find a surgeon who agreed to do exploratory surgery and discovered extensive evidence of endometriosis. Despite their diagnosis, they described how, “strong paternalistic desire to safe-guard the capacity of anyone who can reproduce, to be able to reproduce, interfered with my ability to get the medical help that I needed.”

Like Huxley, their age at the time was a factor, where doctors adamantly refused to provide them with a hysterectomy because they were understood as still being of reproductive age, despite the debilitating pain they experienced and their insistence that they had no desire to use their body in reproductive ways.

Eli was ultimately referred to a pelvic pain specialist who had been recommended on the basis of her being “trans-friendly,” and they were hopeful that the person would be about to “interact with my gender in a way that felt at minimum not violent.” However, Eli described how the provider was immediately distrustful of them, saying,

I’ve had guesses that maybe… there were a lot of people going to her, being like, “I have pelvic pain, nudge, nudge,” you know? Um, when it was harder – ‘cuz this was… five years ago, and it’s easier now in some ways, but it’s not always been such a… clear path for folks who do elect to get a hysterectomy for gender affirmation, and, I’ve had thoughts that like, maybe, she just felt like over-used in that, and she saw me and she just – felt like she was, like, “I know what this person is doing. Um, and I’m not having it.” And she got so angry at me. And she was, like, “I don’t even think you have endometriosis!” I was like, “Well, like, I have the film from my surgery, like, you can look at it!” [Laughing] … the two of us were yelling at each other in the room, and it was so hurtful and she was, she was telling me, she was like, “I will not sign off on this surgery…” and she’s like, all of these horrible things, and I, I left. Because it was really – I mean, it was super delegitimizing. I’ve been dealing with this pain since I was like fifteen years old, and… to just have this person be like, “That’s not real because of what you look like, so I think you’re trying to game the system by pretend.”

Providers Eli had interacted with earlier in their life dismissed their pain and paternalistically refused them any medical interventions in ways that reified cis-repronormative, gendered expectations for their hypothetical future family life. Whereas Huxley elected to strategically not disclose their genderqueer identity, Eli choose a provider based on a recommendation that they were trans-friendly. This specialist, however, could not see past Eli’s non-binary identity. Despite having clear evidence of their diagnosis, she violently refused them a hysterectomy based on the false assumption that Eli was ultimately lying and trying to bypass the lengthy process for accessing gender-affirming hysterectomy by faking endometriosis.

In Photograph 3, Eli’s aim was to subvert the traditional, pregnancy announcement photoshoot. They described the photograph as pushing back against the dominant narrative which positioned their body parts as necessarily gendered and reproductive. For Eli, their uterus was neither a gendered nor a reproductive organ – it was simply an unnecessary body part that caused them pain, but where cis-repro- and transnormativities impacted their ability to access to treatments which would alleviate that pain.

Huxley and Eli’s experiences, together, prompt consideration of how menstrual cycles are more than bleeding that needs to be managed, but necessarily tied to issues of fertility and sterility, which are themselves heavily, cis-repronormatively gendered in contemporary Western society. Further, their experiences are exemplary of transnormative
assumptions and expectations. Fears over how transnormative narratives would impact their care prompted Huxley not to disclose their gender identity, an act of inventive pragmatism aimed at securing their access to their sought-after treatment (Pfeffer, 2012). Additionally, despite a diagnosis of endometriosis and half a lifetime of debilitating pain, Eli’s request for a hysterectomy was understood through a transnormative lens, where the only fathomable explanation for their request, at least according to the specialist, was that they were trying to game the system. When certain procedures, when requested by trans and non-binary people, are understood as warranted exclusively within the context of gender-affirming medical transition, it becomes unthinkable that a person might need these procedures for other reasons.

Conclusion

Critical menstruation studies is a marginalized field of inquiry within the broader field of reproductive health research. Further, menstruation-focused research is virtually absent from the field of trans studies. As a result of these multiple marginalities, little is known about the experiences of trans and non-binary menstruators and that which is reported is often focused on addressing clinical questions, to the exclusion of the experiential. This article seeks to address this gap by carefully considering the experiences of trans, non-binary and infinitely gendered people. In particular, it explores: experiences which complicate the dominant narrative of menstruation-related dysphoria and menstrual suppression as relief; the impacts of cis-, repro- and transnormativities on access to reproductive health care; and the often overlooked phenomenon of the “bloodless period” described by AMAB trans people who access estrogen-based hormonal interventions. Based on this analysis, there is a pressing need for comprehensive guidelines, standards of care and physician training which do not assume a one-size-fits-all approach to menarche, menstrual management, and suppression. Consideration needs to be paid to the processes of menstrual and fertility resumption, including but not limited to that which occurs following the cessation of testosterone. Being trans or non-binary further complicates access to reproductive health care, which is already replete with well-documented barriers. The stories shared by the people who participated in my dissertation research expand our understanding of trans and non-binary menstruators and contribute novel experiences to this nascent area of study. More than a necessarily dysphoria-triggering blood management issue, the experiences shared here remind us that a more comprehensive picture of trans and non-binary peoples’ menstruation and menstrual health is necessary.

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Ethics

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