Menstrual symptoms: the importance of social factors in women's experiences

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ABSTRACT

Background
Menstrual disorders are a common presentation in primary care. Heavy menstrual bleeding is the most common concern, and is often treated by medical and surgical means despite lack of pathology.

Aim
To explore women's experiences of menstrual disorders.

Design of study
Two qualitative studies using semi-structured interviews.

Setting
Inner-city London.

Method
An initial study recruited women with heavy menstrual bleeding via their GPs. A follow-up study recruited women with a variety of menstrual problems via general practice and the community. Interviews were taped and transcribed then analysed using the constant comparative method.

Results
Management of menstruation was a prominent theme in interviews. Women acted to comply with a strong social message that menstruation should be concealed, although this behaviour was often 'taken for granted.' The need to conceal evidence or reminders of menstrual bleeding was particularly important. Onset of menstrual symptoms often challenged established strategies for menstrual management. Menstrual management then became a conscious problem and a source of continuing stress. The breakdown of management strategies, by real or threatened episodes of leaking or staining, influenced consultation behaviour and decisions about treatment.

Conclusion
The social pressure to maintain concealment of menstruation is a strong influence on women's health-related behaviour in response to menstrual concerns. Women's choices may be better understood if attention is paid to the social context in which they live.

Keywords
health behaviour; menstruation; menorrhagia, qualitative research; referral and consultation

INTRODUCTION

Menstrual disorders are a common presentation in primary care.[1] Menorrhagia, or heavy menstrual bleeding, has been the most common cited reason for hysterectomy, despite frequent lack of pathology.[2] Women's reports of heavy bleeding do not correlate well with blood loss, which has led to questions about what women are actually concerned about.[3] Lilford remarked on women's willingness to undergo extensive medical and surgical treatment despite lack of pathology, and suggested that more research was required on the psychosocial factors that influence women.[4] Stirrat suggested that greater attention to 'puzzling' psychosocial influences is required to understand women's health-related behaviour.[5]

In psychosocial studies the emphasis has been on characteristics of women as individuals, for example, studies exploring attitudes to menstruation or psychological morbidity.[6–9] The status of menstruation in society as a whole has not been seen as important when considering women's concerns about menstruation or their menstruation-related behaviours.

Available evidence about the status of menstruation comes from anthropological and sociological literature. Anthropological studies that examined perceptions of menstruation in different cultures have, in the past, conformed to a 'menstruation-as-pollution' agenda.[10] The existence of a universal menstrual taboo and universal views that menstrual blood is polluted was challenged in 1988 by Buckley and Gottlieb.[11] They suggested that such an understanding presumed mono-causal explanations, and was often a product of a male perspective. By presenting studies that refuted

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a universal taboo[12,13] they called for an increased emphasis on fieldwork to examine women's experiences and sense of agency. Recent work emphasising women's experiences confirmed considerable variation in response to menstruation within and between societies.[10,14]

Sociological evidence suggests that menstruation is subject to restrictions in the West, in particular that menstruation should be concealed. Studies of teenage girls show that the message they receive is to 'live as if they are not menstruating'.[15,16] US and UK interview studies report that women identify a range of people with whom they would not discuss menstruation.[17,18] Laws coined the term 'menstrual etiquette' to describe the boundaries around women's menstrual behaviour.[19] The influence of this etiquette on women's menstrual problems and their presentation to medical care is not clear.

In this paper the findings from two interview studies are used to demonstrate the often 'taken for granted' social rules that govern the behaviour of menstruating women, and how those rules influence decisions about menstrual disorders. Primary care practitioners have indicated difficulties in assessing women with menstrual disorders[20] and adult female patients have reported not being understood by practitioners.[21,22] An explicit recognition of the social rules relating to menstrual behaviour in our society may provide a context in which women's needs and choices can be more clearly understood.

How this fits in

Many women treated for menstrual concerns do not have a discernible pathology. The validity of their concerns has been questioned. It has been documented that women are willing to undergo extensive medical or surgical treatment despite lack of pathology. Women's accounts indicate the presence of strong social pressures to keep menstruation concealed. The most important part of menstruation that is concealed relates to menstrual blood. The onset of new symptoms or changes in symptoms and circumstances challenge women's existing strategies of menstrual management. Such changes often result in stress and can influence health-related behaviour.

METHOD

Twenty-one women were interviewed in 1997 and a further 22 were interviewed in 2000–2001. The women were all resident in one inner-city health authority area in London, UK. The age range of interviewees was 18–57 years. The sample was representative of the ethnic make-up of central London. Women described themselves as: white English (*n*=21), black British and Caribbean (*n*=11), white Irish (*n*=4), white Scottish (*n*=2), Asian (*n*=2), Nigerian (*n*=1), Malaysian (*n*=1), and Italian (*n*=1). Details of the method used in the first set of interviews have been described.[23] In brief, women who consulted primary care services about heavy periods were recruited for interview by their family doctors. The second set of interviews was designed to follow up and explore the categories and themes generated in the first set of interviews.

The second study aimed to maximise variation in the sample. Women with any menstrual problem, whether or not they had consulted, and women who did not report any problems were recruited. A variety of recruitment methods were used: notices were placed in women's centres, community clinics, and general practice surgeries, and nurses and doctors working in primary care were asked to bring the study to the attention of women attending for routine registration health checks and to those who had a menstrual concern. Recruitment continued until important themes were saturated.

A topic guide was used for the interviews. Women were encouraged to talk about any aspect of menstruation: their first periods, how they had learned about menstruation, and problems they experienced with menstruation. Women who had problems or who sought medical help were asked about help-seeking behaviour and their consultation experiences. Interviews were taped with the participants' consent and professionally transcribed. The majority of interviews took place in interviewees' homes and the remainder in the offices of the Department of General Practice, King's College London. Coding and the development of analysis were discussed with an experienced qualitative researcher.

Interviewees were asked if they wished to receive copies of the results. Twelve interviewees from the first study indicated that they wanted to see the results and five replied that the results represented their views. Of the second set of interviews, one interviewee preferred to see the interview transcript and another wished to see all summaries and reports. Constant comparative analysis was used to develop categories and themes.[24] NVivo was used to organise the developing analysis.

RESULTS

The initial aim of the interviews was to explore women's labelling of their menstrual symptoms as problematic and their experiences of medical care. The overwhelming importance for women of managing menstruation within social boundaries had not been anticipated before the interviews, but this was quickly apparent. Restrictions on behaviour, both verbal and non-verbal, fit the description of subliminal rules which we may not be aware of, but which govern how we behave and think.[25] Much behaviour around menstruation was 'taken for granted' by women, and the reason for their behaviour was presumed to be self-evident.

Box 1. Perceived social rules related to menstruation.

- 1. A woman must keep private that she is having a period by wearing suitable clothes and by changing usual activities to prevent any visible evidence of sanitary protection.
- 2. She should avoid any episode of staining or leakage by changing activities, and/or by wearing adequate protection in advance of her period.
- 3. A woman will not explain absence from work or difficulties in carrying out duties by explaining that she is menstruating.
- 4. If a woman feels she must give some explanation, she should say she has stomach cramps or that she is unwell.
- 5. A woman will talk to other women about periods only if she knows the other person well, and if the other woman is judged likely to be understanding or to have helpful information and they are in private.
- 6. A woman may speak to another woman who she does not know well if the alternative is breaking the rule that a period must be kept private.
- 7. In relation to rules 5 and 6 above, non-specific terms or euphemisms such as 'time of the month' are adequate.
- 8. It is particularly important not to talk to men about periods; it is considered appropriate to inform sexual partners about menstruation, but sexual intercourse at this time may be considered distasteful.
- 9. Men and women may be aware that you are having a period, but they will abide by the rules and not mention it.

Women related stories about their experiences, often alluding to menstruation or using euphemisms and assuming their behaviour would be understood by the female interviewer. Concealment of menstruation was a prominent theme in terms of women's experiences of menstruation in general, and their definitions and experiences of menstrual complaints. The following results demonstrate perceived boundaries of behaviour and their influence on women's concerns and help-seeking. Names used are pseudonyms.

Menstrual etiquette

The concealment of menstruation, as reported in sociological studies, was important for all of the women interviewed. They aimed to conceal menstruation by verbal and non-verbal means. While women aimed to conceal all aspects of menstruation, it was most important to conceal aspects of menstruation related to blood loss. Vague allusions to abdominal discomfort could be communicated, but any suggestion of staining or the obvious carrying of sanitary protection was avoided. There were few reports of visible leakage or staining, but women were horrified at the possibility of such an occurrence. Dress was altered and activities changed to avoid any indication of menstruation.

Menstruation would not be mentioned when talking to men other than sexual partners. In general, women did not talk to other women about periods except when in a crisis, such as when at risk of staining or in private settings. Women chose other women to speak to because they were perceived to be sympathetic or might have some useful information, for example, if they had medical or nursing qualifications. Asking for help or being asked for help could result in mutual disclosure, but this was not a certainty.

Younger women reported talking among themselves about periods, but this was usually in relation to pregnancy risk. There were few discernible differences by ethnic background in regard to concealment. The prohibition against entering certain places of worship during menstruation was recounted by interviewees who had grown up in Asia; the women reported that this was not openly discussed. Box 1 provides a summary of the rules women sought to conform to.

Women's experiences of coping with menstruation in the workplace were particularly revealing of rules around menstruation. Women in professional or managerial roles had some control over their activities and could alter these according to need, but women lower down in a hierarchy had to explain absence or poor work performance. Menstrual problems would not usually be declared and menstrual-related absence was explained by alluding to abdominal discomfort or being unwell. This increased the difficulty of coping with symptoms for women who felt unable to explain their problem to colleagues or managers:

> *'I'd go through, like, there is all different line managers. I'd go through my supervisor, she's a woman. I wouldn't say I had period pains, I'd just say that I had stomach pains.'* (Crystal, 33 years, suffers from period pain, consulted a practice nurse.)

> *'I wouldn't, even if I was dying of pain. I would say I had a cold or something.'* (Miriam, 31 years, known to have endometriosis and awaiting fertility treatment.)

Concealment was maintained as much as possible, even in a predominantly female workforce. Deidre indicated how she managed to change sanitary protection at work while maintaining concealment:

> *'I must admit though, when I used to work I used to find it a bit awkward because, as I said to you, I use the night-times one which don't really come compactly packed. But the method that I thought of on the spot, as opposed to going from the canteen to the toilet, instead of carrying my bag which is indicating that I'm going to, you know, I stick it under me armpit. But you do think up these little tricks as you go along to sort of try and spare your embarrassment. I mean, even if the canteen is full of women, you still really ... you know.'* (Deidre, 41 years with a long history of heavy bleeding.)

Women who perceived that they were at high risk of breaching concealment sought out colleagues who they thought would be sympathetic. This was a risk, and required negotiation. Colleagues were chosen because they were perceived to understand and were then often depended on to aid concealment. Some interviewees reported that their work colleagues knew more about their menstrual symptoms than immediate family or friends:

'This supervisor, she is very good. There are a good few supervisors. I mean there are guys as well and I wouldn't speak to them. This girl, luckily enough the same time that I am on my period, she is always around kind of thing. I am sure if I said to one of the other girls that I wasn't feeling well that they would let you off.' (Fiona, 38 years, recent onset of cramps and heavy bleeding, recent consulter.)

Two interviewees said they tried to be open with colleagues and acquaintances, particularly if quality of work was affected. One interviewee reported heavy bleeding while the other had no identified problem:

'People do get embarrassed about it, but then I suppose its like trying to break a taboo and try and say, well you know this is what goes on, and it does make you feel maybe different from another day.' (Angela, 38 years, non-consulter, identified no menstrual problems.)

Heavy, prolonged and irregular bleeding also interfered with sexual relationships. For some women and/or their partners, there was an acceptance that sexual intercourse at the time of menstruation was not appropriate. Women commented that this was an unrecognised and rarely discussed problem which was often not openly discussed even within the relationship.

Acknowledgement of menstrual etiquette

Although women acted to comply with the etiquette of concealment, this behaviour was accepted with little consideration of its origin or function. The behaviour was generally 'taken for granted' and women were unable to provide a rationale for their behaviour.

Deidre had a teenage daughter and she was teaching her daughter to be discreet:

'And I've also taught my daughter to be discreet as far as possible.'

Interviewer: Do you think that's important?

'Yeah. But don't ask me why ... [laughs] *but it just is. It's just not something that you openly ... I don't know if it's because it's to do with blood and it's messy and ... I think a bit of it is where it's coming from as well. I think that's definitely got something to do with, you know.'* (Deidre, 41 years with a long history of heavy bleeding, recent consulter.)

Although some interviewees believed that menstrual blood may differ from other blood and not be connected to the general circulatory system, no interviewee expressed beliefs that menstrual blood was in any way dangerous or 'polluted'. Some interviewees' views were informed by feminism and these women considered that the emphasis on concealment should be challenged.

The probing of women's menstrual-related behaviour in the interviews caused women to reflect on their actions. Women were uncomfortable that their conduct appeared to be governed by social rules. The existence of such rules was challenged by some interviewees who felt that times had changed and such issues were no longer hidden. However, their language and the accounts of their behaviour contradicted such statements. Helen, for example, was dismissive of the importance of rules but continued to use 'the curse' as a term for menstruation and reported concealment in a similar way to other interviewees:

'I think that it's very much a women's issue these days, I think, I suppose ... I've always called it the curse, and people say, what do you mean the curse? But I think for women of my generation it's something that you can talk about, that isn't hidden.' (Helen, 36 years, investigated in teens for painful periods, not currently treated.)

Women were reluctant to be seen as influenced by rules that appeared illogical and explained their actions as being a result of other people's inhibitions. These inhibitions were attributed to varying characteristics which interviewees did not share. Characteristics such as shyness, social class, and sexual experience were some characteristics mentioned:

'I don't have a problem with it, I'm quite happy talking to you about it. I get the picture they're not comfortable with it. I mean, I'm from a very different background to most of the people round here.'

Interviewer: In what way?

'It's just weird ... it is down to class, however much I hate to say, it is down to class. I'm public (private) school educated, I'm middle-class background, none of my other friends round here are.' (Sharon, 34 years who had irregular, heavy and painful periods, had dilation and curettage [D&C] in the past, currently awaiting referral.)

'Well, basically they're all single. They've never married so they don't know anything about married life, so like you're looking at something entirely different, aren't you? They've not had sexual relationships so they've not ... they've not had children, so there's no alteration to their body whatsoever, is there?' (Simone, 57 years suffering heavy bleeding and awaiting hysterectomy.)

Influence of menstrual etiquette on women's concerns

Menstrual complaints were defined by symptoms such as pain or bleeding and by problems of managing menstruation. Managing menstruation was primarily about maintaining concealment by adequate preparation before, and awareness of risks during menstruation. All women interviewed, whether or not they identified any menstrual problem, had strategies to prepare for menstruation. Marking of dates in diaries and awareness of physical sensations were used to remind women of the need to prepare:

'I clock in my diary, I asterisk 28 days from the last one, just to keep an eye. I think as well at this age, still it is the whole idea of leaking and starting without knowing kind of thing, so I like to keep a record just so I can wear a panty liner for 24 hours before I think I am going to start, just as a safety precaution.' (Heather, 32 years, non-consulter, identified no menstrual problem.)

A change in menstrual pattern challenged the strategies women had previously used to manage their menstruation. New strategies had to be developed and greater effort was required to cope with symptoms and concealment. Symptoms of increased heaviness or irregularity were found to be most difficult. For these women concealment became a conscious problem, as they were no longer confident of their previous strategies. They were now more at risk of being caught without adequate protection. This fear and the difficulties of management could become a constant concern which was stressful and altered usual behaviour. Megan's periods had lasted 3 days before her baby was born and now lasted 5–7 days with heavier bleeding:

'Since they have got heavier, I have been caught out a few times. I don't tend to do nothing too much. I don't go and drive. If I want to go shopping I'd say, oh, I'll leave it, till the lighter part of the week. I sort of tend to stay in more. I wouldn't go out visiting or anything, sort of thing or I just pop down to the shops, the local shops and come back. I tend to stay home more rather than going out ... I don't think I'd ever stay over at anyone's house or anything like that.' (Megan, 33 years, whose periods were heavier after having a baby, consulted practice nurse.)

In contrast, interviewees whose menstrual pattern appeared very disruptive but had been stable for many years were less stressed by menstrual management. Pauline (37 years) had heavy periods and found it difficult to get adequate sanitary protection. She was using children's nappies at night. Her pattern was quite predictable. She had consulted her GP a few times since her periods started, primarily for reassurance, as friends had suggested she should. She was not considering treatment.

A vocabulary to describe menstrual symptoms was not always available, and problems with concealment were expressed to indicate the severity of menstrual symptoms and as the main aspect of the complaint. Many women were concerned about the impact of using bulkier sanitary protection on their lifestyle. Bulkier methods protected against leakage and staining but might be obvious when wearing more tight fitting clothes. Some women withdrew from exercise classes and some social events because of this. This effect on quality of life was not acceptable to some women interviewed:

'I feel very comfortable in leggings, leggings and short top, and you can't wear a towel with that 'cos it shows. I have to wear those big towels you know, and its obvious, and going to the gym as well, you know, I don't feel comfortable especially changing with people ... wearing nappies, that's what I call them.' (Mary Anne, 29 years, reported pre-menstrual tension, consulted 5 years ago.)

Sharon was considering surgery partly because of the effect of her prolonged bleeding on her relationship with her husband. She had undergone D&C many years previously for similar symptoms with success. She also had some urinary symptoms, so was now considering a hysterectomy and repair. She perceived that she had to fight for this, as the effect on her sexual relationship was not appreciated:

'My marriage was on the point of breaking up. We had always been a sexually active couple so it was a big change in our relationship. Before, when I had constant bleeding, yeah, before I had the operation it was the bleeding because it meant we couldn't do it any time. The woman [doctor] *said these are things women have to put up with. I don't think so. I won't sacrifice my sex life.'* (Sharon, 34 years who had irregular, heavy and painful periods, had D&C in past, currently awaiting referral.)

Difficulties with concealment were experienced before seeking consultation, and these difficulties influenced decisions about treatment. Simone was 57 years old and had experienced heavy periods for many years. She was offered a hysterectomy but rejected this as she felt her periods were likely to stop soon because of her age. At the time of interview she had decided to undergo surgery following a recent holiday. Although she did not have any episodes of staining, she was deeply embarrassed by having to leave out bags of used sanitary protection for the hotel cleaners. She returned to this story a number of times during the interview:

> *'I can't tell you what it is that made me suddenly say to myself, enough is enough, whether it was the embarrassment in the hotel. I don't even know whether the cleaner was a woman or a man, so I don't know why it particularly upset me. They* [the sanitary protection] *were all in a bag. I used to tie them up every morning, so all they had to do was take the bag out and put it into the sack. But for some reason it got to me and I don't know why. But I've never been on holiday and had to do all that, so it upset me more. Maybe it's because there were so many. Perhaps they wondered what had happened —that I'd changed at night into a vampire or something!'* (Simone, 57 years with heavy bleeding and awaiting hysterectomy.)

Aspects of treatment that improved women's ability to manage menstruation were particularly valued. Pain could generally be controlled by regular use of analgesia. Women being treated for heavy bleeding valued medication that reduced blood volume, but not when irregularity was the result. Irregularity of bleeding threatened strategies of concealment and increased levels of concern. However severe symptoms are, concealment was reported to be easier if the time of menstruation is predictable. Zeta suffered from heavy and painful periods and had an intrauterine system fitted. Although her bleeding became lighter, her periods were longer and caused greater problems in management. She was considering removal of the system for this reason:

> *'I mean, a lot of my friends who have Mirena®* [progestogen-only intra-uterine device, Schering] *fitted, they don't have any periods at all you know, it is completely brilliant. I thought, wow, if that happens to me that would be brilliant, but it's not like that. The problem I am now getting is my periods can last anything up to 2 weeks really.'* (Zeta, 29 years, known to have endometriosis, recent consulter.)

Several women interviewed had been prescribed norethisterone, an oral progesterone treatment. These were women in their 40s and 50s who had heavy bleeding. Norethisterone has been commonly prescribed for heavy bleeding in the past but has been shown not to be very effective at reducing blood loss. GPs have been advised not to prescribe the drug for this reason. Women prescribed norethisterone discovered that the drug could be used to control the timing of their bleeding and they altered their use of the medication to suit their needs. Although the volume of blood loss can remain problematic, the ability to plan the timing of menstruation allowed women to feel more secure in managing menstruation:

> *'I don't know if that's a sort of symptom of it, but the norethisterone, although it doesn't make your bleeding any less, at least you can regulate when it's more or less going to happen. So at least that way I felt a bit more confident that I could at least go out knowing this week I'm not going to bleed sort of thing.' (*Frieda, 48 years who had heavy and irregular periods.)

DISCUSSION

Summary of main findings

These findings indicate that women who have concerns about menstrual symptoms feel under pressure to conceal their symptoms and choose treatments that allow them to do this. These studies highlight the importance of understanding the social world in which women live to understand their health-related behaviour.

While menstruation is concealed in general, the most important aspect to conceal is blood loss. All women were bound by a social etiquette to treat menstruation as a private matter which must be managed without drawing attention to it. This etiquette is pervasive and women were not necessarily consciously aware of it.

The impact of menstrual etiquette varied according to the type of problem, women's abilities to adapt, and other aspects of women's lives, such as their control over their working lives. The need for concealment could become a source of constant stress for women, particularly those with heavy and irregular bleeding in low status jobs.

For some of the women interviewed, decisions about consultation and treatment were precipitated by a real or threatened episode of leakage. The findings also highlight the potential differences between women's views of medication and those of the medical profession, where norethisterone was valued for its use in altering timing of menstruation.

Strengths and limitations of the study

These studies used qualitative methodology to allow women's experiences to be explored. Women with a range of problems and women who did not identify any current menstrual problems were recruited. The interview method enabled a better understanding of women's behaviours in relation to menstrual problems. However, the verbatim accounts do not adequately communicate women's horror and fear of leakage threats which were emphasised by facial expressions and physical movement. Although recorded in field notes and used to inform the analysis, these non-verbal aspects were not systematically collected and are not conveyed in verbal quotations.

Interview studies provide accounts of women's perceptions but are not the best method of examining behaviour. Menstrual management is a concealed behaviour and as such is difficult to study. A series of interviews over time would have been more revealing of how boundaries of behaviour influence women's decisions. The studies are limited by the delay between them and the lag between study completion and publication. No difference in social rules was apparent between studies, and the findings are consistent with continuing evidence of menstrual etiquette in other studies.[26]

Comparison with existing literature

A lack of correlation between objective blood loss and women's concerns about menstruation has resulted in a variety of approaches to explain these concerns. Fraser *et al*[27] found that women who were worried about heavy periods were more likely to have variable blood loss and not all periods would be objectively heavy. The findings of the importance of managing menstruation suggest that such a pattern is particularly stressful for women.

There has been an emphasis on finding associations between psychological morbidity and menstrual complaints. Cross-sectional studies in selected secondary care populations found positive associations,[28–30] but follow up of secondary care populations treated for menorrhagia by hysterectomy have shown a fall in psychological morbidity following treatment of the menstrual disorder, suggesting that the direction of causation was from the gynaecological morbidity to psychological morbidity.[31,32] Recent prospective studies in primary care have not shown a specific association between psychological morbidity and heavy bleeding or with consultation.[33,34]

Shapley *et al* found that interference with life from heaviness of periods was the most common reason for consultation in a primary care population.[34] Women with heavy bleeding have been shown to experience reduced quality of life which improves with treatment.[35] What is meant by interference with life or the mechanisms by which quality of life is affected is not clear. These findings suggest that the social pressure to maintain concealment is a major problem for women and that their choices can be understood if attention is paid to women's experiences and to the status of menstruation in western society.

The existence of menstrual etiquette is not a new finding. Despite anthropological and sociological studies of menstrual etiquette, its association with presentation of menstrual disorders is not recognised in the medical literature. The exploration of social and cultural factors influencing patient behaviour is more often studied in less developed societies with traditional models of power, often located in caste, religion, and sex,[36] or in UK ethnic minority groups.[37] These studies locate important social and cultural factors in those designated as different from the majority of the population. The findings in this paper indicate that women living in a large cosmopolitan city are also bound by these social rules.

In western society, control of the body and its functions are particularly important.[38] The social rules described here are also consistent with what is known about women's decisions in relation to contraceptive choices. Irregular bleeding is known to be a common reason for discontinuation of contraceptive methods.[39] Amenorrhoea as a result of contraception is becoming more acceptable worldwide,[40,41] and the more 'westernised' a society the more likely women are to seek amenorrhoea.[42] These trends suggest that regardless of findings in relation to pathology, women will continue to seek treatments that reduce or cease menstruation.

Implications for clinical practice

Women have expressed dissatisfaction following primary care consultations for menstrual disorders.[21–23] These findings should help practitioners appreciate the impact of menstrual disorders on women's lives and the efforts they make to manage menstruation. While the search for pathology and treatment of problems such as anaemia are important, it may be beneficial to include in the consultation an approach where ongoing menstrual management by the patient is also considered.

For the women interviewed, a menstrual complaint consisted of symptoms, but also the management of those symptoms in everyday life. Women wanted treatment that would improve their ability to manage menstruation and to keep it concealed. Medication with irregularity as a side effect may be unacceptable. In this study women preferred predictability, even if symptoms were not improved. Clinicians need to remember that women may not articulate issues around menstrual management, or its effect on intimate relationships, but that these issues are

important in women's decisions. The balance of needs is likely to be individual to each woman according to her circumstances. Clinicians need to explore which menstrual concerns women feel they most need to control, and negotiate treatment with the patient.

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Ethics committee

St Thomas Hospital Research Ethics Committee (EC97/304 and EC00/039)

Competing interests

The authors have stated that there are none

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