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A Sociological Analysis of Premenstrual Syndrome

A thesis

presented to

the faculty of the Department of the Sociology and Anthropology

East Tennessee State University

In partial fulfillment
of the requirements for the degree
Master of Arts in Sociology

by

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December 2003

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Keywords: Menstruation, Premenstrual Syndrome, Premenstrual Dysphoric Disorder, Hysteria,
Culture-Bound Syndrome, Menopause, and Medicalization

ABSTRACT

A Sociological Analysis of Premenstrual Syndrome

by

Kathryn M. Kreyenbuhl-Gardner

Many women self-report discomfort, depression, mood changes, and irritability in conjunction with menstruation which has been termed Premenstrual Syndrome (PMS). Prior to the creation of the disease/disorder category PMS, disorders with similar symptoms like “hysteria” and “involutional melancholia” were ascribed to women reporting those types of complaints. These diagnoses were based on archaic claims about women’s anatomy and behavior. Modern medical researchers contend that women’s complaints have a physiological basis, yet they cannot definitively tie PMS to any specific physiological etiological pathway, either hormonal or neurological. This thesis explores the argument that the social norms for women’s roles and their associated behaviors are related to the appearance of a disease/disorder category named PMS in the United Kingdom and the United States. Many of women’s complaints may instead be symptoms of social problems (with social remedies) related to role conflict or role strain.

ACKNOWLEDGMENTS

I dedicate this thesis to the women of Afghanistan and other women throughout the world who are held hostage by their cultural norms and religious proscriptions. The suffering and hardships that many of these women have endured are incomprehensible to most Westerners. The women are merely attempting to claim their intrinsic rights of free speech and association in addition to the right to obtain an education. I acknowledge my husband, Robert, for his support and for listening to me as I worked out the details of this thesis. My children Myranda, Jacqueline, Quincey, and Eden have listened to me read sections out loud and know more about feminism than other children their age (which is a good thing). I extend my deepest gratitude to Dr. Martha Copp for taking over as my thesis director. Her editing skills are impeccable and I could not have organized my thoughts in such a cogent and cohesive way if not for her. I acknowledge Dr. Dorothy Humpf, who was initially my thesis director, but was taken from us by the insidiously selfish disease of cancer. She was a great scholar and a warm and compassionate human being. I will always miss her. I thank Dr. Niall Shanks for his direction regarding Karen Horney and Dr. Anthony Cavender for turning me on to Robbie Floyd-Davis and Carol Groneman's *The History of Nymphomania*. Dr. Cavender was one of the first professors whom I had at ETSU and he kindled in me an interest in anthropology and the anthropological method that will burn in me until I am compost. I thank my friends, Casey LaVoie and Susan Mahar, for reading my manuscript and offering their comments. I extend much gratitude to my mother, Dorothy Kreyenbuhl, for caring for me as a baby and still loving me through all my adolescent philosophical experimentations. My sister, Angela Conroy, often played the role of devil's advocate throughout the coming together of this thesis—kudos to her argumentative and stubborn nature.

I would also like to acknowledge my father, Robert Leo Kreyenbuhl, who died while I was working on this thesis. Although we had, at times, a contemptuous relationship—I loved him very much and wish that I could call him up just to argue about politics and life one more time. I also want to acknowledge my husband's dad who died the year before my dad, we both miss him very much. My husband's mother, Ruby is still going strong and likes to garden when she can. I also want to acknowledge my step-son's Nana and Papa who are two of the most generous and loving people ever born.

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CHAPTER 1

INTRODUCTION

Dr. Phil, a popular television psychologist, recently aired an hour long program devoted entirely to problems related to women's "raging hormones." He compared women exhibiting premenstrual syndrome (PMS)-type symptoms to Grizzly Bears. It is commonly believed in U.S. society that women exhibit mood swings, irrational behavior, or depressive type symptoms premenstrually. There is hardly a person in the United States who has not heard at least one joke about menstruating women. For example, "Why does it take three women with PMS to screw in a light bulb?" "It just does!" (Figert 1996:12) "What is the difference between a woman with PMS and a terrorist?" "You can negotiate with a terrorist" (Figert 1996:14). These are exemplars of the contemporary popular perceptions held by members of U.S. society regarding menstruating women.

I thought that it would be interesting to examine the popular notions surrounding women and menstruation in order to test whether or not any of these perceptions regarding women and menstruation would hold up under scientific scrutiny from either a medical, sociological, or an anthropological point of view. In order to begin this inquiry, it is important to understand the fundamental physiological process of menstruation and the definition of key terms pertaining to menstruation.

The Biology of Menstruation

Menarche indicates that there is sufficient activity within the ovary to have secreted some estrogen to induce uterine development and to have caused bleeding (menstruation). Fertility is not yet signified during the first two years after menarche because the cycles are anovulatory. The

average cycle lasts for 28 days. The average age for the onset of menarche in the United Kingdom and the United States is 10 to 16 years and has been getting consistently younger in those countries. One hundred and fifty years ago in these nations the average age of menarche was 13 to 17 years of age (Scrambler and Scrambler 1993).

For a menstrual cycle to occur the hypothalamus chemically stimulates the pituitary gland to produce Follicle Stimulating Hormone (FSH) which stimulates the development of a Graafian follicle within the ovary to mature an ovum. As the follicle continues to swell, a sudden surge of Luteinizing Hormone causes the follicle to rupture releasing an ovum. Ovulation usually occurs on the 14th of the cycle. During the development of the ovum, estrogen is produced. When ovulation occurs and the follicle collapses, it becomes a corpus luteum or “yellow body.” During this stage the hormone progesterone is produced. The hormone estrogen thickens the lining of the endometrium—then progesterone produces secretions to fill the glands of the endometrium in preparation for the implantation of the ovum if fertilization takes place.

If fertilization does not take place then the corpus luteum transforms into a hyaline body known as the corpus albicans and levels of estrogen and progesterone fall and the endometrium is shed—causing menstruation. This is a very simplified overview of the process of menstruation—the interaction of hormones and other physiological responses in the menstrual cycle exhibit complex interactions. This is one of the reasons that attempting to thoroughly understand the interaction of the various hormones associated with menstruation is so difficult.

When the term “normal” is used, the more accurate term to use is “average.” There are many variations on menstrual cycle length. The average menstrual cycle length is 28 days but this is variable, especially in relation to women’s ages. At age 12, the average cycle length is 35 days; at

age 45, average cycle length is 27 days, and the average cycle length at age 55 is 52 days (although the average age of menopause is 51).

Disorders Associated with Menstruation

The disorders most commonly associated with menstruation are: amenorrhea, menorrhagia, and dysmenorrhea. Amenorrhea is the absence of menstruation and is divided into two subcategories: primary amenorrhea and secondary amenorrhea. Primary amenorrhea ends when young women reach menarche, but it is not deemed a disorder unless a woman never has menarche and would only be problematic if a woman desired to bear her own offspring. Secondary amenorrhea refers to women who have experienced menarche but at some point (post menarche) menstruation stops. Secondary amenorrhea is often seen in young women who are competitive athletes, especially long distance runners, gymnasts, and swimmers. It is thought to occur in response to low amounts of body fat. Sometimes amenorrhea occurs in conjunction with anorexia and is associated with being underweight and malnourished.

Menorrhagia is the occurrence of excessive bleeding. Sometimes it is caused by the presence of myomas or fibromas growing on the uterus. Often this occurs in response to defects in the mechanisms of blood coagulation and anemia.

Dysmenorrhea is the occurrence of pain associated with menstruation. The etiology is unclear, but it is thought that the powerful uterine contractions that occur during the first few days of menstruation are the most likely cause. Most women experience some cramping in conjunction with menstruation and the most common treatment is over the counter analgesics. A few women experience extremely painful menstruation. As in the case of menorrhagia, excessive bleeding, the reason may be the growth of myomas or fibromas. Treatment for this disorder is often the removal

of the larger fibroids and in some cases a hysterectomy (the removal of the uterus) is performed.

Some physicians have argued that menstruation, while not a disorder, is not necessarily the normal state for women either (Coutinho and Sheldon 1999). It is argued that our paleolithic mothers menstruated infrequently because menarche occurred later, pregnancies were frequent, periods of lactation were much longer than they are today, and life expectancy was much shorter.¹ Menstruation was for many women a rare event whereby secondary amenorrhea in the past may have been something that many women experienced on a regular basis.²

Cultural Interpretations of Menstruation

In many cultures, menarche has been seen as the time when young girls have to relinquish their carefree childhood and are now “cursed” with their monthly periods. In many cultures throughout time and around the world menarche marked young women as eligible for marriage (Shostak 1977). The cultural interpretations of menstruation are fraught with ignorance and superstition. Two predominant themes in the cultural stereotypes support the social construction of PMS in the West. The first theme concerns the view that menstruation is polluting, which tends to stigmatize women and lowers their status. The second theme that dominates beliefs about menstruation is that menstruation implies fertility in women and symbolizes women’s potential

¹This also presupposes that all paleolithic women paired up with men.

² This type of secondary amenorrhea is exhibited in extant human populations today and is exemplified by the San !Kung peoples of sub-Saharan Africa. !Kung women have later menarche than women in the United States and the United Kingdom—17 years and 12.5 years, respectively. !Kung women nurse their infants on demand and on average for three to five years. During this time they rarely menstruate—generally having one or two menses before becoming pregnant again and then lactating for another extended period—!Kung women have, on average, six children. This exemplifies the concept in sociology and anthropology that peoples’ behaviors in response to their environment have cultural and physiological consequences.

fecundity.

Menstruation as Ritual Pollution and Its Prohibitions

In most cultures around the world, menstruation and menstrual blood are defined as polluting. The Polynesian word “taboo” is synonymous with menstruation (Gottlieb 1988). According to Webster’s Ninth Edition Collegiate Dictionary the word “taboo” means: Forbidden to profane use or contact because of supposedly dangerous supernatural powers.

In order to control this pollution, cultures generally impose prohibitions regarding women and menstruation that take two basic forms: The first is the relegation of women to a separate space, whether it is banishment to her room or to an entirely segregated space created specifically for menstruating women. The second prohibition restricts women’s activities.

The ancient Israelites required women to segregate themselves from the household during their menses by retreating to a “menstrual hut” behind the family’s abode. Many cultures share similar ritual purity laws that dictate the temporary restriction of women during their menses to the community “menstrual hut” or to a segregated space (Gottlieb 1988). As Rathus (2000:401) explains:

Among Hindu families in India, the onset of menstruation signifies the loss of the girl’s purity. . . . During menstruation, she is expected to abstain from cooking for the family or participating in religious ceremonies. A menstruating girl might be expected to cease her daily activities and spend time alone in her room, a practice of isolation that may continue even into her marriage.

In the *Old Testament* the book of Leviticus 15:19 states “When a woman has a discharge, if the discharge in her body is blood, she shall continue in her menstrual impurity for seven days.” Leviticus goes on to say that anyone who comes into contact with a menstruating woman will become ritually polluted as well. There were prescribed methods to ritually purify oneself, man or

woman, if one had been polluted. Many orthodox and conservative Jewish women invoked the practice of *mikvah* which involved a ritual bathing at the end of menses plus seven more days after being *niddah*, or spiritually unclean (Daniluk 1998:63). It has been hypothesized that these purity laws originated in the attempt to ward off ritual “pollution” and prevent it from spreading to the rest of the community.

In addition to limiting menstruating women’s contact with others, many cultures prohibit them from touching certain objects. In the late 1800s it was thought that if a menstruating woman touched meat it would spoil. This claim was used as a reason to exclude women from medical school. In the late 1800s and early 1900s, when doctors were faced with the quandary as to whether or not to admit women to medical school, the fact that women menstruated played a crucial role in determining their status. At the time it was thought that women, when menstruating, emitted a chemical “menotoxin” that caused certain plants to wilt and meat to spoil. If a menstruating woman’s touch caused meat to spoil—just imagine the problem for patients if a woman surgeon was permitted to perform surgery while she was menstruating (Houppert 1999:152-153). In the 1940 *Quarterly Review of Biology* there was a paper that described a history of the beliefs about menstruating women as unclean and exerting some influence over objects. The paper explained that a “menotoxin” was the reason for this. The “menotoxin” was described as having deleterious effects on living tissues (Ashley-Montagu 1940).

The idea that menstrual blood contained a harmful substance which some labeled a menotoxin was debated up into the 1950s (Walker 1997:48-49). Professor Bela Schicks observed that the fresh flowers that his secretary religiously placed on her desk wilted faster when she was

menstruating than when she was not (Fluhmann 1939).³ Many researchers were concerned about the effect that menstrual blood would have on a man's penis. David Macht, a pharmacologist from John Hopkins University, studied the effects of menstrual fluid on plant growth. He found "conclusive" evidence that menstrual fluid retarded plant growth. Macht also found menstrual toxin to be damaging to gold fish and depressed maze-running behavior in rats, but his results were inconclusive about the effects of menotoxin applied to male genitalia (in circumcised and uncircumcised guinea pigs). Macht (1943) alluded to the prohibition in Leviticus regarding abstinence during menstruation and made the statement that perhaps the ancient Israelites had a point (Walker 1997:48). Eventually researchers explained that the reason plants died when planted in menstrual blood was because blood is an excellent growth medium for bacteria (Zondek 1953).

One of the earliest known references to menstruating women causing things to spoil comes from Pliny's *Natural History* where he refers to menstruating women as potentially poisonous to men, cows, gardens, bees, milk, and wine.

Contact with it turns new wine sour, crops touched by it become barren, grafts die, seeds in gardens are dried up, the fruit of trees falls off, the edge of steel and the gleam of ivory are dulled, hives of bees die, even bronze and iron are at once seized by rust, and a horrible smell fills the air; to taste it drives dogs mad and infects their bites with an incurable poison. . . . Even that very tiny creature the ant is said to be sensitive to it and throws away grains of corn that taste of it and does not touch them again. (Delaney 1988:42)

These superstitions are not just a part of our past; it is still commonly thought that menstruating women cause preserved foodstuffs to spoil or cucumber vines to wilt. For example, women in

³There is at least one variation of this story that I came across whereby Dr. Schicks gave his secretary a bouquet of roses which wilted quickly. Dr. Schick somehow ascertained that his secretary had been menstruating and he assumed that this was why the roses wilted. In the version of the main body of this thesis—Dr. Schicks read his secretary's diary and made the correlation with her menses and the wilting of the flower upon her desk.

southeastern Europe do not salt or pickle while menstruating and women in Kentucky still do not can food during menses because they believe that the jars of food will spoil, especially the tomatoes (Delaney, Lupton, and Toth 1988:12).

Young women in the United States today are not socially obligated to segregate themselves to the “menstrual hut” nor must they spiritually cleanse themselves (*mikvah*) after menstruation, but they (and people in general) are bombarded with negative messages about the female reproductive system and its byproducts as dirty and smelly. There are ads for feminine hygiene spray and douches, sanitary napkins, and deodorant tampons. Many young women are terrified that they have an odor and everyone will smell them. They are also afraid of bleeding through their pad onto their clothing. In the minds of young women these fears can be truly devastating to their self-image. These negative and contradictory messages have long-lasting consequences for women’s self-image and society’s perception and beliefs about women and menstruation.

Women’s Role as Reproducer and Mother

In many cultures the advent of Menarche is seen as elevating the status of young women because it implies fertility. This time is marked by rites of passage ceremonies or rituals in many cultures of the world as Rathus (2000) explains:

The Kurtatchi, who live off the green coast of New Guinea, greet menarche with an elaborate ceremony The girl’s mother announces the event to their friends and relatives, who go into seclusion with the girl. They paint their bodies in preparation for public ceremonies. The girl and her entourage emerge from seclusion, perform a dance, and blow on a conch shell. The girl parades among the rejoicing villagers. Then there is a feast. (P.401)

Although these types of celebrations define menstruation as a positive event in women’s lives, they also mark women’s fecundity and women’s roles as reproducers and mothers as central

to their place in society. Viewing women's fertility as essential to the propagation of the group heightens women's status, but firmly ties women's status, value, and role to their potential to produce children. Reproduction becomes women's paramount function and is only the way for them to have status or to elevate their status.

During the Victorian Era and through the Progressive Era women were bound by the cultural norms and mores that dictated separate spheres for men and women. This custom echoed the institution of menstrual proscriptions that obligated women to separate themselves from the group while menstruating. Women were relegated to the home, the private sphere, while men worked in the public sphere. Women were expected to behave in ways that were dictated by their roles as mothers (reproducers) and guardians of the private sphere.

For most of the nineteenth century, the social doctrine of "separate spheres" had promulgated the notion that only men were strong enough to survive daily contact with the dirty world of commerce and industry. The home was a sanctuary from the outside world, where wives, mothers, sisters, and daughters were safely distant from the cash economy and where world-weary men might find peace and a renewed sense of honor in the sympathy and love dispensed by women of their families, women whose lifelong training taught them that piety, purity, and submissiveness were inborn attributes of the female character. These same wives and mothers were also expected to be able to cook, to clean, and to raise both male and female offspring in an atmosphere of religion and morality. . . . Even the legal system seemed to concur in this conception of woman's nature and work. An 1873 Supreme Court opinion perfectly described the prevailing idea of womanhood: "The paramount destiny and mission are to fulfill the noble and benign offices of wife and mother. This is the law of the Creator." The doctrine of separate spheres required women to dedicate their lives exclusively to unpaid housework and child care, regardless of their individual personalities, tastes, and abilities. A man might measure his success in any of a multitude of different professions or crafts, but a woman was considered successful only if she were a good wife, mother, and homemaker. (Cott 2000:365)

Historically, in many cultures throughout the world including the West, women were

expected to reproduce, but were not supposed to enjoy sex. The sex act for women was only to be engaged in for the sake of procreation, not for pleasure.

The demonization of all women except the virgin Mary was in sharp contrast to the exaltation of the ascetic model and chastity. Unlike Mary, women were both flesh and matter. Hostile to all that was instinct and passion, immersed in Platonic and Neoplatonic culture, the fathers praised the refusal of sex. It was viewed as an evil linked to human nature, to be conquered (or at least controlled). (Cantarella 1991:169)

These types of statements are representative of the beginnings of the mother/whore motif that dominates the culture of the West. It is also important to recognize that the precept of original sin in Christianity stigmatizes sexuality and, therefore, any sex act that is not sanctioned as reproductive in nature, is sinful. According to Genesis, because women brought sin into the world, they are stigmatized by menstruation yet venerated as mothers. Through the process of bleeding this sin is made visible to the world and many women are thus uncomfortable when they are reminded monthly of their sin. This monthly menstrual event is commonly referred to as the “curse.” A dialectic relationship exists between the notion of menstruation as pollution and the exaltation of women as mothers which produces conflict in women and society as to what the expected behavior for women should be.

This melding of motherhood with womanhood in the West led members of society to believe that women’s biology dictated women’s behavior. Lundberg and Farnham (1947:320) categorized the psychologically healthy woman as the “feminine mother” and described her as knowing “that she is dependent on a phallus for sexual enjoyment, which, as she is genitalized, she is in need of. Having children is to her the most natural thing possible, and it would never occur to her to have any doubts about it.” Any deviations from the expectations that accompanied women’s

role as mother was considered to be pathological. From medieval times, throughout the Victorian Era, and until the 1950s women in the West who showed too much interest in sex were branded nymphomaniacs and women who would not submit to their husbands were branded frigid. The psychological definition of a normal woman was based on her positive response to pregnancy, childbearing and child raising. Women who did not accept this role, according to Lundberg and Farnham (1947:237), “constitute[d] the array of the sick, unhappy, neurotic, wholly or partly incapable of dealing with life. They have always been known and dimly recognized for what they are—the miserable, half-satisfied, the frustrated, the angered.” Lundberg and Farnham (1947:271) also claimed that “the strong desire for children or lack of it in a woman has a crucial bearing on how much enjoyment she derives from the sexual act.” “When feminists “came to perform the sexual act . . . , [they] were frigid” (Lundberg 1947 in Cott 2000:). In the America of the 1950s, motherhood was considered to be the most important role for women. America’s security and way of life was dependent on the way that women carried out that role.

There are still remnants of this attitude prevalent in our culture today. For example, there is a double standard that exists for women who engage in sex with men out of wedlock. These women are likely to be considered more deviant than the men with whom they have sex. This attitude was also reflected in recent commercials that were aired on television in order to combat teenage pregnancy. The commercials urged girls to “just say no!” There were no commercials that told boys to “just say no!”

These paradoxical messages about menstruation, sexuality, and motherhood can be very confusing for women. On one hand, women’s status is exalted as mother, and on the other hand, women are stigmatized by their menstrual blood. Through the social construction of negative

norms associated with women as menstruators, a stereotype characterized women, menstruation, and menstrual blood as polluting and potentially harmful, necessitating the segregation of women in society. This stereotype was used for two and one-half millennia to exclude women from fully participating in the public sphere. Simultaneously, the exalted status bestowed upon women due to their fertility and potential fecundity (implied by menstruation) celebrated motherhood, but denied women the choice to enter the public sphere and gain status by virtue of their public deeds and actions. It also dictated a narrow avenue of acceptable behaviors available to women for their self-expression. Thus, it is significant, yet no surprise that the cultural lore and symptomatology of many women's diseases and disorders implicated behaviors that threatened their central roles as wives, reproducers, and mothers. As will be explained in later chapters, the stigma of taboo that is associated with menstruation in the West historically and contemporarily becomes an "easy mark" for the association of diseases/disorders particular to women. PMS serves as a key example. My thesis will explore how PMS is a sociomedical construct created by the interaction between the stigma of menstruation, societal stereotypes regarding women's nature, the contemporary expansion of women's roles in U.S. society, and the increased medicalization of the human condition.

Methodology

In order to examine the popular notion that women experience mood swings, irrationality, and depression in conjunction with menstruation one must scrutinize the origins of the stereotypes and claims regarding women's personality traits and character. Max Weber claimed that in order to understand a phenomenon one must consider deep and thick historical slices of the cultural contingent context of that phenomenon. Therefore, it is critical to examine menstruation

scientifically while paying careful attention to the cultural and historic context that surrounds the modern diagnosis of Premenstrual Syndrome. The historic and social context for the formation of PMS as a recognized syndrome will make clearer its meaning and will lead, hopefully, to a deeper understanding of the phenomenon. In this thesis I analyze and investigate the personality traits associated with women (stereotypes) in order to assess what influence, if any, that they have had on the social construction of PMS. Chapter 2 describes the social history of the symptoms associated with PMS. Chapter 3 describes the medical research pertinent to the diseases and disorders associated with menstruation including a definition of PMS and its related maladies. Chapter 4 discusses the problems associated with PMS research. Chapter 5 describes the cross-cultural research pertaining to menstruation and then the conclusion follows in Chapter 6.

CHAPTER 2

A SOCIAL HISTORY OF PMS AND ITS SYMPTOMATOLOGY

Social norms and stereotypes do not just appear out of thin air. Social norms are created by the dominant culture in relation to their environment in order to replicate the image of what they believe about themselves through the society at large. Norms also help to maintain order in a group or society. Stereotypes are exaggerated descriptions applied to all individuals of a particular group or category (Macionis 2004:24). The social norms and stereotypes that are common to the West concerning men and women have an ancient origin. Four of the symptoms associated with PMS are depression, anger, irrationality, and mood changes. All of these (perceived) symptoms have analogues in ancient myths and religious doctrines that look more like stereotypes than empirically motivated claims about women's personality traits. The most damning of these myths or religious doctrines portray women as the purveyors of sin, suffering, disease, and death. These are serious claims that stigmatize women from birth. These claims influence societies' beliefs about women and affect how women view themselves and their place in society and the family. They also provide a cultural legacy for the social construction of PMS. The next section will examine the ancient origins of these perceived female personality traits.⁴

Ancient Historical Origins

*Girls are made of sugar and spice and everything nice
Boys are made of snipes and snails and puppy dog tails*

Hesiod, author of *Theogony* and the *Works and Days* (ca 700 B.C.E.), is often pointed to

⁴It would also be interesting to examine the origins of the perceived masculine personality traits, but that would be a different study. Joshua Goldstein does some of that in his 2002 work, *War and Gender*.

as the first misogynist in the West (Cantarella 1991). In *Theogony*, Hesiod recorded the genealogy and history of the pantheon of Greek Gods. Hesiod related the story where Prometheus stole fire from the Gods in order to give it to humanity. This angered Zeus because it lessened the differentiation between mortals and Gods. Zeus pursued revenge and punished “mankind” by sending them the first woman, Pandora. Pandora unleashed upon the world death and disease by opening what has come to be called “Pandora’s Box” (Cantarella 1991:34). The religious dogma of the West has also contributed to the production of many stereotypes regarding women’s bodies and selves. Women were stigmatized as carriers of the “curse” and the purveyors of disease and death. The creation story in Genesis related that woman was created out of man to be a helpmate to him. When Eve partook of the Tree of Good and Evil, sin was introduced into the world. Genesis also stated that because women brought sin into the world they would forever be “cursed” with a difficult labor, and pain would be associated eternally with their reproductive lot in life. Women are born inherently stigmatized by virtue of their gender, stigmatized again at menarche, and live out their lives with the knowledge that they are the source of sin, suffering, disease, and death—no wonder they report depression at higher rates than men.

Subordinate/Passive Women and Dominant/Active Men

The West has long maintained the traditional expectation that the male role was a dominant/active one in sexual or social relations and the female role was a subordinate/passive one (Griffin, 1978). This dichotomous motif is evidenced in the way we describe everything regarding the qualities, characteristics, and perceptions of what constitutes male and female. Aristotle’s theory of how the reproductive cycle worked in humans facilitated the propagation and perpetuation of this stereotype.

Aristotle believed that men's seed was the active agent in reproduction and that women's blood was the passive agent. Aristotle thought that men's seed endowed the menstrual blood with form thus creating a human embryo. Menstrual blood continued to feed the embryo throughout gestation; that was thought to be the reason for the cessation of menstruation during pregnancy.

When the embryo is formed, he [Aristotle] said, next to the sperm flows the menstrual blood, but the role of these two elements is different. The sperm is blood, like the menses, but more complex. Food that is not expelled from the organism is converted into blood, and the converting agent is heat. But the woman, less "warm" than the man, cannot complete the final conversion, which produces sperm. It is the male seed that in reproduction "cooks the female residue" converting it into a new being: the seed, in other words, has an active role, while the female blood has a passive role. Though indispensable, the female contribution is one of matter, with which woman is identified. And the contribution of the woman-matter is passive by nature, while the male contribution, man being form and spirit, is active and creative. In essence the male in reproduction, "converts" female matter with his sperm. (Cantarella 1991:59)

The cultural construction of women as passive and men as active became a significant tenet in Western culture. In Christianity everyone is supposed to be equal in the eyes of God, which was a revolutionary idea in the history of the world, but unfortunately women were still perceived as needing to be dominated. For example, St. Paul said that "man is woman's head" because "Eve" was created from "Adam" and "Christ is man's head" "because man was made in the image of God [*imago dei*], and is the mirror of his glory, whereas women reflect the glory of "man" [matter]." (1 Cor. 11:3, 11:7).

Sigmund Freud's theory explicating gender differences resembled both Aristotle's ideas about passive/submissive women and the U.S. Supreme Court's view as well, as was mentioned in Chapter 1. Freud believed that at puberty boys and girls began their biological journey to their destined male and female forms—which he believed conceived the female as passive and the male as

active (Freud 1938:612-614). In 1947, Lundberg and Farnham, two Freudian psychoanalysts, wrote *The Modern Woman: The Lost Sex*. They argued that the goal of female sexuality was “receptivity and passiveness, a willingness to accept dependence without fear or resentment with a deep inwardness and readiness for the final goal of sexual life—impregnation” (Lundberg and Farnham 1947:237). The expectation of passivity in women bears an emotional price: it renders women’s anger impermissible. Anger is not passive; therefore, when women exhibit anger (disobedience), especially in relation to men personally, to a patriarchal institution/authority, or within their traditional role, their reactions are relegated to the realm of psychological or medical pathology. The “inappropriate” expression of anger is one of the symptoms of PMS noted by its sufferers and diagnosticians.

Irrationality

The view that women were irrational has two ancient sources of origin. The first source that associates women with irrationality is implied by Aristotle’s proposition that women were composed of matter and the second has to do with Hippocrates’ proposition that women’s uteruses moved erratically throughout their torsos. Aristotle claimed in the “On the Generation of Animals,” that women’s natures were more closely akin to nonhuman animals because menstrual blood was semen without a soul (without the ability to impart form) rendering women deformed men (Griffin 1978:231).

Aristotle, Hesiod, and Semonides (7th century B.C.E. poet) all considered women to be composed of matter (made of either water or earth), which linked their nature intrinsically more similar in form to nonhuman animals than men. Semonides is widely considered to be one of the most vitriolic misogynists of the ancient world. His work is known to us through fragments and

was translated from the original Greek by various philologists. In Lloyd-Jones' work, *Females of the Species: Semonides on Women* (1975), Semonides describes the various types of women. One type is made from the earth, another is made from the sea, and many more are made from a specific type of animal, for example: sow, bitch; own daughter of her mother, ass, ferret, mare, and monkey. According to Semonides these types of women are horrible and will cause "misery to any man who holds them in their arms." The woman made from the earth is rather daft: "Another [woman] the Olympians moulded out of earth, a stunted creature; you see, a woman like she knows nothing, bad or good. The only work she understands is eating; and not even when the god makes cruel winter does she feel the cold and draw a stool near to the fire" (Cantarella 1991:35). This view implied that women were unintelligent and unable to make prudent decisions, rendering them prone to irrationality and dependent on men to reason for them.

The assumption that women were irrational and unintelligent was conducive to a potent self-fulfilling prophecy. Mary Wollstonecraft in the *Vindication of the Rights of Woman* (1792) urgently and cogently stressed the necessity of education for women. Wollstonecraft said women were perceived as irrational, not because of their natures, but because they were given no education. Yet education, a gender neutral necessity by today's standards, was defined as harmful to women's health, especially to their reproductive health. Experts widely thought that it was dangerous for women to stimulate their central nervous systems with too much education because it could harm their circulatory systems and possibly lead to "hysteria" or reproductive failure. In the West the view that education was too much stimulus for women's circulatory and central nervous systems persisted well into the 20th century. It was used for many centuries to keep women from obtaining formal education.

During the late 1800s, throughout the turn of the century, and into the first decades of the 20th century in the United States, a debate was underway about whether or not women should be admitted to schools of higher learning. Women were attending Oberlin, Vassar, and Michigan; but widespread attendance by women in U.S. colleges was rare and controversial. In Houppert (1999), Henry Maudsley, the author of *Sex in Mind and Education* (1883) wrote that:

This is a matter of physiology, not a matter of sentiment, it is not a question of larger and smaller muscles, but of the energy and power of endurance, of the nerve force which drives the intellectual and muscular machinery, not a question of two minds that are in equal physical condition, but of one body and mind capable of sustained and regular hard labor, and of another body and mind which for one quarter of each month, during the best years of life, is more or less sick and unfit for hard work. (Houppert 1999: 152)

Ironically, women's wombs, nervous systems, and their entire constitutions were deemed too delicate to handle the rigors of higher education, but no one ever questioned the hard physical labor that many women performed day in and day out, especially women of low socioeconomic status, including women of color.

In *Sex in Education* (1874:45), Edward F. Clarke, M.D., proposed that if women were allowed to be educated that it would be the end of the human race. He believed that the college years came too close to menarche and that the newly flowing menstrual blood made the body susceptible to disease and outside influence. The studying necessary to college life would drain vital energy away from a woman's reproductive organs to fuel the brain. Thus, potentially destroying women's reproductive capability. In 1908 the Supreme Court said: "Let the fact be accepted that there is nothing to be ashamed of in a woman's organization, and let her whole education and life be guided by the divine requirements of her system" (Delaney et al 1988:57).

The view that women's perceived irrationally could be pathological stemmed from the ancient Greek view that women's uteruses (*hysteri*) wandered throughout their bodies. They termed this phenomenon the "wandering womb." The claim that women's wombs wandered throughout their bodies, intrinsically placed women at risk for hysteria and other illnesses. In order to treat these perceived illnesses the uterus had to be manipulated back into its proper position.

The prescribed treatments for these perceived illnesses had various remedies which included:

[the] manual investigation and manipulation of the uterus, the application of leeches to the vulva or neck of the uterus, injections of various substances (e.g., water, milk and water, linseed tea) into the uterus, or as a final resort, cauterization, usually by the application of nitrate of silver. (Walker 1997:34)

The ancient Greeks and modern physicians believed that women's personalities, abilities, and illnesses were all dictated by their perceived base natures and uteruses.

The perceived importance of the uterus in femininity is seen in the prominence it is given in early anatomical drawings Representations of female internal anatomy show a uterus considerably out of scale with the rest of the body until late in the nineteenth century, reflecting the views of W. Tyler Smith in 1847 that the uterus is 'the largest, and perhaps the most important muscle of the female economy' Another physician, Hubbard, addressing a medical society in 1870, explained that it was 'as if the Almighty, in creating the female sex had taken the uterus and built up a woman around it' (quoted in Wood, 1973:29). Ann Wood (1973) notes that 'doctors in America throughout the nineteenth century directed their attention to the womb in a way that seems decidedly unscientific and even obsessive to the modern observer' (Walker 1997:33)

By the 19th century physicians understood that the uterus did not wander throughout women's torsos, but they continued to tie women's complaints and perceived illnesses to their uteruses. "The typical symptoms of a uterine disorder, according to William Byford, a physician writing in America in 1864, are weight loss, peevish irritability and any of a range of 'nervous

disorders' ranging from 'hysterical fits of crying and insomnia to constipation, indigestion, headaches and backaches' . . . (Walker 1997:33)."

The uterus was seen to be closely connected to the central nervous system, and any shock to the system might upset the reproductive functions or even damage or mark an unborn baby (Smith Rosenberg and Rosenberg, 1973; Crawford, 1915). Such beliefs underscored the primary definition of women as reproducers. Experts believed that too much mental stimulation (from education or, for that matter, paid labor in the public sphere) would corrupt women's ability to produce healthy offspring (Weitz 1998). This exclusion was certainly a factor in how women perceived themselves and their menstruation. By barring women from obtaining an education, their fate as irrational beings was thus sealed. Moreover, denying women an education ensured that reproduction would be their only role in society, requiring them to be dependent on men for their livelihood.

Mood Changes

Mood changes are also among the exhibited symptoms that are considered to be components of a PMS diagnosis. This symptom has ancient roots as well in the stereotype of women as subject to mood changes or as fickle in nature. Semonides provides ample evidence in his poetic commentary on the nature of women who were made from water:

Another [woman] he made from the sea; she has two characters. One day she smiles and is happy; a stranger who sees her in the house will praise her, and say, "There is no woman better than this among all mankind, nor more beautiful." But on another day she is unbearable to look at or come near to; then she raves so that you can't approach her, like a bitch over her pups; and she shows herself ungentle and contrary to enemies and friends alike. Just so the sea often stands without a tremor, harmless, a great delight to sailors, in the summer season; but often it raves, tossed about by thundering waves. It is the sea that such a woman resembles in her temper; like the ocean; she has a changeful nature. (Cantarella 1991:35)

In Scrambler and Scrambler there is a quotation from a paper by Laws (1985b) that critiques the supposed pathology of many of the “symptoms” of PMT or PMS, including mood changes in women:

The ‘symptoms’ of PMT [Premenstrual Tension] which the doctors show most concern over—depression, anxiety and so on—are mental states which do not ‘fit’ with women’s culturally-created notions of ourselves as nice, kind, gentle, etc. ‘Mood change,’ is often listed as a symptom—demonstrating that change *as such* is not culturally acceptable. Why *are* women’s moods seen as such a problem? Men have moods too, after all. There’s no evidence that women are in fact more unpredictable or inconsistent than men—it’s a stereotype that men like to encourage. Couldn’t it have something to do with the way that women are supposed to pander to men’s moods: soothing the troubled brow, ‘Did you have a nice day at the office, dear?’ There’s just no room for women to have strong feelings of their own, disrupting this comfortable flow of emotional services. (Scrambler and Scrambler 1993:60).

The angry woman, the irrational woman, and the fickle woman are all examples of ancient claims that pertain to women’s personality traits (stereotypes) that remain extant in Western culture. These claims were (are) not based on *a posteriori* forms of obtaining knowledge, rather, they were (are) based on *a priori* forms of reasoning. There is no scientific evidence available to support these claims made about women, yet they are pervasive in our culture. Women are stigmatized at birth by virtue of their gender and then again as menstruators. Historically, their place in society has been almost exclusively tied to their role as reproducers. Contemporary Western culture has seen a major change in women’s roles but, it has not seen a change in attitude large enough to challenge the veracity of many of these stereotypes, as the next section explains.

Modern Social History of PMS

Victorian Era to WWII

With the discovery of ovaries, the medical profession expanded its obsession with women's reproductive system. In the early 1900s it was thought that women's uteruses and ovaries dictated their health status and personalities. Many perceived medical maladies or personality problems that women reported or were diagnosed with were treated with ovariectomies (the removal of the ovaries) (Frank 1931; Houppert 1999:153).

Many of these ideas, like their precedents, were obtained through *a priori* methods of reasoning based on age-old stereotypes instead of through *a posteriori* methods based on observation, experimentation, and replication. In 1914, Dr. Leta Stetter Hollingsworth, a Columbia psychologist, said that if a woman's nervous system was truly as chaotic as was believed then this would noticeably affect women's work. She commissioned a study that lasted several months.

Hollingsworth recorded the results of women tapping a pencil repeatedly, trying to put a pencil into a small hole (to test hand steadiness and coordination) and she examined the women's typing skills. She conducted her tests of the women's skills at the same time every day after dinner. In her associated paper "Functional Periodicity" she reported that there was no correlation between menstruation and performance. Hollingsworth said that it is hard to understand how the reality of a woman's condition could differ so distinctly from the current scientific body of knowledge. She went on to say that scholars repeated the same story for generations and allowed popular views to influence their thinking (Houppert 1999:156; Rosenberg 1992:66).

Hollingsworth also conducted a study where she examined the psychological states of women and men college students. She concluded that there was more difference between various

women as a whole and various men as a whole than there was between women and men as two distinctive groups (Rosenberg 1992:64). Another woman, anthropologist Elsie Clews Parsons, claimed after years of studying the research papers in the field of gender studies, that much of what was considered to be the natural behavior of women in U.S. society was not found in women of other cultures (Rosenberg 1992:64). These women firmly believed that society's perceptions about women distorted medical research investigating menstruation and its analysis and interpretation.

After years of struggle, women in the U.S. won the right to vote in 1920. The National Women's Party (NWP) worked to legislate an Equal Rights Amendment (ERA). In 1921 the first *KOTEX* feminine hygiene napkins were mass manufactured and became available to women in the United States. Nurses were instrumental in the invention of sanitary napkins. Previously, women used sewn pieces of cloth, much like a baby diaper, that they washed and reused. Just imagine trying to deal with a cloth-diaper-like-thing while wearing hoop skirts and a corset—not to mention dealing with break-through bleeding. The uncomfortable and unreliable diaper-napkins must have caused many working women to experience stress in a public setting or the work-place. This innovation truly helped to enable women to leave the home and venture into the workplace during menstruation and assured that they would not be encumbered by uncomfortable napkin-diapers (Delaney et al 1988:62).

Hygienic advances during the 1920s and 1930s contributed to improved health and increased life expectancy, but women still faced the perpetual possibility of multiple and continuous pregnancy. Most women who engaged in sexual relations with men would at some time in their lives become pregnant. Many women had one child right after another and in essence were slaves to their wombs. Birth control was rare, highly unreliable, and family planning was a utopian

fantasy—wealthier women with private physicians had access to certain forms of birth control and some received abortions, but birth control and the discussion of family planning had been made illegal in the 1870s through a series of regulations called the Comstock Laws. Abortion became illegal in 40 states during the period of 1860-1890 (D’Emilio and Freedman 1997). Margaret Sanger was arrested briefly for opening a birth control clinic that dispensed information about family planning and diaphragms in 1915 and again in 1916. She smuggled diaphragms into the United States from Holland and opened a clinic—women lined up around the block to receive birth control and information about family planning (Cott 2000; D’Emilio and Freedman 1997). At this time childbirth was the major cause of death in women under the age of 40 and many maladies such as prolapsed uteruses were associated with repeated pregnancies. Women in the 1920s and the 1930s often chose to have hysterectomies as a permanent form of birth control, especially those who had medical problems associated with childbirth.⁵

The birthrate plummeted in the 1930s because of the increased use of birth control and the deprivation imposed by the Great Depression. Yet, women were getting out into the public sphere and to a certain extent were powerful advocates for certain issues as was exemplified by the life of the First Lady, Eleanor Roosevelt. A popular play of 1936, “A Woman of Destiny,” tells the story of a woman antiwar “peacenik” who is eventually elected president (Cott 2000:455). This play depicts a woman who achieved high status in the United States while embodying an acceptable role for women in society. Because women were mothers, they were thought to be of high moral character. By extolling the virtues of peace and nonviolence, the hero of the play—the woman of

⁵*The American Experience*. PBS special on the history of the creation of the birth control pill. Aired February 22, 2003.

destiny—was elected to the highest office of the land while staying, safely and obediently, within the confines of femininity. The theme of the play was characteristic of the qualities that the “ideal” civic woman should exemplify. It communicated the fantasy that as long as a woman adhered to the proscribed norms for her feminine role, she could go far.

The idea of the civic woman was now an accepted norm in the public psyche as long as women played an activist role without violating those expectations. Many hardworking and thinking women of diverse backgrounds—culturally and ethically founded the framework during the early part of the twentieth century that in the 1950s and the 1960s would become the civil rights movement and the women’s liberation movement. It would eventually be these women who rejected the notion that women were inherently diseased or baby machines by marching, fists clinched in defiance to patriarchal domination and by becoming doctors, professors, lawyers, and entrepreneurs (or whatever fulfilled their dreams of self-expression).

The Origins of Premenstrual Tension (PMT). Karen Horney first used the term premenstrual tension (PMT) to describe a disease/disorder associated with menstruation in 1931. She noted that women experienced more tension in the days preceding menstruation and during the first few days of the onset of menstruation compared to the rest of the month. Because women’s main source of status in the world was achieved through the role of motherhood, the onset of menses symbolized failed maternity in women’s psyches. This failure to be pregnant caused women to experience nervous tension. Horney also claimed that PMT was a disorder caused by women’s sense of powerlessness in a male dominated world. Margaret Mead, anthropologist and author of such groundbreaking works as *Coming of Age in Samoa* (1928), *Sex and Temperament* (1935), and *Male and Female* (1949), concurred with Horney’s hypothesis. Horney and Mead argued that

Freud's hypothesis of "penis envy" was not the primary underlying psychic force shaping women's personalities. They postulated that women's nervous tension premenstrually and at onset of menses was precipitated by the special powers and privileges that society bestowed to men. They hypothesized that Lundberg and Farmham (*Modern Woman; the Lost Sex*, 1947) accepted too readily Freud's conceptualization of "penis envy" and argued that men suffered from "womb envy."

Mead reported primitive [sic] societies in which male ceremonials imitated gestation and childbearing in an obvious display of "womb envy." American society's attempt to confine women to the home could be understood, from this primitive [sic] perspective, simply as a male attempt to prevent women from having too much power. (Rosenberg 1992:155)

Dr. R. T. Frank (1931) also thought there was a cyclic disorder associated with menstruation that he called Premenstrual Tension (PMT), like Horney. Throughout the 1920s and the 1930s researchers and proponents of the new field of endocrinology were busy classifying and discerning the function of recently discovered hormones. They quickly claimed that these newly discovered hormones were integral components in the etiologies of disease diagnosis. Frank believed that PMT was caused by the overproduction of estrogen from the ovaries and suggested the removal of the ovaries as a viable treatment. Like Horney, Frank claimed that PMT had psychological components as well as physical symptoms of discomfort, but Frank thought that the "T" (tension), a psychological symptom, in PMT was caused by the overproduction of estrogen, not an unfulfilled desire for power in the public sphere, nor an unfulfilled desire for pregnancy.

WWII - 1960s.

On December 7, 1941, the Japanese bombed Pearl Harbor and the United States joined the

Allied Powers to deter the Axis powers from the domination of Europe and southeast Asia. When the United States entered WWII the Depression ended abruptly and the stage was set for the post-WWII boom which would lead in a few years time to the most prosperous period in U.S. history and eventually to a social revolution.

Initially, the changes in women's status in the United States were temporary and the result of a crisis. All citizens were urged to participate in any activity that would bring forth "victory." Women entered the public domain in unprecedented numbers. During WWII women were needed to work in the factories that produced munitions while many men were overseas fighting the Axis powers. Thus the common image of femininity from that time period was of the famous "Rosie the Riveter." Women were admitted to the military as recruits in the Women's Army Corps (WACS) or Women Accepted for Voluntary Emergency Service (WAVES) and 1,000 women pilots joined the Women's Airforce Service Pilots (WASPs). All the women recruits were encouraged to be tough and athletic and were expected to have impeccable morals (Cott 2000; Houppert 1999:157).⁶

During WWII doctors dismissed PMT and/or any cyclic symptoms associated with menstruation as improbable. The military produced training films that emphasized to the recruits that women were no longer the coddled, spoiled, and sickly creatures of the Victorian era who were subject to attacks of the nerves premenstrually and during menstruation. Women were told that the reason they had arrived where they were was because they had learned to take their menstrual cycles in stride. The doctors said that any prohibitions that were associated with

⁶WACS were women of excellent character. If they were over eighteen years of age with no children under the age of fourteen and could pass an intelligence test could join the Army. Young women under the age of eighteen could join the WAVES.

menstruation were superstitious remnants of the Victorian era. Women need not to worry about physical exercise during menstruation as possibly too taxing on their nervous systems; physicians now recommended that women treat cramps with exercise, specifically sit-ups, to insure strong abdominal muscles (Houppert, 1999:157; Martin 1989:120).

Once Allied victory was assured, initiatives to get women to go back into the home and out of the workplace became common—reversing the initiatives that urged women to join the work force for victory at the onset of WWII. The War Manpower Commission stated that “the separation of women from industry should flow in an orderly fashion.” Frederick Crawford, head of the National Association of Manufacturers said, “From a humanitarian point of view, too many women should not stay in the labor force. The home is the basic American Institution” (Cott 2000:484). The nation’s mood was pro-natalist whereby married men and women started families and proceeded to procreate—the baby boom had begun.

When World War II ended the supplemental women’s army was looking to downsize and male soldiers returned to their jobs, Rosie the Riveter was sent home with a rash of new studies that “proved” children needed their moms⁷ at home, that the workplace was potentially hazardous to women’s unborn children, and that women’s cycles made them less-competent workers than men. Enter Katharina Dalton, circa 1950, with a name for this sweeping and debilitating affliction:

⁷Rosenberg (1992) notes that Dr. Benjamin Spock, the world renown and foremost authority on child rearing practices and author of *Baby and Child Care* (1944), said that mothers first and foremost should avoid two dangerous tendencies: rejection and over protection. In a chapter entitled “Special Problems,” Spock said that mothers who wanted to leave their young children for the wage-labor market should seek psychological help. On the other hand, if mothers were too authoritative or smothering it could lead to “Momism,” a condition identified in WWII soldiers who had been smothered by their mothers and thus could not function in wartime. (Rosenberg 1992:151)

premenstrual syndrome (Houppert 1999:158).

Dalton's Conception of PMS

Dalton depicts women who exhibit PMS symptoms as angry, violent, accident prone, cognitively impaired, neglectful of their homes or children, and the purveyors of chaos in American homes:

Once a month, with monotonous regularity, chaos is inflicted on American homes as pre-menstrual tension and other pre-menstrual problems recur time and time again. Wonderfully happy and often long-term marriages and partnerships break-up under the strain, because one partner is an unpredictable, irrational, or violent woman suffering from Premenstrual Syndrome. (Dalton 1999:1)

According to many sources, 20% to 90% of all women suffer from some sort of menstrual related discomfort (Figert 1997:21;Olesen and Woods 1986).⁸ Dalton (1999:2) claims in *Once a Month*, that 5.5 million women in the United States suffer from PMS, yet later in the text she claims that 40% of all women suffer from PMS (Dalton 1999:137).

PMS is a man's problem too. With about 40 percent of women suffering from PMS, the law of averages ensures that sooner or later a man will find himself on the receiving end. It could be his mother, sister, partner, girlfriend, or any woman in his workplace or anywhere else. If he has not learned to handle the situation and doesn't know where to turn for help, then it could be a very traumatic experience indeed (Dalton 1999:137).

Dalton (1999:266) declares that PMS is "the world's most common disease." She also claims that "menstrual problems are widespread and often debilitating (Dalton 1999:263).

Dalton (1999:159, 269) claims that "the cost to industry because of menstrual problems is high and is measured in millions of pounds, *liras*, *kroners*, and dollars, as well as in terms of human

⁸The statement that 20% to 90% of all women suffer from a menstrual related malady is statistically meaningless.

misery, unhappiness, and pain.” Women are a large part of the work force today and Dalton (1999:165) suggests that women do only innocuous duties premenstrually or while menstruating. According to Dalton (1999:157), more children are involved in accidents when their mothers are menstruating or premenstrual. Dalton makes the claim that the Russian cosmonaut, Valentina Tereshkova, the first woman to orbit the Earth, had to be brought down because she began to menstruate heavily: “Valentina Tereshkova, who in 1973 had to be brought down after only three days in space when she began to menstruate heavily in zero gravity” (Dalton 1999:162). Dalton gives the year of Tereshkova’s historic orbit of the Earth as 1973, but the year was actually 1963 (Oberg 1981:249). She also gets the facts wrong: From Oberg’s *Red Star in Orbit*, “Tereshkova soared on. Originally a flight lasting a single day had been scheduled, with two possible day-long extensions if all went well. These extensions were allowed after she seemed to make a good adjustment to weightlessness” (Oberg 1981:68).

Today, women are not exclusively defined as reproducers and mothers, but according to Dalton, mothers are the linchpins of their families. Therefore, if something goes wrong with the mother then the entire family will suffer, and if there is something wrong with the family then it is the mother’s fault.

The mother is the linchpin of the family. When her life is made miserable each month by the effects of PMS, it affects the whole family: husband, babies, schoolchildren, and teenagers. Children, even infants of only a few months, are very sensitive to changes in their mother’s moods. If they can not understand the reason for a change, they will react to it in their own peculiar way.

Health professionals and social workers soon recognize when one of the mothers in their care is in her premenstruum. The usually tidy house is not picked up, the beds aren’t made, dirty dishes sit on the kitchen table, and there might be a burnt cake on the counter by the sink. Perhaps the children went off to school late, in yesterday’s clothes, and chances are that meals will not be ready on time. (Dalton 1999:143-

144)

Are women as mothers—those who stay at home or who work outside the home—totally responsible for the condition of the household and the children? Dalton says in *Once a Month* that marriage is an “equal partnership,” but from her aforementioned statements it is obvious that Dalton thinks that women are primarily responsible for the household and the children. Nowhere in her statement does she mention a man or a husband who neglected to make the beds, burnt a cake, or got the kids to school late wearing dirty clothes. The social expectations for women’s behavior, when merged with statements from medical professionals like Dalton’s, converge in the minds of women to create an image of womanhood that is very difficult to live up to. Women may grow frustrated after trying, and failing, to meet such high standards. They may blame their perceived inadequacies as care-givers and housekeepers, not the impossible set of expectations associated with their role in its social context. A typical example of how women blame themselves for their perceived inadequacies as care-givers and housekeepers is noted in Olesen and Woods’ (1986)

Culture, Society, and Menstruation:

“I’m married, have a small child who was very much wanted, and a loving husband who has a good job.” However, the woman has a menstrual problem and is desperate. She may feel uncomfortable, depressed, edgy, or angry for days on end. The phrase I hear over and over is “out of control,” the last thing a woman is brought up to be. She cannot live up to the image of herself as a good woman that she maintains through the rest of her cycle: that is cheerful, compliant, easing everyone else’s social relations. She often is embarrassed by her mood swings, sometimes humiliated. She feels she *should* be able to manage this on her own. Generally she does not discuss this problem with friends or other family members and tends not to get help for it. This isolation makes PMS even harder. As the conversation goes on, it turns out that her partner is quite fed up with the whole business of moods. (P.147)

Women have cyclical hormonal changes in their bodies throughout their menstrual cycle

and many women experience a vast array of events and emotions—negative and positive, throughout the month, but does this truly indicate a disease/disorder state? Does any expression of an emotion denote irrationality or pathology in a woman? Does any expression of an emotion—whether it is anger or elation, sadness or happiness—represent a disease state? Or do professionals diagnose a disease/disorder only when women’s emotions contradict traditional expectations for the feminine role? It has been suggested there may be a “disorder” that could be termed “post-menstrual euphoria.” For example, in the post-menstrual phase of the menstrual cycle, some women, it has been suggested, are abnormally energetic (cleaning, cooking, and laundering), sweet and nice, regardless of how horrendous the social setting. Perhaps, only during the premenstrual phase and during the first three days of menstruation are women able to express levels of anger and irritability relevant or appropriate to their particular situation (Abraham 1984).

Dalton says over and over again in her book that her goal is to help women. She also makes it quite clear that she wants to help women behave in ways acceptable to their children, partner, and society as well.

Some men remain unaware of the problem until they awaken one morning to a hysterical and completely irrational woman with whom it is impossible to reason, and who may become violent. This is recognizing PMS the hard way. Others who are more observant, may gradually become aware of her changing moods. She may become pessimistic, negative, and withdrawn at times, and at those times nothing can be done to please her. She may be snappy, argumentative, impatient, and illogical; or she may shriek, yell, and swear. She may even be violent, ready to bang on the table, slam doors, throw plates, vases, and books, kick the cat or dog, or hit those nearest and dearest to her, which means her husband and children. (Dalton, 1999:140)

Dalton wants men to be aware of PMS so that they may recognize the symptoms of the disorder and immediately get their wives to start keeping a daily diary. After six months of keeping

the daily diary Dalton suggests that the husband should accompany his wife to the doctor's office because the physician would be more receptive to the woman and a PMS diagnosis if her husband corroborated the woman's "troublesome" behavior (Dalton, 1999).

Dalton makes the claim that PMS has been around for thousands of years. She produces evidence for the existence of PMS by employing what many feminists consider to be misogynist stereotypes associated with women throughout the ages:

It has been suggested that PMS is a disease of the twentieth-century civilization but this is true only to the extent that the media today exploits it, and it offers a chance for profit to quacks and entrepreneurs. PMS has been around for thousands of years. Hippocrates in 400 B.C. suggested that it was caused by "agitated blood trying to find a way out of the body." A century earlier S[e]monides of Ceos, the Greek poet, wrote a classical program about the changing moods of women, which he likened to the changing moods of the sea. This image provides an unmistakable representation of the sudden personality changes of the premenstrual woman (Dalton 1999:133).

Dalton's conceptualization of PMS is a reflection of her historical and culturally contingent context. Her definition of what is "normal" behavior for women is based on what are widely considered to be stereotypical, sexist, and misogynistic definitions and expectations for women. Her definition for what is normal behavior for women is also based on the definition of what constitutes normal behavior for white middle-to-upper class women. She freely admitted that Semonides of Ceos' writings, which were labeled misogynistic by feminists and non-feminists alike, reflected the true nature of women's behavior (Cantarella 1991). Therefore, Dalton's definitions, formal or informal, of what constitutes "normal" women's behavior are not accurate and they are certainly not based on scientifically obtained evidence.

Women's Liberation

WWII brought unprecedented changes to the pre-established norms associated with

women's roles, but when "victory" was won, women were expected to go back to their pre-established roles. Many women continued to work throughout the 1950s and into the 1960s even though the prevalent attitude of the nation was that women, especially middle and upper class white women, should be the guardians of the domestic sphere. In 1960 when President Kennedy was elected, many women thought that he would appoint more women than ever to important posts in his administration, but this was not the case. Eleanor Roosevelt was rather astonished by President Kennedy's omission of women from his administration so she sent him a list of qualified women who would be excellent choices for government positions. Kennedy appointed a total of nine women to his administration. Women activists and feminists protested loudly and fiercely to the president and he finally responded by creating the Commission on the Status of Women (Schneir 1994:38).

This commission, headed by attorney Pauli Murray, and her junior colleague, Mary O. Eastwood, found that women were the most under used resource in the United States. The study also found that women who worked in the wage labor market faced several difficulties. For example, the committee found that women who worked in the wage labor market were usually paid less than men for the same work. Women were overlooked for promotions and pay raises because it was assumed that they would be leaving the wage labor market when they married and eventually became pregnant. Women were prohibited from working in certain jobs and industries because of their gender. There were inadequate child care facilities available to working mothers and many women could not afford the few facilities that were available. All of these difficulties still pose problems for many women and working mothers in the wage labor market (Schneir 1994:71-102).

The civil rights movements of the 1960s led to the women's liberation movement of the 1970s whereby fundamental and lasting changes in women's roles and their expected behaviors took root and bore fruit. For example, more women than ever were enrolled in the nation's colleges and women were entering the wage-labor market in unprecedented numbers. The pill was available to married women in the 1960s; whereby, they could plan when they wanted to become pregnant and limit the number of children that they bore. Unfortunately, because of the stigma of promiscuity associated with single women and sexual relations the pill was not readily available to them until the middle of the 1970s. To many women this presented the intolerable situation that they were still not in control of their reproductive lives and health. Feminists believed that unless women had total control over their reproductive life they would always be at the mercy of their reproductive imperative and at the beck and call of men, and that was totally unacceptable. In 1972, this impetus to retrieve the ownership of their bodies led the Boston Women's Health Collective to publish *Our Bodies, Ourselves*.

In 1973 abortion was legalized in this country when the Supreme Court ruled in favor of plaintiff Jane Roe whose lawyers represented her anonymously. *Roe v. Wade*, would establish a precedent for all other women. Jane Roe was a pregnant woman who wanted access to a legal abortion, but because abortion was illegal she did not have access to one. Her lawyers argued that denying Jane Roe access to an abortion was a violation of her constitutional right to privacy, guaranteed under the 14th Amendment's concept of personal liberty. By a seven to two margin the supreme court justices ruled in favor of the plaintiff and abortion was legal in the United States for the first time in 125 years (Cott 2000:568). A second attempt for implementing the legislation that could establish an Equal Rights Amendment was instituted by the National Organization for

Women (NOW). Women had won the right to control their reproductive life and it seemed as if women were on their way to total equality.

Cultural Lag

In the 1970s and the 1980s more women than ever were in the workplace and more women than ever were enrolled in the nation's colleges and universities. During this time there was a popular commercial for perfume. An attractive woman dressed in a slinky dress—appears on the screen—holding a pan singing a song that went like this: “I can bring home the bacon, fry it up in a pan and never ever let you forget that you are a man—because I’m a woman!” This sums up in a simplistic way what women were trying to be—everything to everyone in their lives. The “new woman” was a great employee, great wife and helpmate—sexy lover and potentially great and energetic mother. This image of women was non-threatening to men because the only role that was going to change when women went into the workplace was theirs—men’s could stay the same—no problem.

The home was seen traditionally as men’s “shelter from the storm,” and women were supposed to provide this sanctuary for men and live in perpetual domestic bliss. That is a lovely fantasy, but, when the reality of what that meant for working women came to bear on a relationship between a man and a woman—living together or married—it took on an entirely different meaning. When women’s primary profession changed from “domestic goddess,” to a “goddess of multitasking,” cracks in the dam of domestic bliss began to appear.

Women quickly realized that being everything to everyone was incredibly difficult and inherently unfair and demeaning to women. Women’s place in society was changing rapidly but society was not changing at the same rate in order to meet the needs of women’s changing

priorities. For example, there were still the same problems facing women that were outlined and pinpointed by the Commission on the Status of Women: unequal pay for equal work, promotion and salary lethargy, sexual harassment, and inadequate child care. This phenomenon created what some researchers have termed a “cultural lag” (Hochschild, 1989). Cultural lag describes how women’s roles in society changed without society changing in relation to women’s changing roles. Women soon realized that men’s roles and their definitions along with women’s were going to have to change if there was going to be equal opportunity for all women.

I hypothesize that the stress that was precipitated as a result of this cultural lag in relation to society’s static expectations for women in the United States was a factor in the proliferation of the PMS diagnosis. The emotions that women expressed as a result of cultural lag were the emotions that have been deemed inappropriate for women to exhibit such as, anger or irritability. Women became angry and resentful when they came home from work and still had domestic chores to do. Hochschild called these unpaid domestic chores, which were primarily women’s responsibility, the “second shift.” Some career women have half-jokingly suggested that they should obtain “wives” (Hochschild, 1989), which adds support to the hypothesis that male roles have lagged behind the changes women experienced. According to Macionis (2004:100) in the year 2003 women still do most of the housework.

Many men have dedicated hours and hours of hard work to building their careers, sometimes at the expense of their relationship with their families. Career building in our culture consumes energy and dedication. In order for women to have successful careers it is necessary for them to engage in this intensive career building. The most common age for this intensive career building—the late 20s and early 30s—coincides with the optimal time for women to become

pregnant. Women are faced with a dilemma—delay childbearing or delay career building—doing either one has serious consequences. Delaying childbearing into the late 30s and 40s increases women’s risk for complications in childbirth and increases the incidence of birth defects. Women who delay career building in order to begin a family risk not achieving their highest public goals. Women face a quandary as to which choice to make; consequently many choose both. Some women may be able to juggle this schedule with no problem; some women have helpful partners and a few women have partners who have assumed primary responsibility for the household. Some have traditional husbands with traditional family values and some are single heads of households. Many women are on their own, but all must juggle “the strain of maintaining the two roles that these women experience as they attempt to be cool-headed and competitive at work but warm-hearted and nurturing at home” (Hays 1996:16).

Women’s roles have changed dramatically in the last forty years, but many of society’s attitudes and behaviors have not changed at the same rate creating certain problems. For example, when women went out into the workplace in unprecedented numbers in the 1970s and the 1980s they faced low wages and promotion lethargy. Women were (are) still underpaid for doing the same jobs as men and many women found (find) themselves in positions with great responsibility yet possess little authority. Men were (are) seen as having families to support—employers often passed (pass) over women for promotion and raises because men needed to earn a higher wage, whereas women were (are) seen as only having themselves to support or as merely supplementing the family income.⁹

⁹Which of course is problematic because there are many women who are heads of households, lesbians have partners and children but cannot be officially married, and promotions and raises should be based on merit not one’s marital or filial status.

Women are still the primary caregivers for children and the primary custodians of the household. Although there have been strides made by some men to close the gap in the distribution of domestic chores, women work the equivalent of one month a year more than men doing domestic chores (Hochschild 1989). Married women with children face inadequate childcare facilities plus the second shift. Single mothers face all these problems plus the disadvantage of having to take time off to care for a sick child or to take a child to a doctor's appointment. Women, heads-of-households and married women, juggle career, chores, child rearing, errands, and relationships—finding time to exercise and maybe to have some fun—but they have to be scheduled weeks in advance. Even then a sick child can wreak havoc with the best laid plans.

Cultural lag (unchanging wage labor conditions to accommodate women's schedules and the second shift) in conjunction with vestigial claims made about women's personalities (stereotypes) contributed to a climate conducive to the social construction of PMS. The social construction of a medical framework like PMS serves as a placeholder for the emotion ensuing from men and women's public and private relationship problems. Claims made about women's personalities (stereotypes) have promoted an environment in which disorders such as PMS are created out of women's "failure" to conform to an outdated role of passivity and subordination.

PMS "Hysteria." In 1980 PMS was litigated as a mitigating circumstance in the defense of two women on trial for murder in Great Britain. The expert testimony in these cases was provided by Dr. Katharina Dalton (Dalton 1999:172). This catapulted PMS into the spotlight in the 1980s. PMS became the topic of talk shows and received widespread media coverage. Suddenly women's reports of PMS as a malady became pervasive in the United States. Some researchers have called the 1980s and the early 1990s the era of PMS hysteria (Figert 1996:7). The ubiquity of PMS

coverage, in combination with the rise in the number of women in the wage labor market, gave men and women a medical scapegoat for the problems actually caused by the disparities in their personal and public relationships. PMS also provided a method for the diffusion of their interpersonal tensions and the assuagement of women's frustrations with a labor market that denied them raises, promotions, and power.

CHAPTER 3

PREMENSTRUAL SYNDROME (PMS) AND ITS VARIANTS

PMS—A Definition and a Description

Horney (1931) and Frank (1931) argued for a disease/disorder category called PMT whereby women exhibit and experience nervous tension premenstrually and at the onset of menses. In the 1950s, in the United Kingdom, Dr. Katharina Dalton and a colleague, Dr. Raymond Greene, “argued that emotional tension was only one of many components of this condition and they proposed that instead it should be referred to as premenstrual syndrome” (Richardson 1995).

In 1953 Drs. Dalton and Greene published the first paper on PMS in the British scientific literature in the *British Medical Journal* and in 1954 Dalton established the world’s first premenstrual syndrome clinic in London (Dalton 1999:X). According to Dalton, “Premenstrual Syndrome is the recurrence of symptoms before menstruation with complete absence of symptoms after menstruation.” Dalton’s conceptualization of PMS does not include specific symptoms in her clinical definition, because “there are too many to mention, over 150 to be exact” (Dalton 1999:7). Some of the symptoms that Dalton mentioned in her book were: depression, mood swings, headaches, irritability, grouchiness, edema, bloatedness, sore throats, vertigo, lethargy, breast tenderness, backache, painful joints, appetite cravings, asthma, hay fever, red eyes, styes, and acne. She also discussed at length the symptoms that are the central subjects in this thesis—mood changes, anger, depression, and irritability—as well as more unusual symptoms such as hair pulling, self-mutilation, and metatarsalgia (pain in the feet). Dalton recognized that many people occasionally experienced the aforementioned symptoms but in order to be diagnosed with PMS the recurrence of symptoms had to be noted for a minimum of six menstrual cycles and observed

continuously during treatment. The symptoms must be present for fourteen days or less before menstruation, and cannot begin prior to ovulation. There must also be a complete absence of symptoms after menstruation (Dalton 1999:7).

Dalton hypothesized that low levels of the hormone progesterone in the late luteal phase of the menstrual cycle caused PMS symptoms. Following the creation of the premenstrual syndrome clinic in London, many women in Great Britain and the U.S. were diagnosed with PMS. Most women diagnosed with PMS were treated with the hormone progesterone.

PMS and PMC

In 1983, The National Institute of Mental Health (NIMH) recognized the existence of PMS. Its definition omitted the physical complaints (cramps, bloating, headaches, etc.) that many women reported and emphasized the psychological aspects (mood changes, depression, anger, and irritability) that women reported in conjunction with their menstrual cycles.

In 1983 the National Institute of Mental Health (NIMH) sponsored a conference on PMS. The participants proposed that a difference of 30 percent between premenstrual and postmenstrual mood scores should be the criterion for PMS as a clinical diagnosis. . . , a rule which has become the ‘gold standard’ in PMS research (Walker 1997:149).

NIMH’s definition emphasized the **change in intensity** of depression, mood, and irritability—exclusively. NIMH’s definition of PMS is different from Dalton’s definition in three basic ways: first, Dalton’s definition included at least 150 symptoms, including physical discomforts, whereas, NIMH’s definition makes no mention of the physical discomforts; second, NIMH’s definition considers the change in intensity of depressive and irritability symptoms as the criterion used to make a diagnosis; and, third, Dalton’s PMS is treated with progesterone and

NIMH's PMS is treated with serotonin reuptake inhibitors. How can Dalton's definition of PMS be so radically different from NIMH's?

In psychiatric circles the mood changes that are reported in conjunction with menstruation are referred to as Premenstrual Mood Changes (PMC) (Gold 1985:3). More women seek treatment for depression than men and psychiatric epidemiologists concluded that hormonal or reproductive events probably did have an effect on depression rates but that these were likely to be of small magnitude (Gold 1985:3). It is possible that men actually suffer from depression at the same rates as women but that they do not seek treatment for depression at the same rates as women because of society's expectations for their behavior. The stigma associated with depression may prevent men from reporting depressive symptoms and may encourage them to mask their emotions.

According to the American Psychiatric Association's Research Diagnostic Criteria (RDC), chronic depression is diagnosed when symptoms of depression last for two weeks or more. The type and severity of depression that many women reported fulfilled the required criteria for depression, but the depression should only be exhibited premenstrually and during the first three days of menses. Therefore, women who reported depression or mood changes in conjunction with their menses did not meet the temporal criteria associated with chronic depression and could not be diagnosed with an affective disorder (Gold 1985:3). Two thirds of women with a lifetime history of major depression report PMC compared with a much smaller proportion for never-depressed controls, and an excess of women with severe PMC report a lifetime history of major depression (Endicott, Halbreich, and Schact 1981). PMC may be associated with mini-episodes of certain subtypes of an affective disorder or it could be that menstruation exacerbates a pre-existing

affective disorder (Endicott, Halbreich, and Schact 1981). This split in the etiology between psychology and biology of menstrual related maladies continued to influence their discussion and classification well into the 1980s and the 1990s.

PMDD and its Inclusion in the DSM

Three to 5 percent of women in the U.S. report monthly symptoms of depression, mood changes, anger, or irritability in conjunction with their menstrual cycles that cause them extreme distress (Gold 1997). This disorder has been termed premenstrual dysphoric disorder or PMDD and is listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. PMDD is considered to be an affective (mood) disorder and is treated with tricyclic antidepressants and serotonin reuptake inhibitors. Therefore, PMDD's etiology is distinct from Dalton's proposed etiology for PMS, which is related to progesterone levels, but is very similar to NIMH's proposed etiology of PMS, which makes the claim that PMS (PMC) is an affective disorder with a neurological etiology. It was a controversial addition to the psychiatric nosology in that many people were fearful that women would be further discriminated against in the labor market because the disorder only affected women. On the other hand, it was argued that if women were suffering and biomedical doctors could ameliorate their symptoms, then by all means treatment should be extended to all of them.

Initially, PMDD was named LLPDD—Late Luteal Phase Dysphoric Disorder. LLPDD was first included in Appendix A of the DSM III-R. The criteria whereby diagnosis was discerned are strikingly similar to the definition of PMS (PMC) used by the NIMH. The method used to confirm the diagnosis is the prospective daily self-ratings diary kept for at least two symptomatic cycles. There can be exceptions to this whereby the diagnosis is made provisionally until it can be

confirmed by the diaries. What are the criteria that are used to diagnose LLPDD? It is a very long list:

A. In most menstrual cycles during the past year, symptoms in B occurred during the last week of the luteal phase and remitted within a few days after the onset of the follicular phase. In menstruating females, these phases correspond to the week before, and a few days after, the onset of menses. (In non-menstruating females who have had a hysterectomy, the timing of the luteal and follicular phases may require a measurement of circulating reproductive hormones.)

B. At least five of the following symptoms have been present for most of the time during each symptomatic late luteal phase, at least one of the symptoms being either (1), (2), (3), or (4):

- (1) marked affective lability, e.g., feeling suddenly sad, tearful, irritable, or angry
- (2) persistent and marked anger or irritability
- (3) marked anxiety, tension, feelings of being “keyed up,” or “on edge”
- (4) markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
- (5) decreased interest in usual activities, e.g., work, friends, hobbies
- (6) easy defatigability or marked lack of energy
- (7) subjective sense of difficulty in concentrating
- (8) marked change in appetite, overeating, or specific food cravings
- (9) hypersomnia or insomnia
- (10) other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of “bloating,” weight gain.

C. The disturbance seriously interferes with work or with usual social activities or relationships with others.

D. The disturbance is just not merely an exacerbation of the symptoms of another disorder, such as Major Depression, Panic Disorder, Dysthymia, or a Personality Disorder (although it may be superimposed on any of these disorders).

E. Criteria A, B, C, and D are confirmed by prospective daily self-ratings during at least two symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.)(Figert 1996:56).

In 1987 there was no noted efficacious treatment for LLPDD, so experts felt that the

disorder could not put in the main body of text. However, in the early 1990s the antidepressants Prozac and Xanax became readily available and were deemed as effective treatments for PMDD. In 1995 it was included in the main text of the DSM-IV.

The inclusion of PMDD in the DSM is controversial for two important reasons: first, the inclusion further perpetuates the cultural myth that some women are, by virtue of their gender, mentally ill (unjustifiably irrational and bitchy), and second, it promotes the exclusion of women from the most powerful and prestigious positions in the workplace. The claim, that there are pejorative and pervasive sentiments regarding menstruation in U.S. culture is evidenced by all the jokes and innuendoes that portray women as “crazy” premenstrually and during menstruation, victims of their raging hormones, and incapable of ratiocination. There is hardly a person in the West who has not heard at least one joke about menstruating women. For example, “What is the difference between a woman and a pit bull? A pit bull doesn’t wear lipstick!”(Figert 1996:12) After the first Persian Gulf War a joke circulated that went like this “Did you hear that they pulled 15,000 soldiers out of Saudi Arabia? They replaced them with 5,000 women with PMS because they are three times meaner and they retain water better” (Figert 1996:14). These are exemplars of the contemporary popular perceptions of menstruating women, and many women maintain these perceptions of themselves as well. In *Psychobabble and Biobunk* (2001), Carol Tavris concluded that PMDD is just “ancient superstition in pompous new jargon.” When one examines the cultural stereotype that women have an inherent menstrual related disorder, the consequence is that people dismiss women’s anger as a product of their physiology—thus dismissing perhaps inappropriate behavior (mitigating circumstance in British murder cases), ignoring legitimate grounds for anger, or trivializing women’s experiences and responses to their social context. Some women have

buttons or coffee cups that have inscribed sentiments that reflect these beliefs. For example, “I’ve got PMS. What is your excuse?” Or, “I’ve got PMS. Stay the hell away from me!” (Figert 1996:14). “What does PMS really stand for? Putting up with Men’s Shit!” “PMS–Harness the energy!” (Figert 1996:18)

The second negative implication of including PMDD in the DSM-IV is the effect it could have on women in the workplace. Traditionally, menstruation has been used to exclude women from the most important and prestigious professions in U.S. society.

The most commonly cited example of cultural attitudes about PMS is the “Woman in Authority with Raging Hormones scenarios.” We can probably trace the “raging hormones” idea to a public statement by Edgar Berman, Hubert Humphrey’s physician during the 1968 presidential campaign. Berman stated that he did not want a woman in a position of power because she would be subject to “raging hormonal influence” each month (as cited in Corea 1985; Fausto-Sterling, 1985). Berman clarified his views on the subject in a 1976 interview with journalist Gena Corea: “‘Menstruation may very well affect the ability of these women to hold certain jobs,’ he told me. ‘Take a woman surgeon. If she had premenstrual tension—and people with this frequently wind up in a psychiatrist’s office—I wouldn’t want her operating on me.’” (Figert 1996:11)

In 2003 there are many women surgeons and about half of all new medical students are women, but there are still many places professionally where women are under-represented in the U.S. For example, women are under represented in the United States House of Representatives, the U.S. Senate, the U.S. Presidency, and as CEOs of major corporations.

Official protests against the inclusion of PMDD into the DSM-IV were filed by the American Psychological Association’s Committee on Women, the National Women’s Health Network, the Boston Women’s Health Collective, and the National Organization for Women. The reasons cited for their anti-inclusion position were the lack of scientific evidence to support a

disorder category named PMDD and the associated stigma would cause more harm than it would ameliorate (Figert 1996:163).

Some of the professionals in the work group that debated the question of whether PMDD should be included in the DSM-IV made the claim that they should not discriminate against women suffering from this disorder but, that they should combat the stigma that may be created through education about the disorder and the stigma associated with mental illness in general. There should be education on both topics, but the stigma associated with a mental illness diagnosis would still be hard to dismiss. The stigma associated with mental illness in our society has serious social and political consequences. For example, for many years homosexuality was considered to be a mental illness (inverted personality disorder) and was listed in the DSM-II which fueled discriminatory treatment of homosexuals. Gays and Lesbians lobbied the APA intensively to remove homosexuality from its official list of mental disorders. In 1973 homosexuality was deleted from the DSM-II and was no longer considered to be a mental illness or a disorder. Drawing a parallel argument, then, more women would be further stigmatized than helped by the inclusion of PMDD in DSM-IV.

The addition of PMDD to the DSM-IV in 1995 is an example of a compromise in the struggle for the ownership of PMS's etiology between psychology, psychiatry, and medicine. Psychiatrists are adherents of neurological etiologies for the evaluation, treatment, and interpretation of affective disorders.

Both the neurological and hormonal etiological pathways postulated for menstrual related disorders/diseases have cemented women's responses to menstruation firmly to their physiology—consequentially rendering women inherently “at the mercy” of their “raging hormones”

or “neurological glitches.” If women are at the mercy of their “raging hormones” or their “neurological glitches” then the only remedy for their happiness is a medical one and the ownership of women’s life courses are subsumed under the auspices of physicians or psychiatrists and their prescription pads. The medicalization of the human condition, especially, the segmentation of women’s life courses into discrete sociomedical phases—menarche, pregnancy, childbirth, and menopause—has serious consequences for the way women feel about themselves and their place in society. The medicalization of women’s bodies also has serious consequences for the way society views women and for what their role should be in society, a topic that I will address in the next chapter.

CHAPTER 4

METHODOLOGICAL PROBLEMS WITH PMS RESEARCH

What are the Criteria for Discerning a Menstrual Disorder/Disease?

How would the definition of a disorder associated with women's menstrual cycles be discerned? Often a woman's deviation from a normal menstrual cycle is classified as a disorder. Examples of deviations are irregular cycle lengths, amenorrhea, or excessive bleeding. If a normal menstrual cycle is the measurement framework for optimal women's health, then we must know the definition for a normal menstrual cycle. A normal menstrual cycle is divided into two broad categories of discussion—one of a biological nature and the other of a psychological nature. Biologically, the definition of a normal menstrual cycle is quite complex—only one in eight women have cycles that span the average 28 days and many have cycles that have an average span of 35 days or 23 days (Scrambler and Scrambler 1993:Chapter 1). There are many other variations around the 28 day theme as well, whereby discerning what is normal may not be very easy or even possible. As women come closer to menopause the number of days in women's cycles may change, becoming more or less. Therefore, when talking about the normal number of days in women's menstrual cycles, the only number of days that can be discussed is the average cycle length. The differences in cycle length, the amount of bleeding (heavy or light), the discomfort of cramps or bloating, and many other aspects of menstruation are subjective and are impossible to systematize into a regular schema that defines what is normal.

Historically, what constituted a healthy menstrual cycle psychologically was a mental state that was conducive to the creation, bearing, raising, and maintenance of a proper home environment for children. For example, if a woman was diagnosed as "frigid," her fear of sex or

her lack of sexual desire for her partner was considered a disorder state because if she wasn't having sex with her husband then obviously no child would be conceived. Or, with the diagnosis of "nymphomania," if a woman enjoyed sexual relations too much, then she would continually be interested in sexual relations, shirking her household responsibilities and her children. It is also reflective of the Victorian ideal that "proper" women should not enjoy sexual relations. A proper Victorian lady had sex with her husband because she wanted her desire for a child fulfilled. Nymphomania also implied that sexual relations were a way that women could express themselves and find gratification within the sexual act without pregnancy or child rearing.

Medically, biologically, and psychologically the most common definition of what was considered a normal menstrual cycle was a cycle that maximized a woman's fertility and any deviation from that was considered to be abnormal. By definition, then, a psychologically, biologically, and medically healthy woman was a woman with a "normal" menstrual cycle with many children. Today, even the inevitable cessation of menstruation, menopause, is referred to as estrogen deficiency disease and is an example of a disease/disorder that afflicts women and is defined in relation to estrogen levels. A "normal" estrogen level is associated with women's peak reproductive years.

If a woman works outside the home—has a career and never has a child—does that automatically make her abnormal and therefore riddled with PMS? If potential fertility and successful reproduction are the hallmarks of healthy women, then can only regularly menstruating women who are also well adjusted mothers and exemplary housekeepers be normal women?¹⁰

¹⁰In the 1970s, studies printed in *Psychology Today* by Karen Paige proposed that it was women who were conservative—stay-at-home-mothers with no ambitions outside the home that were inclined to suffer from menstrual related disorders (Delaney, 1988; Houppert, 1996).

What is Normal?

What is normal and abnormal? Who decides what is normal and abnormal? Do women get to decide what is normal? Do physicians, psychiatrists, psychologists or medical researchers decide what is normal? Does society decide what is normal? Do all of these groups decide, or does one group have more influence than the others? Are any of these groups biased in a particular way? Do certain groups (psychologists, psychiatrists, and physicians) fight over the ownership of perceived maladies? Does the male's embodied experience of the world determine what is the norm?

Physicians and psychiatrists, generally speaking, relate information to patients and often proffer diagnosis and treatment in accordance with averages. Averages equal and answer the question of what is normal, regarding human anatomy and physiology. One of Darwin's three basic tenets of evolution states that the individuals who comprise a species exhibit variation. This is the basis of natural selection and variation is certainly an inherent characteristic of the human species. All individuals have a unique physiological and psychological response to their environment and specific substances within their socioecosystem; therefore when one speaks of human disorders/diseases one must be aware of this inherent variation. Perhaps, instead of speaking of means and medians when physicians discuss diagnosis and treatment they should refer to scales and continuums. Instead of treating outliers as anomalies with no importance to advancing diagnosis and treatment perhaps these anomalies should be studied. For example, approximately 1 in about 250 people exhibit an immunity to the HIV virus; therefore, studying these folks helps medical researchers to understand HIV infection better and helps to find a more efficacious treatment. In regards to menstrual cycle research, perhaps medical researchers should study women who never report any menstrually related problems to gain insight into the perceived problem.

Embracing human variation in health research is a relatively new approach; throughout time it was assumed that men and women's bodies responded similarly to medicines and treatments for particular illnesses. Research was not conducted on women—it is only in the last twenty years that research has been done on women's physiological states (Pear 2000:5). Yet, somehow, it has been known for thousands of years that women suffer from a disease/disorder that has now been termed PMS. This seems scientifically questionable.

Throughout much of Western society's history, the virtues that have been traditionally associated with mental health have also been the same traits associated with the epitome of masculinity. Rationality, decisiveness, and independence are all personality traits associated with virile and healthy men. Irrationality, mood changes, and dependence upon men are traits that are associated with women and women's maladies. The beliefs that women are naturally less rational than men, subject to whims, and require a man for sexual and emotional satisfaction create a set of expectations for behavior that when exhibited by women at the perceived wrong time or in the wrong way are considered deviant and constitute a disorder/disease. How can this be? How can women ever behave in a way acceptable to society? For more on women and mental health see Phyllis Chesler's *Women and Madness* (1989) and Jane Ussher's *Women's Madness: Misogyny or Mental Illness* (1991).

Problems Inherent to PMS Research

The 1992 edition of *Our Bodies, Ourselves* considered the topic of PMS in depth. The authors, all medical professionals well versed in feminist debate, not only speculated about the pros and cons of progesterone but took the critique one step further, observing that “the placebo response rate is so high for PMS that uncontrolled trials made all remedies seem effective” (Boston

Women's Health Collective 1998; Dalton 1999; Walker 1997). A hormonal etiology for PMS would suggest that a physical exam or a blood test should reveal unequivocally whether or not one has PMS (Walker, 1997). The problem with a blood test for PMS is that the interactions between the gonadal hormones and the androgens are so complicated that women would have to undergo blood tests every day in order to ascertain the exact amount of each hormone that was present in their system and when that hormone was found temporally in women's individual cycles. The costs associated with this type of testing would be prohibitive—not to mention time consuming for the participants—and it is debatable as to whether or not researchers would still be able to determine the exact etiology of PMS.

There have been no studies to date that show that PMS is a disorder based on low amounts of progesterone in the late luteal phase of the menstrual cycle (Asso 1988:15-36; Dalton 1999:22; Hamilton 1984:7). Dalton no longer treats women with progesterone for PMS. Dalton now makes the claim that PMS is a result of progesterone receptors not working as efficiently as they should in some women (Dalton 1999:22, 79). Dalton freely admits that there are many methodological problems with research on PMS. For example:

1. The precise definition of PMS must be followed, with absence of symptoms in the post-menstruum.
2. There is a high dropout rate [high attrition rate for trial participants].
3. There is a high placebo response.
4. Trials take a long time, at least six months of daily recording.
5. A high number of volunteers is needed.
6. There are over 150 possible symptoms, both psychological and physical.
7. Trials are limited to mild cases for ethical reasons
8. Participating women must have regular menstrual cycles
9. The women must not be using hormonal contraception or IUDs.
10. Participants cannot plan to be pregnant within six months (cite)

The first problem that Dalton cites as a research hindrance is that health care professionals

must use the correct definition for diagnosing PMS. Does she mean her definition? The NIMH's definition? The DSM-IV's definition? Hippocrates's definition? The differences in the definitions of PMS by different medical professionals are troubling.

The problem of whether or not severe PMS–PMDD—is a real mental disorder is actually a particular case of the general problem of when any set of conditions constitutes a mental disorder. In *Creating Mental Illness* (2002) Rutgers sociologist Allen Horowitz argues that “psychiatrists, epidemiologist[s], and clinicians simply accept as mental disorders whatever conditions the DSM lists. They do not ask how these conditions came to be regarded as mental disorders . . . there is no reason to accept that any particular group of symptoms represents a valid form of menstrual disorder.” (Flora and Sellers 2003:19-20)

How can one treat a disease/disorder if one doesn't know what it is? Dalton does seem to understand that in order to treat a disease/disorder one must know what one is treating, but which definition is correct? Just as no clear definition exists for this disease/disorder category, is the name PMS, PMC, PMDD, or PMT?

The second major problem with PMS research is that along with the discrepancy of the various definitions the experts cannot agree on an etiology for PMS or its various related maladies. For example, the mental health professionals seem to think that PMC and PMDD have neurological etiologies related to problematic serotonin levels. Treatment by these professionals consists mainly of the prescription of serotonin reuptake inhibitors, anti-anxiety medications, sedatives or tranquilizers, and tricyclic antidepressants. The endocrinologists and gynecologists look to hormonal fluctuations as the cause of PMT and PMS. At one time the treatment of choice was the hormone progesterone, but this is no longer the case and often women are put on the birth control pill in an effort to ameliorate PMS symptoms. In extreme cases many women opt for a hysterectomy, which removes the entire uterus and stops menstruation permanently. Estrogen is

still made by the ovaries; therefore, if there is a hormonal etiology for PMS, a woman must have an ovariectomy (oophorectomy) as well. According to Gray (1941), often the persistence of premenstrual syndrome type symptoms after hysterectomy and bilateral ovariectomy implies a neurological basis for PMT rather than an ovarian one. Gray's conclusion that premenstrual symptoms must be neurological instead of hormonal omits another possibility: The symptoms may be societal in origin.

According to scientific and medical reports of the 1983 NIMH conference in the *Journal of the American Medical Association (JAMA)*, panelists "were hard-pressed to define the disorder precisely and seemed all too aware that their research is plagued with methodological difficulties". . . . Even well-known and respected PMS researchers noted in the *American Journal of Psychiatry* that "despite 50 years of study, no biochemical correlates have been systematically identified, and no treatment has been consistently demonstrated to be more effective than placebo in well-designed double-blind studies". . . . In an edition of the *New England Journal of Medicine*, another PMS researcher pointed out that "[v]ery little is understood about the patho-physiology of the syndrome, and there is much speculation" (Vaitukaitis 1984:1372). (Figert 1996:127)

A third problem concerns the methods for obtaining data on PMS and its variants. PMC, PMDD, and PMS are primarily diagnosed by daily diaries or retrospective questionnaires, such as the Moos' Menstrual Distress Questionnaire (MMDQ) (Moos 1969). Women are asked by their health care professionals to keep a daily diary for three to six months. Diaries, much like retrospective questionnaires, encourage women to report only negative symptoms in conjunction with their menstrual cycles. The word "distress" in the title of Moos' Menstrual *Distress* Questionnaire automatically implies that menstruation causes distress. Many problems are associated with how PMC and PMS are reported and diagnosed; for example, only 20-50 percent of women with self-identified premenstrual complaints actually report the symptoms associated

with PMC: depression, mood changes, irritability, and anger on their retrospective questionnaires or in their diaries. Global, retrospective reports of water retention and pain are more likely to be recorded in conjunction with concurrent, daily reports than are those for arousal or cognitive changes (Gold 1985:5). No one wants to discount the experiences of women, but there are various studies that show that men and women's recollections of the past are often distorted. It could be that women associate mood changes and depression with menstruation because of cultural and societal stereotypes that reinforce these beliefs.

Many researchers have examined the hypothesis that questionnaires like the MMDQ reflect cultural and societal stereotypes that reinforce the belief that women have mood changes, irritability, and depression premenstrually and in the first few days of menstruation. For example, men basically report the same beliefs about what women experience during the menstrual cycle as women report.

Parlee gave small samples of men and women the MMDQ 'with instructions to indicate what women experience during the menstrual cycle' (1974:239). She found that women and men gave very similar reports of the kind of 'symptom changes' occurring before and during menstruation. Moreover the reports of the women and men in Parlee's study were comparable to those of the women in a study by Moos (Moos, 1969). (Scrambler and Scrambler 1993:36)

The results obtained from the women's group tested by Parlee could suggest that the women were experiencing distress associated with their menstrual cycle and that the men personally observed these same symptoms in women they knew. It seems implausible that men could be so aware of women's menstrual cycles as to associate the same symptoms with menstruation as the women. One plausible explanation as to why men associated the same symptoms with menstruation as women could be that the MMDQ's questions reflect the

predominant stereotypes held by individuals living in Western societies associated with menstruating women. If men gave answers to the MMDQ because of cultural stereotypes, it seems reasonable to suggest that women could do so as well (Parlee 1974:229-240).

A large study conducted by AuBuchon and Calhoun (1985) to measure the effect of “social expectancy” on individuals consisted of one group that was told that the purpose of the study was to research the symptoms associated with the menstrual cycle and the second group was told nothing about the menstrual cycle research aspect of the study. There was a control group as well that was composed of men. The women who were told about the menstrual cycle aspect of the study reported symptoms commonly associated with menstrual related problems.

The results indicated that those women who had been told that it was a study of menstrual symptoms reported significantly more negative psychological and somatic symptoms at the premenstrual and menstrual phases than the other two groups. In fact, those women not told the nature of the study reported a very similar pattern of symptoms to that reported by the men. AuBuchon and Calhoun conclude that social expectancy has a considerable effect on the reporting of symptoms. (Scrambler and Scrambler 1993:37)

Studies have shown that the power of suggestion has an effect on women who report PMS type symptoms, as well. Women who are shown films or papers that present PMS type disorders as the norm for women when surveyed afterwards are more likely to report PMS type symptoms than women who have not been shown information on PMS as the norm (Olasov and Jackson, 1987). With the widespread coverage of PMS by the media few women or men have not heard of PMS.

With respect to mood changes it should be noted that there is a higher correlation between particular days of the week and mood than there are mood changes in association with women’s menstrual cycles. Studies show that men regularly cycle through mood changes, on both daily and

monthly cycles as well (McFarlane 1988). Taylor (1988) elaborates on men's moods:¹¹

A double standard exists. Everyone is aware that men's moods change, but a man does not need to explain his temper tantrums and male violence is accepted as part of their nature. (The traditional wifely role was to placate men's moods.) PMS is now cited as the cause, and female frustration can continue to be ignored or invalidated, drugs are used to soothe the women and ensure that they are not disruptive. (Scrambler and Scrambler 1993:105)

If the definition of PMS is unclear, the etiological pathway is unknown, and data are unreliable, how can one scientifically claim PMS is a disease/disorder? The psychomedical explanations for women's inappropriate anger and rage lies with women's raging hormones or with a neurological glitch—women have no control over their hormones or serotonin levels but, physicians and psychiatrists with prescription pads can help women to gain that control. The medicalization of emotions perceived of as pathological because they are deemed unsuitable for women to exhibit has led to the creation of PMS. Women's bodies are subject to many changes throughout their lives and thus become subsumed under the auspices of the medical profession, but often, “. . . , talk about the body and about sexuality tends to be talk about the nature of society”(Brown 1998;215).

The Medicalization of The Human Condition

The medicalization of the human condition is a concept engendered from medical sociology

¹¹I do not want to go into a prolonged tirade about the oppression of women by the patriarchy for I feel that to be fruitless in the pursuit of solutions. I have been struck though by the biomedical fact that men have much more of the androgen testosterone than women. There are daily fluctuations in men's testosterone levels and it has been hypothesized that men may even have monthly fluctuations in their testosterone levels. It has been established that the level of testosterone in men over the age of fifty drops about 1 percent each year. Yet, these fluctuations in men's testosterone levels are not considered to be diseases, they are considered to be normal. Why are hormonal fluctuations in men considered to be normal and in women they are considered to be diseases?

and anthropology. Medicalization generally refers to the expansion of medicine as an institution of social control within a culture—particularly in ethical or religious domains (Figert 1996:98-100).

Medicalization is composed of two inter-related social processes: The first is that a medical meaning is correlated to a behavior or a condition. The second is that medicine is responsible for eliminating or controlling behaviors and experiences defined by society as deviant. Women have not been exclusively passive victims in the process of the medicalizing their bodies. Childbirth is a biological reality that puts women in contact with health care providers at regular intervals. Childbirth is also a dangerous situation for both the mother and the infant, therefore much of the medicalization of women's bodies is a response to women's roles as childbearer and mother.

Medical research has stigmatized and medicalized many of the physical manifestations of the normal cycles of women's reproductive life course—menarche, menstruation, pregnancy, and menopause. Women in the 1950s, 1960s, and into the 1970s were routinely anesthetized during childbirth and hospitalized for many days after giving birth (Davis-Floyd 1987).¹² Infants often had to be pulled out of women's birth canals with forceps because the mothers were too sedated to push. Pediatricians discouraged breast feeding in favor of fortified formulas that were costly, timely to prepare, and less nutritious for the infant (Davis-Floyd 1987).

Unfortunately, many of the other aspects of the medicalization of women's bodies have been created without examining the genesis of their existence and have led to much misunderstanding of women's sexuality, anatomy, and physiology. This misunderstanding has

¹²I am also very aware of the fact that childbirth is sometimes dangerous for the mother and baby. The leading cause of death in women under the age of 40—just 50 years ago was childbirth, but pregnancy is not a disease. Pregnancy is how our species propagates itself. I don't know anything that is more natural than that.

become less entangled in superstition but, to a certain extent has been, confused by medical lingo and psycho-babble. PMS is an example of women giving a medicalized description of their situation which requires a medical solution for its amelioration. When women lash out at their co-workers or family, instead of looking to see if there could be a social remedy for women's perceived inappropriate anger or rash behavior, a medical model provides a framework from which an explanation and treatment can be formulated.

Negative and hostile feelings can be shaped and transformed by doctors and psychiatrists into symptoms of new diseases such as PMS (premenstrual syndrome) or Attention Deficit Disorder In this way such negative social sentiments as female rage and schoolchildren's boredom or school phobias . . . can be recast as individual pathologies and "symptoms" rather than as socially significant "signs." This funneling of diffuse but real complaints into the idiom of sickness has led to the problem of "medicalization" and to the overproduction of illness in contemporary advanced industrial societies (Brown 1997:216)

Our society has become accustomed to popping pills to rid itself of its ills. PMS and the constellation of related perceived disease/disorder categories are susceptible to over diagnosis in a culture that medicalizes the human condition at an almost exponential rate. The more healthcare we can get the more we want whether we truly need it or not. It is easier to pop a pill than to restructure our filial or workplace relationships. In many aspects PMS obviates individuals' personal responsibility (actions) in social relations, public and private, and invitingly blames a set of symptoms rather than an individual's apparently "irrational" or "bad" behavior or the harmful social patterns they have constructed. The root of the social problems between men, women, and society remain unearthed and continue to grow.

Hysterectomy as an Example of Medicalization

Hysterectomy has become one of the most common procedures performed on women and

serves as a strong example for how women's bodies have been medicalized. It has been noted that hysterectomies are often done when other less invasive procedures could be performed. Often they are performed without a valid medical reason at all.

The United States has the highest rate of hysterectomy in the industrialized world (Boston Women's Health Collective, 1998). In the time period from 1965-1985 there were fifteen million hysterectomies performed in the U.S. (Coutinho and Segal 1999). In 1994 alone, there were 556,000 hysterectomies in the U.S. and 458,000 oophorectomies.

The permanent medical suppression of menstruation is accomplished with a surgical procedure called hysterectomy. A total hysterectomy is the surgical procedure where the uterus and cervix are removed, and many times the ovaries are removed as well, which is a controversial surgery. The removal of the ovaries is called an oophorectomy—sometimes it is called a ovariectomy. Some physicians argue that it is necessary to remove the ovaries in order to prevent ovarian cancer, but androgens that affect sexuality are produced by the ovaries and many women report the loss of their sex drive when the ovaries are removed. Androgen replacement therapy is fairly effective in returning women's sex drives to their pre-oophorectomy level, but testosterone does have some annoying side-effects: acne, facial hair growth, and lowered voice (Boston Women's Health Collective, 1998).

Ten percent of all hysterectomies are done to save women's lives (Boston Women's Health Collective, 1998). Life-threatening conditions that require a total hysterectomy are invasive cancer of the uterus, cervix, vagina, and the fallopian tubes, severe uncontrollable pelvic infections (PID), rare cases of severe and uncontrollable bleeding, and some rare conditions associated with childbirth, including rupture of the uterus. The remaining 90 percent of hysterectomies are

performed for a variety of reasons, the most common reasons are precancerous changes of the endometrium called hyperplasia, fibroids, extreme endometrial growth, endometriosis, and excessive menstrual bleeding.

Hysterectomies are life-savers for women with invasive cancer, severe PID and some rare emergencies, but most of the disorders treated with hysterectomies have other less radical treatments that can be just as effective. For example, many private physicians recommend a hysterectomy for fibroids. Fibroids are solid benign tumors that grow on the uterus and it seems that their growth is related to estrogen production; often, they are exacerbated by hormones from oral contraceptives or by post menopausal estrogens. They often distort the shape of the uterus causing pain and excessive menstrual bleeding. Although most physicians recommend a hysterectomy for fibroids, there is another procedure that is just as effective, but the uterus and the cervix are not removed so the side-effects are lessened. The name of the procedure is myomectomy. Generally, an abdominal incision is required and the fibroids are scraped from the uterus, leaving it intact (Boston Women's Health Collective, 1998). The most contemporary procedure for the treatment of fibroids is one that cuts off the blood supply to the tumor, thus killing it.

PMDD as an Example of Medicalization.

Soon after PMDD was included in the 1995 DSM IV Eli Lilly and Company developed a "pink pill" just for women called *Sarafem* containing a serotonin reuptake inhibitor. According to the *Village Voice*, Jean Endicott, professor of clinical psychology at Columbia University's College of Physicians and Surgeons, conducted a roundtable discussion in 1998 where a study was discussed that found that 55% of women diagnosed with premenstrual type symptoms got

significant relief from increased calcium intake. The group went on to comment that “the area of calcium [supplements as PMS treatment] is not well explored” (Spartos 2000).

That leads critics to wonder why other treatment options are getting the cold shoulder. “Why not spend pages and pages pushing calcium?” asks Caplan who served on the DSM-IV committee. And although there is evidence that people with PMDD can feel better with only intermittent doses of Prozac– and suffer fewer side effects like sexual dysfunction–the studies Lilly presented to the FDA looked solely at the effectiveness of daily doses, or roughly double the amount some researchers say is needed (Spartos 2000).

It should be noted that the exact symptoms serotonin reuptake inhibitors claim to eliminate are listed as possible side-effects of the medication. For example the most common side-effects associated with Prozac (Fluoxetine hydrochloride: brand name *Sarafem*) are: nausea, sexual dysfunction (anorgasmic), loss of libido, headache, decreased appetite, weight loss, and insomnia. There are also a few serious side-effects associated with Prozac that include ventricular arrhythmias, sudden death, and suicidal ideation. Nausea and headache are some of the most frequently reported physical discomforts associated with PMS and depression is the main discomfort associated with PMDD; therefore, why would anyone prescribe a drug that had as a possible side-effect suicidal ideation (Flora and Sellers 2003:41). Pharmaceutical companies stand to make billions of dollars from the sale of serotonin reuptake inhibitors such as, *Sarafem*. If placebo and calcium are practically as effective as serotonin reuptake inhibitors or hormones—with far fewer side-effects and less costly—then why expose women to drugs with potentially dangerous side-effects and why waste research funds when an effective treatment for HIV infection, malaria or tuberculosis could potentially save millions of lives (PROFIT)?

HRT as an Example of Medicalization

It should be noted that many recent studies have shown that hormone replacement therapy

(HRT), once thought to be a cure-all for the plethora of difficulties reported in association with menopause, has as much efficacy as placebo and has potentially serious side-effects. This is according to a recent study conducted by the Women's Health Initiative which was funded by the federal government (U.S. Department of Health and Human Services 2003). The study examined the effects of HRT on 16,608 postmenopausal women who were randomly given placebo or *Prempro* for a period of five years (U.S. Department of Human Services 2003).

HRT can be effective in lessening women's discomfort from "night sweats" and "hot flashes," but "most researchers agree that estrogen pills and progestin pills fail to make older women feel better by improving their memory, sleep and sex lives"(Johnson City Press 3/18/2003) Jennifer Hays, a psychologist from the Baylor College of Medicine who directed the analysis of the study, said, "The average woman will not experience an improvement in her quality of life by taking this pill [HRT] (Johnson City Press 3/18/2003)." It was also noted by researchers that while HRT "decreased the number of women who had hip-fractures and colon cancer it slightly elevated women's risk for heart attacks, strokes, and breast cancer" (Johnson City Press:3/18/2003). The FDA has recently approved the new lose-dose HRT, but urged that it be taken for the shortest possible duration.

Unnecessary hysterectomies, the prescription of serotonin reuptake inhibitors for PMDD, and HRT for menopausal symptoms are all examples of how women's bodies have been medicalized. The medicalization of women's bodies has played a significant role in the creation of PMS and its prescribed treatments. Medicalization provides women a framework, PMS, for the acknowledgment and amelioration of women's complaints, and provides them with a treatment, but it does not address the social and filial structures that created the problems in the first place.

CHAPTER 5

CULTURE-BOUND SYNDROME

Is PMS a culture-bound syndrome?

In order to ascertain whether or not PMS has a biological, psychological, or cultural etiological pathway a cross-cultural comparison of menstrual beliefs, practices, and symptoms may be required to illuminate the query. The way that women react to menstruation is a complex interaction between environment, culture, and biology. There are many historical and cross-cultural examples of menstrual rituals and disease/disorders (Buckley and Gottlieb 1988; Cott, 2000; Canterella, 1991; Daniluk, 1998; Delaney, Lupton, and Toth 1990; Ehrenreich and English 1973, Figert, 1996). Cross-culturally we see much variation in the way women react and experience menstruation. By contrasting the menstrual beliefs, practices, and diseases/disorders found in other cultures with Western cultures one is able to tease out relevant information as to how these beliefs, practices, and diseases/disorders may be shaped and created by their culture of origin.

Definition of a Culture-Bound Syndrome

A culture-bound syndrome is an illness or a disorder that is found exclusively in a particular culture or a particular group of people. An example is Koro, which is found in southeast Asia. Koro afflicts men only; it causes a man to believe that his penis has been swallowed by his stomach and that death is imminent. This disorder is found only in southeast Asia and no organic cause has been identified to explain the men's symptoms. Researchers postulated that some disorders are socially or culturally specific and are "constructed" and then manifested through the norms and mores of their culture of origin. Conversely, some illnesses previously thought to be culture-bound syndromes have actually been attributed to the physical circumstances of the group. For example,

Piblotak is an illness found in the circum-polar peoples. Piblotak may cause an individual who experiences an extreme shock to behave in a totally irrational way, such as taking off all their clothes and rolling around in the snow, jumping into freezing water, or just acting in ways contrary to their normal behavior. It is now thought that these people suffer from vitamin D deficiency, sunlight deprivation or stimulus deprivation in general. So, there are some illnesses that are definitely constructed by culture (Koro) and some that may be specific to a culture but, have an organic etiology conceived only in that specific group (Piblotak).

A Historical Study of Menopause and Culture-Bound Syndrome

In the West there is the myth of the “Crone” or the wicked “Witch” who is an old, crazy, woman who never married and lives with 100 cats or dogs. She lives in a cottage in the forest and waits for little children to visit so that she can fatten them up and eat them (Delaney, Lupton, and Toth 1988:162). The notion that the old woman in the story devours children instead of bearing them is significant as an indicator of women’s lost status. As old women–witches or crones–they no longer produce children.

An example of a historical culture-bound syndrome in the West is “involutional melancholia.” It was a widely held belief in the West that women during their climacteric (perimenopause and menopause) were more susceptible to depression and insanity than at any other time in their lives; historically, this was called “involutional melancholia.” “Involutional melancholia” was treated with tranquilizers and was removed from the DSM-I in 1963 (Boston Women’s Health Collective, 1998).

When the investigators looked at the temporal association between menopausal symptoms and depression, they discovered that “it is the women who are already depressed who are the ones reporting the depression,” said McKinlay, rather than

the reverse—menopausal symptoms causing depression. Women already depressed were twice as likely to report hot flashes, cold sweats, and irregular flow or menstrual cycles to their physicians. (Hunter 1996)

After the removal of involuntional melancholia from the DSM-I the treatment of menopause has gradually moved from the domain of psychiatry and psychoanalysis to gynecology and endocrinology, much like perceived menstrually related disorders like PMT and PMS (Boston's Women's Health Collective 1998). "Involuntional melancholia" has only been documented in the United States and the United Kingdom—it has not been found in other populations cross-culturally which could mean it is a culture-bound syndrome.

Historical examples abound with disease/disorder categories created and explained by "objective" scientific fact that were actually manufactured by cultural beliefs. For example, physicians coined the term *vitalism* because they believed that a "vital force" permeated the human body and was the source of all energy.

Mid-nineteenth-century medical theory postulated that the ganglionic nervous system served as a storage for the "vital force" and was the source of all energy. This nervous system was directly connected to the reproductive system and the central nervous system, including the brain. This physiology was not peculiar to women, but because of women's more complex reproductive physiology—puberty, menstruation, childbirth, lactation, [and] menopause— their reproductive organs drew more energy from the ganglionic system, and hence, their storage of vital force was always in danger of depletion. Any breakdown in a woman's reproductive organs could cause trauma to her nervous system and through it to other parts of the body. (Weitz 1998:244)

It is noted by Barbre that the pathologies associated with menopause were supported by "objective" scientific research (Weitz 1998:249). The idea that women had a high probability of going insane or becoming chronically depressed after menopause comes from the Victorian era's medical views on women's anatomy and physiology. Perimenopause and menopause represented

the failure of the system that had regulated women's entire lives, and the crisis it presented was not to be taken lightly. Doctors asserted that menopause disrupted the integral connection between women's reproductive organs and their central nervous systems, putting the reproductive organs in a "disturbed" state, and precipitating "a critical and dangerous time for her. . . ." (Weitz 1998:247).

In the Victorian era women were subjected to the cultural belief that they were morally superior, but physically and cognitively inferior to men. Childbirth made women morally superior to men and raising children was considered to be women's *raison d'être*. As discussed previously, women's reproductive organs were assumed to control everything about their behavior. Moral insanity defenses are recorded for menopausal women defendants in Victorian court proceedings. The way a woman reacted to her menses, childbirth, and lactation would determine how her body responded to menopause. For example, if she had an abortion or used birth control too much it could cause her to suffer from "moral insanity" or "involutional melancholia" after menopause. If a woman danced or exercised too much, dressed inappropriately or pursued too much education, she would lower her reserve of the "vital force" which would be needed to escape menopause unscathed. In addition to women's reproductive activity, education was believed to drain women's "vital force" away from her uterus to the brain, which was considered to be dangerous because it could exacerbate menopausal symptoms. A woman could alleviate the symptoms of perimenopause and menopause by remaining calm, devoting her life to domesticity, holding on to her innate nurturing role, staying away from mentally vexing behaviors like reading novels or studying Latin, and concentrate exclusively on her role as mother—serving as a paragon of virtue (Weitz 1998:245-247).

Contemporary Cultural Conception of Menopause

Menopause is no longer considered to be a disease that imperils women with a “moral crisis” or “involutional melancholia,” but is termed an “estrogen deficiency syndrome.” Women’s estrogen production is at its peak during her reproductive years. Therefore, the years of a woman’s reproductive cycle, when estrogen production is at its peak, is still considered to be the norm. Disease/disorders associated with menopause have a hormonal (physiological) etiology or a psychological etiology similar to the etiological pathways associated with PMS. The depression sometimes reported by menopausal women has been seen by psychiatrists or psychologists as a response to the loss of their fertility or to the leaving home of their grown children (“empty nest syndrome”). There would be no hormonal or neurological etiology for those responses, they would have to be societal in origin.

Estrogen deficiency syndrome and empty nest syndrome have etiological pathways endemic to women’s responses to their roles as reproducer and mother. These diagnoses still denote a disease/disorder/syndrome unique to women because of their reproductive role in society which supports the hypothesis that women’s diseases/disorders are defined by that which prohibits reproduction or reflect women’s inability to reproduce.

There are certain physical discomforts associated with menopause in the West such as vasomotor symptoms (hot flashes and night sweats) that cause more distress than fluctuating hormone levels. Nor should we forget that for most women menopause is not a major crisis and that many feel relieved to be free from menstrual periods and the possibility of pregnancy (Raymond 1988).

Myths of women’s mental instability had traditionally been used to keep women out

of positions of power—raging hormones during our menstrual years and waning hormones at midlife and after. Modern research finds that women at midlife are actually less likely to be depressed than younger women. A recent review of all English-language studies investigating the relationship between natural (nonsurgical) menopause and depression found no evidence of such a link. (Boston Women's Health Collective 1998:554-555)

Today the literature regarding menopause constantly reminds the reader that menopause is not pathological—it is just another part of women's lifecourses. Cross-cultural studies are proving to be beneficial at teasing out how biological responses to menopause differ from culture to culture—thus reinforcing the sociological or anthropological claim that there is a social or cultural aspect to all disorders. For example, women in Japan report less vasomotor difficulties (hot flashes) than women in the United States. In studies it has been shown that Japanese women report no more hot flashes than people (men and women) of any age group, 10 percent of whom report hot flashes. It has been suggested that the lack of hot flashes in Japanese women could be associated with the high amounts of soy products in their diet which have been shown to contain large amounts of phyto-estrogens. The research is inconclusive at this point (Boston's Women Health Collective 1998:558). Japanese society venerates older women, thus they have high status within their culture. This could play a role in the way these women feel about themselves in relation to the aging process (Daniluk 1998:245). It is also important to remember that even women in North America have different responses to menopause (Daniluk 1998:245).

Researchers have found no convincing link between menopause and depression. Instead of depression, many post-menopausal women report increased levels of happiness (Daly et al 1993; Daniluk 1998; Hunter 1996; Raymond 1988).

A Historical Study of Hysteria and Culture-Bound Syndrome

The word “Hysteria” comes from a Greek word meaning “that which proceeds from the womb” (Maines 1999:21-47). Women have wombs, men do not. Therefore, this is an affliction with which only women can suffer. “Hysteria” is mentioned in ancient Egyptian texts, it is found in the medical texts of Hippocrates and Galen, it is discussed in medical texts from medieval times into the Renaissance, and was discussed at length by Sigmund Freud. The physical and emotional symptoms of “hysteria” are broad and change slightly over time. Generally they form a constellation of symptoms that include irrationality, anger, headaches, and edema (bloating)—with a vast array of treatments.

Sometimes women were prescribed the rest cure, but the most common treatment for married women experiencing problems related to their wombs was intercourse with their husbands. The solution was more problematic for unmarried women. Massage of the pelvic area and the vulva was recommended and this treatment was generally performed by a physician or a midwife. Eventually, physicians invented hydro apparatuses and other machines such as vibrators to massage their female patient’s vulvas who were suffering from hysteria (Maines 1999:21-47).

The androcentric view of sex within a patriarchal social context did not view women’s sexual satisfaction as a priority of sexual relations. Women were expected to be sexually satisfied through intercourse with their husbands, no attention was paid to women’s clitorises. Women still had sex drives regardless of their historically/culturally contingent social context, but women’s sex drives were viewed as illness and many doctors “defined female orgasm under clinical conditions as the crisis of an illness, the ‘hysteria paroxysm’” (Maines 1999:3).

The diagnosis of hysteria, as described by Freud, relegated the etiology of women’s

neuroses, especially hysteria, to their inability to give up their childhood attachments to their clitoris (penis envy) and transfer their sexual satisfaction to the vaginal barrel. In other words, Freud believed that infantile women had clitoral orgasms and adult mature women had orgasms when their husbands penetrated their vaginas. Women's inability to transfer their orgasmic response from the clitoris to the vaginal barrel would have a propensity towards developing hysteria.

If the transference of the erogenous excitability from the clitoris to the vaginal entrance succeeds, the woman then changes her leading zone for the future sexual activity; the man on the other hand, retains his from childhood. The main determinants for the woman's preference for neuroses, especially for hysteria, lie in this change of the leading zone as well as in the repression of puberty. These determinants are, therefore, most intimately connected with the nature of femininity. (Freud 1938:614)

In 1952 the term hysteria was dropped by the American Psychiatric Association. (Maines 1999:2). The symptoms traditionally associated with hysteria—irrationality, mood changes, anger, headaches, and bloating—are also commonly associated with PMT, PMS, PMC, and PMDD. Therefore, the disease/disorder category that includes these symptoms is not new. The symptoms associated with “hysteria” are quite similar to the symptoms of PMS—the only difference between the two is the form of treatment.

Women were still describing the same types of complaints to their physicians into the 1950s and were generally given tranquilizers for their symptoms. Dalton related many of these symptoms to the low levels of progesterone premenstrually and prescribed progesterone to women. Yet Dalton's claims in, *Once a Month*, echo the archaic treatment/prescription for hysteria: “the most difficult thing to understand is that just when women suffering from PMS are most unbearable is also the time when some of them enjoy sex the most. It may sound contradictory and

incomprehensible, but that gives some idea of the irrationality that accompanies the hormonal upset” (Dalton 1999:141). This exemplifies that some people in positions of authority, as well as the general population still believe that women require a good “\$#!*” (session of intercourse) to stay mentally healthy and thus also require men to provide this treatment for them.

Cross-Cultural Data Regarding Menstruation

The !Kung Women of Sub-Saharan Africa

In some cultures menstruation is “a thing of no account.” The !Kung of sub-Saharan Africa, a contemporary gatherer-hunter group, consider menstruation to be insignificant even though they have the exact same hormonal fluctuations as every other woman in the world. The San !Kung are a very interesting gatherer-hunter group and they live much in the same way that their (our) ancestors lived 100,000 years ago. (It must be noted that their lifestyles have definitely been affected by the modern world.) There is a menstrual hut in !Kung society and there is a “marriage hut” in !Kung society. The men watch the women interact while they are menstruating and there is not much of an attempt to hide the menstrual blood. The women do not have access to a lot of water because they live in the Kalahari desert, so hygiene responses would be particular to their culture.

The !Kung’s disregard for menstruation as “a thing of no account,” is paralleled in their evident freedom from what women in industrialized societies know as premenstrual syndrome (PMS). In a test designed to assess the presence, level, and quality of PMS among the !Kung, Shostak interviewed selected women every other day during at least two consecutive menstrual cycles, while her husband drew blood samples from them. The blood was tested for the hormonal variations common in women at different stages of their cycles, variations that are known [sic] to produce psychological as well as physiological changes. The interviews showed that the women did not “have any expectation or belief comparable to that held in the West of a premenstrual or menstrual syndrome. Nor did they recognize any effect of the menstrual cycle on women’s moods or behavior. They were surprised when asked

about it. (Delaney, Lupton, and Toth 1988:15-16)

The psychological changes that many women experience are not caused by universal hormonal variations or the !Kung women would also experience the psychological changes, as proposed by medical researchers. The !Kung women are in excellent physical condition, they often walk five to ten miles a day gathering the group's sustenance. They have a later menarche and bear on average five children whom they nurse for two to three years at a time. Because of their prolonged periods of lactation menstruation is a rare event for many !Kung women. Secondary amenorrhea is commonly experienced, therefore some have postulated that this is the reason that !Kung women do not experience physical discomforts or mood changes.

Cross-cultural information from WHO

In 1972 at a meeting of social scientists from many parts of the world a recommendation was made to the World Health Organization Task Force on Psychosocial Research in Family Planning that they undertake a large cross-cultural study of women's patterns and perceptions of menstrual bleeding. The study took place in ten countries—commencing in 1973 and ending in 1982. The study looked at 14 distinct socio-cultural groups from Egypt, India (Hindu High Caste, Hindu Low Caste), Indonesian (Javanese and Sudanese), Jamaica, Mexico, Pakistan (Punjab and Sind), Phillipines, Republic of Korea (South Korea), United Kingdom, and Yugoslavia (Moslem and Non-Moslem). All the women had to be parous (have borne a child), non-pregnant, non-menopausal, and non-lactating. The women were divided into three broad groups: lower status women, higher status women, and Moslem women. WHO's study also included in their final work a book review of 500 books and articles (Snowden and Christian 1983).

The two major focuses of the study were to examine patterns and predictions of menstrual

bleeding and the examination of perceptions of menstruation. The major reason for conducting the study was to ascertain what types of birth control women would actually use with as few side-effects as possible, specifically the amount of amenorrhea (cessation of menstruation) that women would tolerate. Most of the questions asked were concerned with the frequency, duration, and the amount of menstruation. The study also asked women about any symptoms of discomfort that they might experience associated with menstruation.

The majority of women in the cultures investigated reported some physical discomfort in conjunction with menstruation, which was largely confined to the time leading up to and during the bleeding episode and was rarely reported after the menstrual period.

The most common physical symptoms were back pain and abdominal pain; headache, breast swelling and discomfort, limb pains and abdominal swelling were also experienced. These symptoms were reported in both the premenstrual stage and menstrual stage—there was no clear pattern of distinct menstrual or pre-menstrual symptoms to emerge. Women in all cultures reported negative mood changes associated with menstruation but, in general, fewer women reported mood changes than reported physical discomfort. Overall, women reported physical discomforts at higher rates than they did mood changes.

Cross-culturally, women who reported heavy blood loss were also more likely to report negative mood changes. Women who reported discomfort also have a tendency to report negative mood changes. Almost all respondents agreed that sexual relations (intercourse) should be avoided during menstruation—the U.K. was the exception. Most women in the study said that they did not abstain from cooking during menstruation, but three-fourths of the Indian women said that they should avoid cooking for their families during menstruation, especially Hindu Indian women. The

Indonesian women abstained from bathing during menstruation and most women wore garments that were more conducive to protecting them from break-through bleeding. In women who reported mood changes the highest number was from Yugoslavian Muslims, where 73 percent of women reported mood changes and the next highest was reported in women from the United Kingdom where 71 percent of the respondents reported mood changes. The lowest was reported by Indonesian, Sudanese where 23 percent of the women reported mood changes and Indonesian, Javanese where 34 percent of the women reported mood changes.

The belief that menstrual blood was polluting, dirty, and should be concealed was pervasive among the women in the study. For example, “despite the fact, that the majority of the respondents believed that menstruation was an essential feature of femininity a substantial proportion of respondents also believed that menstruation was dirty” (Snowden and Christian 1983:353). All women had pejorative terms with which to refer to menstruation. In the U.K. women called menstruation “the curse”; women in India used the words “avadi” (polluted) and “chulabarne” (outside the hearth); and in Indonesia, Javanese women use the term “kortoran” (dirt). Women in the aforementioned cultures also had phrases to refer to menstruation that implied that they were unwell or sick: in the U.K. women said that they were “unwell”; in India, “tabiyat kharab” (not feeling well); and Indonesia, “udur” (sick). It must be noted that when women speak of menstruation, how they refer to it depends on to whom they address their remarks. Meaning that when speaking to men and whether or not they were speaking formally or informally played a role in the words that women chose to refer to menstruation.

When asked about their overall feelings toward menstruation—whether or not menstruation was a negative or a positive experience—most women said that menstruation was a positive

experience. Most women thought that menstruation was associated with continuing youth, fertility, and femininity. Most respondents believed that menstruation was a natural, vital, physiological event that was indicative of health. Even though a substantial proportion of respondents believed that menstruation was dirty, most women said that menstruation was a natural way to rid the body of toxic wastes. Menstruation was also valued as a means for knowing whether or not they were pregnant. Therefore, the only acceptable duration of secondary amenorrhea was during the nine months of pregnancy and during lactation, otherwise regular menstruation signified vitality.

The most interesting finding that was reported in WHO's study of cross-cultural menstrual patterns was that women often behave differently with regards to menstruation than how they speak about menstruation.

Beliefs expressed about menstruation are not consistent with behavior. Women holding the belief that menstruation is like an illness—do not necessarily behave as if they are ill. Conversely, women not holding the sickness belief are among those demonstrating the greatest behavioral changes during menstruation. (Snowden and Christian 1983:142)

“In Mexico, Yugoslavia, and the United Kingdom, urban women were reported to be more prone than rural women to adopt a sick role; women in rural communities were thought to be more likely to regard menstruation as a natural phenomenon” (Snowden and Christian 1983: 132). Higher status women were less likely to believe that menstrual blood was polluting or that they should not cook or bathe during menstruation yet they were obsessed with washing and staying odor free during menses, reported higher levels of menstrual discomfort and mood fluctuation, and were more likely to adopt some form of the sick-role associated with their menses (Snowden 1983: 139-140). The higher status women may have more access to treatments for the amelioration of their

experienced menstrual symptoms than middle status and lower status women. This is especially likely in the U.K., where women have been exposed to the medical disease/disorder category of PMS and a wide assortment of treatments are available to them. Therefore, they are more likely to seek treatment than women in other cultures and adopt some aspect of the sick role even though they know that menstruation is a regularly occurring event in their lives. It could also be that higher status women have more time for self-reflection than lower or middle status women. Because higher status women may have been exposed more to Western medicine than middle or lower status women, they may look to eradicate or lessen some of the “symptoms” that they experience premenstrually or at the onset of menstruation.

This exemplifies that psychosocial and societal forces play a large role in how women perceive and then act on their feelings about menstruation. The individual woman has her subjective experience and beliefs about bleeding. She also incorporates into her beliefs and behaviors the norms and mores of her culture’s proscriptions regarding menstruation. There is an intimate meeting between the subjective experience of a woman bleeding and her society’s norms regarding menstruation. Often women behave in ways that reflect their cultures’ norms even though they may violate their personal beliefs. This is highly relevant to the study of PMS in the West in that most women believe menstruation is a natural event that has certain side-effects—some positive and some negative. The personal belief that menstruation is a natural event interacts with cultural norms and the dictates of societal authorities to produce diseases/disorders that are particular to their culture—a culture-bound syndrome, namely PMS.

Medical anthropologists have hypothesized that PMS is a culture-bound syndrome found only in the developed nations of the West (Johnson 1987; Martin 1994; Rodin 1992). For example,

PMS is only named and treated in the West. Women cross-culturally experience mood changes, but women report physical discomfort at much higher rates and it is generally speaking these women who report mood changes. It seems reasonable to claim that if a woman has a headache or cramps that she could feel irritable or “moody.” When people have the flu or stomach upset they are not at their peak levels of happiness. Because more women report cramps and headaches than they do mood swings it seems reasonable to claim that they are feeling irritable or “moody” due to their physical discomforts, not that mood changes, irritability, or depression are separate symptoms emblematic of a disorder/disease state.

Consequently, it is problematic to discuss PMS outside of its social context. Unfortunately, it is still viewed by popular culture and many physicians as a disease/disorder that is primarily associated with a hormonal etiology or a neurological etiology. The psychological symptoms of PMS—depression, anger, mood changes, and irritability once ascribed to “hysteria” and “involitional melancholia” are now seen as the products of “raging hormones” by endocrinologists or as serotonin imbalances in women’s brains by psychiatrists.

Some researchers have suggested that PMS was viewed by many health care professionals and women as a way of listening and responding to women’s complaints and concerns. Other than treating women’s health problems or complaints with intercourse with their husbands or massage of the vulva to “hysteria paroxysm” by physicians, women were told to act in certain ways (don’t get an education, don’t dance too much, have plenty of babies, and be a good wife) or else have their concerns dismissed entirely. Therefore, with the discussion of PMS everywhere in the media it seemed as if women’s voices were finally being heard. Yet PMS could also be seen as a way to trivialize women’s valid emotional responses to their social context by rationalizing them away as

“raging hormones” or “neurological glitches” instead of examining the social context that conceived many women’s feelings of anxiety, rage and frustration.

Authors such as Rodin (1992) and Ussher (1991) have linked the discussion of PMS in the medical literature to earlier medical discussions of hysteria, arguing that PMS serves the same purpose in modern society that hysteria did in the nineteenth century. Both effectively control women, . . . but they also define what is acceptable and unacceptable behaviour for women. In other words, both PMS and hysteria serve a moral purpose. In both of these conditions ‘good’ and ‘bad’ women are identified, and in both it is the control of the ‘bad’ behaviour (as defined by a clinician) which is paramount. Hence in PMS studies the focus is always on the mental aspects of women’s experience—the irritability, anger and depression—not on physical aspects. A ‘good’ woman is patient, caring cheerful and undemanding. A ‘bad’ woman is irritable, angry, self-oriented or depressed. The PMS label allows these good and bad aspects to be contrasted and discussed—most emotively through the use of the ‘Jekyll and Hyde’ metaphor. The social consequences of this bad behaviour are emphasized—murder and mayhem apparently result from PMS. Thus the ills of society can conveniently be placed at the feet of women who have behaved badly. The bad behaviour may not be their fault—we should feel sorry for them and try to help them—but nonetheless it is women who are thought to be behaving badly, all of which conveniently shifts attention away from the major sources of violence, both inside and outside the home. (Walker 1997:170)

PMS is a place holder for women’s symptoms like depression, mood changes, anger, and irritability, and serves the same function in society as hysteria did in the past. PMS is a catch-all category for the organization of women’s complaints which appears to acknowledge women’s feelings but does nothing to identify their root etiologies. PMS is a way to isolate certain relationship problems, whether of a public or a private nature, into a classification that foists the blame for the problems from individual parties onto a medical condition. It is a scapegoat for many of the social problems men and women experience regarding issues of power and dominance within families, at the workplace, and throughout the society-at-large. Until these issues are addressed, PMS will continue to be reported and there will be many purported treatments, but the relevant social problems will still be ignored and will continue to exist.

CHAPTER 6

CONCLUSION

At the onset of this research project I was sure that I would find the discrete physiological etiology of PMS. I was initially convinced there was a physiological basis for PMS, but after a thorough inquiry into this subject I realize that there may not be any clear solution or resolution to this query. I have become convinced more than ever that the problematic mental symptoms associated with PMS bear a striking resemblance to the antiquated diagnosis of “hysteria” in women and this troubles me greatly. In PMT, PMS, PMC, LLPDD, PMDD, or “Hysteria”—no matter which disorder/disease category one examines, interprets, or discusses—it appears that we are illustrating symptoms of a multi-faceted phenomenon with real implications and consequences. In that no organic physiological etiology has been discerned for PMS and its sister maladies, it would seem that either the dismissed etiology of “hysteria” as a psychosomatic manifestation was correct or the etiology of the perceived disorder was cultural in origin.

One unifying factor present in this disorder/disease category is that it is exclusively associated with the female gender and that there is no corresponding disorder/disease category in men. When men speak of their testicles, they attach positive attributes to them and their virility—yet women’s wombs (*uterus/hysteri*) are viewed problematically by both men and women. Of course, men can be afflicted with testicular cancer or some other afflictions of that nature, but testicles by definition are a good thing, indicative of a man’s viability in the world. Granted—a man can have “no balls”—but this makes him what? A woman. The lower-status gender is female and accordingly, makes one susceptible to the afflictions commonly associated with women. Therefore, disease in women is often defined and diagnosed in terms that reflect the absence of what is perceived of as

constituting the superior personality traits of men.

From at least the time of Aristotle to the 1700s, women's wombs were thought to wander around their abdominal region inducing women's emotionality and fragile countenance. Any problems that women had or any perceived strange or weird behaviors that women exhibited were attributed to their wandering womb. Heretofore, women's wombs were the major predictors of women's maladies and any treatment prescribed was dictated in conjunction with this conception of reality. "Hysteria" is no longer mentioned in the DSM, yet remnants of this world view are still to be found within the modern (contemporary) world view and may prejudice the treatment of women by today's health care professionals. The world view that conceived hysteria still structures many of our society's ideas about what women's personality traits should be and what the prescribed role for women's behavior should be in general, even after the second wave of modern feminism. It could be that our society's expectations (ideals) about what constitutes the "natural behavior" of women are contrary to the way women actually behave. When our expectations contradict women's actual behaviors, instead of changing our expectations, we deem the actualized behavior pathological, thus creating a social climate conducive to the production of a cultural construct—PMS. In Western culture the human condition has been medicalized and this has contributed to the proliferation of PMS by providing women and men with a medical framework from within which to articulate their concerns and problems instead of examining the structure of their personal and public relationships.

Women have been seen as passive agents with tendencies toward irrationality and depression. These perceived personality traits prohibited women from education and, in effect, excluded them from the public sphere. It would be nice to think that these ideas about women's

personalities are ancient relics of misogynist philosophers, religious zealots, or archaic myths from a bygone era, but unfortunately they are still alive in our culture today. Some of them are barely breathing but many have proved to have great endurance and play a role, presently, in the way men and women form their en-gendered identities. The antiquated notions that women are passive, compliant, innate nurturers, less rational than men, or have uncontrollable and unpredictable mood changes created a new term PMS for the archaic disorder/disease category once termed hysteria. The continued propagation of these stereotypes and the validation of PMS by medical professionals reinforces these stereotypes as well and help to create a feedback loop that exacerbates discrimination against women while promoting absurdities about women's personalities.

As women became more active in the public sphere they veiled their activism either in the role of "exemplar of virtue," or in the role of "mother." As long as women acted in the public (civic) sphere in ways that reflected their moral feminine superiority they could advocate for their agenda. Goldstein in *War and Gender* (2003) hypothesizes that when women claim special status as mothers or moral exemplars they reproduce the stereotypes particular to both men and women. Both these roles reflected stereotypes of women that were common in the West until the women's liberation movement of the 1970s. There are now very negative stereotypes that are associated with feminist women as exemplified by comments made by people like Rush Limbaugh. For example, Limbaugh uses the term "feminazi" to refer to feminists and makes statements like, "the reason feminists created the women's liberation movement was so that ugly women could get jobs." On Bob Novak's show on CNN, Novak asked Patrica Ireland, the former president of NOW, "isn't it true that almost all the members of NOW are lesbians?"

Menstrual disorders rank among the top ten conditions that women present in general practice (Scrambler and Scrambler, 1993, chap.4). Therefore, women obviously believe that they are having a problem or experiencing some kind of discomfort in relation to their menstrual cycle. Does this imply that the majority or at least a large percentage of premenstrual or menstruating women are afflicted with a disease/disorder/syndrome—PMS? No, it implies that a certain amount of discomfort is normally associated with menstruation—it does not imply that women are “crazy” or mentally ill by virtue of their gender. It also implies that PMS is real—in the sense that society (the medical establishment and *en masse*) recognizes a disorder category named PMS and women look to their physicians to confirm what society tells them about menstruating women. Stereotypes regarding women’s mood changes abound in Western culture and often when people believe that certain things are real, they become real in their consequences (Thomas and Thomas, 1928:572). Considering that the placebo effect seems to be just as effective as every other treatment prescribed by physicians for PMS it would seem that it would be an excellent choice as a viable therapy for PMS and its related maladies.

Many women self-report PMS type symptoms at their family doctors’ and therapists’ offices so they definitely react to something that is quite real to them. One plausible explanation for PMS could be that women are looking for relief from the multitude of roles they must fulfill in today’s fast paced life styles. By showing how the stereotypes for women’s expected behavior were created in conjunction with problems in society like “culture lag,” it is easy to see how the disease/disorder PMS is a scapegoat for women’s lack of power in a patriarchally structured society. Women are frustrated because their stress is caused by role conflict and that it is interpreted as pathological because society has not adjusted itself to accommodate the changing

place of women in it.

PMS and its related maladies reflect the frustration of women who are supposed to be “sugar and spice and everything nice.” When one lives every day in the world it is impossible, for men or women, to always cooperate and facilitate congeniality. These expected personality traits are primarily associated with women and when women act in contradiction to society’s behavioral expectations, they are viewed as problematic and in many cases pathological. For thousands of years in the West women’s human reactions of anger and frustration were deemed so problematic that a disease/disorder category was created to control them and treatments were imposed to eliminate their negative behaviors. Until gendered stereotypes and their associated personality traits are relegated to the dustbin of history the consequences of their existence will continue to plague humanity and will further hinder the possibility for improved human relationships.

Although we chuckle when we read about Aristotle’s hot and cold–fully baked theory of morphogenesis–the idea of women as passive and men as active is alive and well in the West today. These are the default positions for understanding men and women’s behavior as is reflected in the title of a recent best-seller, *Men are from Mars and Women are from Venus*. This is just a modern reproduction of Aristotle’s “half-baked”–“fully baked” theory. The reality is that women and men exhibit fewer differences from each other than they do with members of their same sex. Figuratively and literally, both men and women come from the same planet, Earth–not Mars or Venus.

Epilogue: The Narrative of Menstruation

The story that society tells women about womanhood in general and menstruation in particular has a large influence on the story that women tell themselves about menstruation and

how they impact on the way women experience menstruation. As a society we should be more conscious of how we discuss and structure our narrative concerning menstruation in order to provide future generations with a metaphor for menstruation that is healthier for women and relates better to their multifarious roles in our society.

There are stereotypes in society regarding men as well, that are just as untrue as the stereotypes regarding women. It is equally important to address the stereotypes that are associated with men as well as the stereotypes associated with women: both have serious consequences for our society.

Many parents are trying to provide a positive greeting to their daughter's menarche by planning private ceremonies of celebration to be shared together in conjunction with participating in programs like "Take Your Daughter to Work Day." There is an excellent book available for young women on menstruation, *The Period Book* (Gravelle and Gravelle, 1996). Of course, the negative connotations of menstruation in Western culture are so pervasive that it is hard for parents to single-handedly correct these misconceptions.

This thesis suggests ample directions for research on PMS. A historical study of women's prescribed medications since the late 1940s into the 2000s could be fruitful.

In order to test the hypothesis that U.S. women report PMS symptoms because of the inequities in the home and the wage-labor market, it would be interesting to study a country like Norway or Sweden where large numbers of women work outside the home and hold positions of power within those countries' governments. We would want to note at what rate do those women report PMS type symptoms, if at all.

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