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**Waging hormones: An analysis of the premenstrual syndrome in  
America**

**Lovaas, Karen Elizabeth, Ph.D.**

**University of Hawaii, 1993**

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WAGING HORMONES:  
AN ANALYSIS OF THE PREMENSTRUAL SYNDROME  
IN AMERICA

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE  
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By

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This work is dedicated to my beloved sister, Catherine Carol Lovaas, who died on January 15, 1993. The example of her life will always be a rich source of inspiration.

## ABSTRACT

Research stressing menstrual cycle-linked pathology occurs at times of demographic opportuneness, medical expansion, and sociopolitical advantage. Despite the failure of medical science to validate the cultural belief that biological functions determine women's capabilities and shape her appropriate social roles, efforts to do so continue. The premenstrual syndrome, or PMS, is a contemporary example of this effort.

The primary conclusion of this research is that the PMS phenomenon has been two-edged in terms of what it represents and its consequences. On the positive side, women with severe cyclical symptoms, whose concerns were previously dismissed, gained confirmation that they were neither alone nor crazy. As better research on premenstrual symptoms evolves, chances for efficacious treatment improve. Women have been active participants in the debate over PMS, asserting their health needs, critiquing the inadequacies of the research, and challenging the classification "premenstrual syndrome." Some PMS support groups and non-profit organizations provide an opportunity for raising women's consciousness about the cultural denigration of the menstrual cycle and their shared experience of gender discrimination as women. Many women are apparently more able to express interpersonal and social concerns premenstrually that they may suppress at other times.

The negative aspects of PMS are significant. Although medical attention to PMS is in part a result of organized pressure on the institution of medicine, it is also a consequence of the fact that when remedies (purported or real) for female problems become profitable, interest grows. PMS propaganda has successfully persuaded many women to pathologize cyclical changes they had considered normal. Some of the groups organized to assist women with PMS have lent uncritical support to the use of ineffective and sometimes hazardous treatments. The medical profession has largely studied PMS

outside the context of women's lives, thus entirely ignoring social causes of women's distress in a sexist society. Women's justifiable anger about inequitable conditions is easily discounted by women themselves, their families, their employers, and society at large when women are medically designated irritable and "bitchy" due to raging hormones. This in turn lessens the chances for structural changes to improve the conditions of women's lives.



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## PREFACE

Chapter One of this dissertation explains that in feminist research, it is appropriate for the researcher to account for herself. Therefore I have included this short preface to offer a personal perspective on the subject of the premenstrual syndrome and hormones.

Like many girls, my primary sources of information about the menstrual cycle were an "educational" movie in elementary school, pamphlets inside boxes of menstrual pads or tampons, and the ideas of my friends. This information amounted to a vague notion of a mysterious biological event that was supposed to signal womanhood. My mother's strange, resigned tone of voice as she signed the form allowing me to attend a sex-segregated school session about puberty registered without dampening my curiosity. In fact, the atmosphere of secrecy about the subject heightened my anticipation of menarche. My first menstruation arrived and passed without fanfare; the secrecy on the subject continued.

As a young woman, I had a rather "macho" attitude about menstrual cycle changes. Though I was mortified on occasions when I discovered too late that my period had come, I was pleased that, other than bleeding, the cycle usually did not intrude on my awareness. I was slow to pick up on the regularity of some changes in my breasts and bowels. I never had the extreme cramps, headaches, backaches, or nausea that some women do.

While researching and writing this dissertation, I had two unexpected opportunities to become more directly acquainted with the endocrine system. First, my husband was diagnosed with hyperthyroidism. We had noticed some physical changes (increased appetite, weight loss, sweating, protruding eyes) and emotional changes (mostly increased irritability) for which other explanations, such as stress or lack of exercise, seemed

inadequate. X-rays and blood tests implicated the thyroid, which for unknown reasons, was producing an excessive amount of thyroid hormone. With treatment, the initial set of symptoms receded but within a few months had been replaced by another set. My husband was now very cold much of the time, his vocal pitch dropped, his weight increased; he would sometimes, suddenly, become very depressed. The next set of blood tests indicated an insufficient level of thyroid hormone.

The changes were dramatic and troublesome and we were both greatly relieved when the prescribed thyroid hormone pills seemed to return him to his familiar self. His physical and emotional states are not static, but a more reasonable correlation between those states and his life circumstances is again apparent. Variations in the level of a single hormone made our lives something of an emotional rollercoaster for about a year and a half.

The second direct brush with altered hormone levels came when, in the process of trying to conceive a child, I agreed to hormone treatments. I took a drug called Clomid which acts as an estrogen blocker during the menstrual and preovulatory phases of each cycle and took progesterone during the postovulatory and premenstrual phases. For me, the progesterone seemed to dampen emotional and sexual responses. In addition, my cycles were lengthened and I had much more breast tenderness. I did not enjoy the changes and was acutely aware of the bargain being struck in terms of potential benefits and risks. I wonder how progesterone affects women who take it to alleviate PMS.

In the course of doing this research I paid closer attention to my cyclical changes. My own experience of the premenstrual time is not consistent. Usually I notice minor physical changes and little if any emotional change; sometimes both types are noticeable. Emotional changes are generally in terms of intensity. How I feel about my life premenstrually can serve as a kind of barometer. If things are going well, it can be a wonderful time, in which I am more affectionate, empathetic, and sexually charged. I like

that I am also more likely to confront problems with people that I may have been avoiding or postponing. From what I have observed, in my own life and in conversations with many other women, being premenstrual does not cause women to be temporarily insane or out of control. Hormonal changes do not make women "bitchy." The issues that arise premenstrually are already there, but, for some reason, we may feel freer to express them at that time.

If I ever have a daughter, I want to teach her exactly what women told me was the most important thing that they think girls should be taught: that menstruation is not dirty, shameful, or accursed. That is what generations of women in this country have been taught by our social institutions and it is time to change the lesson.

## CHAPTER ONE

### INTRODUCTION

In an article on the premenstrual syndrome (PMS), feminist philosopher Jacquelyn Zita argues convincingly that "much of the research being done on PMS is, in fact, suspect and that the stature and popularity of the idea of PMS rests upon invidious ideological assumptions about the nature of women."<sup>1</sup> Much menstrual cycle research, past and present, reflects a similar prejudice, designating women as physiologically and emotionally unstable and inherently prone to illness because of what has been seen as the overwhelming influence of the female reproductive function. Perhaps, as Gloria Steinem has pointed out, if men were able to menstruate, "menstruation would become an enviable, boast-worthy, masculine event."<sup>2</sup> Instead, menstruation in this culture has long been permeated with shame and negativity and cloaked in silence.<sup>3</sup>

The contemporary public attention focused on PMS confronts that silence, acknowledging pains and concerns shared by many women; validation by the medical profession is a gratifying experience for women formerly told that their disturbing symptoms were "all in their heads." At the same time, that attention functions to expand the stigma and negativity associated with the menstrual cycle, labelling what many women assumed to be normal changes as pathological symptoms and extending medicine's reach into women's daily lives.

Recent PMS literature invokes references from the 6th century B.C. to the present to contend that PMS is an age-old, world-wide disease of women, at long-last seriously addressed in the 1980s.<sup>4</sup> Robert T. Frank's 1931 paper "The Hormonal Causes of Premenstrual Tension" is widely credited with being the first systematic analysis of premenstrual changes but it was not until the 1970s that the volume of literature on PMS

multiplied.<sup>5</sup> Interest continued expanding throughout the 1980s, particularly in the United States. Articles and anthologies covering the biomedical--as well as the psychological, sociological, anthropological, political and legal--aspects of PMS now abound.

Yet after sixty years of medical research, there is still no widespread consensus on the definition, prevalence, etiology or treatment of PMS and medical studies vary widely in their lists and classifications of symptoms. Treatments are available from many physicians, nurse-practitioners, psychotherapists, chiropractors, acupuncturists, and herbalists, and reflect the wide variety of theories of what causes PMS. There are numerous self-help books, PMS hotlines, and support groups available for assistance. One may purchase greeting cards, calendars, and books of PMS jokes, or sport T-shirts, pins, and key chains proclaiming, "It's not PMS, I'm always bitchy." PMS is a cultural event.

The phenomenon of the premenstrual syndrome engenders a host of questions about its historical appearance, present strategic meanings, and future implications. If a majority of women suffer--and have always suffered--negative, sometimes debilitating, premenstrual symptoms, why was it so long neglected and so recently raised to popular prominence? It is important to understand how the study of PMS has developed and expanded.

How is PMS being used by, for, and against women? Is it sheer coincidence that these questions have emerged when women are in the wage labor force in large numbers, fighting for fair wages, day care, reproductive rights and other institutional changes? It is vital to analyze the reasons for the kind of public attention PMS has received in the recent sociopolitical climate, as well as to comprehend how individual women participate in constructing, modifying and challenging the public discourse on PMS.

What do the answers to the above questions suggest about how the issues comprising "PMS" should be addressed? What changes in our social arrangements are indicated? The results of this research have implications in a number of areas affecting

women's lives, including health care and education, child care, division of household labor, wage scales, and gender roles.



## BACKGROUND

American culture has a long history of misnaming women's sexual and reproductive experience; throughout, largely negative meanings have been assigned to the menstrual cycle. Menstruation has been used frequently as a rationale for excluding women from access to educational, employment and political opportunities since the last century. Though little is in fact known about human emotional functioning, popular misconceptions flourish regarding women's purported emotionality and irrationality, increasingly linked with female hormonal cycles. Such assumptions support the dominant cultural ideology of polarized gender roles.

PMS has tremendous strategic potential in this arena. A loosely organized, vaguely defined collection of some one hundred and fifty symptoms, PMS is said to afflict anywhere from five to ninety-five percent of all women from menarche to menopause with physical ailments from acne to water retention and psychological ills from absentmindedness to withdrawal.<sup>6</sup> Some of these symptoms are contradictory--for instance, both increased and decreased libido appear on some lists<sup>7</sup>--and few of them are gender specific. Relying only on this list of symptoms, most people of both sexes could be said to suffer from premenstrual syndrome on occasion.

PMS is also alleged by some researchers to take a great social toll in terms of its impact on the home and workplace. According to British physician and researcher Katharina Dalton, who has championed the use of progesterone therapy for PMS treatment, PMS causes marital breakdowns, increases suicides, shoplifting, homicides, alcoholism, child abuse and other assaults.<sup>8</sup> Dalton claims that because it contributes to absenteeism and accident-proneness on the job, PMS and other menstrual problems cost U.S. industries approximately eight percent of the total wage bill. She estimates that one-tenth of "all menstruating women suffer from PMS severe enough to deserve treatment"

and that in the U.S. alone there are "over 5 1/2 million women with incapacitating monthly problems."<sup>9</sup>

The medical discovery and development of PMS has not taken place in a vacuum. Endocrinologist Estelle Ramey has suggested that PMS is more frequently reported in the U. S.:

This country has just about the highest reported incidence of dysmenorrhea and premenstrual tension as compared to other western countries, especially the western countries. This cannot be genetic. It points to the involvement of other factors--life style, exercise, diet, self image.<sup>10</sup>

Johnson argues that PMS is a western culture-bound disorder and, as such, functions as "a symbolic barometer of status and role changes of women in modern society."<sup>11</sup>

Riessman argues that in a time of declining fertility rates, increasing numbers of gynecologists per capita and a larger "pool of appropriately aged women," market conditions favor such a disease construction.<sup>12</sup> As Riessman indicates, the medical and legal professions, the pharmaceutical and insurance industries are all potentially major beneficiaries of PMS. Politically, the 1980s and early 1990s have seen a strong conservative trend in this country and a backlash against the women's movement of the 1960s and 1970s. It is essential to understand how women are faring in this critical period.

## THE CURRENT STUDY

The primary aim of this study is to explore, within the larger social context, the differences and similarities among women of different backgrounds in perceiving their menstrual cycles and utilizing their awareness of the PMS phenomenon in their lives. This analysis is based on interviews with forty-five women selected from three sample groups in Northern California.<sup>13</sup> Objective and subjective information from two hundred and eighty-eight questionnaires gathered from the same populations is also incorporated. The work is thus grounded in the reality of women's own voices, expressing positive and neutral subjective experiences as well as the negative, and interpreting the external authority of medicine and culture.<sup>14</sup>

The task of interpreting current ideas is made easier by pursuing their cultural genesis and watching their development over time. It is often hard for us to recognize the assumptions underlying commonly held ideas of the present, and scientific research is particularly prone to being viewed as value and assumption free. We tend to see ourselves as liberated from earlier constraints, as the beneficiaries of continual progress, freer in our new knowledge than people have ever been. We would be wise to remember Howard Gadlin's caution that "what appears to be a liberation from past oppression is often only a transformation of that oppression."<sup>15</sup>

Therefore, before analyzing the original research, there is a summary of relevant socioeconomic factors and a survey of the medical and popular literature of PMS to provide a context for better understanding the contemporary scene and linking it with the past.<sup>16</sup> This review serves as a background for interpreting the interaction between the private and public discourse on PMS, allowing us to comprehend how and why groups of women have taken part in shaping, incorporating and resisting the dominant popular views of the menstrual cycle as pathology.

This study contributes to the PMS discussion on several levels. It recognizes women's knowledge and analysis of our own experience and confirms the transformational quality of women interviewing women and women forming support groups. It reviews the links between the historical evolution of PMS and its social context, exposing ideological subtexts. It is part of the process of questioning the popular and scientific presentations of what currently constitutes normalcy and pathology in the menstrual cycle, contributing to the growing literature challenging the sexist biases, hidden cultural premises, and reductionist tendencies in the sciences.

Working with adult women provides an opportunity for better understanding the transmission of menstrual ideology across the generations, by their parents to them, and by them to their daughters. The feminist assumptions underlying this study support a model of openness and reclaiming of the menstrual experience from its negatively defined past. The process of information exchange in the interview situation is itself a challenge to the perpetuation of silence.

This study offers both caution and encouragement to women readers. It is critical to consider the pathologizing and stigmatizing effects inherent in considering all cyclical changes as female illness and to question the notion of relying on premature, simplistic hormonal explanations and solutions. Feminist analysis provides tools for correcting and normalizing biased views of women's menstrual cycle experience. It is also advisable to be well-informed on medical and non-medical treatment alternatives, seeking information and support from other women, and examining the various circumstances affecting well-being before deciding what can or should be changed.

Feminist researchers have assessed the failings of menstrual cycle research in medicine and the social sciences, while supporting the need for new and different kinds of studies. Major problems with conventional research include: "A focus on context-free factors inside the organism;" reliance on positivist and reductionist methodological

assumptions;<sup>17</sup> and, an emphasis on negative or problematic aspects of the cycle.<sup>18</sup> Feminist investigators seek to develop a perspective that is both self-reflective and critical of the dominant conventions of research just as they reject standard scientific canons such as total objectivity, the equating of quantification with neutrality, and the splitting of subject and object.<sup>19</sup>

One effective alternative to past menstrual cycle research is a multidisciplinary approach that is woman-centered, takes into account the situational components of experience, and encompasses positive or neutral aspects of the cycle as well as negative aspects. This study addresses the weaknesses cited above and takes advantage of a feminist, multidisciplinary methodology. It combines a social historical review of the history and literature of PMS with qualitative analysis of interviews and quantitative analysis of a questionnaire. The inclusion of qualitative methods "increases the ability to gather information that is missing from the discourse of sociological knowledge due to the over-emphasis on topics which can be studied through quantification."<sup>20</sup>

In addition to its critical approach to traditional research and its openness to alternative and multiple methodologies, feminist research can "emphasize 'insider' perspectives."<sup>21</sup> It attempts to gain and share an understanding of how women's "everyday worlds, their trials and troubles, were and are generated by the larger social structure."<sup>22</sup> Reinharz describes feminist research as working to correct a societal imbalance by confirming and revaluing the previously discounted experience of women. She redefines experience as "interesting (not arbitrary), effective (in the sense that our ideas shape our world and are not simply shaped by it), uniquely human, and contextual."<sup>23</sup>

The feminist researcher is

able to locate herself as a subject in history so that her own vantage point arises from the same social relations that structure the everyday worlds of the experience of those she studies.<sup>24</sup>

The relationship between researcher and researched is one of dialogue between reflective individual women with the purpose of exploring and enlarging understanding of the issues under study. In working with the knowledge thus gained, the researcher strives to take the analysis "beyond the experience of the researched while still granting them full subjectivity."<sup>25</sup> How are the outcomes of such research evaluated? Acker, Barry, and Esseveld suggest that "adequate reconstruction" rather than predictability is the test. They list three criteria for adequacy: First, "the active voice of the subject should be heard;" second, "the theoretical reconstruction must be able to account for the investigator as well as for those who are investigated;" and third, "the reconstruction should reveal the underlying social relations that eventuate in the daily lives we are studying."<sup>26</sup> The reader will judge how successful this effort has been in meeting those standards.

At the societal level, the results of the study suggest several avenues for social change. I believe, for example, that when menstrual education reflects the reality of women's experience, when quality health care is available to women of all classes, when wages and household labor are fairly distributed, and when interpersonal relationships are built on bases other than unequal gender roles, a disease construction like PMS will not wield the potential for being used against all women that it now does.

At the same time we need to consider how much of a role research recommendations actually play in shaping public policy, and what kind of policies are truly capable of effecting social change. Frequently progressive policies are enacted, then swiftly reversed as the political climate or economic factors shift. There is the potential to improve the lives of many women in this culture by articulating our experience of the menstrual cycle and "making the private consciousness public and consequently

empowered."<sup>27</sup> I hope that the conducting and sharing of this study will itself contribute to the process of social change.

## OUTLINE OF CHAPTERS

Chapters Two through Six of this dissertation review the history of the literature on the menstrual cycle and the premenstrual syndrome. Chapter Two provides a cultural history of the medical and popular literature of menstruation through the beginning of the twentieth century. In Chapter Three, the research delineating a "premenstrual syndrome," beginning with the sex hormones studies of the 1920s and 1930s, is reviewed. Chapter Four looks at the attitudes and research of the war and post-war years and into the 1960s. Chapter Five examines the cultural context in which the premenstrual syndrome became a matter of popular interest and concern, covering the period from the 1970s through the present. Chapter Six summarizes the large body of contemporary scientific, popular, and critical literature on PMS.

Chapters Seven through Nine report the results of my original research, the qualitative analysis of interviews conducted with forty-five women in Northern California. Chapter Seven looks at how women from the three sample populations involved discussed PMS. Chapters Eight and Nine explore four main themes that emerged from the interviews: Chapter Eight focuses on how women view the issues of control and hormones; Chapter Nine examines the roles of stress and emotion in the reporting of premenstrual symptoms.

Chapter Ten summarizes and considers the implications of the history and contemporary experience of the menstrual cycle. It is followed by appendices related to the methodology used in preparing this dissertation (including questionnaires, demographic and consent forms, interview questions) and a sample list of symptoms associated with the premenstrual syndrome.



## NOTES

<sup>1</sup> Jacquelyn N. Zita, "The Premenstrual Syndrome: 'Dis-easing' the Female Cycle," Feminism and Science, ed. Nancy Tuana (Bloomington: Indiana University Press, 1989) 189-90; see also Sophie Laws, "The Sexual Politics of Pre-menstrual Tension," Women's Studies International Forum 6(1) (1983): 19-31; Louise Lander, Images of Bleeding: Menstruation as Ideology (New York: Orlando Press, 1988); Jane M. Ussher, The Psychology of the Female Body (New York: Routledge, 1989); Carol Tavris, The Mismeasure of Woman (New York: Simon & Schuster, 1992).

<sup>2</sup> Gloria Steinem, "If Men Could Menstruate: A Political Fantasy," Ms Oct. 1978: 110.

<sup>3</sup> Patricia McKeever, "The Perpetuation of Menstrual Shame: Implications and Directions," Women & Health 9.4 (1984): 33-47; Paula Weideger, Female Cycles (London: The Women's Press, 1975).

<sup>4</sup> For example, Katharina Dalton has said that "we know now that it is the world's commonest, and probably the oldest disease;" see her The Premenstrual Syndrome and Progesterone Therapy (London: William Heinemann Medical Books, Ltd., 1977) vii.

<sup>5</sup> Robert T. Frank, "The Hormonal Causes of PMT," Archives of Neurological Psychiatry 26 (1931): 1052.

<sup>6</sup> P. M. Shaughn O'Brien, Premenstrual Syndrome (London: Blackwell Scientific Publications) 1987.

<sup>7</sup> Jo Ann Cutler Friedrich, The Premenstrual Solution: How to tame the shrew in you (San Jose: Arrow Press, 1987); Michelle Harrison, M.D., Self-Help for Premenstrual Syndrome, rev. ed. (New York: Random House, Inc., 1982); Ronald V. Norris with Colleen Sullivan, PMS: Premenstrual Syndrome, (New York: Rawson Associates, 1983).

<sup>8</sup> Katharina Dalton, Once a Month, 2nd. rev. ed. (Claremont: Hunter House, 1983) xiv, 211.

<sup>9</sup> Mary Brown Parlee has questioned the assumptions underlying this type of statistical reasoning, that is, the practice of generalizing from a single sample to the female work force or the entire female population of the United States; see "Media Treatment of Premenstrual Syndrome," Premenstrual Syndrome: Ethical and Legal Implications in a Biomedical Perspective, (New York: Plenum Press, 1987) 199.

<sup>10</sup> Estelle R. Ramey, "The Endocrinologist's Approach," Premenstrual Tension: A Multidisciplinary Approach, ed. Charles H. Debrovner (NY: Human Sciences Press, Inc., 1982) 44.

<sup>11</sup> Thomas M. Johnson, "Premenstrual Syndrome as a Western Culture-Specific Disorder," Culture, Medicine, and Psychiatry 11 (1987): 351; see also Emily Martin, The Woman in the Body: A Cultural Analysis of Reproduction (Boston: Beacon Press, 1987), and "Premenstrual Syndrome: Discipline, Work, and Anger in Late Industrial Societies," Blood Magic: The Anthropology of Menstruation, ed. and intr. Thomas Buckley and Alma Gottlieb (Berkeley: University of California Press, 1988) 161-81.

<sup>12</sup> Catherine Kohler Riessman, "Women and Medicalization: A New Perspective," Social Policy Summer 1983: 10.

<sup>13</sup> These groups are described at the start of Chapter Seven.

<sup>14</sup> I share an assumption stated by Carol Gilligan: "that the way people talk about their lives is of significance, that the language they use and the connections they make reveal the world that they see and in which they act." In a Different Voice: Psychological Theory and Women's Development (Cambridge: Harvard University Press, 1982) 2.

<sup>15</sup> Howard Gadlin, "Private Lives and Public Order: A Critical View of the History of Intimate Relations in the U.S.," Massachusetts Review Summer 1976: 304.

<sup>16</sup> In reviewing the medical and historical developments related to menstruation and women's status and definition in the U.S. since the late 19th century, I have relied largely on secondary sources (particularly for the information from the nineteenth and early twentieth centuries). I read the early medical research locating and labelling a premenstrual syndrome and a broad cross section of the medical studies since. I surveyed the relevant social science studies through the present. Most of the widely used gynecological texts and popular PMS books were examined as well as a sampling of articles and programs in the popular media.

<sup>17</sup> Randi Daimon Koeske, "Lifting the Curse of Menstruation: Toward a Feminist Perspective on the Menstrual Cycle," Lifting the Curse of Menstruation: Toward a Feminist Appraisal of the Influence of Menstruation in Women's Lives, ed. Sharon Golub (New York: Harrington Park Press, Inc., 1985).

<sup>18</sup> Janice Delaney, Mary Jane Lupton, and Emily Toth, The Curse: A Cultural History of Menstruation (New York: E.P. Dutton & Co., Inc., 1976); Penelope Shuttle and Peter Redgrove, The Wise Wound: Eve's Curse and Everywoman (New York: Richard Marek Publishers, 1978); Esther Rome, "Premenstrual Syndrome (PMS) Examined Through a Feminist Lens," Culture, Society, and Menstruation, ed. Virginia L. Olesen and Nancy Fugate Woods (Washington, D.C.: Hemisphere Publishing Corporation, 1986); Ussher.

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## CHAPTER TWO

### THEORETICAL AND HISTORICAL FOUNDATION

"Have you any notion how many books are written about women in the course of one year?" Virginia Woolf asked an audience of women. "Have you any notion how many are written by men? Are you aware that you are, perhaps, the most discussed animal in the universe?"<sup>1</sup>

As Ehrenreich and English have vividly chronicled, the last century has seen the rise of a large class of experts purporting to speak authoritatively on woman's true nature and the social implications proceeding from her biology. This chapter and the four that follow review the literature on women since the mid-nineteenth century, addressing a single angle of the many sided woman "question" or "problem:" How have professional and popular culture in America portrayed the phenomenon of the menstrual cycle? And what specific themes from the past have carried over into the current discourse on PMS?

This chapter provides a background for the contemporary debate on women and PMS. First, to provide a theoretical orientation for the interpretation of the rhetoric on women's biology, the social construction of illness and the critique of mind/body dualism are discussed. Second, the shift from a subjective understanding of the body to a mechanical view is described. Third, the history of ideas about menstruation in the nineteenth and early twentieth centuries is surveyed.<sup>2</sup>

## THEORETICAL BACKGROUND

### The Social Construction Of Illness

Whether or not a particular behavior or experience is viewed by members of a society as a sign or symptom or illness depends on cultural values, social norms, and culturally shared rules of interpretation.<sup>3</sup>

One assumption underlying this historical review of literature on PMS is that culture and ideology have played an important part in the definition and treatment of PMS and of all illnesses, that is, that illness is socially constructed.<sup>4</sup> We have a tendency to view the work of science as removed from cultural influences; in fact, science is a social activity, situated in a specific historical setting. In the field of medical science the selection of what kinds of human experiences will be investigated and treated depends on where attention is and is not being focused at any given time: "Social agenda are embedded in these choices."<sup>5</sup> Thus, attitudes and values are found in scientific discourse as well as "hard" facts. And the facts, too, can be "shaped into lessons and prescriptions reflecting values and biases."<sup>6</sup>

The institution of medicine has been primarily the province of a professional class of elite, White males, whose cultural authority is legitimized by science. Physicians' authority requires dependence as well as legitimacy: the prerogative "to interpret signs and symptoms, to diagnose health or illness, to name diseases, and to offer prognoses" allows them to shape "patients' understanding of their own experience" and produces the "conditions under which their advice seems appropriate."<sup>7</sup>

Given the desire to establish and maintain their position of authority, doctors "tend to identify their own interests with those of the powers that be."<sup>8</sup> As increasing numbers of doctors are trained, the supply in some fields of specialization eventually exceeds the demand, requiring new areas for expansion. More than social authority and

prestige is involved: "large profits accompany each redefinition of human experience into medical terms, since more drugs, tests, procedures, equipment, and insurance coverage are needed."<sup>9</sup> As noted in Chapter One, there are many benefactors in the case of PMS.

There are several reasons why women's lives have been particularly prone to this process of giving medical meanings to or medicalizing experience. One explanation is that women's bodies offer more perceptible cues of ongoing biological processes--for example, menstruation, childbirth, lactation--than do men's bodies. The presence of such visible signs fits in with the biomedical approach to illness which seeks objective markers of disease and has resulted in the medicalization of normal experiences in women's lives. Women's own efforts to be less constrained by some biological functions--e.g., the use of contraceptives to avoid or plan the timing of pregnancies, the use of anesthetics to reduce labor pains--may "simultaneously have strengthened the control of a biomedical view of their experience."<sup>10</sup>

In *Illness as Metaphor*, Sontag explains that one of the means by which illness expands is by viewing any form of deviation from social norms as illness.<sup>11</sup> Deviance is "implicit in medical definitions. . . . physicians create and reinforce social norms when they define behaviors or conditions as pathological."<sup>12</sup> Because men are generally used as the standard of normalcy, women's experiences have been readily defined as different and therefore abnormal, pathological, deviant.

Women as a group are structurally subordinate to men and the unequal power relations in society are reproduced within most male doctor/female patient relationships.<sup>13</sup> Women may be more prone to trust medical authority than to define their own experience, because of their subordinate social status. This creates a dilemma:

Medical ideology attains the power to instill enormous anxieties or bring enormous relief, depending on whether it contradicts or validates women's own experience. . . . Either a physiological event is not defined as a

medical event, in which case a women feels she is not being taken seriously, or it is so defined, and a women's reality is then channeled into the stultifying confines of the biomedical model, the complexities of her life experience being reduced to an "entity" called a disease.<sup>14</sup>

This desire to have experience validated by medical authority has sometimes conformed to the interests of the profession and contributed to the construction of new areas of pathology in female biology. When the interests of physicians and groups of middle and upper class, primarily White women are complementary, the result is "a consensus that redefines a human experience as a medical problem."<sup>15</sup>

#### "Rethinking Biology:" The Critique Of Mind/Body Dualism

Medical research, like much of conventional wisdom, assumes a clear split between body and mind, the biological and the social; in this dyad biology is seen as dominant. A refinement of the notion has emerged in the form of the increasingly popular interactionist view which recognizes that the social and the biological have effects on each other, while contending that they comprise two entirely separate realms. Feminist philosopher Jean Grimshaw argues that the biological and the social are indivisible:

The central argument against the idea of biology as a substratum is that it is not possible to identify an absolutely clear, non-social sense of "biology;" the biological is not a realm or sphere which can be isolated as a cause of any feature of human life. But neither is it possible to identify a clear non-biological sense of the "social."<sup>16</sup>

Lewontin, Rose, and Kamin assert that "the biological and the social are neither separable, nor antithetical, nor alternatives, but complementary. . . . All human phenomena are simultaneously social and biological."<sup>17</sup> Human action is the result of



many varied "interacting and intersecting" causes which cannot be reduced to a single or even small subset of sources.<sup>18</sup> Even such fundamental life-sustaining activities as eating, sleeping, and sex are shaped by social custom and conscious individual direction.

The body itself is "a site of the interplay between biology and culture."<sup>19</sup> Our experience of our bodies is in part the product of our history as a species, but it is also the creation of our social arrangements and our individual ways of relating to those arrangements. The process of human development may be described as involving "interpenetrating" rather than interacting relationships, or as the "dialectical development of organism and milieu in response to each other."<sup>20</sup>

I believe that this explanation is far more plausible than what is offered by the essentialism of biological or cultural determinists. Why then, is the notion of a separate, objective body as the base on which the subjectivity of mind and culture is mounted, so pervasive? Perhaps because it parallels our sociopolitical structures:

The hierarchical nature of human social organization makes the subject-object dichotomy seem only natural when we contemplate the physical world. But that alienation is also of direct political relevance. The alienated organism must accommodate itself to the facts of life: "That's life, so you'd better learn to live with it." Accommodation as a political goal is hypostasized as a concrete, necessary relation between organisms and their environments, quite outside their control. Thus psychic maturation is seen as learning to replace wishes about the world with acceptance of its actual nature.<sup>21</sup>

In the next section, we begin examining the history of ideas relevant to an understanding of our current conception of the menstrual cycle and PMS, starting with the inception of the view just critiqued, the mind/body split.

## THE BODY AS MACHINE

It is decided that matter is dead.

That the universe acts as a machine which can be described by describing the actions of particles of matter upon other particles according to immutable mechanical laws.

That the secret of the universe may be revealed only through understanding how it works. That behind the material "how" may lie the first cause, which is immaterial.

That the particular (like the parts of a machine) may be understood without reference to the whole.<sup>22</sup>

In this excerpt from Woman and Nature, Susan Griffin describes the result of a major shift in the way the body was understood that took place in the 1600s and 1700s. In the Renaissance, the philosophy of vitalism held that spirit and matter were united in the universal rhythms of life, making God's design visible in all of nature. In the practice of medicine, doctors trusted the subjective descriptions of patients as well as the report of their own senses, and many matters of the body could be "left to the healing powers of nature."<sup>23</sup>

But the mechanistic model, beginning with the science of Kepler and Galileo and the philosophy of Descartes, brought about profound changes in all areas. The field of medicine both participated in and was influenced by these changes: "In particular, studies in anatomy and physiology served to demonstrate the power of empirical investigation and mechanical explanation, often contradicting established wisdom about the body."<sup>24</sup> Doctors now relied on new techniques to analyze the body, locate objective signs of disease, and perform interventions, independently of the patient. This positivistic model has continued to be the dominant approach of medical science:

In the evolving emphasis on objective, physical measurement we can see the concern with defining disease as deviation from the normal or average; in the emphasis on underlying causation, not visible to the subjective senses but objectively rooted in the physical world, we find the roots of the search for generic universal diseases; and the high value placed on the dispassionate, objective investigator empirically observing the basic mechanisms of nature is an important source of the belief in the scientific neutrality of medicine.<sup>25</sup>

In "The Machine Metaphor in Medicine," Osherson and AmaraSingham point to three factors that facilitated the change to a mechanistic model. In economic terms, seeing individual human beings as essentially interchangeable fits in with the marketplace view of labor. Politically, the appearance of a more orderly science held strong appeal during the social upheavals of the 17th and 18th centuries. And psychologically, the greater emotional distance between doctor and patient would have been suitable to the techniques of surgical intervention on an objectified body, disencumbered of subjective and spiritual meanings.<sup>26</sup>

From the second to the eighteenth centuries, it was the common premise of medicine that female and male bodies were very similar in structure, the male version being the superior of the two in teleological perfection. The female reproductive organs were believed to be the analog of the male's but inverted, and located inside rather than outside of the body. Menstruation was seen as the necessary excretion of an excess blood; men could accomplish the same healthy function by having their blood let. By 1800, these beliefs were widely attacked: "Whereas in earlier accounts the blood itself may have been considered impure, now the process itself is seen as a disorder."<sup>27</sup> They were supplanted by a view of women and men as opposites in every respect, the sciences supporting male superiority and unequal gender roles.<sup>28</sup>

Laqueur argues convincingly that this transformation in the understanding of the human body was not the result of scientific breakthroughs but of "new ways of representing and indeed of constituting social realities." This emphasis on differences between the sexes came at a time when "the foundations of the old social order were irremediably shaken, when the basis for a new order of sex and gender became a critical issue of political theory and practice."<sup>29</sup> Laqueur cites Tocqueville's opinion that in response to the undermining of traditional patriarchal authority by democratic institutions, Americans had delineated separate functions for women and men as a means of maintaining clear status differences between the sexes.

Woman's role as health provider also underwent a dramatic shift between the seventeenth and the mid nineteenth centuries. In the colonial family, women were the primary care givers. They were the major lay practitioners up until the early 1800s. They were the exclusive attendants at childbirth until the numbers of midwives began decreasing in the late 1700s.<sup>30</sup> In health care and overall, women's roles and opportunities narrowed in post Revolutionary democracy as the areas where men had authority over women's lives expanded.

## MENSTRUATION IN THE VICTORIAN AGE

Since the early nineteenth century, menstrual politics has taken two positions with regard to menstruation and economic life: first, that *factories and businesses pose a fatal threat to women's reproductive life*; second, that *the menstrual cycle threatens the health of American capitalism*.<sup>31</sup>

The mid-nineteenth to the early twentieth centuries witnessed the converging forces of industrialization, the large scale movement of population to urban centers, and successive waves of immigration. The household lost its place as economic focal point to mechanized factories, offices, and farms. Men left the household to join the new labor markets; women stayed in the new haven of the home to bring up the children. In 1860 only 15% of American women were in the wage labor force outside of the home.<sup>32</sup>

Lander calls this period a time when "middle class women lost their economic function and began to find their voice."<sup>33</sup> Groups of women organized for access to higher education and the professions, political rights such as suffrage, property rights, and the right to limit family size. At the same time, the female invalid came onto the scene:

the female nervous disorders of anorexia nervosa, hysteria, and neurasthenia became epidemic; and the Darwinian "nerve specialist" arose to dictate proper feminine behavior . . . , to differentiate treatments for "nervous" women of various class backgrounds, and to oppose women's efforts to change the conditions of their lives.<sup>34</sup>

The periodicals of the late 19th and early 20th centuries were full of articles espousing new physiological and social theories that females and males were properly

regarded as opposites. Darwin's argument that sexual selection was the cause of female and male differences provided a biological base to social definitions of femininity and masculinity.<sup>35</sup> Some biological scientists argued that the differences between women and men were traceable down to the cellular level. Geddes and Thompson were convinced that basic, unchangeable differences in the metabolism of female and male cells existed, accounting for an oppositional and complementary psychology of the sexes. Female "anabolic" metabolism produced women who were "more passive, conservative, sluggish, and stable" while, because of their "katabolic" metabolism, men were "more active, energetic, eager, passionate, and variable."<sup>36</sup> Women were regularly admonished to avoid the dangers of betraying their true nature by being overly active in mental or physical pursuits. According to *The Cult of True Womanhood*, woman's proper sphere was the home, her proper roles, wife and mother, her proper demeanor, passive, gracious, self sacrificing, sentimental. To stray from her naturally ordained confines was to invite ill health, moral ruin, the downfall of the family, and the weakening of the nation. In xenophobic response to the large numbers of immigrants, White middle class women were strongly encouraged to "be fruitful and multiply."

Two short novels written at the end of the 1800s brilliantly portrayed the suffocating results of the experts' view of the "sensitivities" of women, particularly middle class women. Charlotte Perkins Gilman's *The Yellow Wallpaper*<sup>37</sup> and Kate Chopin's *The Awakening*.<sup>38</sup> Both deal with the, literally, maddeningly restricted lives women were expected to live, regardless of their talents and passions. Both books end with the self-destruction of the books' heroines; in their own lives, Gilman was a popular lecturer and writer for many years after writing *The Yellow Wallpaper*, but the references to a woman's sensual desires outside of marriage in *The Awakening* provoked a tremendous negative response that followed Chopin until her death in 1904.

The feminine gender role incorporated what has been referred to as "functional ambiguity."<sup>39</sup> That is, although assertions about woman's nature "formed an ideological system rigid in its support of tradition," this system was at the same time "infinitely flexible in the particular mechanisms which could be made to explain and legitimate woman's role."<sup>40</sup> Woman was seen as imbued with more spiritual qualities than a man, but more restricted by her animality; she was expected to guide and guard the family's morals even though her presumably more corporeal nature was said to limit her own moral capacity. Her body distinguished and constrained her role:

While the sentimental poets placed woman among the angels and doctors praised the transcendent calling of her reproductive system, social taboos made woman ashamed of menstruation, embarrassed and withdrawn during pregnancy, self-conscious and purposeless during and after menopause. Her body, which so inexorably defined her personality and limited her role, appeared to woman often degrading and confining.<sup>41</sup>

The impression given by late nineteenth century books is that most middle class women suffered from an illness of some sort. The problem invariably stemmed from her reproductive organs, specifically her ovaries and/or her uterus, with typical symptoms including headaches, depression, menstrual problems, muscular aches, and weakness. Possessing these organs was thought to leave one prey to many disabilities foreign to men, particularly nervous disorders. According to Ann Douglass Wood, doctors found "a certain moral depravity inherent in feminine nervous disorders" which they variously discussed as an effect or the cause of the physiological symptoms.<sup>42</sup> (Wood also points out that medical preoccupation with the uterus detracted from common and serious illnesses such as breast cancer and consumption). A number of vague syndromes were given names. Two of the most common of these disorders--with strong parallels to PMS--were hysteria and neurasthenia.<sup>43</sup>

The womb was the center of an inherently unstable system of involuntary periodicity and periodicity was generally equated with illness. The extreme sensitivity of female nerves made it almost invariable that some irritant would upset her delicate balance, resulting in hysteria. Hysteria is thus:

simultaneously the norm of the female body taken to its logical extreme and a medical category that effectively defines this norm as inherently abnormal. This representation provides an image of woman as always lacking and needing control.<sup>44</sup>

A disease of middle and upper class women, there was no known organic cause or effective medical treatment for hysteria. As mentioned above, a virtual epidemic of nervous disorders coincided with a period of feminist activism. Elaine Showalter has written of the social acceptability of a disease construction that allowed the channeling of women's discontent through illness rather than being expressed through activism for social and economic change: "The hysteric's deviance and rebellion are carefully programmed and delimited by the social order."<sup>45</sup>

A term less familiar to us than hysteria, is neurasthenia. This disease was primarily diagnosed in middle and upper class women in the U.S. It was commonly understood as a nervous disorder linked to the uterus and menstrual cycle; however men were also sometimes diagnosed with neurasthenia. Female or male, the idea was that the nervous system was of rather delicate construction:

Physicians in the late nineteenth century believed that each individual possessed a fixed amount of nervous energy, determined mainly by heredity, which acted as a messenger between various parts of the body. Neurasthenia resulted when demand exceeded supply; even a tiny excess could cause the entire system to break down.<sup>46</sup>



There was still no consensus on the definition, diagnosis, symptomatology, and treatment of neurasthenia in 1920, although thousands of patients had been diagnosed as having it during the previous fifty years. In an article drawing parallels between PMS and neurasthenia, Dr. Charles King states that many of the women diagnosed as having neurasthenia in the late 19th century would now be said to suffer from PMS.<sup>47,48</sup>

Menstruation was "both the evidence and the explanation" of pathological functioning in women.<sup>49</sup> Two theories of menstruation were predominant, both of which led to the conclusion that the menstrual cycle was a serious impediment to health requiring women's social restriction to a separate sphere. The first, Pfluger's ovulation theory, postulated that menstruation and ovulation occurred simultaneously, linked by nerve impulses: "a nervous impulse traveled from the ovary via the spinal cord to the uterus to create a pelvic congestion, which was then relieved by menstruation." The second, called menstrual wave theory, depicted menstruation as "an external manifestation of rhythmic changes--expressed in such measurements as pulse, temperature, and blood pressure--affecting the entire organism."<sup>50</sup>

In the 1840s, some physicians in the United States and Europe began likening menses to the heat of female animals. One American physician described the similarity in these terms: "The bitch in heat has the genitals tumified and reddened, and a bloody discharge. The human female has nearly the same."<sup>51</sup> The analogy between menstruation and heat meant that only a fine line separated women from beasts:

The whole cultural baggage of brunst, rut, heat--words hitherto applied only to animals--and the neologism estrous, derived from the Latin oestrum, "gadfly," meaning a kind of frenzy and introduced to describe a process common to all mammals, was subtly or not so subtly laden on the bodies of women.<sup>52</sup>

Historian Thomas Laqueur has indicated that common sense does not account for the desire to equate women's reproductive cycle with that of animals. There was an effort to remove the metaphysical meanings and thus to rationalize reproduction which resulted in an articulated though incomplete explanation. The kind of convoluted thinking embraced by the scientists involved is evidence of "the extraordinary cultural burden" that women's reproductive biology carried:

Whatever one thought about women and their rightful place in the world could, it seemed, be mapped onto their bodies, which in turn came to be interpreted anew in the light of these cultural demands.<sup>53</sup>

Research on menstruation served as a rationale for excluding women from what was now designated as men's sphere and denying women the full exercise of their rights. In Sex in Education, Edward H. Clarke, Harvard professor and, arguably, "the most influential theorist of menstrual disability," argued against higher education for women on the basis that any exercising of the mind during menses disrupted the natural processes of ovulation and menstruation.<sup>54</sup> Thirty years later, in his classic Adolescence, G. Stanley Hall, considered the leading psychologist of his time, echoed Clarke's ideas and recommended four day monthly rest periods for women during menstruation. This period would be ideal for religious contemplation, he felt, given women's propensity "'to a natural piety and sense of dependence'" at that time.<sup>55</sup>

Physicians sometimes advised that physical exercise was not a desirable alternative and recommended confinement during the "monthly sickness."<sup>56</sup> In fact, menstruation was said by one doctor to make education, exercise, and employment all out of the question, an enterprise so demanding that "'the female seems to live chiefly for this purpose."<sup>57</sup> This left marriage, including maternity, and care of home and children as the only suitable occupation for women. The author of one popular obstetrics text

went so far as to describe menstruation as a disease caused by the violation of nature's law, that is, failure to be pregnant.<sup>58</sup>

Women physicians of the late nineteenth century generally disagreed with these views, supporting higher education, coeducation, and physical exercise for women. There was agreement that too many women were not strong and well, but women doctors and health reformers cited physically distorting clothing styles and working conditions rather than behavioral violations of middle class gender roles as causes. Dr. Mary Putnam Jacobi also cited women's "new function as lucrative patients" as a contributing factor to their poor health.<sup>59</sup>

Leta Stetter Hollingworth's 1914 study comparing women's and men's cognitive and motor abilities found that the menstrual cycle did not have the tremendous effect on women that Clarke and Hall envisioned. She explained the incongruity between the widely held scientific stance and her results in two ways. First, some "facts" were actually traditional attitudes about women. Scientists had focused on menstruation "as the probable source of the alleged 'mystery' and 'caprice of woman kind.'" Second, physicians' ideas were based on seeing patients with mental or physical ailments rather than the general population of women. The generalizations they made were rarely challenged by other male investigators.<sup>60</sup>

Clelia Mosher's research on menstruation covering the time period from 1890 and 1920 provided evidence that reports of menstrual cycle related troubles had decreased by the 1920s. Mosher pointed to the roles of self-fulfilling prophecies from nineteenth century training about menstruation and physically constricting, weighty dress styles as producing the greater distress in the 1890s.<sup>61</sup> As more and more women obtained college educations and entered careers it became conspicuously apparent to many women that study and work need not have adverse health effects. However, the idea that women

could safely increase their participation in the public spheres met continued resistance in the twentieth century.

## SUMMARY

This analysis of the history of menstruation in the United States is based on two important and related theoretical assumptions: First, that our experience of illness is socially mediated and, second, that human reality is at the same time, and inseparably, a function of both biology and culture.

The mechanistic model of medicine prevalent today developed within the context of social and conceptual revolutions that resulted in the creation of a marketplace society. In the 1800s, the ideology of female and male as precise opposites in every aspect dominated American society. Menstruation and all female reproductive functions were seen as defining and limiting women's role in society. Concurrent with the nineteenth century wave of feminism, medical research decrying women's social activism, higher education, and physical exercise was common. Physicians and scientists argued that such activities endangered female reproductive organs and therefore the country's population growth, as well as the moral basis of society. The increasing pressures of modern civilization were thought to be especially stressful for women's bodies, resulting in numerous nervous ailments such as hysteria and neurasthenia among middle and upper class White women. Analogies were made between human menstruation and the heat of animals, suggesting that women were closer to the animal world than men.

A number of women physicians and researchers critiqued the content and intentions of inaccurate and derogatory medical research. These critics focused their attention on two main areas: 1) the contributions of physicians' economic incentives, physically constricting women's fashions, and poor working conditions to women's ill health, and 2) the role of male bias in distorting medical research on women.

Despite adverse social norms and sex discrimination, increasing numbers of women from the middle and upper classes sought college educations and careers as the 19th century drew to a close and the new one began.

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<sup>4</sup> Peter L. Berger and Thomas Luckmann, The Social Construction of Reality: A Treatise in the Sociology of Knowledge (New York: Anchor Books, 1967).

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<sup>6</sup> Lander, 6.

<sup>7</sup> Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, Inc., 1982) 14.

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<sup>11</sup> Susan Sontag, Illness as Metaphor (New York: Farrar, Strauss and Giroux, 1977).

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43 Ehrenreich and English. See also an interesting article comparing the use of a temporary insanity defense based on menstrual cycle related hysteria in an 1865 trial with contemporary use of a PMS defense: Allen D. Spiegel, "Temporary Insanity and Premenstrual Syndrome: Medical Testimony in an 1865 Murder Trial," New York State Journal of Medicine September 1988: 482-92.

44 Mary Poovey, "Scenes of an Indelicate Character: The Medical 'Treatment' of Victorian Women," Representations Spring 1986: 147.

45 Showalter 161; see also Ehrenreich and English, 133-40; Carroll Smith-Rosenberg, "The Hysterical Woman: Sex Roles in 19th Century America," Social Research 39 (1972): 652-78.

46 Barbara Sicherman, "The Uses of Diagnosis: Doctors, Patients, and Neurasthenia," Journal of the History of Medicine and the Allied Sciences 32 (1977): 34.

47 Charles R. King, "Parallels Between Neurasthenia and Premenstrual Syndrome," Women & Health 15 (1989) 1-23.

48 "The available clinical materials suggest that neurasthenia was a complex reality for the doctors and patients charged with interpreting puzzling mental and physical difficulties they did not understand. If the particular insights of late nineteenth century physicians into the psychological and psychophysiological aspects of illness disappoint us, it is not altogether certain that we have, even today, found satisfactory solutions to conditions of this sort." Sicherman, 54.

<sup>49</sup> Ehrenreich and English, 110.

<sup>50</sup> Lander, 40.

<sup>51</sup> Quoted in Laqueur, 27. See his insightful discussion of the origins of these comparisons, 24-31.

<sup>52</sup> Laqueur, 30-31; also discussed in Thomas Laqueur, Making Sex: Body and Gender from the Greeks to Freud (Cambridge: Harvard University Press, 1990) 218-21.

<sup>53</sup> Laqueur 1986, 30.

<sup>54</sup> Vern L. Bullough and Martha Voght, "Women, Menstruation, and Nineteenth-Century Medicine," Bulletin of the History of Medicine 47 (1973): 69-70. See Edward H. Clarke, Sex in Education: or a Fair Chance for Girls (Boston: James R. Osgood & Co., 1874).

<sup>55</sup> G. Stanley Hall, Adolescence: Its Psychology and its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education Vol. I (New York: D. Appleton and Company, 1904) 411-12. Outlandish sounding as this advice may be, it was still included in menstrual education given in the mid 20th century.

<sup>56</sup> Gena Corea, The Hidden Malpractice: How American Medicine Treats Women as Patients and Professionals (New York: William Morrow and Company, Inc., 1977) 98 (citing Dr. Taylor, 1871).

<sup>57</sup> Corea, 98 (quoting Dr. Hollick, 1850).

<sup>58</sup> Cited in Lander, 49.

<sup>59</sup> Cited in Nancy F. Cott, "Passionlessness: An Interpretation of Victorian Sexual Ideology, 1790-1850," Signs 4 (1978): 307. See also Mary Putnam Jacobi, The Question of Rest for Women during Menstruation (1886; Farmingdale: Dabor Social Science Publications, 1978).

<sup>60</sup> Hollingworth, cited in Bullough and Voght, 78-79. See also Leta Stetter Hollingworth, Functional Periodicity: An Experimental Study of the Mental and Motor Abilities of Women During Menstruation (New York: Columbia University Press, 1914).

<sup>61</sup> Bullough and Voght, 79-80; see also Clelia Duel Mosher, "Normal Menstruation and Some of the Factors Modifying It," Johns Hopkins Hospital Bulletin 12 (1901): 178-79.

## CHAPTER THREE

### THE 1920s - 1930s: CONSUMER CULTURE AND SEX HORMONES

My attention has been increasingly directed to a large group of women who are handicapped by premenstrual disturbances of manifold nature. It is well known that normal women suffer varying degrees of discomfort preceding the onset of menstruation. Employers of labor take cognizance of this fact and make provision for the temporary care of their employees. . . .

. . . . Not only do [these women] realize their own suffering, but they feel conscience-stricken towards their husbands and families, knowing well that they are unbearable in their attitude and reactions.<sup>1</sup>

In this first discussion of a premenstrual tension syndrome as a medical entity, many women are described as impaired by "an excessive amount of female sex hormone" that imposes upon their employers and families. This chapter explores the sociocultural climate in which this research was done and the concurrent ideas on feminine psychology before examining the content of the era's most influential menstrual cycle research.

## THE SOCIAL SETTING

In 1908, the Supreme Court handed down a decision upholding an Oregon law limiting women's working day in industries to ten hours. The decision did not distinguish between women with and without children, pregnant or not pregnant. It treated all women as carriers of the species, predicating the state's stake in women's bodies:

... as healthy mothers are essential to vigorous offspring, the physical well-being of women becomes an object of public interest and care in order to preserve the strength and vigor of the race.<sup>2</sup>

At the time, many women active in labor unions were pleased with the decision, assuming that it would lead to improved working conditions. However, the laws enacted after the decision created more limitations for women than advances.<sup>3</sup>

Along with trade unionism, feminist activists in the early twentieth century again focused on suffrage, but also on an Equal Rights Amendment, and birth control. Their efforts led to some enhancement of opportunities for women but neither activism nor World War I appreciably furthered women's progress toward economic and political equality in the 1920s and 1930s. The belief that women belonged in the home after marriage held force. Married or single, the approximately 25% of women in wage earning jobs, were characterized as holding casual jobs or working for "pocket money."<sup>4</sup> During the thirties, the number of working wives increased from 11.7% to 15.2% as many men were laid off or had salary reductions during the Depression. But these women were perceived as stealing men's jobs and faced significant discrimination by the states and the Federal government. In terms of ethnicity, over 57% of women with jobs were African Americans or foreign born Whites in 1930. Overall, working wives seem to have been more an indication of poor families than of women's emancipation.<sup>5</sup>

In the early 1920s, women had some political leverage due to the expectation that they would constitute a unified, powerful voting bloc. Women's reform groups were thus successful in pushing through progressive maternity and child legislation. But when women voted in relatively small numbers and not as a bloc, that momentum soon evaporated. The Equal Rights Amendment never gained the full support of active women's organizations and despite a long struggle failed to pass. There was also a considerable fear of radicalism in the twenties and feminist groups were among those labeled as "subversive," "anti-family," and "Bolshevik."<sup>6</sup> When labor activism, New Deal programs, and Eleanor Roosevelt's influence contributed to more political involvement for some women in the thirties, those women were less likely to refer to themselves as feminists.

In the 1920s, personal fulfillment and liberation as a woman were promoted as being a matter of buyable goods and enhanced personal appearance. One symbol of this new emphasis was the 1920 debut of the Miss America pageant. The membership of feminist groups was aging and younger women appeared disinterested in making a commitment to continuing the struggle. Rapp and Ross describe the overall impact of these changes on the feminist movement:

A dramatic transformation of American culture, fusing sex, love, and consumerism, made the all-female organizations of the feminists seem stodgy and outmoded. . . . Paradoxically, while some women benefited from an opening up of new "life-styles," the net effect of the new culture was to demobilize and destroy the old one within which feminism had thrived for several generations.<sup>7</sup>

Essentially, the commercial culture of the era co-opted feminist concerns. Howard Gadlin described it as a time when "feminists experienced the need to redefine personal identity, but business dominated the process of redefinition."<sup>8</sup>

A new world of appliances, beauty products, and women's magazines had arisen to sell women a vision of themselves as engineers of scientific home management, architects of a more alluring self. Advertisers heavily targeted women with their ads. New or improved products did increase the amount of latitude women had in some areas of their lives. Less voluminous and restrictive women's clothing and simpler, less time-consuming hairstyles are examples of new fashions that allowed women more ease. By the 1920s, contraception had changed from a radical cause to a common practice among middle class women and, in the 1930s, among working class women. In 1920, women nurses were instrumental in Kimberly Clark's production of the first successful disposable "sanitary napkin" using leftover bandage material from WW1.

In the glut of commercial products and advertising, many menstrual related products were introduced in the twenties and thirties. In 1936, Facts and Frauds in Woman's Hygiene: A Medical Guide Against Misleading Claims and Dangerous Products was published, suggesting how fast and large the business of "feminine hygiene" and "protection" was growing. The women writing the book believed that women's bodies were beset with sex-specific problems from menarche to menopause and argued that business took advantage of the situation for financial gain: "Women constitute a more profitable market than ever before. . . . For every patent medicine offered for the exclusive use of men, there are a hundred offered for women alone."<sup>9</sup>

Because there was a strong prohibition against subjects such as menstruation, a variety of strategies were devised to attract this new market of women without offending delicate sensibilities. Were women embarrassed to publicly purchase intimate items? The seller offered a plain wrapper sent through the mail. The ads, especially prominent in women's magazines, were laden with euphemisms: "feminine hygiene," "marital hygiene," "sanitary napkin." What many took to be a new candor about women's physiology and sexuality was in fact candy-coated accusations of uncleanness, repulsiveness, frailty,



inferiority. Ad campaigns for products to clean, disinfect, and deodorize the genitals abounded. Interestingly, in the midst of a competitive rivalry, advertisers were uniform--as if by tacit agreement--in the images conjured to depict the results of noncompliance with the new code of consumption: shattered romances, insanity, even death.<sup>10</sup>

Sex, as well as consumption, was offered as a path to emancipation, though the image of the flapper served the ideology of separate spheres for women and men as the doctrine of passionlessness had.<sup>11</sup> Zelda Fitzgerald's life provides an example of tensions in the female gender role for relatively privileged women in the twenties and thirties; Tillie Olsen's Yonnandio is a better opening into the lives of poor working class women in these years.<sup>12</sup>

## FEMININE PSYCHOLOGY

The new feminine psychology reinforced many of the old gender roles. Ideas about the female psyche as defined by Sigmund Freud were adopted and adapted to fit the new American mood: "Women were passive and irrational, their nature grounded in sexually-bound, instinctually determined psychological needs."<sup>13</sup> The phenomenon of hysteria helped set the stage for Freud's influence in this country; Carroll Smith-Rosenberg has termed psychoanalysis the "child of the hysterical woman."<sup>14</sup> The change in emphasis from biology to psychology, or uterus to brain, as the seat of ambiguous female diseases such as hysteria and neurasthenia made psychiatrists and psychologists new authorities on women in this century. But as Smith-Rosenberg's phrase suggests, the two areas were complementary rather than contradictory.

Freudian ideas were disputed by some women scholars. An early critique of Freud was made by German psychoanalyst Karen Horney in a series of writings in the late twenties and early thirties.<sup>15</sup> She challenged the male bias of psychoanalytic theory and concepts such as masochism and penis envy in women, countering with the issue of men's envy of women's ability to give birth. Horney gave greater emphasis to the significance of cultural influences on women, especially the social disadvantages women face.<sup>16</sup>

Horney described premenstrual tensions as disturbances "directly released by the physiological processes of preparation for pregnancy." She expressed surprise at the apparent lack of interest in perimenstrual psychological changes:

It is remarkable that so little attention has been paid to that fact that disturbances occur not only during menstruation but even more frequently, though less obtrusively, in the days before the onset of the menstrual flow.<sup>17</sup>

However Horney did not believe that all women were prone to suffering premenstrual tension: "This particular time in women's cycle represents a burden only to those women in whom the idea of motherhood is fraught with great inner conflicts." Horney indicated that she did not share gynecologists' view that menstruation constituted a "basic weakness" resulting in "lesser efficiency of women."<sup>18</sup> But for every Horney there were several psychologists who viewed menstruation as seriously handicapping women. Such a stance is particularly interesting when it belongs to women whose ability to hold professional positions themselves contradicts their expressed opinions. According to a 1932 monograph entitled The Psychological Effects of Menstruation by Freudian psychoanalyst Mary Chadwick, a woman experienced menarche as castration and was "unbalanced" and "unreliable" during her menstrual periods ever after. She was seen as likely to blame her mother for her state and seek revenge; she was liable to be envious of her father. Chadwick asserted that a woman experiencing menstrual symptoms actually wanted to be a man, her symptoms reflecting:

that she is not the man she wishes to be, the disappointment over sex reaching a climax each month at the same time, a few days before, during or after the actual period of the flow.<sup>19</sup>

Generally, in the eyes of the new experts, menstruation and other aspects of female reproductive biology, remained "physical diseases and intellectual liabilities."<sup>20</sup>

## MEDICAL SCIENCE

In the 1920s, the fields of obstetrics and gynecology (OB/GYN) became a single medical specialty. Many within the new field believed themselves capable of dealing with all facets of women's lives. In an early volume of the American Journal of Obstetrics and Gynecology, one enthusiast of the merging of the two branches of medicine specifically dealing with women lauded the union as the best approach for the study of woman "in a larger way in all her economic relation to the public weal":

Who is better prepared than the gynecologist and obstetrician to study and promote investigations in relation to woman from the standpoint of the great field of medicine in all that concerns her development, education, fitness for marriage and maternity, her evolution; and also her degeneracies as a criminal, as a pauper, or as a prostitute.<sup>21</sup>

There was considerable tension in OB/GYN caused by the varying styles and ideologies of what had been separate disciplines. The two prominent positions taken were based on the degree of intervention espoused in medical care. This was most evident in the treatment of childbirth. Conservative practitioners deemed many interventions in childbirth faddish, dangerous, and more concerned with doctors' convenience than with health considerations.

One of the rationales given for the interventionist approach was that American women had been weakened and made less fit for reproduction by modern civilization:

The twentieth century woman has by education and environment developed into an extreme type of hypersensitiveness; she is possessed of a nervous system susceptible to impressions and feels pain more acutely; hence, her physical and mental forces are easily depleted.<sup>22</sup>

The same argument had been made in the nineteenth century to support the idea that women belonged in the home.

Women's interest in relieving the pain and reducing the risks associated with childbirth contributed to the climate for the use of new methods by doctors favoring interventions. Sumney and Hurst have suggested that the discourse emphasizing the fears, pains, and risks of childbirth created a context in which "women sought control by detaching themselves from the process."<sup>23</sup>

By the end of the 1930s, OB/GYN was a well established specialty. Today many women continue to rely on gynecologists for the majority of their medical care. The ideology and practice of active intervention has continued to be pre-eminent within the profession, although the debate resurfaces at times. (Some of the common treatments about which there is considerable controversy include Estrogen Replacement Therapy, Caesarian sections, hysterectomies, and mastectomies.)

SEX HORMONES RESEARCH  
AND THE EMERGENCE OF PREMENSTRUAL SYNDROME

In the beginning of the twentieth century, much of the research in sex endocrinology inquired into the measurement of normal and abnormal sexuality. Researchers expected to locate diseases in the sex glands that might explain the cause of menstrual pains as well as behaviors deemed sexually perverse, such as homosexuality. Identifying the specific substances responsible proved very difficult.<sup>24</sup>

Seen as the connection between the genes and sexual characteristics, the sex hormones were the focus of a biology that reduced "dynamic organic processes to a physiological model of the action of hormones."<sup>25</sup> Female and male sex hormones were presumed diametrically opposed. The female sex hormone affected female sex organs, the male sex hormones affected male sex organs. The presence of estrogen in a male would be, by definition, an indication of sexual abnormality, that is, homosexuality or hermaphroditism. Robert T. Frank, who did some of the early work on female sex hormones, was one of those who believed they were exclusive to females, and defined feminine appearance and behavior.<sup>26</sup>

In the late twenties to the mid thirties, most of the key sex hormones--estrogens, androgens, and progesterone--were isolated and characterized. The studies of sex hormones led to an understanding of the role of the pituitary and the ovarian hormones in ovulation, finally correcting the long held erroneous belief that ovulation occurred around the time of menstruation. The discovery of so-called female sex hormones in males, and vice versa, challenged the assumption of the biological paradigm of a clear association between specific hormones and femininity and masculinity.<sup>27</sup> These new findings were considered "very disturbing" to the scientific community.<sup>28</sup>

Diana Long Hall argues that commonly offered explanations for decisions on what is worth studying--such as the comparative ease of studying difference over similarity, and the tendency to focus on what can be more readily analyzed--ignore the sexist bias involved in research. She offers the following indications of sexist bias in the biological research of the twenties: First, the fact that the biological paradigm was used to oppose feminist claims for women's equal rights; second, the assumption that the sexes are opposites, which was the belief underlying biologists' interests in finding the root of the dissimilarity of the sexes; third, the way biologists reacted to the discovery of estrogens in males and other findings raising doubts about the paradigm's assumptions.<sup>29</sup> Writing in the 1970s, Hall observed that the biological paradigm of the 1920s had significantly changed without disappearing altogether: "While its preoccupation with the biological issue of masculinity/femininity has not been abandoned, it has dissolved into a number of technical issues."<sup>30</sup> (The current popularity of biological explanations for human behavior is discussed in Chapter Five.)

Female cyclicity attracted considerable interest from medical researchers in the thirties. Anthropologist Emily Martin found a pattern of studies concluding that menstruation was typically accompanied by negative symptoms that interfered with normal functioning. Martin points out the importance of the context of such research, occurring as it did in the years between the World Wars when women were accused of usurping men's jobs and pressured to leave work.<sup>31</sup> Researchers also began to focus specifically on the premenstrual phase of the menstrual cycle in the 1930s.

With Frank's 1931 paper, "The Hormonal Causes of Premenstrual Tension," concern about menstruation and women's ability to perform wage-earning jobs expanded to include the days preceding menses. Frank is credited with being the first person to characterize and suggest medical treatment for a premenstrual "symptom complex."

Frank believed that the cause of premenstrual tension was "excessive hormonal stimulus":

the continued circulation of an excessive amount of female sex hormones in the blood may in labile persons produce serious symptoms, some cardiovascular, but the most striking definitely psychic and nervous (autonomic).<sup>32</sup>

He described the foremost complaint as "a feeling of indescribable tension from seven to ten days preceding menstruation" which was relieved shortly after the menstrual flow began. The severity of symptoms ranged from "minor" occurrences of "increased fatigability, irritability, lack of concentration and attacks of pain" to "grave systemic disorders" that were incapacitating.<sup>33</sup>

Frank expressed concern not only for individual women's personal suffering as a result of mental and physical tension, but also for the effect on others due to "many reckless and sometime reprehensible actions" of women that "lead occasionally to extreme unhappiness and family discord."<sup>34</sup> Women who behave in this way then "feel conscience stricken toward their husbands and families, knowing well that they are unbearable in their attitude and reactions."<sup>35</sup> Readers familiar with the contemporary literature of PMS will recognize the description of a woman patient as "unbearable, shrew," or as having a "husband to be pitied."<sup>36</sup>

The treatment prescribed by Frank was roentgen therapy, or x-rays of the ovaries, which he said worked to "tone down the ovarian activity";<sup>37</sup> in some cases, a "sterilizing dose" was given.<sup>38</sup> He noted that roentgen therapy had the disadvantage of sometimes causing "the severest neurovascular symptoms of the menopause."<sup>39</sup> In milder cases, Frank prescribed diuretics and/or laxatives to promote the excretion of hormones. Fortunately, x-rays are no longer used to treat premenstrual symptoms.



In Israel's 1938 report of his study of 14 women, he called premenstrual tension a "relatively uncommon" syndrome which "may be more frequent than is now suspected." Israel estimated 40% of normal women suffer "unpleasant symptoms" prior to menstruation.<sup>40</sup>

Israel referred to Frank's 1931 study as the first "seemingly plausible explanation of the cause." His own findings "suggested that premenstrual tension is caused, not by an excess of circulating estrogen, but rather by the presence of unantagonized estrogen."<sup>41</sup> He recommended progesterone therapy: "Progestin may correct an actual deficiency by substitutive action or may modify an existing excess of estrogen by favoring its elimination."<sup>42</sup>

The following year in a two part work, psychoanalyst Therese Benedek and Dr. Boris Rubenstein argued that there were clear correlations between "ovarian activity and psychodynamic processes" throughout a woman's menstrual cycle. Because it combined the contemporary medical and psychoanalytic thought in a unique way that influenced research in this field in the decades that followed, I want to explore their work at some length.

In studying nineteen women being treated for neuroses, Rubenstein used vaginal smears and basal body temperature to chart inferred hormonal fluctuations during the menstrual cycle while Benedek analyzed the contents of conversation and reported dreams from therapy sessions to infer the presence of female "instinctual drives." Together, they claimed that they could correlate the hormonal changes with the psychological changes and predict ovulation and menstruation.

The study divided the menstrual cycle into two parts: the preovulative-ovulative phase and the premenstrual-menstrual phase. Analysis of the first half was easier, they said, because of the higher hormone levels during that phase. During the second half of the cycle they found that "the instinctual tendencies which the hormones control are not

clearly manifested in the psychological material."<sup>43</sup> The psychological data was "less charged with energy" and gave the feeling that "the patient had a freer choice of material, and of its elaboration."<sup>44</sup>

Nevertheless, Benedek and Rubenstein claimed that analysis of the psychological material allowed them to distinguish different "premenstrual types," which may occur in the same person over a series of cycles. They said that the diagnosis of these types was not possible by looking at the conscious level of women's "expressed attitudes and symptoms," that is, it required the knowing eye of experts to be discerned.<sup>45</sup>

Benedek and Rubenstein described three types of premenstrual phases, characterized by the levels and relationship between progesterone and estrone. They associated estrone with "the presence of active heterosexual libido" and progesterone with "a passive, receptive instinctual tendency." These correlations were inferred in Part I of their study on the preovulative-ovulative phase and they believed them to have been confirmed in Part II on the premenstrual-menstrual phase.<sup>46</sup> The three types of premenstrual phases were:

Type 1: A decrease in progesterone level accompanied by an increase in estrone. The concomitant conscious emotional state is described as "tense, aggressive and extraverted."

Type 2: The progesterone level is maintained and the estrone level increases. The accompanying state is "fearful, desperate and self-destructive."

Type 3: There is a progressive decrease in levels of both hormones. The conscious emotional state is "lacking aggression, dependent and sad."<sup>47</sup>

Despite their statement about the psychoanalytic evidence being "less charged" premenstrually, Benedek and Rubenstein state several times, in the same article, that the late premenstrual days are apt to be more emotionally tense than any other time within the cycle. Thus they found that lower hormone production premenstrually can result in an emotional state they believed more appropriate to high hormone levels. They offered

three possible answers to the question of why the "complexity and acuteness" of the premenstrual emotional state might not be explicable by looking at hormonal levels alone.

First, Benedek and Rubenstein suggested that present psychological factors influence the endocrine system. They cite as an example their interpretation of one woman's very light menstrual flow as the result of an unconscious desire to be pregnant.<sup>48</sup> They said they were unable to draw any conclusions about the primacy of psychological or hormonal factors from observing this influence.<sup>49</sup>

Second, they hypothesized that premenstrually, some women respond to female hormones distinctively on the basis of past experience:

Many women, who do not show marked or neurotic reactions corresponding to their gonad function during other phases of the cycle, show psychological reactions during the premenstrual phase.<sup>50</sup>

According to this line of thought, women re-experience the "neurotic constellation" from their anxiety about or response to menarche:

Fear of what will happen to one's body often suffices to describe the emotional condition preceding the menstrual flow. Fear of pain, fear of mutilation, fear of birth. . . .<sup>51</sup>

Third, the authors stated that there is also a sociological contribution to the interaction of psychological and biological factors: "Sociological factors are extremely important in the adaptation to the biological task of women."<sup>52</sup> *How* this interaction might work was not addressed in the article.

The Benedek and Rubenstein study was influential for many years. The belief that women's emotions directly result from hormonal changes still has wide currency as does the idea that sociological, psychological, and biological factors interact in complex ways in the experience of the menstrual cycle. As a statement of the times in which it was written, this article represents the fascination with the power of sex hormones and the desire to

account for the "mysterious" feminine psyche in rational terms. Later researchers would continue to develop methods of categorizing types of women and types of negative premenstrual experiences.

## SUMMARY

As we saw in the last chapter, 19th century scientific research about the female reproductive system took place in the context of feminist activism and considerable debate about women's proper place in society. During the time period covered by this chapter, the menstrual cycle became the object of increasing attention from the scientific and the business communities. Again, political and economic interests were important factors in the social climate in which menstruation was discussed.

The 1920s and 1930s were a time of little real economic gain for women. Between World Wars I and II, women were again depicted as belonging in the home. It was only acceptable for them to work for "pin money" before marriage, or to contribute to the family income without supplanting the man's role. Feminist concerns were largely co-opted by an enticing vision of individual liberation through happy consumerism.

Menstruation was viewed as debilitating, making women unreliable in the workplace and disruptive in the home. Retailers, psychologists, and doctors all claimed to have the answer. Ads insinuated dangerous effects of menstruation and promoted products to mask those effects and restore germ-free bliss. Freudian analysis of feminine psychology pointed to a lack of adjustment to woman's maternal role as creating premenstrual instability. As the institution of medicine expanded and the profession became more specialized, OB/GYNs offered to take women in hand, for better or for worse.

The new field of sex endocrinology supported the old notion of traditional sex differences, citing opposing sex hormones as their origin. The theme of women as constrained by their biology continued in new terms. Female hormone levels were zeroed in on as the purported cause of a premenstrual tension syndrome. Researchers claimed the ability to trace women's moods to changing hormonal levels in the menstrual cycle.

From Frank's 1931 article on premenstrual tension to the PMS literature of the 1980s, several common features appear in the research: the assumption that the days prior to menstruation are problematic; the clinical definition of this problem as a symptom complex or syndrome; a belief that the female endocrine system and/or maladjusted feminine psychology is the root cause; an expressed concern for negative effects of this syndrome on the economy and the family; and the willingness of some medical practitioners to apply little understood and ineffective therapies to women diagnosed with the premenstrual syndrome. It is still true that, as Israel first stated in 1938, "the treatment of premenstrual tension does not, in the absence of a proved etiology, rest on a solid foundation."<sup>53</sup>

## NOTES

<sup>1</sup> Robert T. Frank, "The Hormonal Causes of PMT," Archives of Neurological Psychiatry 26 (1931): 1053, 1054.

<sup>2</sup> Muller v. Oregon, 208 U.S.412 (1908), cited by Janice Delaney, Mary Jane Lupton, and Emily Toth, The Curse: A Cultural History of Menstruation (New York: E. P. Dutton & Co., Inc., 1976) 52.

<sup>3</sup> Delaney et al., 52.

<sup>4</sup> William H. Chafe, The American Woman: Her Changing Social, Economic, and Political Roles, 1920-1970 (New York: Oxford University Press, 1972) 64; also see Barbara Ehrenreich, The Hearts of Men: American Dreams and the Flight from Commitment (Garden City: Anchor Books, 1984) 7.

<sup>5</sup> Chafe; Carol Hymowitz and Michaela Weissman, A History of Women in America (New York: Bantam Books, 1978).

<sup>6</sup> Rayna Rapp and Ellen Ross, "The 1920's: Feminism, Consumerism, and Political Backlash in the United States," Women in Culture and Politics: A Century of Change, ed. Judith Friedlander, Blanche Wiesen Cook, Alice Kessler-Harris, and Carroll Smith-Rosenberg (Bloomington: Indiana University Press, 1986) 53.

<sup>7</sup> Rapp and Ross, 55.

<sup>8</sup> Howard Gadlin, "Private Lives and Public Order: A Critical View of the History of Intimate Relations in the U.S.," Massachusetts Review 17 (1976): 321. An example of the packaging of freedom is seen in an ad campaign developed by a nephew of Sigmund Freud in 1929, which featured "a parade of ten young women lighting 'torches of freedom' on Fifth Avenue on Easter Sunday as a protest against women's inequality." Their torches were lit cigarettes. Stuart Ewen, Captains of Consciousness:

Advertising and the Social Roots of the Consumer Culture (New York: Mc-Graw Hill Book Company, 1976) 167; see also Rapp and Ross.

<sup>9</sup> Rachel Lynn Palmer and Sarah K. Greenberg, Facts and Frauds in Women's Hygiene: A Medical Guide Against Misleading Claims and Dangerous Products (New York: The Vanguard Press, 1936) 10.

<sup>10</sup> For some examples of these ads, see Marshall McLuhan, The Mechanical Bride: Folklore of Industrial Man, (Boston: Beacon Press, 1951).

<sup>11</sup> Nancy Cott, "Passionlessness: An Interpretation of Victorian Sexual Ideology, 1790-1850," Signs 4 (1978): 219-36.

<sup>12</sup> Nancy Milford, Zelda: A Biography (New York: Harper & Row, 1970); Tillie Olsen, Yonnandio (New York: Delacorte Press, 1974).

<sup>13</sup> Gadlin, 323.

<sup>14</sup> Cited in Barbara Ehrenreich and Deirdre English, For Her Own Good: 150 Years of the Experts' Advice to Women (Garden City: Anchor Books, 1979) 139-40.

<sup>15</sup> According to Paula Caplan, Freud was sufficiently displeased by her criticism of him that he referred to her as "the Danish cow." Paula Caplan, The Myth of Female Masochism (New York: New American Library, 1985) 43.

<sup>16</sup> Elaine Showalter, The Female Malady: Women, Madness, and English Culture, 1830-1980 (New York: Penguin Books, 1987) 19.

<sup>17</sup> Karen Horney, Feminine Psychology, ed. Harold Kelman (New York: W. W. Norton, 1973) 99.

<sup>18</sup> Horney, 106.

<sup>19</sup> Mary Chadwick, The Psychological Effects of Menstruation, Nervous and Mental Disease Monograph Series No. 56 (New York: Nervous and Mental Disease Publishing Company, 1932) 39.



<sup>20</sup> Ehrenreich and English, 140.

<sup>21</sup> G. G. Ward Jr., "Physiology, The Basis of Future Gynecology," American Journal of Obstetrics and Gynecology 3 (1922): 577, cited in Pamela S. Sumney and Marsha Hurst, "Ob/Gyn on the Rise: The Evolution of Professional Ideology in the Twentieth Century--Part I," Women & Health 11.1 (1986): 135.

<sup>22</sup> Clelia Duel Mosher, Women's Physical Freedom (New York: The Women's Press, 1923), cited in Sumney and Hurst, 140.

<sup>23</sup> Sumney and Hurst, 138.

<sup>24</sup> Diana Long Hall, "Biology, Sex Hormones and Sexism in the 1920's," Women and Philosophy: Toward a Theory of Liberation, ed. C. C. Gould and M. W. Wartofsky (New York: G. P. Putnam's, 1976).

<sup>25</sup> Hall, 87. The term "hormone" comes from the Greek "horman" meaning to set in motion. A 1905 article in Lancet said it might be appropriate to call the "chemical messengers" secreted by glands by the name hormones (OED).

<sup>26</sup> Hall; A. S. Parkes, "The Rise of Reproductive Endocrinology, 1926-1940," Journal of Endocrinology 34(3): xx-xxxii.

<sup>27</sup> Hall, 29; Parkes, xx.

<sup>28</sup> Parkes, xxvi.

<sup>29</sup> Hall, 92.

<sup>30</sup> Hall, 91.

<sup>31</sup> Emily Martin, The Woman in the Body: A Cultural Analysis of Reproduction (Boston: Beacon Press, 1987) 117-20.

<sup>32</sup> Frank, 1056.

<sup>33</sup> Frank, 1053.

<sup>34</sup> Frank, 1054, 1056.

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- 53 Israel, 1722.

## CHAPTER FOUR

### THE 1940s - 1960s: FROM ROSIE THE RIVETER TO

### THE FEMININE MYSTIQUE

For countless generations, women have suffered the distressing mental and physical symptoms of premenstrual tension, and its role as a disruptive force in the harmony of the home and community has been well-known. But the economic factor as a problem of decreased productiveness and absenteeism in industry has only gradually, in the past decade or two, come to the fore. Criminologists recently have also pointed out the serious sociologic implications of premenstrual tension in its more severe form as an etiologic factor in crimes of passion and violence <sup>1</sup>

With these thoughts, Joseph Morton opened a "Symposium on Premenstrual Tension" in 1953. With small adjustments in the time estimates given, the same ideas might well have been written thirty years later. This chapter surveys the period of the 1940s through the 1960s, outlining the social and economic climate, influential ideas about women's psychology, the growth of the medical industry, and the research on PMS during the period.

## THE SOCIAL SETTING

Though women had been criticized during the 1930's for attempting to usurp men's jobs, they were actively recruited to take men's positions during WWII. Women's presence in the labor force increased from 25% to 36% in the 1940s, including many more office and factory jobs. Women who had previously done work considered appropriate to their gender in sales, the service industry, and domestic labor often moved into heavy industry and other conventionally male occupations, making better pay and enjoying better working conditions than ever before.<sup>2</sup>

Magazine articles during the war years depicted women on the job, doing men's work as well as or better than men, and improving their figures at the same time, according to pieces like "Waistline by Uncle Sam." Titles indicated that a role reversal was involved: "When Women Wear the Overalls," "Women in Slacks," "Women Man the Machines." "Rosie the Riveter" was a familiar face in ads and on magazine covers.

Popular articles about women's health and hygiene in the early forties discussed how to deal with cramps and making a post-pregnancy comeback. The message was that one's reproductive functions need not affect one's work. For example, Newsweek had an item regarding women in the workplace titled, "Women thrive on it; health of workers," in March 1945.

Most women wanted to keep their jobs and income at the end of the war, in contrast to their intentions at its start to leave work when the men returned.<sup>3</sup> After the war women were laid off in enormous numbers and told that they belonged back in the home. Lay off rates for women were 75% higher than for men.<sup>4</sup>

By the mid to late 1940s, the number of articles in popular periodicals on women's work had declined; what remained often dealt with women's home industries. Throughout the fifties there was a renewed emphasis on the importance of cultivating one's beauty and

the advisability of having one's babies while young. Women were counseled to devote themselves to the arts of homemaking.

Nevertheless, the total number of working women was greater in the 1950s than in the war years and it increased steadily throughout the fifties and sixties. One third of all American women worked in the late 1950s and 40% worked in the mid 1960s. Among African American women the figure was 50% in both decades.<sup>5</sup> Typically, working women were older, married women doing part-time clerical or sales work. Few were career women and in many cities there were shortages in fields like nursing, social work and teaching.<sup>6</sup> Women were a smaller percentage of the professional work force in the sixties than they had been in the forties.

The number of women in college compared with the number of men was less in 1958 than it had been in 1920, and 60% of those women dropped out, often to marry. The average marriage age for women was twenty years old and dropping into the teens.<sup>7</sup> A 1962 Gallup survey found that both young single women and women with adolescent children did not realistically plan for their middle and old age in terms of education and development of job skills.<sup>8</sup>

Once again the ideology of separate spheres supported low paying jobs with little opportunity for advancement for women. In the post-war era, men were viewed as the primary breadwinners--and earned about twice the salary of women--but many women were in fact working to avoid poverty for their families. Helping the family was seen as a legitimate reason for a woman to have a job, working for a sense of personal autonomy or gratification was not. The most important socially defined roles for a woman were wife and mother, with which outside jobs should not be allowed to interfere.

Why the large-scale return to the vision of domestic happiness? Is postwar affluence a sufficient explanation? In Homeward Bound, Elaine Tyler May argues with considerable sense and evidence that the image of a happy family promised "a

psychological fortress that would protect them against themselves."<sup>9</sup> Americans were fearful of external threats in the form of Soviet communism, and internal dangers in the form of decadent liberalism. They hoped that the right kind of home life "would fulfill virtually all its members personal needs through an energized and expressive personal life."<sup>10</sup>

There is evidence that many women did not find these social prescriptions satisfactory. Phyllis Chesler's research on the "female career as a psychiatric patient" found a consistent pattern in the fifties and sixties of greater institutionalization of women than men, a higher incidence of neurosis and psychosis in women than in men, and more frequent reporting of "worry, fear of breakdown, and need for help" by women than by men.<sup>11</sup> Doctors prescribed tranquilizers and stimulants to many unhappy housewives.

#### Popular psychology

gave women and men a vocabulary with which to tame and manage their frustrations. Many of life's traumas could be categorized in psychological terms and, to some extent, then explained away.<sup>12</sup>

Psychological advice functioned very differently for men and women. The stress men experienced was seen as caused by the pressures of work. The home was supposed to fulfill a man's need for soothing comfort. But for women to experience stress in the home or in relationship with their husbands was a pathological lack of adjustment requiring professional help:

In other words, although psychology provided an explanation for men's woes and the home offered a cure, the home was often the source of women's stress and psychology offered the cure.<sup>13</sup>

In the early sixties, the attention of popular media turned to the issue of the unhappiness of American housewives. Although the subject received tremendous exposure, serious analysis and effective solutions did not emerge from newspapers,

magazines, radio, or television. In The Feminine Mystique, Betty Friedan profiled the tenor of articles and shows in the broadcast media about unhappy, middle-class White women who kept house. Sometimes too much education was singled out as a contributing factor, sometimes arguments were made for new programs helping women to adjust to the life of homemaking. Magazines churned out articles on making family life and marital sex more fulfilling.

The bottom line seemed to be that there really were no social issues to be resolved: women must simply accept the requirements of their naturally ordained role. A March 7, 1960 Newsweek issue made this point and added that American housewives were failing to make a proper show of gratitude for their good fortune:

From the beginning of time, the female cycle has defined and confined woman's role. As Freud was credited with saying: "Anatomy is destiny." Though no group of women has ever pushed these natural restrictions as far as the American wife, it seems that she still cannot accept them with good grace.<sup>14</sup>

One of the safe outlets for women's discontent with suburban family life was the new genre of humorous books about the trials and tribulations of the housewife. Jean Kerr's Please Don't Eat the Daisies is a popular example from the 1950s.<sup>15</sup> Erma Bombeck continues writing this extremely marketable brand of literature today.

Poet and essayist Adrienne Rich's work during the same period offered a more trenchant picture of the shattered illusions of the woman of the fifties, and looked forward to the new woman to come. Here is the opening of her poem "Snapshots of a Daughter-in-Law," written in 1958-60:

You, once a belle in Shreveport,  
with henna-colored hair, skin like a peachbud,  
still have your dresses copied from that time,

and play a Chopin prelude  
called by Cortot: "*Delicious recollections  
float like perfume through the memory.*"

Your mind now, moldering like wedding-cake,  
heavy with useless experience, rich  
with suspicion, rumor, fantasy,  
crumbling to pieces under the knife-edge  
of mere fact. In the prime of your life.  
Nervy, glowering, your daughter  
wipes the teaspoons, grows another way.<sup>16</sup>

The 1960s was an era of tremendous political activism and significant challenges were made to the visions of domestic tranquility in the nation and the home. The steadfast institutions of American culture were radically critiqued by groups including African Americans, students, the New Left, and women. Youth became the largest group in the U. S. population in the sixties; 25% of those between the ages of twenty-one and twenty-four years of age were in college and college campuses became sites of political activism.<sup>17</sup>

In 1961, approximately 50,000 White, middle-class, housewives decided it was time that "Women Strike for Peace." Around 1964, a growing number of women activists began overtly expressing anger about their second class status in civil rights and antiwar groups. In 1966, Betty Friedan founded the National Organization for Women (N.O.W.). By 1970, groups of women were fighting to challenge existing gender politics and had organized approximately fifty Women's Liberation groups in New York City alone, thirty-five in the San Francisco Bay Area and many others around the country.<sup>18</sup>



Although Friedan's book about the "schizophrenic split" between the real experience of women's lives and the popular image they attempted to match--the "feminine mystique"--was the most famous analysis of suburban miseries, other American critics of the plight of women are worth mentioning. Alice Rossi's 1964 article "Equality Between the Sexes: An Immodest Proposal," pointed out that for the first time in history, motherhood was deemed a full-time, lifetime job:

It is a paradox of our social history that motherhood has become a full-time occupation in precisely the era when objectively it could, and perhaps should, be a part-time occupation for a short phase of a woman's life span. I suspect that the things women do for and with their children have been needlessly elaborated to make motherhood a full-time job.<sup>19</sup>

Rossi felt that women had deceived themselves into believing that life within a single family household would be a sufficiently satisfying one but it had not resulted in any improvement in the quality of life for women or children.<sup>20</sup> Also in 1964, Ellen and Kenneth Keniston wrote that "The most effective forms of oppression are those with which the victim covertly cooperates." Without positive role models in alternative livelihoods, they explained, women internalized the socially sanctioned feminine role and tolerated "voluntary servitude" rather than face societal condemnation.<sup>21</sup>

The ideal of the married suburban housewife came under attack from other directions as well. Although feminism is frequently blamed for the changes in the institution of the family often described as the downfall of the family, Barbara Ehrenreich has cited examples from "Beat" literature and the philosophy of Playboy magazine to persuasively argue that a "male revolt" against the breadwinner ideal was underway well before the second wave of American feminism had begun.<sup>22</sup> Ken Kesey's One Flew Over the Cuckoo's Nest (1962) and Norman Mailer's An American Dream (1966) are examples of two well-known novels from the sixties in which women characters represented a

confining, emasculating society that was oppressive to "real" men. According to these authors, marriage was a female plot.

## PSYCHOLOGY

Psychological explanations for human behavior were very popular in the three decades of the forties, fifties, and sixties. Reproduction was assumed to be the controlling power in the female psyche. Premenstrual tension was referred to as one of the psychosomatic disorders of women, common in the "immature, dependent personality."<sup>23</sup> One gynecologist wrote that two groups of women, those in the upper class and those urged by women leaders into an unnatural "pseudomale life," were especially prone to psychopathology due to conflicts between maternal instinct and fear of pregnancy.<sup>24</sup>

Freudian psychoanalyst Helene Deutsch was also concerned about women becoming too masculine. In her 1944 book The Psychology of Women, she declared that the core of the feminine psyche was narcissism, passivity, and masochism, and the central feminine role was mother, servant of the species. Unfortunately, sometimes "social pressure compelled women to assume 'masculine' functions;" this masculinity complex of active women stemmed from failure to exorcise the ghost of the female organ trauma, penis envy.<sup>25</sup>

For Deutsch, menarche represented the culmination of the development of feminine psychology and physiology. She saw menstruation as "one of the most interesting of psychosomatic problems" due to the "intermingling of biologic hormonal events and psychologic reactions."<sup>26</sup> Deutsch believed that many women stayed in bed needlessly during their periods, especially upper class women who had been overindulged during adolescence. However, she believed that the true purpose of women who attempted to hide during their menstrual periods was

the desire of these women to flee from the reactions of their environment (taboos) and from their own intensified aggressions and sexual dangers, their intensified readiness to enter into conflicts with others, etc.<sup>27</sup>

Deutsch saw aggression and depression as common features of menstruation. When experienced prior to menstruation she saw them as a disappointed reaction to an early recognition of not being pregnant. Like Benedek and Rubenstein in 1939, she hypothesized that there were psychological reverberations from prior experiences in each menstrual cycle:

In the course of the menstrual cycle the premenstrual bodily sensations are repeated over and over again. This experience teaches women to be sensitive to the preliminary stages of the organic processes. Here the parallelism between the biologic process and the psychologic reactions may express an inner perception originating in experience.<sup>28</sup>

Women who experienced a sense of relief when their period actually began had relived the "prepuberty expectation that something terrible is about to happen to them" and were consoled by the appearance of this ordinary function.<sup>29</sup> Deutsch believed that people tended to resist the notion of physiology affecting psychology but she remarked that the view that "psychological factors can express themselves in various menstrual disturbances" was gaining in popular acceptance.<sup>30</sup>

Critiques of sexist bias in psychoanalytic theory and practice, such as those by Karen Horney and Viola Klein,<sup>31</sup> came out amid the widespread popularizing--often with great distortion--of Freud's ideas. A particularly sexist example of this literature for mass consumption was Modern Woman: The Lost Sex by journalist Ferdinand Lundberg and psychiatrist Marynia Farnham, which came out in a popular paperback version in 1947. Lundberg and Farnham saw modern life and especially the feminist response to it as the cause of female neuroticism. Feminism was a "deep illness" of women suffering from penis envy and guilty of "deep desires to engage in lecherous and sensual activities." To halt the dangerous influence of the "masculine woman," programs encouraging

childbearing and domesticity were needed as was psychiatric treatment, especially for unmarried women and men past the usual marrying age.<sup>32</sup>

If unmarried women were viewed with suspicion, mothers did not escape disapproving scrutiny: if they worked they might be guilty of maternal deprivation, if they devoted themselves to child raising, they might be suffocatingly overprotective. As mid-century ideas about child rearing focused on pathology, women lost their presumed expertise in mothering to new experts.<sup>33</sup>

Philip Wylie's bestselling Generation of Vipers which came out in 1942, depicted the American "Mom" as an insidious incarnation of fascism.<sup>34</sup> John Bowlby's 1951 WHO report, Maternal Care and Mental Health, seemed to equate the idea of a mother holding a full-time job with a parent's death or imprisonment in terms of its negative implications for the quality of family life.<sup>35</sup> Maternal deprivation was considered to cause "conditions as diverse as mental subnormality, delinquency, depression, dwarfism, acute distress and affectionless psychopathy." The concept developed an enormous reputation and was the focus of many studies of human and animal infants.<sup>36</sup>

Women did not fare much better in the work of Erik Erikson in the 1950s and 1960s. In Childhood and Society, Erikson used the term "Mom" in Wylie's sense to describe a woman for whom "remnants of infantility join advanced senility to crowd out the middle range of mature womanhood, which thus becomes self-absorbed and stagnant."<sup>37</sup> Building on Deutsch's ideas but avoiding terms like masochism and penis envy, Erikson offered a new elaboration on the theme of the "fully feminine woman" in his 1964 article, "Womanhood and the Inner Space." He theorized that an important distinction between female and male may be seen in terms of female "inner space" versus male "outer space." A woman's femininity was based on her "sense of vital inner potential." When that inner space was "full," a woman was literally fulfilled. Conversely,

Emptiness is the female form of perdition. . . . To be left, for her, means to be left empty, to be drained of the blood of the body, the warmth of the heart, the sap of life. . . . Such hurt can be re-experienced in each menstruation; it is a crying to heaven in the mourning over a child; and it becomes a permanent scar in the menopause."<sup>38</sup>

Similarly, Wolfgang Lederer, in The Fear of Women, wrote that women seek "fulfillment" rather than freedom. They require the presence and protection of a man, one "strong enough to let her know that she is the magic vessel whence all his deepest satisfactions and most basic energies must flow."<sup>39</sup>

Several male authors suggested that fear and loathing of menstruation was inappropriate. Menstruation, the mystery of blood flowing from the "magic vessel," was something men should admire and not fear, according to Lederer. H. R. Hays challenged menstrual myths and taboos in his 1964 book, The Dangerous Sex: The Myth of Feminine Evil.<sup>40</sup> Other books written in the sixties explored cultural rituals that represented male envy and emulation of the female reproductive role in general, menstruation in particular.<sup>41</sup> Although male writers like Erikson, Lederer, Hays, and Bettelheim in the sixties attempted to look behind traditional stereotypes and fears of women, they did not substantially critique the biases of their professions. That would come when women in the seventies and eighties began performing radical surgery on the biases and assumptions underlying social and physical science.

Finally, the results of a 1962 psychological study of the factors involved in the experience and labeling of emotional states are included here because the study influenced the thinking of some of the most interesting researchers of PMS in the 1980s. Schachter and Singer were interested in the question of what specific internal or external cues allow a person to identify and label his or her emotional state. They proposed that the process is one in which cognitive factors interact with "a state of physiological arousal" and tested

three related hypotheses. First, when individuals have no ready explanation for a state of physiological arousal, they will describe their feelings "in terms of the cognitions available" to them. Schachter and Singer hypothesized that "precisely the same state" might be given very different emotional labels "depending on the cognitive aspects of the situation." Second, when individuals have entirely reasonable explanations for states of physiological arousal at hand, they will experience no need to consider any alternative cognitions. Third, under the same cognitive circumstances, individuals will have an emotional response only to the extent that they experience a state of physiological arousal.

The experiment consisted of injecting subjects with either epinephrine (an adrenal hormone that produces arousal) or a placebo, with one of three sets of interpretive information. Some were informed that the injection would produce side effects such as sweating and increased heart rate; some were misinformed that the injection would cause other side effects such as itching or headache; some were given no information on what to expect. Next, the subjects were placed in contexts designed to produce euphoria or anger. As Schachter and Singer had predicted, the appropriate emotions were only displayed and reported in the presence of both a state of physiological arousal and a salient emotional label. Informed subjects injected with epinephrine interpreted their response as due to the injection. Subjects injected with the placebo did not experience emotion despite the contexts in which they were placed. And those subjects injected with epinephrine who were either uninformed or misinformed about its effects experienced the emotion appropriate to the contexts in which they were placed. The authors conclude that "Cognitive factors appear to be indispensable elements in any formulation of emotion."<sup>42</sup> The import of these findings was not evident in the research on PMS until twenty years later.<sup>43</sup>

## MEDICAL SCIENCE

Demographic changes in the postwar years, such as the dramatic upswing in the birthrate and rapid economic growth, supported the expansion of Obstetrics and Gynecology (OB/GYN) as an increasing percentage of the population could afford to be cared for by specialists.<sup>44</sup> As discussed in the last chapter, OB/GYN had firmly established itself in the twenties and thirties. In the forties and fifties, gynecologists continued to take the stand that they were capable of--and should be seen as responsible for--caring for many aspects of women's lives:

The obstetrician saw his role as guiding women's work and family roles, analyzing her psychological problems, training her for her primary reproductive roles, and treating the physiological and psychosomatic illnesses of her reproductive tract.<sup>45</sup>

Connections were made between the reproductive health of women and the health of the nation; many social problems were described as a result of the former. The authors of a 1962 monograph, argued that the statistics on infertility, illegitimate children, abortions, and divorces were all tied to the "state of ill health in the reproductive functioning of the women of our nation."<sup>46</sup>

An article entitled "The Psychologic and Family Impact of the Diseases Peculiar to Women" focused on the specific impact of women' health on the family unit. Two previously mentioned themes appear in this article: mother blaming and inadequate adjustment to the gender role. Its author offered a compendium of the potential negative effects of diseases such as PMS on children and husbands:

the children deprived of their mother, a husband deprived of his mate and sex partner, the household deprived of its home-maker, and financial burdens imposed by depriving the family of its income-producer if the



patient is gainfully employed, the cost of medical care, and the cost of a replacement (maid, cook, nurse).<sup>47</sup>

The author estimated that most gynecology patients have no organic disease and suggested that some women have a tendency to assume the sick role despite the burdens and "danger" it causes the family.<sup>48</sup> He recommended training aimed at orienting young women to their feminine role as a means of avoiding such problems.<sup>49</sup>

Overall medical science became increasingly specialized, moving away from gross anatomy, nutrition, and organ systems and toward a molecular level of analysis.<sup>50</sup> There were--and are--substantial financial benefits in specialization. In the fifties and sixties the number of people working in medicine grew from 1.2 million to 3.9 million. Health care expenditures increased from \$12.7 billion to \$71.6 billion a year. Medical care became one of the country's biggest industries and between 1945 and 1969, physician's rates rose 3.8% each year, their annual incomes 5.9% each year. For the sake of comparison, consider that during the same time period, the consumer price index rose 2.8% yearly.<sup>51</sup>

With a decline in the birth rate starting in the mid sixties, and the longer term decline in infectious disease, there were changes in the kinds of health issues with which people were concerned. Chronic illnesses like obesity, "on which only an affluent society can afford to dwell" became the focus of medical attention and "re-engaged medicine intimately in questions of social behavior and moral choice."<sup>52</sup>

## MENSTRUAL CYCLE RESEARCH

Much of the menstrual cycle research of the 1940s supported a view that menstruation need not serve as an obstacle to women's gainful employment. Georgene Seward described menstruation as enervating in 1934; ten years later she stated that it had no impact on women's task performance. In 1944, Seward wrote that women too often used menses as a form of "socially acceptable malingering."<sup>53</sup> She offered as evidence statistics showing a drop in menstruation-related absenteeism after compensation for menstrual leave was rescinded.<sup>54</sup>

There was a steady trickle of articles on premenstrual tension in the medical journals during the 1940s, though few of them came to public attention. One that did was an article in the Journal of the American Medical Association by Charles Freed which was summarized in Newsweek in April 1945 under the title of "Eve's Accursed Hormones." Newsweek's synopsis included an estimate that premenstrual tension affected 40% of women sufficiently to make it responsible for lessened efficiency in business, greater social and marital discord, and ultimately, significant economic losses. Freed's treatment for premenstrual tension was testosterone therapy, apparently reflecting an analysis that if female hormones were the problem, male hormones were the solution.

An article that should have received more attention was a 1942 study by J. Gillman. Gillman found that an injection of progesterone during the follicular phase induced some premenstrual symptoms in the 14 women he studied. He therefore critiqued Israel's progesterone deficiency theory, saying it provided an insufficient basis for continuing to treat premenstrual tension with progesterone.<sup>55</sup>

By the 1950s, hormones were repeatedly cited as the source and solution for women's nervous tension problems. A woman might be "hysterical" but a vague hysteria of the womb was no longer the culprit, cycling hormones were. Hormone therapy offered

a "Promise for Happiness," the title of a 1954 article in Woman's Home claimed. In the 1960s, there was "New Help for the Monthly Blues" in Ladies Home Journal and "Advice for Women who are Once a Month Witches" in Redbook. These titles are representative of the media messages routinely repeated from the 1950s through the 1980s: female hormonal cycles are depicted as creating emotional instability; correcting hormone levels or ratios is the proposed solution to restoring domestic equanimity.

In 1953, the International Record of Medicine published a symposium on premenstrual tension (PMT) with articles on its history, etiology, psychiatric aspects, economic and legal implications, and treatment. The contributors viewed PMT as a common female malady, affecting approximately one-half of all women during the two weeks between ovulation and menstruation. The stated goal of the symposium was to "establish the syndrome of premenstrual tension as a clinical entity" and elucidate its cause and treatment.

A number of themes common in PMS research from the 1930s to the present appear in this collection of articles. The lead-in editorial by Joseph Morton referred to "countless generations" of women suffering from a "not yet fully understood" disorder that was a "disruptive force" in homes and communities, lessening economic productivity and boosting criminal behavior in women.<sup>56</sup> Morton and other contributors asserted the interrelationship of physiology and psychology, specifically the endocrine glands and emotional disturbances. In a separate article on treatment for PMT, Morton summarized the therapies that had been applied thus far and pointed out that, as more recent researchers have continued to do, nearly every hormone to reach the market has been tried as a cure:

Practically every commercially available hormone has been used by the various investigators and for almost every report indicating the value of a certain hormone another could be found decrying its use.<sup>57</sup>

One of the constants in the history of research into a premenstrual syndrome is the striking description of symptoms employed. Writers frequently create vivid images to support the argument that this syndrome explains widespread social attitudes toward women as being unable to make up their minds, overly emotional, and unreliable. In this symposium, S. Leon Israel best exemplifies the use of dramatic language to portray suffering from premenstrual symptoms.

According to Israel, awareness of the approach of menses may have a variety of "tormenting accompaniments," including a "foreboding sensation of impending insecurity;" "manic activity" that "beggars description;" an increase in thirst and appetite that causes "wonderment;" "spectacular alteration of personality;" "hairtrigger temper;" "recurrent frenzy of catatonic-like depression."<sup>58</sup> The premenstrual phase is sometimes "dramatized by nymphomania." Furthermore, the fact that the premenstrual phase of the cycle is a regularly repeated event lends an added pressure: "The monotonous periodicity of the syndrome evokes the additional distress of fearful expectancy."<sup>59</sup> Reading such descriptions, a naive reader might question how women function at all during that perilous portion of every month.

The symposium included an article on the relationship of PMT to crimes by women, a theme of continuing importance in the field of research with serious potential consequences for all women. Author Howard Oleck, a New York lawyer and law professor, counseled that ancient law as expressed in the Bible represented an "instinctive, pragmatic wisdom" about the menstrual cycle, which he felt was lacking in his own day:

The Bible spoke of women's time of "uncleanness" and showed a glimpse of penetrating perception in classifying menstrual phenomena as a kind of "sickness." Almost startling in its modern sound is the prophet Jeremiah's analogy in his Lamentations between the desolate, chaotic melancholy of

his era and the condition of a "menstruous woman." And Ezekiel warned that men should not "come near to a menstruous woman."<sup>60</sup>

Biblical references, quotes from ancient physicians, and psychohistorical guesses about notorious women of the past are all examples of the genetic fallacies appearing in PMS literature. Universalizing the notion of menstruation as an illness that makes women dangerous to men and society as a whole is probably the most slanderous form of misogynist thought in this literature.

Oleck regarded PMT as a large and important legal problem in 1953 and argued that there was a pressing need to establish the legal framework for a PMT defense: "The courts will be faced with this problem very soon."<sup>61</sup> PMT should be treated in the legal arena as a form of insanity, a temporary insanity, according to Oleck. A PMT defense should follow the same rules of evidence as for insanity, using a woman's medical history and medical examinations as proof. For example, the notion of "irresistible impulse" allowed in Federal courts would be appropriate to PMT, in his opinion. Acquittal on these grounds should not mean a woman's release; evidence that a cure had been effected would be necessary, perhaps requiring her institutionalization in the mean time.

Finally, one contributor to the symposium wrote from a psychiatric point of view. Edward Suarez-Murias judged that the psychological symptoms of PMT were related to how a woman psychically accepted menstruation and how, on an unconscious level, she used menstruation to express her dissatisfactions with troubling circumstances in her life or her feelings about being a woman. He correlated a woman's overall emotional makeup and level of emotional maturity with whether or not she perceived specific stimuli as disturbing:

the difference between having or not having certain stimuli qualified as noxious, distressing, or alarming greatly depends on the adaptive capacity of the organism of the patient and on her attitude towards the stimulus.<sup>62</sup>

Suarez-Murias took issue with Benedek and Rubenstein's assertion that they were able to pinpoint correlations between hormone levels and instinctual female drives. He also differed with them in believing that women's conscious as well as unconscious associations were important to understanding premenstrual tension:

At most, it may be accepted that changes in attitude and behavior can be correlated to the proliferative and the secretory phases of the cycle, also to some degree to the ovulatory and to the menstrual periods, but beyond that it seems speculative and unwarranted to establish correlations. It is more important to understand the broad psychologic aspects of premenstrual tension in terms of the meaning of the reproductive apparatus specifically and of femininity in general to the psyche of the woman, both consciously and unconsciously. Even taken in this broad manner the problem is still complex.<sup>63</sup>

Later studies, primarily in the 1970s and 1980s, used social cognition theory to more actively explore the role of beliefs in the experience of PMS.<sup>64</sup>

Two other 1953 articles that appeared in the British Medical Journal are worth mentioning here. Psychiatrist Linford Rees believed the cause of premenstrual tension was mostly physiological--"hydration, blood chemistry changes, autonomic nervous system responses"--but emphasized that it was "of complex causation in which personality and constitutional and emotional factors operate in addition to the primary physiogenic changes."<sup>65</sup> Severino and Moline suggest that Rees' explanation of multiple causative factors may represent "the first biopsychosocial model for viewing PMS."<sup>66</sup>

Although he thought that treatment with progestogens or androgens was most productive, Rees suggested an "important but limited role" for psychotherapy in the treatment of premenstrual tension. Basically, it would be a "simple kind" of educational effort that could "help the patient in understanding the condition and can improve her

attitude and reaction to it." Rees thought that psychotherapy would be particularly useful in treating two types of women.

First, it would help the "tense, anxious, striving, obsessional type of woman" who is intensely bothered by the negative impact of premenstrual symptoms on her overall state. She was likely to stay at her normal level of activity despite the symptoms, thereby worsening them. Teaching this woman about the syndrome and its cause while advising her to adapt her activities in line with her premenstrual symptoms would be useful, according to Rees.

Second, counseling should be provided for the type of woman who was "hypochondriacal or very dependent" and might "allow the premenstrual tension state to interfere unnecessarily with her work and social activities." In this case, the same kind of explanation of the syndrome would be given, this time intended to produce "a more salutary attitude to her symptoms."

Rees believed that suggestion played no role in symptom development for two reasons: 1) he found that the majority of patients weren't aware of the connection between the symptoms and the menstrual cycle and 2) he claimed that there were no significant placebo effects. Research since the 1970s has come to very different conclusions about placebo effects and PMS.<sup>67</sup>

An article by physicians Katharina and Raymond Greene, that also appeared in the British Medical Journal in 1953, was the first of many articles by Dalton, who has been one of the most influential of all researchers in this field.<sup>68</sup> Dalton and Greene suggested that "premenstrual syndrome" would be an improvement over premenstrual tension since tension was only a single manifestation--and not necessarily the most significant--of what may be numerous symptoms of the syndrome. They also felt that another label, better than "PMS," would likely emerge when there was a fuller understanding of the syndrome's

cause; however, there is still little agreement about PMS and the term PMS has prevailed in the medical and popular literature.

Dalton and Greene hypothesized that the cause of the syndrome was a disturbed ratio of estradiol (a form of estrogen) and progesterone, which led to greater retention of water in the tissues and most of the resulting symptoms. Their own prescription, which they claimed was "almost invariably effective," was progestogen therapy.

According to Dalton and Greene, PMS "is the commonest of the minor endocrine disorders."<sup>69</sup> They believed that women generally accepted one week of suffering each month without protesting to their physicians "but not necessarily without disturbing the tranquility of their homes."<sup>70</sup> Thus once a month, otherwise tranquil homes were disrupted by women suffering various levels of distress. Homes were only one of the social arenas affected by premenstrual women; Dalton and Greene also cited studies showing a negative impact on American factories and an increase in violent crime by women. These subjects would continue to be prominent interests of Dr. Dalton's.



## PMS RESEARCH IN THE SIXTIES

One of the recurring themes in PMS research is the idea that cyclical changes trigger innate drives and/or revive earlier emotional responses.<sup>71</sup> In 1961, psychoanalyst Natalie Shainess found that many of the 103 women she studied experienced strong desires for love and feelings of anxiety, helplessness, and hostility during the premenstrual phase. Shainess believed that menarche contained "a summation of all the feminine feelings and attitudes up to that point"<sup>72</sup> and that "unpleasant, humiliating, or unloving" experiences with one's mother at menarche were the origin of premenstrual symptoms.<sup>73</sup>

... at a time when the body physiologically recapitulates the experience of menarche, there is a compulsive repetition of the emotional climate of the experience--especially in relation to the mother--and there exist intensified feelings relating to the self, particularly regarding femininity.<sup>74</sup>

Shainess found that the women who did not report premenstrual tension (13%) had been prepared in advance for menstruation and had mothers who responded positively to their menarche. Research examining the possible roles of preparation for menstruation and the response to menarche in the etiology of PMS continued in the seventies.

Three very influential works on PMS were published in the late 1960s. Psychologists Ivey and Bardwick published their study of effects of the menstrual cycle on moods in 1968. Like Benedek and Rubenstein in their 1939 study, Ivey and Bardwick were interested in correlations between the hormonal and emotional changes during the menstrual cycle.<sup>75</sup>

Interviewing twenty-six college women around the time of ovulation and again prior to menstruation in two consecutive cycles, Ivey and Bardwick found evidence of more positive thinking at ovulation and more pessimistic thinking prior to menstruation. Premenstrually, twenty-one of the women had higher anxiety scores--for death, mutilation,

separation, guilt, shame, and diffuse anxiety--than they had around ovulation time. Of the other five, one subject had scores which were extremely similar during ovulation and premenstrually. Another three "expressed more than the usual anxiety over some environmental factor at the time of the ovulation test sessions," voicing concerns that "ranged from the attempted suicide of a friend to the prospect of facing a great deal of make-up school work due to illness."<sup>76</sup> Overall, the pattern was a consistent one:

As psychologists we would expect to find strong individual differences in reaction during the menstrual cycle. Instead, in almost all of our subjects, we found the consistent and significant mood swings characteristic of a particular menstrual cycle phase."<sup>77</sup>

The authors also found "consistent themes of hostility and depression as well as themes of noncoping during the premenstrual phase."<sup>78</sup> They suggested that the theme of inability to cope "may be similar to Benedek's description of active striving at ovulation versus passive reception at premenstruation."<sup>79</sup>

Ivey and Bardwick concluded that "the menstrual cycle exercises gross influences on female behavior:"

That females may cope or not cope, test anxious, hostile, or depressive, appear healthy or neurotic on psychological tests, is due as much to menstrual cycle phase as to core psychological characteristics.<sup>80</sup>

Unless they were able to measure "core psychological characteristics" and compare them with clearly defined cycle phase changes--capabilities not in evidence in this article--it would have been impossible to support such a judgment.

The Menstrual Distress Questionnaire (MDQ) developed by Rudolf Moos in 1968 has since been utilized by many other researchers. Moos had reviewed the studies done on the menstrual cycle from the 1930s to 1950s and found that many different methods had been used by researchers. Therefore, different results in menstrual cycle studies might be

attributable to the techniques used in gathering the data.<sup>81</sup> Moos concluded that there was a need for a standardized method of collecting information on menstrual cycle symptoms.

The MDQ has eight categories with a total of forty-seven symptoms compiled from various sources. The eight categories are pain, concentration, behavioral change, autonomic reactions, water retention, negative affect, arousal, and control. The group of symptoms under arousal stands out because, unlike all the others, they would typically be considered positive feelings, for example, "affectionate," "feelings of well-being," and "bursts of energy, activity." Moos explained that he had included that grouping because some authors had referred to a correlation between positive feelings such as well-being and excitement and phases of the menstrual cycle, especially the premenstrual phase.<sup>82</sup> However, a check of the single citation Moos offered of such an author, yielded no mention of positive menstrual cycle experiences. The Menstrual Distress Questionnaire's title reflects the assumptions inherent in its content.<sup>83</sup>

A number of British publications by Katharina Dalton during the sixties examined the negative effects of the menstrual cycle. Among other things, she found associations between menstrual cycle phase and low test scores, naughty behavior by schoolgirls, overanxious mothers, accidents, low productivity, and crime. At the close of the decade, Dalton's book The Menstrual Cycle, summarizing many of her findings, was published in New York. The foreword, written by her husband Tom Dalton, conveys a key message of the book:

The old cliché, "it's a woman's privilege to change her mind," calls for an even greater tolerance now that it is realized that every woman is at the mercy of the constantly recurring ebb and flow of her hormones.<sup>84</sup>

Ignoring the remark's paternalism for the moment, its claim that "every" woman is at the "mercy" of hormones is simply a rewriting of the old argument that biology--

especially for women--is destiny. Unfortunately, it is a contention that never seems to lose its appeal. Much of the literature on PMS since 1969 has shared this ideology.

According to Dalton, PMS is an extremely common experience for women that can be exacerbated by stress or good times. In The Menstrual Cycle, Dalton gave a profile of the kind of woman most likely to suffer from PMS. She would have the physical traits of large breasts, dark nipples, lots of hair, and big hips and she would have strong maternal instincts and want a big family. Presumably, this description is derived from her clinical experience.

Dalton explained her belief that the main initiating cause of premenstrual symptoms is insufficient production of progesterone by the ovaries, leading to a chain of reactions including water retention, which is frequently cited both as a symptom and as a cause of other symptoms. Dalton's solution is her own brand of hormone therapy. She described her progesterone treatments as appropriate not only for cases involving premenstrual pain, but also in order to alter patterns for the sake of convenience. "Most people," Dalton said, "would agree to assisting the handicapped."<sup>85</sup>

Based on her own and colleagues' findings, Dalton estimated that over 50% of the women studied, who were in categories such as new prisoners, disorderly prisoners, attempted or completed suicides, employees calling in sick, accident admissions, women requesting a doctor's housecall, and mothers with sick children, were within the paramenstruum at the time, that is, were in the eight day period including four days preceding menstruation and the first four days of menstrual bleeding.

In Dalton's eyes, the menstrual cycle is rife with pathology, with negative symptoms particularly clustered around the time of bleeding, ovulation, and the week to ten days prior to bleeding. She sees the menstrual cycle as causing problems that are important to address not only because of the suffering of individual women but because of harmful effects on husbands, children, schools, business, and society at large.

## SUMMARY

The evolution of the clinical entity known as the premenstrual syndrome or PMS reflects the lasting influence of the cultural ideology of woman's definition by biological function in the U.S. Though research on PMS as a recognized medical phenomenon began in the early thirties, interest in it was slow in the war years of the forties, growing substantially after the war.

Women's social roles underwent significant changes during the decades of the 1940s, 1950s, and 1960s, and medical science influenced the public's perception of what constituted a physically and psychologically healthy woman. During WWII, a healthy, well-adjusted woman was one who served her country ably, was physically strong, and was capable of working hard without losing her femininity or threatening men's livelihoods and social status. After the war, particularly if she was from the middle class, she was expected to return to her responsibilities as wife, child rearer, homemaker, adapting her strength and intelligence to making an art of those activities. Counseling and prescription drugs were appropriate means to facilitate adjustment to her "natural" role.

The new middle class ideal bore little resemblance to economic, social, and political realities. The numbers of women in the wage earning work force continued to grow. Women attempting to realize the image of happy housewife frequently found insufficient satisfaction in that life. Out of personal dissatisfactions, heightened political awareness, and concrete experiences of social activism, women began to organize for their own interests in the 1960s.

The institution of medicine expanded, growing increasingly specialized and profitable during these decades. As demographic markets shifted, chronic illnesses and socially stigmatized behaviors became focal points of medical attention.

Researchers attempted to isolate specific causes of premenstrual distress in feminine psychology, especially feelings about pregnancy, and in physiology, particularly the endocrine system. Researchers hypothesized an interplay of psyche and soma, sometimes viewing psychological stresses as exacerbating physical phenomena, sometimes seeing psychological tension as a response to the sensations of approaching menses that indicated lack of adjustment to the feminine role. Studies such as Ivey and Bardwick's, perpetuating the ideas that women relish the sick role and are inherently unstable, are an accurate barometer of the social perception of women into the 1960s.

Medical research in the forties was in line with the wartime need for working women. The earlier view of menstruation as a drawback to women's efficiency was shelved and little was written about PMS during those years. In the socially conservative fifties, premenstrual syndrome research resumed and picked up momentum. Female hormones were again the most frequently cited physiological culprit and cure; this time word reached women's magazines.

Whatever its theorized cause, PMS was deemed a matter of widespread concern, rather than an affliction of individual women. It was frequently described as having negative repercussions for the family, industry, community. As we have seen in each time period, the cycles of interest in the menstrual cycle as problematic have coincided with periods of medical expansion, conservative ideology, and followed periods where women have made renewed forays into public arenas. The next chapter explores the social milieu of the years in which PMS became a household term.

## NOTES

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## CHAPTER FIVE

### THE 1970s-1990s: FROM LIBERATION TO BACKLASH

Once a month, with monotonous regularity, chaos is inflicted on American homes as premenstrual tension and other menstrual problems recur time and time again with demoralizing repetition.

Katharina Dalton<sup>1</sup>

This quote comes from the introduction to Dalton's Once a Month which was first published in 1979, right before premenstrual syndrome began making headlines that would persist through the next decade. Probably no other name was more closely associated with PMS in the eighties than Dalton's. This was due largely to her advocacy of progesterone therapy, a controversial PMS treatment, and her role as medical expert in two prominent British court cases in which PMS figured. Dalton's newer writings carried the same tone and message they had in the 1950s and 1960s; she continued to disseminate a view of PMS as a calamitous problem "incapacitating" 5.5 million American women and having dire repercussions: "the suffering, unhappiness, and social consequences of it are without limitation."<sup>2</sup> This message was one that appealed to many people in the 1980s, for a variety of reasons.

This chapter covers the period of time from the 1970s to the beginning of the 1990s, focusing on the social circumstances of the era in which PMS emerged as a cultural phenomenon. Included are an investigation of relevant demographics, socioeconomic and cultural trends, and tensions between opposing political movements and their counterparts in the sciences.

## DEMOGRAPHIC AND CULTURAL TRENDS

Chapter One referred to Riessman's argument that market conditions--a declining fertility rate, higher numbers of gynecologists per capita, and a larger number of women in their thirties--were favorable to the construction of a disease like PMS. Did those conditions change after she wrote in 1983?

The fertility rate was around 1.8 per woman throughout most of the 1980s (increasing slightly to 1.9 in 1988<sup>3</sup>), far below what it had been in the late 1940s, 1950s, and 1960s. The number of gynecologists continued to grow. Riessman cited a 1979 total of 25,215 gynecologists; in 1987, the number of gynecologists had risen to 32,300,<sup>4</sup> an increase of 28% in the total number of gynecologists. The number of women from the postwar baby boom who were in their thirties in 1980 was 15.9 million in 1980 and reached 20.5 million in 1988.<sup>5</sup> The conditions Riessman cited as opportune for PMS clearly lasted throughout the decade of the 1980s.

Why are her thirties considered the most prevalent time for a woman to experience PMS? Riessman did not clarify her reference to women in their thirties as "appropriately aged." Common sense points to the notion that women--and--men would tend to become more attuned to common fluctuations in their bodies as they age, recognizing patterns in events that seemed random earlier in their lives.

Dalton suggests that premenstrual symptoms might be magnified in a woman's thirties:

Age and pregnancy are two factors which tend to make the symptoms of the premenstrual syndrome worse and last longer, so it may be first diagnosed in the thirties.

One popular hypothesis, endorsed by Dalton, is that menstrual cramps diminish with age and pregnancy while premenstrual symptoms worsen. Dalton goes on to report a

suggestion made by an American doctor in 1963 that menstrual-related symptoms be known as "mid-thirty syndrome."<sup>6</sup>

O'Brien indicates that no studies have confirmed the commonly stated assumption that PMS occurs most often among women in their thirties who have had one or more children. O'Brien considers the medical and social factors that may produce the higher occurrence figures:

It is probable that PMS occurs throughout reproductive life but is reported more frequently in the third decade. . . . The oral contraceptive pill protects many women from the symptoms of PMS, and when many discontinue therapy in their mid-thirties, opting for barrier methods or sterilization, their PMS is unmasked.

. . . . It may be that the underlying endocrine changes of the cycle remain constant throughout reproductive life, but that the woman's tolerance diminishes as the stress contributory factors outside of PMS increase. These include increased work stress with seniority, increased family stress, and greater scope for intrafamilial conflict as family size increases.<sup>7</sup>

Thus reports of PMS may rise as women stop using oral contraceptives, or, without an actual increase in occurrence of negative symptoms, higher stress levels may lessen women's tolerance for the symptoms.

Another likely factor in increased reporting is the publicizing of PMS. The widespread coverage of PMS in the media offered women a new explanation for their experience and encouraged greater awareness of the publicized symptoms. Afternoon talk shows and popular women's magazines--frequently targeting this age group--provided repeated, largely uncritical coverage of PMS. Whatever the comparative weights of confluent factors for greater reporting of PMS among women in this age group, the



overall market conditions in the 1980s were propitious for PMS in terms of numbers of births, gynecologists per capita, and women in their thirties.

What other demographic changes were evident in the 1970s and 1980s? Summing up the results of the 1980 U.S. Census, Bianchi and Spain state, "Fertility is at a historic low, while women's educational attainment and labor force participation are at an all time high."<sup>8</sup> The number of American women graduating from high school rose from 60.2% in 1960 to 84.5% in 1980. College enrollment figures for the same period increased from 12% of all women 18 to 24 years old in 1960 to 25% in 1981.<sup>9</sup> The number of women enrolled in colleges and universities was greater than the number of men in the 1980s. In the 1987-88 school year, more women than men received bachelor's and master's degrees; men still receive many more doctorates than women in most fields.<sup>10</sup> Women's participation in the labor force continued to grow in the seventies with over one-half of American women in the labor force in 1980.<sup>11</sup> In 1986, that figure was 54%.<sup>12</sup>

There have been some significant shifts in the areas of marriage and divorce. Though 90% of women have married by age thirty--a figure consistent for the last one hundred years--many women now marry at a later age than their mothers. In 1983, the median age for first marriage was 22.8, two and one-half years later than in 1960.<sup>13</sup> More couples live together instead of, or before, getting married; that figure was over three times higher in 1983 than in 1960.<sup>14</sup> The number of divorces climbed steadily in the sixties and seventies, doubling between 1970 and 1980.<sup>15</sup> This has had a significant economic effect; women typically experience a severe drop in their standard of living after divorce. According to Lenore Weitzman, the average woman's standard of living is reduced by 73% the year after a divorce.<sup>16</sup>

Women began heading more and more households at a time when it became much more difficult to support a family on one salary, because "by 1976 only 40 percent of the

jobs in the country paid enough to support a family."<sup>17</sup> Poverty has become a reality for increasing numbers of women:

In 1980 two out of three adults who fit into the federal definition of poverty were women, and more than half the families defined as poor were maintained by single women.<sup>18</sup>

The number of working mothers continues to grow; in the mid 1980s, two-thirds of all women with children had wage earning jobs. In 1986, 68% of women with children aged six to seventeen years, 54% with children under six, and 50% with children under one year of age were in the labor force.<sup>19</sup> How do mothers in the labor force fare compared to women working in the home and men in the labor force?

Studies show that working mothers have higher self-esteem and get less depressed than housewives, but compared to their husbands, they're more tired and get sick more often.<sup>20</sup>

Some aspects of women's lives have undergone very little change in the last twenty years. For instance, the ratio of women's to men's earnings has shown extraordinary stability, with a woman making on average 70% of what a man working full-time makes. And regardless of whether she works or has children, a woman probably handles the burden of a very skewed division of household labor that shows little change in the last few decades.

Reviewing the studies on division of household labor during the 1960s and 1970s, sociologist Arlie Hochschild found the women did an average of fifteen more hours of work a week than the men:

Over a year, they worked an extra month of twenty-four-hour days a year. Over a dozen years, it was an extra year of twenty-four hour days. Most women without children spend much more time than men on housework; with children, they devote more time to both housework and childcare.

Just as there is a wage gap between men and women in the workplace, there is a "leisure gap" between them at home. Most women work one shift at the office or factory and a "second shift" at home.<sup>21</sup>

Averaging the results of three studies from the 1980s reported by Hochschild yields a twenty-hour a week leisure gap between women and men.<sup>22</sup>

To summarize the indicators of women's social status during the last two decades reviewed here, American women, on the average, have been: marrying later; having fewer children; having children later; divorcing more often; experiencing higher rates of poverty; earning more college degrees; entering the wage labor force in higher numbers; earning significantly less than men; and performing significantly more of the household labor than men.

Social institutions in this country have not kept up with most of the changes, which leaves women in increased financial jeopardy, having neither the old reliable refuge of long term marriage nor independent economic viability for themselves and their children. Meanwhile, the kind of marital relationship women increasingly aspire to have is based on more equality; again, the institution is far behind women's needs.<sup>23</sup> Hochschild's research on the "second shift" and a 1990 Virginia Slims Poll indicate that women feel growing resentment about the inequities in household responsibilities. The same poll also found that women generally thought less of men in 1990 than they did in 1970.<sup>24</sup>

Some cultural trends complicated women's and men's lives. Both sexes experienced longer life spans and different stages and transitions within the span. The nature of wage and domestic labor has undergone frequent modifications with the introduction of rapidly changing technologies, which contributes to more frequent job changes and higher standards for household maintenance. Arlene Skolnick believes that such changes are evidence that for the last four decades we have been in the midst of a

major cultural transition with important psychological repercussions for how we view ourselves and each other:

Transitions can be problematic periods in which both individual identities and family relationships have to be redefined and renegotiated. . . . The emergence of a heightened sense of self is a natural by-product of this more complicated life course.<sup>25</sup>

Skolnick uses the phrase "psychological gentrification" to describe the heightened self consciousness and tendency toward introspection that resulted.<sup>26</sup>

One facet of this increased attention to the self, which continues today, was a health and fitness mania. Joggers seemed to be everywhere. What one ate and did to keep fit were prime topics of conversation. Spending on over-the-counter medications and vitamins rose 43% between 1982 and 1988.<sup>27</sup>

Despite the dramatic improvements in North Americans' overall health in the last thirty years, people express growing dissatisfaction with their health. According to an article in the New England Journal of Medicine, contributing factors include: a longer life span, more lingering illnesses, more doctor visits for minor complaints; more time spent focusing on one's body with the thoughts becoming increasingly negative the more preoccupied one is; more attention to subtle symptoms; and an expectation that there are remedies for all discomforts.<sup>28</sup>

New dieting regimens and weight loss clinics proliferated as research turned up evidence of large numbers of anorexic and bulimic young women trying to achieve a cultural ideal of thinness targeted primarily at women.<sup>29</sup> Weight and signs of aging are viewed as conditions to be carefully monitored and controlled.

Personal responsibility for one's health was again accentuated, a popular eighties' slant on psychosomatic medicine. Best selling books like Norman Cousins' Anatomy of an

Illness, and Bernie Siegel's Love, Medicine, and Miracles,<sup>30</sup> stressed the role of attitude in fighting illness, recommending the techniques of laughing and positive visualization.

The changing and static conditions affecting women's lives in particular since the beginning of the 1970s have brought mixed results. (Of course, how large scale changes affect individual and groups of women is dependent to a great degree on their socioeconomic status and ethnicity as well as other specific life circumstances and personal characteristics.) From a feminist perspective, some changes are leading in the positive direction of less social inequality and a wider range of personal options for women. From a conservative point of view, the same changes are perceived as threatening to traditional social structures and damaging to women. The next section examines the influence of feminist and conservative groups within American society pursuing very different ends with regard to women's contemporary status and roles.

## FEMINISM AND THE NEW RIGHT

The women's movement that began in the sixties went in at least two directions in the seventies. Groups like NOW worked along reformist lines, organizing, pressing for women's rights legislation, and filing sex discrimination suits. Other feminists sought the liberation of women from their assigned social role and presented a more radical critique of society.

Significant political reforms were achieved by pressure from women's groups in the late sixties and the seventies. Title VII of the 1964 Civil Rights Bill and the 1967 Executive Order 11246 made sex discrimination by the federal government and its contractors illegal. Groups of women used Title IX legislation to gain entrance into schools receiving federal funding and corporations with federal contracts. They fought unsuccessfully, again, for an Equal Rights Amendment. They made some advances--and continue to work for more substantial gains--on issues such as access to predominantly male jobs, pay equity, day care, maternal leave, equitable insurance practices.

Radical feminists recognized that sexism was reflected in everyday experience and internalized in personal assumptions: that the personal is political. Through the process of consciousness raising, groups of women discovered their shared experience of oppression. Ideally, all women could participate in the women's movement:

The Women's Liberation Movement exists where three or four friends or neighbors decide to meet regularly over coffee and talk about their personal lives. It also exists in the cells of women's jails, on the welfare lines, in the supermarket, the factory, the convent, the farm, the maternity ward, the streetcorner, the old ladies' home, the kitchen, the steno pool, the bed.<sup>31</sup>

One way of recounting the richness of the feminist movement in the 1970s is by recalling some of the seminal books of those years: Sisterhood is Powerful, The Dialectic of Sex, Woman in Sexist Society, Radical Feminism, Beyond God the Father, Against Our Will, Of Woman Born, The Mermaid and the Minotaur, Woman and Nature, Gyn-Ecology.<sup>32</sup> To leaf through these books twenty years later is to rediscover the tremendous urgency, acuity, and momentum of feminist thinkers and activists in those years. Polls are of limited value in measuring public sentiment, still, an interesting indicator of the persuasiveness of the feminist message is seen in the results of Harris polls of 1970 and 1975. Their 1970 poll found 42% of Americans favored attempts to improve the status of women; five years later, 63% said they approved.<sup>33</sup>

Many women's lives have been changed by this women's movement. There are now rape counseling centers, safe houses for battered women, women's presses and bookstores, Women's Studies programs, and many other signs of a feminist consciousness around the country. Fewer women, especially younger women, identify themselves as feminists in the last few years but more women express agreement with feminist goals and values. Despite the very conservative mood of the country in recent years, it is hard to imagine the dissolution of the progressive trends produced by contemporary American feminists.

## BACKLASH: THE POLITICALLY CONSERVATIVE 1980S AND 1990S

There was no sudden leap from a liberal period ending in the seventies to a conservative one beginning in the eighties. The so-called "silent majority" spoke up during the sixties, and Richard Nixon was returned to the presidency in 1968. Conservatives capitalized on negative reactions to anti-establishment politics:

Proponents of the New Right gained strength by calling for militance in foreign policy, opposing the Equal Rights Amendment, and condemning student radicalism, the counterculture, feminism, and the sexual revolution.<sup>34</sup>

In Backlash: The Undeclared War Against American Women, Susan Faludi presents ample evidence of the negative repercussions of the conservative swing on women's rights. Faludi cites both polls and studies that indicate a drop in the percentage of men who supported feminist advances between the 70s and the 80s. According to the 1988 American Male Opinion Index, under one-quarter of the 3000 men surveyed voiced approval of the women's movement; the majority reported that they preferred traditional women's roles. The poll concluded that men tended to support general principles of equal rights but "when the issues change from social justice to personal applications, the consensus crumbles."<sup>35</sup> In 1990, the same index found the percentage of men polled who *opposed* gender roles changes and other feminist goals grew from 48% in 1988 to 60% in 1990. During the same time, the number of men willing to adapt to such changes dropped from 52% to 40%. A 1989 New York Times poll found a minority of men agreed that society had not changed sufficiently to make women equal, while a majority of women agreed. A majority of the men also said that the women's movement "made things harder for men at home."<sup>36</sup>



Faludi notes that there is an important economic element to consider in analyzing the backlash against feminism. Men consistently define masculinity as the ability to provide well for a family, according to 20 years of Yankelovich Monitor surveys. During the economic decline of the 80s, men whose wages provided sole economic support for their families dropped 22%. The number of such men declined to 8% during the same period. The average man under thirty earned 25 - 30% less than he would have in the early 70s.<sup>37</sup> In these circumstances, the appeal of the conservative message that feminism is dangerous is obvious.

Conservatives "determined much of the tenor of the 1980s."<sup>38</sup> Political analyst Sidney Blumenthal argues that "at the heart of conservatism is an intellectual elite, motivated mainly by ideology,"<sup>39</sup> an elite that has garnered high government positions and funded large think tanks furthering their views. They have had a significant impact on the direction of the country as exemplified by the resurrecting of states' rights as a means of scuttling progressive legislation and Supreme Court decisions they oppose and the stacking of the courts with conservative thinkers. The ideologues of the political and religious right continue working to undermine the advances women have made in the areas of affirmative action and reproductive rights and to deter progress in other problem areas such as child care and pay equity. Calling themselves advocates of "family values," particularly stressed during the 1992 election campaign, their actions could be more accurately described as anti-women. Many of their efforts focus on maintaining women's subordinate social status by, for example, overturning abortion rights, limiting availability of contraceptives, and censoring school textbooks depicting egalitarian gender roles.

## THE POLITICS OF SCIENCE

In Chapter Two, we looked at the impact of Darwinian ideas on the social and scientific ideology in the 19th century during another time of political activism by women. Both the heredity vs. environment--or nature vs. nurture--debate and the attempt to find a scientific basis for sex roles have the power of a lasting fascination in this country. Social Darwinist ideas recurred in this century, making a strong comeback in conservative, biological determinist arguments in the 1970s and '80s. This time around, however, there was a feminist critique of science in progress. In the late sixties, feminist activists and authors began critiquing the biases inherent in the physical and social sciences. The discussion here is limited to a few areas of medicine and biology.<sup>40</sup>

The 1960s saw the beginning of a period of health care activism with the development of free, community controlled clinics as an alternative to the traditional institution of medicine. The women's health movement that surfaced in the late sixties and early seventies was an outgrowth of alternative health care activism and feminism. The movement offered a critique of the expense, dangers, abuses, ignorance, and sexually discriminatory politics of medical institutions for women in this country<sup>41</sup> and worked to change the way women related to their health and health care. Women were encouraged to stop playing a stereotypically passive role in relation to their gynecologists and assert themselves.<sup>42</sup> In Vaginal Politics, Ellen Frankfort provided a concrete explanation of how many women had come to relinquish control of their bodies to medical experts:

. . . by the time a woman is forty she has been poked and probed so frequently, whether it be for menstrual difficulties, contraception, vaginal infections, childbearing, abortion or Pap smears, that she is convinced her body is not her own.<sup>43</sup>

The Boston Women's Health Book Collective published Our Bodies, Ourselves in 1971. The book's authors believed that coming to understand one's body and taking control of that part of one's life could function as a "starting point for liberation." Women could exploit "untapped energies" once they were freed from the kind of unhealthy preoccupations that lack of education, inadequate health care, fear, and shame fostered:

Picture a woman trying to do work and to enter into equal and satisfying relationships with other people--when she feels physically weak because she has never tried to be strong; when she drains her energy trying to change her face, her figure, her hair, her smells, to match some ideal norm set by magazines, movies and TV; when she feels confused and ashamed of the menstrual blood that every month appears from some dark place in her body; when her internal body processes are a mystery to her and surface only to cause her trouble (an unplanned pregnancy, or cervical cancer); when she does not understand or enjoy sex and concentrates her sexual drives into aimless romantic fantasies, perverting and misusing a potential energy because she had been brought up to deny it.<sup>44</sup>

The approach was one many women were ready to hear. Since 1971, Our Bodies, Ourselves has gone through several revisions and numerous printings and has been translated into other languages. As of early 1991, approximately two and three-quarters million copies had been sold in the U. S. alone.<sup>45</sup>

Some feminist critiques of medical science have focused on erroneous versions of female sexuality. In a 1973 article, Diana Scully and Pauline Bart attacked the way in which female sexuality had been described in gynecology textbooks since 1943:

In the last two decades at least one-half of the texts that indexed the topics stated that the male sex drive was stronger than the female's; she was interested in sex for procreation more than for recreation. In addition, they

said most women were "frigid" and that the vaginal orgasm was the "mature" response.<sup>46</sup>

Scully and Bart quote the 1970 version of one popular textbook that counseled a new wife to "allow her husband's sex drive to set their pace" and try to "gear hers" to his. The textbook's authors kindly added that "if she finds after several months or years that this is not possible", she should see her doctor.<sup>47</sup> Apparently, the reports from Kinsey and Masters and Johnson regarding women's active pleasure in sex--as well as from hundreds of years of historical accounts--had not reached many gynecologists' offices.<sup>48</sup>

In 1976, Shere Hite, who was familiar with Kinsey and Masters and Johnson, published her study of female sexuality. In Hite's judgment, it was not mere coincidence that the sexual revolution occurred during a period of social unrest and political activism. She contended that the phrase "sexual revolution" was a misnomer for the increased attention on sex in the 1960s:

Sexuality and sexual relationships can be surrogates for (or obscure our need for) a more satisfying relationship with the larger world--for example, with work. . . . Meanwhile, the commercialization and trivialization of sex advances further and further into our private lives and obscures their deeper meaning for us. In fact, we haven't had a sexual revolution yet, but we need one.<sup>49</sup>

As had happened in the twenties, the advertising industry repackaged social resistance and peddled personal liberation through consumption and the commodification of sex.

There are, however, positive consequences of the more open discussion of sexuality. Women had been led to believe that males had uncontrollable sexual appetites. They frequently took sole responsibility for contraception. Many learned to fake orgasms during intercourse. Bookstores now display many books written in similar spirit to Lonnie Barbach's 1975 book For Yourself, a guide to having orgasms, which she dedicated to "all

women who want to develop their sexual and nonsexual potential."<sup>50</sup> The clitoral orgasm has regained legitimacy.<sup>51</sup> American women are counseled to actively explore and express their sexuality, alone and/or with partners, in ways that they were not prior to the 1970s. "Sexual liberation," according to Barbach, "is a beginning."<sup>52</sup> The jury is still out on the long term consequences of the sexual revolution for women.

Removing erroneous and damaging psychological definitions is another form of liberation. Women entered the field of psychology in great numbers in the 1970s and 80s and began changing the way women's psychology was discussed. In a 1968 article, entitled "Kinder, Kuche, Kirche as Scientific Law: Psychology Constructs the Female,"<sup>53</sup> Naomi Weisstein said that "Psychology has nothing to say about what women are really like, what they need and what they want, essentially, because psychology does not know." This statement appeared at the beginning of a large-scale critique by feminist critics and social scientists of how the field of psychology defined, researched, and treated women. Essentially, they demonstrated that male behavior had long been the measure of human behavior, relegating women to the realm of abnormality.

In 1972, prodded by women in its membership, the American Psychological Association formed a task force to assess the status of women within the field of psychology. The next year, the APA made the psychology of women an official division within the organization. In the mid-seventies, new professional journals focusing on women began appearing. By 1987 one author of a college text on the psychology of women was estimating that approximately one hundred thousand related books and articles had been published during the preceding fifteen to twenty years.<sup>54</sup>

Women have raised fundamental issues about the way the theory and practice of psychology has treated women. Phyllis Chesler's Women and Madness<sup>55</sup> attacked the misogyny she saw pervading the entire institution of mental health. Some women have continued in Karen Horney's tradition and published important feminist revisions of

psychoanalytic theory.<sup>56</sup> Challenging conventional psychological wisdom about developmental stages,<sup>57</sup> Gilligan and Belenky, et al., wrote books arguing that women utilize different, not inferior, styles of reasoning and relating.<sup>58</sup> Other areas of research which resulted in findings upsetting existing expert opinion include the impact of working mothers on children (it is often positive, not negative, especially for female children), multiple roles for women (show a greater correlation with happiness than the traditional homemaking role), and the psychological impact of abortion (fewer negative outcomes are indicated than previously assumed).<sup>59</sup>

There is a growing body of mental health research on the amount of stress in women's lives.<sup>60</sup> A consistent finding in the research is that "the objective stressfulness of situations is also a function of the extent to which they limit personal autonomy and block access to and control over resources." In the areas of work and family, "women's roles are more likely than men's to be associated with low control over outcomes."<sup>61</sup> Because of low occupational status and feminine socialization, women are also more likely than men to view stressful situations as unchangeable, which increases the likelihood that they will use emotion-based coping techniques to attempt to adapt to the stress.<sup>62</sup> Social expectations about female traits and behaviors (such as physical slimness, nurturance, passivity) and are a source of subjective stressfulness when women perceive themselves as failing to fit those norms.<sup>63</sup>

In the biological sciences, women focused attention on the sexist bias permeating what were claimed to be objective studies.<sup>64</sup> This body of work shares two major premises. The first is that science is not an apolitical enterprise. Scientists learn and perform their science within a particular sociopolitical milieu. Like everyone else, they are unable to entirely divorce themselves from that setting and its concomitant belief structures. The second premise is that, in particular, biological essentialist or determinist

ideas are inaccurate as science and reflect political ideology more than scientific evidence.<sup>65</sup>

The subject of sex and gender role differences was a very popular theme in the biological determinism of the 1960s to the 1980s. Books in the late sixties by authors including Lionel Tiger and Desmond Morris<sup>66</sup> argued for fundamental differences between human females and males based on analogies to selected primates. The basic assumption underlying all forms of biological determinism, including sociobiology, is that genetic and hormonal elements are more substantial than social or psychological contributions to human behavior.

In the late seventies, sociobiology received tremendous popular media coverage as a new "breakthrough" in science.<sup>67</sup> Entomologist E.O. Wilson is credited with articulating the core of sociobiological analysis, that human behavior is motivated by an innate desire to pass on our own genetic code. Wilson's Sociobiology: The New Synthesis opens: "Sociobiology is defined as the systematic study of the biological basis of all social behavior."<sup>68</sup> R.C. Lewontin has written that the "systematic" in sociobiology is not properly labeled as scientific study:

Sociobiology is a frankly and explicitly political science whose program is to provide, eventually, the scientific tools of "correct" social organization. Yet the world to be made will be pretty much the aggressive, domination-ridden society we live in now. <sup>69</sup>

Stereotypical gender roles are included in sociobiologists' contention that what is universal is natural:

And their universals include the double standard, sexually aggressive men, the sexual division of labor, conflict between male and female and between parent and child, and families in which men bring home the bacon while women care for the kids.<sup>70</sup>

Carol Tavis discusses the often repeated claim that males are aggressive and indiscriminate in their sexuality while females are coy and extremely selective: "Sociobiological explanations of competitive, promiscuous men and choosy, inhibited but flirtatious women fit right in with many elements within the popular culture." Significant empirical evidence to the contrary does not seem sufficient to overturn cultural beliefs or "scientific" axioms of oppositional sex roles. Tavis cites primatologist Sarah Blaffer Hrdy's statement that the stereotype of women as coy endures "despite the accumulation of abundant openly available evidence contradicting it."<sup>71</sup>

Neurophysiologist Ruth Bleier is among those who have pointed out that although biological determinism has always had its proponents, historically, it has surfaced and achieved popularity in the midst of social turmoil and activism against inequities.<sup>72</sup> One example of an early response to the rise of the women's liberation movement is a 1970 article in the New York Times magazine by Lionel Tiger, dramatically entitled, "Male Dominance. Yes, Alas. A Sexist Plot? No." Tiger warned of the disadvantage the premenstrual state holds for American girls facing exams: "A whole career in the educational system can be unfairly jeopardized because of this phenomenon."<sup>73</sup> In the 1973 book, The Inevitability of Patriarchy, Stephen Goldberg argued that male social dominance is an inevitable product of biology, in particular, the result of differences between male and female hormones. Goldberg wrote:

Human biology precludes the possibility of a human social system whose authority structure is not dominated by males, and in which male aggression is not manifested in dominance and attainment of position, of status and power. <sup>74, 75</sup>

In that case, of what use is a struggle for women's rights and equality?

The preponderance of evidence in the social and physical sciences lends far greater support for the similarities of the sexes in most aspects of human nature. A leader in



brain-hemisphere research contrasted the paucity of evidence for sex differences with the vast quantity of evidence for human similarities:

Why then do reputable investigators persist in ignoring [this evidence]? Because the study of sex differences is not like the rest of psychology. Under pressure from the gathering momentum of feminism, and perhaps in backlash to it, many investigators seem determined to discover that men and women "really" are different. It seems that if sex differences (e.g., in lateralization) do not exist, then they have to be invented.<sup>76</sup>

In The Dialectic of Sex, Shulamith Firestone wrote that feminism and Freudian psychology appeared around the same time, both systems of thought that offered to decipher the "woman question."<sup>77</sup> In the 1970s and 1980s, sociobiology vied for the same slot against an updated feminism.

## SUMMARY

Why did a syndrome which medical researchers in this country had been interested in since at least 1931 become the headline news that it did in the 1980s? This chapter catalogs many of the interrelated demographic, economic, cultural, and political factors involved in creating an overall social climate in which PMS as a phenomenon could take hold as a focal point for specific groups within the population and command attention from the mainstream imagination as well.

First, the large population of women in their thirties, a low fertility rate, and an increased number of gynecologists created favorable market conditions for a PMS industry benefitting medical, pharmaceutical, and entrepreneurial (in such forms as self-help books, workshops, alternative treatments/remedies) interests.

Second, significant socioeconomic trends led to increased tensions between women and men. The changing family structure and the feminist movement presented radical challenges to the security of old hierarchical arrangements between the sexes. To many men, women's higher educational levels and greater participation in the wage labor force, were perceived as encroachments into male territory. Meanwhile, many women struggled with the stresses of double shifts at work and home, and difficult financial burdens due to unequal pay and greater responsibility for children after divorce. At the same time, women had higher expectations of personal relationships with men based on equality.

Third, there were cultural trends toward closer attention to one's self, particularly one's mental and physical health. Women, in particular, expended more time and energy to achieve and maintain a cultural ideal of thinness at odds with average weights and shapes. The impact of attitudes and lifestyle on health was also a popular theme. Assuming greater responsibility for one's health is a two-edged sword. On the positive

side, it encourages a more informed, less passive stance as consumers of medicine. Conversely, it can lead to an "unhealthy" preoccupation with minor symptoms and an inappropriate sense of self-blame for being ill or contracting a disease.

Finally, the antipathetic political interests of feminists and conservatives, initiating and responding to cultural changes, further charged the atmosphere in which both social and scientific debates took place. Feminists exposed and fought widespread discrimination against women. Conservative factions in society defended their territory fiercely. Traditional gender roles were challenged in an unprecedented fashion. Feminist critiques of science and medicine challenged many assumptions about women and advocated a more active and skeptical role for women as practitioners and consumers. Proponents of sociobiology continued the search for a biological basis for traditional gender roles.

In some ways it is even more difficult to assess the recent past than the more distant. How does one quickly achieve perspective and balance the power of one's own memories with the data of collective experience? Despite the inherent quandary for the researcher, the period of the 1970s through the early 1990s can be fairly described as an uneasy, stressful time of change, particularly in terms of the relations between men and women. Profound conflicts emerged, accompanied by strong feelings. Enter an explanation for women's anger and complaints about their life circumstances as well as a potential rationale for stereotypical gender roles and sex discrimination: PMS.

## NOTES

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- <sup>2</sup> Dalton, xiv.
- <sup>3</sup> Vital Statistics of the United States, 1988.
- <sup>4</sup> Statistical Abstract of the United States, 1990.
- <sup>5</sup> Statistical Abstract of the United States, 1990.
- <sup>6</sup> Dalton, 20.
- <sup>7</sup> P. M. Shaughn O'Brien, Premenstrual Syndrome (London: Blackwell Scientific Publications, 1987) 39-40.
- <sup>8</sup> Suzanne M. Bianchi and Daphne Spain, American Women in Transition (New York: Russell Sage Foundation, 1986) 1.
- <sup>9</sup> Bianchi and Spain, 115, 116.
- <sup>10</sup> The NEA 1991 Almanac of Higher Education (Washington, DC: National Education Association, 1991) 10-13.
- <sup>11</sup> Bianchi and Spain, 3.
- <sup>12</sup> Arlie Hochschild, The Second Shift (New York: Avon Books, 1989) 2.
- <sup>13</sup> Bianchi and Spain, 9-11.
- <sup>14</sup> Bianchi and Spain, 19.
- <sup>15</sup> Hochschild, 249.
- <sup>16</sup> Lenore Weitzman, The Divorce Revolution (New York: Free Press, 1985) xii.
- <sup>17</sup> Caroline Bird, The Two-Paycheck Marriage (New York: Wade Rawson Pubs., Inc., 1979) 4; quoted in Barbara Ehrenreich, The Hearts of Men: American Dreams and the Flight from Commitment (Garden City, New York: Anchor Books, 1984) 173.
- <sup>18</sup> Barbara Ehrenreich, 172.

- 19 Hochschild, 2.
- 20 Hochschild, 4.
- 21 Hochschild, 3-4.
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<sup>32</sup> Morgan; Shulamith Firestone, The Dialectic of Sex (New York: William Morrow and Company, Inc., 1970); Vivian Gornick and Barbara K. Moran, eds., Woman in Sexist Society (New York: New American Library, 1972); Anne Koedt, Ellen Levine, and Anita Rapone, eds., Radical Feminism (New York: Quadrangle/The New York Times Book Co., 1973); Mary Daly, Beyond God the Father (Boston: Beacon Press, 1973); Susan Brownmiller, Against Our Will (New York: Simon and Schuster, 1975); Adrienne Rich, Of Woman Born: Motherhood as Experience and Institution (New York: W. W. Norton & Company, Inc., 1976); Dorothy Dinnerstein, The Mermaid and the Minotaur (New York: Harper & Row, Publishers, Inc., 1976); Susan Griffin, Woman And Nature: The Roaring Inside Her (New York: Harper & Row, Publishers, Inc., 1978); Mary Daly, Gyn/Ecology: The Metaethics of Radical Feminism (Boston: Beacon Press, 1978).

<sup>33</sup> Carol Hymowitz and Michaela Weissman, A History of Women in America (New York: Bantam Books, Inc) 371.

<sup>34</sup> Elaine Tyler May, Homeward Bound: American Families in the Cold War Era (New York: Basic Books, Inc., Publishers, 1988) 225.

<sup>35</sup> Cited in Susan Faludi, Backlash: The Undeclared War Against American Women (New York: Crown Publishers, Inc., 1991) 60.

<sup>36</sup> Cited in Faludi, 61.

<sup>37</sup> Faludi, 65.

<sup>38</sup> Sidney Blumenthal, The Rise of the Counter-Establishment: From Conservative Ideology to Political Power (New York: Random House, Inc., 1986) xiii.

<sup>39</sup> Blumenthal, xiv.

<sup>40</sup> These choices should not be read as disregard for feminist critiques and important contributions to numerous other fields of study and practice.

<sup>41</sup> See, for example: Suzanne Arms, Immaculate Deception: A New Look at Women and Childbirth in America (Boston: Houghton-Mifflin, 1975); Gena Corea, The Hidden Malpractice: How American Medicine Mistreats Women as Patients and Professionals (New York: Harper & Row, Publishers, Inc., 1977); Claudia Dreifus, ed., Seizing Our Bodies: The Politics of Women's Health (New York: Random House, Inc., 1977); The Federation of Feminist Women's Health Centers, How to Stay Out of the Gynecologist's Office (Culver City: Woman to Woman Publications, 1981); Diana Scully, Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists' Care (Boston: Houghton Mifflin Co., 1980); Barbara Seaman and Gideon Seaman, Women and the Crisis in Sex Hormones (New York: Rawson Associates Publishers, Inc., 1977); and, Richard W. Wertz and Dorothy C. Wertz, Lying-In: A History of Childbirth in America (New York: Schocken Books, 1979). This is an abbreviated list of some of the significant books of the late seventies and early eighties; there have been many more in the years since.

<sup>42</sup> Sheryl Burt Ruzek, The Women's Health Movement: Feminist Alternatives to Medical Control (New York: Praeger Publishers, 1978) 9.

<sup>43</sup> Ellen Frankfort, Vaginal Politics (New York: Bantam Books, 1973) 19-20. Women with less access to the amount of medical care that this implies--or without accurate information about their bodies--might have a greater sense of ownership of their bodies but may be more likely to have undiagnosed health problems.

<sup>44</sup> Boston Women's Health Book Collective, The New Our Bodies, Ourselves (New York: Simon & Schuster, 1984) xix. The 1984 edition included the prefaces from the earlier editions; the quote is an excerpt from the preface to the first edition. A new edition came out in 1992.

<sup>45</sup> Conversation with Judy Norsigian of The Boston Women's Health Book Collective, March 18, 1991.

<sup>46</sup> Diana Scully and Pauline Bart, "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks," American Journal of Sociology 78 (1973): 1045-1049. See also Diana Scully, Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists (Boston: Houghton Mifflin Company, 1980).

<sup>47</sup> Edmund R. Novak, Georgeanna Seegar Jones, and Howard W. Jones, Novak's Textbook of Gynecology (Baltimore: Williams & Wilkins, 1970) 662-63; quoted in Scully and Bart, 1048.

<sup>48</sup> See also Mary Jane Sherfey, The Nature and Evolution of Female Sexuality (New York: Random House, Inc., 1972). Sherfey's hypothesis in this book is that "one of the requisite cornerstones upon which all modern civilizations were founded was coercive suppression of women's inordinate sex drive."

<sup>49</sup> Shere Hite, The Hite Report (New York: Dell Publishing Co., Inc., 1976) 503.

<sup>50</sup> Lonnie Garfield Barbach, For Yourself: The Fulfillment of Female Sexuality (New York: The New American Library, 1975).

<sup>51</sup> See Laqueur's discussion of Freud's creation of the vaginal orgasm and Masters and Johnson's rediscovery of the clitoral orgasm: Thomas Laqueur, Making Sex: Body and Gender from the Greeks to Freud (Cambridge: Harvard University Press, 1990) 233-34.

<sup>52</sup> Barbach, 173.

<sup>53</sup> Morgan, 268.

<sup>54</sup> Cited in Mary Roth Walsh, ed., The Psychology of Women: Ongoing Debates (New Haven: Yale University Press, 1987) 4. See her brief overview of the history of the field of the psychology of women.



<sup>55</sup> Phyllis Chesler, Women and Madness (New York: Avon Books, 1972).

<sup>56</sup> Jean Baker Miller, Toward a New Psychology of Women (Boston: Beacon Press, 1976); Juliet Mitchell, Psychoanalysis and Feminism, (London: Allen Lane, 1974); Nancy Chodorow, The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender (Berkeley: University of California Press, 1978); Paula J. Caplan, The Myth of Women's Masochism (New York: New American Library, 1985).

<sup>57</sup> Books about life stages based on men's lives were popular in the 1970s and 1980s; see, for example, Daniel J. Levinson, C. N. Darrow, E. B. Klein, M. H. Levinson, and B. McKee, The Seasons of a Man's Life (New York: Knopf, 1979).

<sup>58</sup> Carol Gilligan, In a Different Voice: Psychological Theory and Women's Development (Cambridge: Harvard University Press, 1982); Mary Field Belenky, Blythe McVicker Clinchy, Nancy Rule Goldberger, and Jill Mattuck Tarule, Women's Ways of Knowing: The Development of Self, Voice, and Mind (New York: Basic Books, Inc., Publishers, 1986).

<sup>59</sup> See Walsh for a good sampling of these and other questions. Also Elizabeth Howell and Marjorie Bayes, eds., Women and Mental Health (New York: Basic Books, Inc., Publishers, 1981).

<sup>60</sup> See Rosalind C. Barnett, Lois Biener, and Grace K. Baruch, eds., Gender & Stress (New York: The Free Press, 1987) for an excellent overview of this research area.

<sup>61</sup> Barnett, Biener, and Baruch, 351.

<sup>62</sup> Women often use self-consoling behaviors, such as eating, and self-changing behaviors, such as diet and exercise, when they do not perceive themselves as having power to alter circumstances. Barnett, Biener, and Baruch, 355.

<sup>63</sup> "Dieting itself is an important chronic source of stress" in women: Barnett, Biener, and Baruch, 354.

<sup>64</sup> The list includes: Michael S. Teitelbaum, ed., Sex Differences: Social and Biological Perspectives (Garden City: Anchor Books, 1976); Ruth Hubbard, Mary Sue Henifin, and Barbara Fried, eds., Women Look at Biology Looking at Women (Cambridge: Schenckman Publishing Company, Inc., 1982)); Janet Sayers, Biological Politics: Feminist and Anti-Feminist Perspectives (London: Tavistock Publications, 1982); Marian Lowe and Ruth Hubbard, Woman's Nature: Rationalizations of Inequality (Elmsford: Pergamon Press, Inc., 1983); Carol Tavris and Carole Wade, The Longest War: Sex Differences in Perspective, 2nd ed. (San Diego: Harcourt Brace Jovanovich, Publishers, 1984); Ruth Bleier, Science and Gender: A Critique of Biology and Its Theories on Women (Elmsford: Pergamon Press, Inc., 1984); Anne Fausto-Sterling, Myths of Gender: Biological Theories about Women and Men (New York: Basic Books, Inc., Publishers, 1985); Sandra Harding, The Science Question in Feminism (Ithaca: Cornell University Press, 1986); Nancy Tuana, Feminism & Science (Bloomington: Indiana University Press, 1989).

<sup>65</sup> The work of male scientists such as paleontologist Stephen Jay Gould and geneticist R. C. Lewontin shares this criticism of sociobiology.

<sup>66</sup> Lionel Tiger, Men in Groups (New York: Random House, 1969); Desmond Morris, The Naked Ape (New York: McGraw-Hill, 1968).

<sup>67</sup> Marian Lowe, "Sociobiology and Sex Differences," Signs 4 (1978): 124.

<sup>68</sup> E. O. Wilson, Sociobiology: The New Synthesis (Cambridge: Harvard University Press, 1975).

<sup>69</sup> R. C. Lewontin, "Sociobiology: Another Biological Determinism," Women And Health: The Politics of Sex in Medicine, ed. Elizabeth Fee (Farmingdale, New York: Baywood Publishing Company, Inc., 1983) 248.

<sup>70</sup> Fausto-Sterling, 197.

<sup>71</sup> Carol Tavris, The Mismeasure of Woman (New York: Simon & Schuster, 1992) 214. See also Sarah Blaffer Hrdy, "Empathy, Polyandry, and the Myth of the Coy Female," Feminist Approaches to Science, ed. Ruth Bleier (New York: Pergamon Press, 1988).

<sup>72</sup> Bleier.

<sup>73</sup> Cited by Tavris and Wade, 152.

<sup>74</sup> Stephen Goldberg, The Inevitability of Patriarchy (New York: William Morrow & Co., 1973) 78. See Floyd W. Matson's critique of aggression as instinct in The Idea of Man (New York: Dell Publishing Co., Inc., 1976).

<sup>75</sup> Biology is not the only field prone to universalizing male dominance and female subordination. See Eleanor Leacock's critique of the attempt to use anthropological data to the same end, "Ideologies of Male Dominance as Divide and Rule Politics: An Anthropologist's View," Woman's Nature: Rationalizations of Inequality, ed. Lowe and Hubbard (Elmsford: Pergamon Press, Inc., 1983) 111-21.

<sup>76</sup> Marcel Kinsbourne, "If Sex Differences in Brain Lateralization Exist, They Have Yet To Be Discovered," The Behavioral and Brain Sciences 3 (1980): 241-42; cited in Tavris, 53.

<sup>77</sup> Firestone.

## CHAPTER SIX

### CONTEMPORARY REVIEW OF THE LITERATURE ON PMS

A PMS greeting card in the 1980s: on the front of the card is a cartoon drawing of a woman sitting on an examining table, clutching the front of her hospital gown, slightly recoiling from the doctor ("Dr. Hymen") who is pointing at her, saying, "It's all in your head, honey buns. Nyuck, nyuck." The caption above says, "My gynecologist laughed when I told him how bitchy I get during my period." The inside caption reads: "So I shot him."

In November 1981, the American media carried the news that two women in Britain had employed a premenstrual tension defense in their separate murder trials. PMS expert Dr. Katharina Dalton testified on behalf of the women in both cases. The argument that the women's capacity to control their behavior was diminished by PMS resulted in a lessening of the sentences from murder to manslaughter. Both women were required to accept progesterone therapy from Dalton to "stabilize" them.<sup>1,2</sup>

The news made big headlines here, having elements that could be tailored for a good sensational story: the battle of the sexes in a courtroom; dramas of passion and violence starring "hysterical" women. Though set in England, the story resonated for Americans.<sup>3</sup> As we have seen, beliefs about differences between the sexes and the role of biology in shaping women's nature are continuing themes in our cultural history. With PMS, attempts to explain female behavior in light of the female reproductive system settled on hormones.<sup>4</sup>

In the 1970s and 1980s, discussion of PMS continued expanding outside of the confines of medicine and psychology, taking on many different forms including news

reports, first hand accounts, advice columns, lay organizations, and numerous self-help books.<sup>5</sup> Talk shows began devoting air time to women claiming to suffer its devastations and experts hawking solutions. Critical literature, both within the field of medicine and from social science and feminist points of view, also emerged. This chapter surveys recent perspectives on PMS from popular culture and media, the medical and social sciences, and feminist critiques.

## POPULAR DISCOURSE ON PMS

An informal sampling of newspaper clippings on the subject of PMS from the 1980s covers the topics of caffeine and PMS, exercise and PMS, diet and PMS, Vitamin B6 and PMS, food cravings and PMS, sunlight and PMS, husbands and PMS, and a purported medical test for PMS. Estimated numbers of women suffering from PMS from this sample ranged from 10% - 90%. An article culled from a small publication called The Psychic Reader explained how channeling male beings can adversely affect a woman's reproductive system: "When a male being is not aware of the maleness of his energy, this can cause menstrual problems in the channel." This is one hypothesis that has not been explored in the medical literature. The headlines of numerous articles appearing in popular periodicals are melodramatic and ominous, referring to PMS as "the monthly menace," "an internal earthquake."<sup>6</sup>

Sometimes the tone of PMS discourse is lighter--at least on the surface. Menstrual humor, in the form of puns, riddles, and jokes, has been part of popular culture for a long time.<sup>7</sup> PMS humor appeared in the 1980s and quickly became a commodity, surfacing in slogans on buttons, t-shirts, key chains, calendars, and greeting cards (see example at start of this chapter). One can purchase books of PMS humor or a "warning" sign to hang on a doorknob.<sup>8</sup> Comics added PMS to their standard fare. The message explicit or implicit in nearly every example of PMS related humor encountered in the course of this research is that PMS makes women "bitches": mad, sad, and bad. A strong, harsh sounding term of contempt, "bitch" is not considered obscene and thus can be used safely--and liberally--in the media. "Bitch" is a flexible term in its capacity to assign negative feeling, intention, and behavior to a woman, and to label her spiteful, malicious, ill-tempered, or promiscuous.<sup>9</sup>

### Self-Help Organizations and Books

The goal of various PMS lay organizations and support groups is to offer women information, assistance, and encouragement seen as lacking from the medical profession. Women attending one self-help seminar reported that their health care providers had responded by telling them to take tranquilizers, recommending a psychiatrist, not taking their complaints seriously, or telling them their symptoms were "all in their heads."<sup>10</sup> Women participating in support groups have reported many positive consequences from being in the group, including realizing that they were not the only ones experiencing problems, and gaining new information, emotional support, motivational encouragement for making changes in their lives, increased self-esteem, and a greater sense of control.<sup>11</sup>

PMS societies, foundations, programs, and resource centers sprang up in the 1980s. One of the best known lay organizations is PMS Action, Incorporated of Irvine, California, founded by Virginia Cassara. Cassara was treated with progesterone for PMS by Dalton in 1979 and returned to the U.S. intent on sharing her satisfaction with progesterone treatment with American women. According to Cassara, doctors should prescribe progesterone rather than difficult and unproductive diet and exercise regimens. In answer to a question regarding potential side effects of long-term progesterone treatment, Cassara once responded that nothing, not even cancer, could be worse than PMS.<sup>12</sup> Also prominent is PMS Access of Madison, Wisconsin. PMS Access has an 800 number for "free information on PMS, its causes, symptoms, management, physician referrals and support groups." It also sells a newsletter, booklets, journals, books, and a slide show on PMS. For women unable to obtain progesterone through their physicians, the organization, a division of Madison Pharmacy Associates, makes its own pharmacists available. The organization's business card states "PMS Training and Accreditation from Dr. Katharina Dalton, M.D."<sup>13</sup>

Numerous lay guides to PMS came out in the 1980s. Self-help books follow the problem-solution organizational pattern. The more powerfully the need is established, the more gratitude and acceptance for the provided answers is assumed. PMS books promise, "finally," scientific remedies: "the first book on record to offer a real solution to the problem," "a new understanding of causes and cures," "complete treatment," "a doctor's proven program."<sup>14</sup> They are written to help women better "cope" with their moods and problems, manage their stress, and "tame the shrew" within them.<sup>15</sup>

PMS books are also written to help men

to understand the capricious and temperamental changes of women, so that the image of woman as uncertain, fickle, changeable, moody and hard to please may go, to be replaced with the recognition that all these features can be understood in terms of the ever-changing ebb and flow of her menstrual hormones.<sup>16</sup>

The most dramatic advice and stories deal with the impact of PMS on relationships between wives and husbands. A woman who has recognized that she suffers from PMS should inform her husband at a time when she is feeling well: "tell him how guilty you feel about your periodic loss of control, . . . . tell him that you know you're being horrid but you can't help it."<sup>17</sup> Dalton recommends having the husband and other family members keep track of a woman's menstrual symptoms on a calendar in order to better understand her problem. Interviews with family members are also advised

as those closest to the PMS sufferer will know best how she changes from the happy, charming individual which she is on most days into the lazy, irritable and unpredictable female she becomes as menstruation draws near.<sup>18</sup>

Dalton has been quoted as saying that women who fail to seek treatment for PMS "will get what they deserve from men."<sup>19</sup>



Melodramatic language and stories abound in these books: "Fifteen Years of Borderline Insanity" and "The Curse of Eve" are examples of chapter titles. Some books show a rare ability for long-range diagnosis: readers will be impressed to learn that Mary Tudor, Katherine of Aragon, Queen Victoria, Elizabeth I, Pauline Bonaparte, Mary Todd Lincoln, Lizzie Borden, Alice James, Sylvia Plath, Maria Callas, Judy Garland, and Joan Crawford may have all suffered from PMS, although, since they are all deceased, it is difficult to determine with certainty.<sup>20</sup>

In the stories offered by Dalton, Lever, and other popular publications on PMS, telling details of a woman's life circumstances are often included yet there is no discussion regarding the impact of these circumstances on her health, state of mind, and actions. Situations such as extended families to care for and other responsibilities for which there is little social recognition, are not specifically addressed either as contributing factors or potential areas for improvement. The writings on PMS, by Dalton in particular, reinforce stereotyped gender roles, stressing women's obligation to be cheerful wives, mothers, homemakers. Anger in women is generally depicted as an aberration:

A majority of women with PMS at some time or another, when under great stress or pain, say they have become angry, yelled, screamed, had a car accident, thrown something, or felt as if they wanted to throw something or act out against someone.<sup>21</sup>

Alter the statement to begin "A majority of people, when under great stress or pain. . . ." and the commonness of the feelings and behaviors described is immediately apparent.<sup>22</sup>

Where does this anger come from and how is a woman to dispel it? The most common cause of PMS postulated in self-help books is an imbalance in estrogen and progesterone levels. To correct the imbalance, some PMS manuals recommend vitamin, mineral, herbal or other dietary supplements. For example, one argues that PMS is a sleep disorder best treated with the amino acid tryptophan, another that the problem is a

deficiency of essential fatty acids in the diet remedied by the seed oil of the Evening Primrose plant.<sup>23</sup> Despite the fact that caffeine is one of the most consistently confirmed factors in breast swelling and soreness, some books on menstrual problems advise drinking coffee.<sup>24</sup> The most common recommendations by all are regular exercise, dietary changes (reduced sodium, sugar, caffeine; smaller, more frequent meals), and stress reduction (meditation, yoga, biofeedback).<sup>25</sup> When these methods are ineffective, the majority of the books recommend progesterone therapy. Dalton alone endorses progesterone without reservation.

Out of the many books on PMS published in the early eighties, two of them stand out for the following reasons: 1) they manage to avoid the melodramatic, guilt-ridden tales with which some of the other books in this genre are rife; 2) they expressed considerable doubt about the value of progesterone therapy for PMS at a time when it was gaining in popularity and recommend a cautious, informed approach to PMS clinics where progesterone and other unproven treatments are dispensed, often at high cost; and 3) they offer intelligent discussions of the sociological aspects of PMS.<sup>26</sup> In contrast, other popular books overstate the case for progesterone, and understate, disregard, or deny the case against it.<sup>27</sup>

### Talk Shows

During the 1980s, television talk shows became increasingly popular and PMS quickly made the list of hot topics to discuss. As the older baby boomers have entered their mid to late forties, the spotlight has moved on (to menopause, for example), but PMS continues to occupy center stage from time to time. In June 1991, an installment of a popular afternoon talk show hosted by Oprah Winfrey featured the founder and three other members of MPMVA, an acronym for Male Premenstrual Victims Association. The four men discussed the difficulties they face living with wives suffering from PMS. Their

complaints? The first man (MPMVA's founder) said his wife became "totally unpredictable" when she was premenstrual, that he was in the wrong no matter what he might say, and his wife had once hit him in the back with a telephone. The second said that after asking him and the kids to keep the noise down, his wife had broken the television set with a hammer. The third man said his wife regularly wanted a divorce two days before her period began and had told him she would rather sell herself on the street than be with him. The fourth MPMVA member's wife had asked him and the kids to leave the house. She complained a lot about "household stuff," like waiting three months for him to do some painting, but only complained when she was premenstrual. He claimed that her PMS led him to "contemplate murder ten times a year." He had initially assumed that his wife used PMS as "an excuse to be a bitch." All agreed that crying was one of the most common behaviors their wives exhibited premenstrually and that they [the husbands] often felt as if they were "walking on eggshells." After reading about PMS, MPMVA members said they had learned that their wives had "no control" over their feelings and actions premenstrually. The belief that their wives were out of control, rather than truly angry, unhappy, or dissatisfied, seemed to be far more acceptable to them.

Later, the men's wives appeared on the program. They reiterated the theme that they were unable to help or control themselves. The wife of the third man (the woman who had considered prostitution as an alternative to her marriage) described PMS as something that "washes over you like a tidal wave." She said she didn't deserve her husband because of everything he had given her and described two days of "horror" followed by two weeks of "making up for it" each month. Feelings of guilt and sustained efforts to make amends are another common theme in PMS discourse. What kinds of things did the wives feel most guilty about doing? In answer to Oprah's question of what was the worst thing they had ever done premenstrually, one woman said she had become upset over an unfamiliar number on the phone bill and suspected her husband of being

involved with another woman. A second woman said that she had been very upset over a ruined dinner and had thrown a fork in the sink so hard that it had bounced up and broken the window above the sink. (The majority of subjects mentioned as problematic premenstrually were household issues: cooking and cleaning chores, bills, noise, interruptions.) The program ended with a question posed to a woman who started her own PMS clinic in Colorado: what would women like men to know about PMS? The answer: "I love him. It's not him, it's me."

The popular literature assumes that PMS is an accepted medical ailment affecting most women. People familiar only with what popular culture has conveyed about PMS could easily come to the conclusion that PMS attacks women, then women attack men.<sup>28</sup> They might believe that many of the stereotypes about female emotionality, irrationality, jealousy, and vindictiveness are immutable, biologically based facts about women's nature.<sup>29</sup> They might think that women's anger and violence were products of hormonal fluctuations peculiar to women rather than reflections of human characteristics, social inequities, or specific life circumstances. For the most part, popular literature and culture continue to portray PMS in a simplistic, uncritical fashion. Meanwhile, medical and social science discourse on PMS have become increasingly sophisticated.

## MEDICAL SCIENCE

The number of English language medical articles published on PMS between 1980 and 1987 was more than three times what it was in the 1970s.<sup>30</sup> Why this sudden, enormous increase in interest in a noncontagious illness that had been studied for fifty years? The previous chapter outlined relevant socioeconomic factors contributing to increased interest in the subject. The American medical community's concern with PMS was also heightened by increased requests from women for progesterone therapy following American media coverage of the British trials and word of Dalton's use of progesterone treatments in Britain.<sup>31</sup> But before the British trials that thrust PMS into American public attention, medical research on PMS was surging. An article in the American Journal of Obstetrics & Gynecology in early 1981 by two highly respected researchers appeared to legitimize PMS as a research focus.<sup>32</sup> In April 1981, the Journal of the American Medical Association hailed the trend, calling PMS America's "newest women's health issue."<sup>33</sup>

The range of prevalence estimates has been extremely wide, from 5%<sup>34</sup> to 97%<sup>35</sup> of the female population who are between menarche and menopause. Attempts to define and diagnose PMS have focused on two main issues: the timing of symptoms (and their absence after the premenstrual and menstrual phases of the cycle) and the severity of symptoms. Most researchers focus on the time period from a week to ten days prior to the start of menses through the first couple days of menses. Severity of symptoms is usually discussed in terms of the degree to which they disrupt or interfere with a woman's everyday life.<sup>36</sup>

From the beginning, most PMS researchers have assumed a link between hormone levels and PMS. As hormonal assays became better, easier, and less expensive, researchers were quick to apply them to investigations of PMS etiology.<sup>37</sup> The hormonal

imbalance theory of PMS was reinforced by the success of the prostaglandin theory of dysmenorrhea (menstrual pain due to uterine cramping) in the late 1970s, which held out the hope that other women's ailments previously dismissed either as a fact of life to be coped with or as psychogenic in origin could be understood as physical pathologies treatable with drugs.<sup>38,39</sup> The prostaglandin theory was touted as a straightforward solution to the problem of painful menstrual cramps. However, the explanation that a chemical, excess prostaglandins, causes cramps which can therefore be treated with a neutralizing drug, antiprostaglandins, does not explain why some women have high levels of prostaglandins, nor why some women without high levels of prostaglandins, experience cramping. Prostaglandin inhibitors also relieve pain, which may be why they are helpful for cramps (aspirin is an example of a mild prostaglandin inhibitor). In addition, the treatment is not without a downside: prostaglandin inhibitors can cause disturbing side effects.<sup>40</sup> None of these drawbacks to the model inhibited a slew of articles in women's magazine or several popular books proclaiming that menstrual cramps had at last been labeled real and cured by modern medicine.

A variety of specific physiological causes and myriad treatments (addressing specific symptoms or postulated causes) have been espoused for PMS during the last sixty years. Severino and Moline list ten categories of proposed physiological etiologies (as of 1989): hormones, neurotransmitters, circadian rhythms, prostaglandins, pyridoxine (vitamin B6), nutrition, allergic reactions, yeast (*Candida albicans*), evolution, and altered blood rheology (the idea that women with small blood capillaries would be more susceptible to PMS).<sup>41</sup> Considerable experimental research has been conducted and large numbers of anecdotal reports have been compiled. There continues to be no consensus on the nature of PMS or the best approach to its treatment.<sup>42</sup> One PMS researcher suggests that "there is probably more to learn from the mistakes of previous studies than there is from the data which they have produced."<sup>43</sup> Up until the last few years, and without

substantial empirical evidence, the most common theory of PMS etiology by far has been hormonal.

There are ongoing efforts to define PMS as a psychological disorder. In the appendix of "Proposed Diagnostic Categories Needing Further Study" in the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) "Late Luteal Dysphoric Phase Disorder" is described as a "pattern of clinically significant emotional and behavioral symptoms" generally occurring during the week prior to, and usually ending in the first few days of, menstruation.<sup>44</sup> With this controversial inclusion in DSM-III-R, the classic reference book of psychiatry, what is commonly referred to as PMS made additional strides in the process of institutionalization.<sup>45</sup> The inclusion does not indicate, however, that attempts to find a psychogenic cause of PMS have succeeded where others have failed. As Severino and Moline concluded after a review of the literature, "Results have been inconsistent and inconclusive in all studies of the psychological etiology of PMS."<sup>46,47</sup>

Psychosocial approaches assume a connection between social factors and a woman's premenstrual experience of emotions. Notman hypothesizes that PMS may be related to a woman's desire to express aggression. Girls are socialized to be nonconfrontational, learning that female expression of aggression is inappropriate, therefore women may develop premenstrual symptoms as an alternative to directly expressing aggression. Premenstrual symptoms may indicate conflicts about anger, power, and control that are cut off from other avenues of expression, according to Notman.<sup>48</sup>

A few studies have examined the impact of an external or internal "locus of control"<sup>49</sup> on whether a woman has negative premenstrual symptoms. In general, they have found that women diagnosed with PMS feel themselves under the control of external

forces more than women without PMS; this feeling is particularly pronounced during the premenstrual phase.<sup>50</sup>

Another prominent line of psychosocial inquiry on PMS looks at the relationship between stress and premenstrual symptoms. Unwanted life changes were the best predictor of premenstrual distress in one study. High stress levels that diminish a woman's general sense of well-being may lead her to perceive or experience more negative symptoms. The most frequently cited source of stress reported in studies is the result of conflict with a significant partner. The direction of the relationship between stress and menstrual cycle phase is not clear.<sup>51</sup> It is may be that premenstrual symptoms are aggravated by stress and they may become an additional source of stress.<sup>52</sup> From the research to date in this area, stress appears to have an important role in reports of premenstrual symptoms.

Researchers have attempted to demonstrate a correlation between the premenstrual phase and a decrease in cognitive function, by studying, among other areas, scholastic performance, arithmetic tests, anagrams, puzzles, a variety of standardized tests. Dalton, for example, asserts that among girls, the quality of school work and marks on examinations are lower and there are more behavioral problems premenstrually.<sup>53</sup> However, according to Joan Chrisler, "none of these studies have reported any significant premenstrual deficits."<sup>54</sup> Most of the research on creativity has also found no differences between women and men. A study by focusing on the question of whether menstrual cycle phase affects creative thinking found no significant effects. Despite the assumption on the part of some women participants that their scores on the various measures used would be worse premenstrually, the women's performances were the same or better premenstrually than postmenstrually. The author offers two possible explanations for the improved premenstrual performance: Parlee's hypothesis of a "premenstrual elation syndrome"<sup>55</sup> or a deliberate effort to offset expected deficiencies. Chrisler concludes that



"any sex differences in creative achievement are far more likely to be caused by lack of opportunities and lack of recognition of women's work than by any biological processes."<sup>56</sup>

There is a body of literature attempting to prove that women suffering from PMS are causing significant social problems. The person most frequently quoted and identified with this research is Katharina Dalton.<sup>57</sup> Her statistics on negative consequences of PMS purport to show that PMS leads to increased rates of suicide, accidents,<sup>58</sup> violence, and crime<sup>59</sup> by women and costs to the business community and the economy from absenteeism<sup>60</sup> and lowered productivity.<sup>61</sup> The family unit is also said to suffer when the life of its "linchpin," the mother, "becomes a misery each month."<sup>62</sup> According to Dalton, children are the most sensitive in response to their mothers' premenstrual changes: "they find it impossible to understand the mood changes and fluctuations and may react with psychosomatic problems, such as a cough, runny nose, endless crying or vomiting."<sup>63</sup> She believes that PMS may account for child abuse, school absenteeism, and problems previously labeled sibling rivalry.<sup>64</sup>

Up until PMS became a socially prominent issue in the early eighties, there was little criticism of the medical model of PMS. It was vaguely defined, representing as many as one hundred and fifty symptoms. Almost anything a woman might sense anywhere within herself during the latter half of the menstrual cycle could come under the heading of PMS, including distressing thoughts and strong emotions. Depending on where she went for treatment, a woman presenting PMS symptoms might be prescribed psychotherapy, vitamin supplements, dietary changes, an exercise program, stress reduction techniques, or progesterone. One popular Obstetrics and Gynecology textbook considered water retention and stress the primary symptoms of PMS and suggested the following list of treatments to alleviate them: dehydration, hormone therapy, supportive therapy,

sedatives/tranquilizers.<sup>65</sup> Convincing evidence that these treatments are effective is lacking.

The best known proponent of progesterone therapy for PMS is Katharina Dalton, who has consistently claimed that it produces striking results in patients:

When women with the premenstrual syndrome who have been treated with progesterone return to the doctor, it is often difficult to recognize them as the same women who first came for advice and treatment.<sup>66</sup>

In 1979, when Dalton published the book from which the above quote is taken,<sup>67</sup> other researchers were beginning to challenge her evidence and discredit progesterone as an effective treatment for premenstrual symptoms<sup>68</sup> but the death knell for progesterone did not come until the early nineties. An article in The Journal of the American Medical Association in 1990 reported that a large, carefully controlled study found progesterone has "no clinically significant therapeutic effect greater than that of placebo" for treating premenstrual symptoms.<sup>69</sup> The next year an article in The New England Journal of Medicine reported 1) no evidence that the biology of the second half of the menstrual cycle causes PMS; 2) continued attempts to focus on physiological abnormalities of the premenstrual phase were unlikely to find anything relevant to PMS; and, 3) no physiological rationale for progesterone therapy for PMS.<sup>70</sup>

According to a 1991 account Dalton, at seventy-five years of age, was still practicing medicine and dispensing progesterone in London.<sup>71</sup> A survey of twenty-six randomly selected PMS centers done in the late eighties found that 80.7% of the centers were prescribing progesterone for PMS. The only therapies more frequently prescribed were vitamin/mineral and diet.<sup>72</sup> The information on the inefficacy of progesterone treatment does not appear to have reached the general population and the popular media are not demonstrating much interest in the topic.<sup>73</sup>

The medical literature, at least in part in response to strong outside criticism, eventually became more self-critical.<sup>74</sup> During the mid to late eighties, more careful distinctions were made between minor and severe symptoms, between premenstrual symptoms and a syndrome. Standardized measures for diagnoses were refined. There were more concerted challenges to the hormonal imbalance and hormonal deficiency models that had reigned from the start.<sup>75</sup> Brooks-Gunn proposed that two different phenomena were being addressed, the existence of premenstrual symptoms and one or more premenstrual syndromes. She added that prevalence was regularly overestimated: "Errors of inclusion rather than exclusion characterize this research."<sup>76</sup> A 1986 editorial by Reid made the similar point that it is important to distinguish between normal and problematic cyclic changes, adding that the failure to clearly distinguish

creates the unfortunate situation where many healthy women have found themselves pejoratively categorized as suffering from a condition that may have significant implications regarding their health and functioning in society.<sup>77</sup>

Most research has been based on an assumption that the menstrual cycle causes negative effects in women, and used instruments such as the Moos Menstrual Distress Questionnaire to document them. The common focus of the research is on the phases of cycle assumed to be a problem, the premenstrual and menstrual phases (frequently referred to as the paramenstruum); some studies focus on ovulation.<sup>78</sup> The division of the menstrual cycle into phases provides a convenient way of talking about different events that also creates the impression of a process with very discrete segments. In fact, many women are only aware of their cycle phase when they are bleeding.

There are other problems with the research. The large number of studies using clinical and university populations creates a selection bias toward narrow, atypical samples:

The focus on nonrepresentative subgroups of women prevents the systematic investigations of sociodemographic characteristics such as age, socioeconomic or employment status, ethnicity, fecundity, or contraceptive usage. This omission means that hormonal/biochemical factors are separated from the context of women's lives. This separation results in a reinforcement of a reductionist biological (hormonal) etiology of the menstrual cycle as it prevents the simultaneous study of biological and sociocultural factors and the possible interaction between them.<sup>79</sup>

Some research methods tend to elicit stereotypical beliefs about the menstrual cycle.<sup>80</sup> The use of retrospective self-reports of menstrual cycle experience,<sup>81</sup> volunteer samples, and studies in which women know the focus is the menstrual cycle all result in increased reporting of experience in line with cultural expectations.<sup>82</sup>

New explanatory theories for PMS continue to surface. A significant trend in the research at present is away from a single cause and toward a multiple factors model: "it is more likely that each individual symptom is the result of multiple endocrine, biochemical, interpersonal, intrafamilial and environmental factors."<sup>83</sup> At this stage of the research, the lack of specific information about complex neuroendocrine processes precludes a detail understanding of "precise mechanisms in any manifestation of the cycle:"

There are wide individual differences in the relationships between neuroendocrine processes and physical and psychological, and behavioural factors even where group associations have been repeatedly found. The importance of individual factors such as transient physiological and psychological state, personality differences, genetic differences, and environmental variables can hardly be overstated.<sup>84</sup>

Additionally, there are differences between individuals, and differences between the cycles of individual women, and each cycle experience is related to varying degrees of internal and external influences.<sup>85</sup>

The complexity of this model, which is increasingly referred to as a "biopsychosocial" model,<sup>86</sup> is strikingly different from theories of hormonal imbalance and female masochism or neuroticism. Psychiatrist Sally Severino and physiologist Margaret Moline explain this approach to the study of PMS in more detail:

No longer can we understand the whole person from only one viewpoint. Physiologically, women are cyclically functioning human beings. Psychologically, they have a unique development in the context of a sociocultural milieu. The biopsychosocial model applied to PMS would state that a defect in any one factor (biological, psychological, or social) is a necessary, but not sufficient, condition for the development of PMS. A biological defect may determine some features of PMS (e.g., premenstrual timing), but psychosocial factors may determine what symptoms the woman reports, when she reports them, and the severity and impact of her symptoms on her daily functioning. Premenstrual syndrome, according to this concept, would be the result of maladjusted interactions among biological, psychological, and social factors.<sup>87</sup>

Though the biopsychosocial model amends some of the critiques that have been leveled against PMS research, it begins from the premise that a distinct clinical entity exists, an assumption still unproven. One also wonders what happens following a biopsychosocial diagnosis of PMS? Medical practitioners, and the State, sometimes express a desire to serve as paternal overseers of all aspects of women's lives<sup>88</sup>--not a desirable outcome--but, in fact, doctors' prescriptions are not for social interventions or political changes improving the conditions of women's lives. Most often, doctors prescribe drugs, surgery,

rest, exercise, dietary changes; in other words, they focus on the body in a vacuum. If counseling is prescribed, the remedy is more likely to encourage adapting oneself to one's circumstances than to altering situations that may be sickening. By contrast, feminist investigations of PMS focus primarily on social and political contexts and solutions.<sup>89</sup>

## FEMINIST ANALYSES OF PMS

As we saw in the last chapter, the 1970s was a period of tremendous feminist activity. Bringing menstruation out into the open as a subject for discussion and artistic representation, and an event for ritualized celebration,<sup>90</sup> was among many radical deeds of the time and unnerved many people. The 1976 book, The Curse: A Cultural History of Menstruation, applauds works by artist Judy Chicago (Red Flag, Menstruation Bathroom), and numerous other menses-related events of the early 1970s:

Women writers and artists are bringing menstruation itself out of the water closet and using it as an emblem of celebration, not shame. . . . And we believe that by approaching the subject "woman" through the most elementary and obvious aspect of womanhood, we will give our sisters a new respect for what has been, for most, a friendly monthly nuisance.<sup>91</sup>

The authors, Delaney, Lupton, and Toth, were among the first to protest the relentlessly negative presuppositions underlying menstrual cycle research. They countered with their own "Menstrual Joy Questionnaire" which asks women to evaluate their experience of this list of pleasures during different phases of the menstrual cycle: high spirits, increased sexual desire, vibrant activity, revolutionary zeal, intense concentration, feelings of affection, self-confidence, euphoria, creativity, and feelings of power.<sup>92</sup>

Two significant and popular books on the psychological and cultural aspects of menstruation were published in the 1970s. The aim of Weideger's 1976 book, subtitled "The Physiology and Psychology, the Myth and the Reality," was to confront the taboo against openly discussing menstruation and to present an "uncommon" outlook:

The uncommon view of menstruation and menopause begins with a new law: *Variation is the rule*. . . . In every instance in which uniformity of experience is supposed to exist, a new look will uncover variation.<sup>93</sup>

Weidinger's conclusion that difference rather than sameness is the rule did not come from reviewing published research alone. One of the strengths of the book is that she based much of it on responses to a detailed questionnaire in which nearly six hundred women discussed their experiences of and feelings about the menstrual cycle. (One of the book's weaknesses is its treatment of the subject of PMS: Weidinger gives a largely unquestioned synopsis of the medical model and expresses dismay that progesterone therapy was not taken more seriously by American doctors and made more available to American women.) Weidinger believes that we will never improve the social status of women without a change in attitudes about our biology, emotions, and cyclicity. She argues that the menstrual cycle is part of women's substance that needs to be reclaimed if women are to fully experience life.

The Wise Wound, published in Great Britain and the U.S. in 1978, is a unique work on menstruation, perhaps best described as a hybrid of poetry, politics, and psychoanalysis. It is certainly one of the most positive and eloquent explorations of the subject. Like Weidinger, Shuttle and Redgrove advocate lifting the silence imposed by old taboos and changing our social attitudes about menstruation. But they go further, advancing the argument that the menstrual cycle is "an unexplored resource"<sup>94</sup> that is "usually treated as a dustbin."<sup>95</sup> They describe the apparent "epidemic" in negative symptoms as the result of a vicious circle, or feedback loop, they term the "howlback circuit:"

First, there is how the woman feels in herself at the menstruation end of her cycle, the paramenstruum.

Secondly, there is the effect that her changes may have upon other people.

Thirdly, there is the way society may pay her back for these real or imagined disturbances.



. . . . *I am tabooed and this makes me feel horrible which causes me to behave unpleasantly so I am ostracized and tabooed so I continue to feel horrible and behave unpleasantly.*<sup>96</sup>

The authors express concern with the emphasis on understanding people through hormones, a tendency they see as resulting in part from the improved scientific technology for measuring hormone levels. They insist that human beings should not be understood as "hormone-robots" and suggest instead that we are "a webwork of psychological energies of which disease is a last-resort language, or a slave-language of riot after repression."<sup>97</sup> According to Shuttle and Redgrove's analysis, the paramenstrual time in the menstrual cycle represents an opening, a "moment of truth," in which the social oppression a woman regularly experiences becomes an intolerable outrage. In other words, perhaps "*society is a lie, and the period is a moment of truth which will not sustain lies:*"

Thus a woman may with all goodwill and a desire for a peaceful life keep her feelings quiet about some dissatisfaction with her life, a bad habit of her lover's, some discrimination against her because she is a woman, . . . . As a person conforming to society, she will for most of the month keep quiet about this, saying to herself, "it's all for the best. . . ." But then, maybe at the paramenstruum, the truth flares into her consciousness: this is an intolerable habit, she is discriminated against as a woman, . . . , I will not be a punch-ball to my loved ones, . . .<sup>98</sup>

Shuttle and Redgrove believe that another piece of the PMS puzzle is female sexuality; they refer to findings by various researchers of a paramenstrual peak in sexual interest in many women.<sup>99</sup> Honoring women's sexual needs and preferences might replace the "menstrual epidemic" with

the "Quadruply Sensuous woman" capable of enjoying without fear (and therefore on this hypothesis without pain) not only her orgasm, her

childbirth and her breast-feeding as deep erotic experiences, but menstruation also for what it can give.<sup>100</sup>

The Wise Wound offers a vision that in a society promoting equality and embracing the erotic the menstrual cycle would take on entirely different meanings than those now generally associated with it. The womb would not be viewed as bleeding tears at each period, femininity would not be defined as passive receptivity, the power of female sexuality would not be feared. Cyclical changes would be accepted as natural rather than dreaded as signs of physical abnormality or mental instability. The entire dynamic of women's relationships with their bodies would be transformed. In the 1980s this book was positively invoked<sup>101</sup> or derided<sup>102</sup> by other feminist scholars examining the same terrain.

Anthropologist Emily Martin picks up on the theme of premenstrual anger as symptomatic not of female illness but of social disease. Anger is viewed as more of a problem in women, particularly in light of their common role of peacemaker within the family. What are the possible reasons why "women might feel extreme rage at a time when their usual emotional controls are reduced?"<sup>103</sup>

. . . the sources of this diffuse anger could well come from women's perception, however inarticulate, of their oppression in society: of their lowered wage scales, lesser opportunities for advancement into high ranks, tacit omission from the language, coercion into roles inside the family and out that demand constant nurturance and self-denial--to only begin the list.<sup>104</sup>

Martin notes that some women seem to agree to being oppressed. She believes this is because of the way the hierarchy embedded in gender roles portrays men's authority as authentic and preordained. In combination with force or threat of force and uneven economic and political playing fields, women may not see any other alternative to the

gender system. If the causes of women's premenstrual anger are social, and were labeled and recognized as such, she speculates that women's anger could serve productively to connect them in their experience as an oppressed group, "instead of sending them individually to the doctor as patients to be fixed."<sup>105</sup>

Martin traces the distortion of menstrual experience to the requirements of an industrial economy in the nineteenth century.<sup>106</sup> The distorted meanings once attached to menstruation have been redirected at the premenstrual phase of the cycle. Martin contends that this shift in focus has occurred because the nature of women's experiential state just prior to menstruation is incompatible with the demands of the wage labor system. Because it operates within the same socioeconomic conditions, biological and medical science has cooperated in constructing this new definition of menstrual cycle pathology, framing the premenstruum as a period of emotional instability that is socially dysfunctional. She points out that a number of symptoms listed under the umbrella term PMS--for example, problems with mental concentration and physical coordination--could conflict with women's ability to execute mental or physical disciplines common to the kinds of jobs and household work women are especially likely to perform.

Martin concludes that in late industrial societies such as ours, PMS represents the continuing oppression of women rather than any physical abnormality in menstruating women.<sup>107</sup> The institution of science supports the economic status quo and cannot be expected to propose any solutions altering the present definition of menstrual cycle pathology. Instead of adjusting hormone levels, we could be considering how "the organization of society and work . . . might be transformed so that it could demand less constant discipline and productivity."<sup>108</sup> We could be looking for ways to organize time and work to take advantage of particular strengths of the menstrual cycle: "Are women, drawing on the different concepts of time and human capacities they experience, not only able to function in the world of work but able to mount a challenge which will transform

it?"<sup>109</sup> Martin assumes this can be done because of a consciousness and inclination for resistance grounded in practical experiences of living in a female body and, stereotypically, having primary responsibility for housekeeping.

Dena Taylor's Red Flower: Rethinking Menstruation<sup>110</sup> is like The Curse and The Wise Wound in recommending that menstruation be reclaimed by women and including positive reports of paramenstrual experience. Her book might be described as a "New Age" approach, emphasizing menstrual rituals, poetry, and dreams. In discussing PMS, Taylor encourages the kind of alternative medicine and home remedies found in some of the self-help books mentioned above. Like the medical, self-help, and popular literature, and unlike most of the other feminist authors discussed in this section, she accepts the medical definition of a premenstrual syndrome.

Two other books from the 1980s addressed the political uses of menstrual cycle research and cultural beliefs: Seeing Red: The Politics of Premenstrual Tension and Images of Bleeding: Menstruation as Ideology.<sup>111</sup> Seeing Red is a small collection of essays published in Great Britain that approaches PMS as a "medical invention" and "political construct"<sup>112</sup> which serves to lessen women's credibility and define female behavior in biological terms. The essays dispute the evidence for PMS pointing to the underlying ideological bias, examine the media coverage of the PMS court trials and critique their role in perpetuating the notion that women are "biologically unreliable,"<sup>113</sup> and discuss the relevance of the profit motive in the PMS phenomenon.<sup>114</sup>

Images of Bleeding surveys the history of menstruation ideology before exploring what a woman-centered view of menstruation might look like. Louise Lander suggests that menstruation is perceived as more intimidating to men than childbearing "because a menstruating woman represents freedom from the burdens of pregnancy and nursing and thereby poses a potential threat to the world of men."<sup>115</sup> The goals of defining women in terms of their reproductive function and maintaining their second class status has led to a

series of strategic campaigns rationalizing the institution of medicine's role in the process. Lander labels the four primary methods used moralizing, proscribing, psychologizing, and biologizing. PMS falls under the last category, which Lander describes as having a special appeal for women because their concerns have often been discounted by characterization as psychosomatic or neurotic. But biologizing premenstrual changes is no improvement because women are

simultaneously reduced to their hormone levels and their psychological state is discounted, . . . not because they are neurotic but rather because they are premenstrual. Rather than the psychosomatic hypothesis, medicine erects a somatopsychic hypothesis, the psyche controlled by the soma, by the ups and downs of hormone fluctuations.<sup>116</sup>

Lander classifies feminist responses to menstrual ideology in this century as either minimizing or glorifying menstruation, both of which she views as inadequate. Minimizers are described as attempting to downgrade the importance of the menstrual cycle in women's lives or eliminate menstruation altogether. She includes Shulamith Firestone, Germaine Greer, and proponents of menstrual extraction in this category.<sup>117</sup> In the case of menstrual extraction, Lander faults supporters for falling into "the conventional Western--and male--scientific notion of control over nature as opposed to cooperating with nature."<sup>118</sup> The glorifiers' camp, in which Lander situates feminists Shuttle and Redgrove, Adrienne Rich,<sup>119</sup> and Judy Chicago, is criticized for "rhetorical masturbation" and "ahistorical gushings."<sup>120</sup> While there is an important point to be made about the dangers of reverting to oppositional gender roles,<sup>121</sup> Lander's analysis fails to take into account the power of reclaiming and redefining what has been despised, not only for the individual but as a means for changing social perceptions and norms.

To map out a positive new direction for understanding the menstrual cycle, Lander finds helpful clues in biology:

that cyclicality is a function of life, not of femaleness; that hormonal influences affect both sexes and operate in extremely complex ways, with the causal arrows between hormones and behavior pointing in both directions; and that from an evolutionary perspective the way modern human females experience menstruation is anomalous.<sup>122</sup>

Unfortunately, as we have seen, the medical and popular discourse on PMS that wins public attention does not deliver this information; it reinforces a belief in female cyclicality and hormones (and their connection with reproductivity) as defining characteristics of the female sex.

Finally, having touched on feminist artistic, psychological, cultural, anthropological, and political reflections, we look at PMS from the viewpoint of a feminist philosopher. Jacquelyn Zita exposes a number of epistemological problems with the medical model of PMS. She zeroes in the "epistemic leap" involved in "the step from observable cyclicality to the presumption of pathology, which requires disease-model thinking."<sup>123</sup>

According to Zita, women's statements about their experience are first codified as negative symptoms from a masculinist standpoint. Cyclicality is assumed to be female deviance from a male standard of non-cyclicality. Behaviors and moods such as assertiveness and anger are seen as deviating from feminine norms of passivity and geniality. This medical focus on the negative and on deviance from a male standard facilitates "the transition from simple descriptive language to disease-model theorizing."<sup>124</sup> Informal, subjective language of female experience is codified into "quantifiable symptoms and signs sharing in common a pattern of premenstrual cyclicality."<sup>125</sup> Frequently, women's subjective reports contain stereotypical attitudes about the menstrual cycle and female traits which are then built into this first level of theory formulation.

At the second level, the description is detached from the context of the woman's situation and her reactions to it. Her behaviors are measured against what is perceived as correct social behavior. Additional coding of the initial information defines the experience as a member of a complex of symptoms. In the process, "the specific meanings of many women's sufferings and anger are homogenized and reified into generic categories. . . which point towards an underlying yet indeterminate pathology."<sup>126</sup> Given the large and varied list of symptoms being used to identify the syndrome, almost any cyclic change in emotion, behavior, or physical condition fits the diagnosis of PMS. Thus:

This linguistic tour de force is preconditioned by hidden research assumptions which presume the negativity of premenstrual changes, leave unclear the baseline against which deviation is measured, and expand the list of symptoms so that the syndrome seems to become a fact about women or women's nature.<sup>127</sup>

As an alternative perspective to the medicalized body, Zita suggests we recognize how the body is "symbolically mediated."<sup>128</sup> As such the body is open to myriad constructions dependent upon how the subject and observer interpret it. She hastens to add that this view does not preclude acknowledging intrinsic dysfunctions or pathologies which may hurt or incapacitate and which may or may not be curable. Premenstrual distress, sometimes severe, is a reality for some women. Yet ignoring the influence of life circumstances, ideology, and sociocognitive factors on experience leaves us with an incomplete understanding of that reality. The areas of concern to Zita are central to the research on attributional approaches to premenstrual experience.

### Attribution Theory and PMS

A major complaint of social science researchers is the ignoring of external variables such as social circumstances and cultural beliefs in much of the medical and psychological

research on PMS. When is anger justified and when is it symptomatic of illness? Why are particular behaviors viewed by society as improper, even abnormal in women?: "Who has been given the authority to interpret the female body and are those interpretations not influenced by misogynist assumptions and socio-cognitive factors that affect perception?"<sup>129</sup> A number of feminist researchers have begun asking such questions.

In the 1970s and 80s, social scientists became increasingly involved in menstrual cycle research, frequently including the role of stereotyped beliefs and social expectations in women's experience of the cycle.<sup>130</sup> The theory behind this approach is that women report physical and emotional symptoms which they expect to have in the paramenstruum. (Premenstrual experiences are neither denied or reified in this research.) The research has gone under various names, e.g., stereotyped beliefs,<sup>131</sup> social cognition,<sup>132</sup> and attribution.<sup>133</sup> Attribution studies ask: how do attitudes and feelings affect the experience and reporting of cyclical changes? Are reported changes a reflection of social beliefs and feelings about the menstrual cycle. Do reported changes mirror learned beliefs or direct experience?<sup>134</sup>

One of the most cited articles on menstruation from the seventies was "Women Learn to Sing the Menstrual Blues" in which Karen Paige found a correlation between the religious beliefs of Catholic and orthodox Jewish women and negative menstrual symptoms.<sup>135</sup> Others, examining the potential impact of attitudes toward menarche on later responses to menstrual cycle experience, believe that the "subjective context in which it [menarche] occurs might influence the capacity of some women to respond positively or negatively to the events of the biological cycle."<sup>136</sup>

In a 1977 study by Ruble, forty-four Princeton undergraduates were told the study was related to contraception and involved a new method using an electroencephalogram (EEG) to predict the date menses would start. After a simulated EEG, each woman was told that 1) her period was expected in one or two days, 2) her period was due in a week



to ten days, or, 3) she was given no information. Using menstrual cycle histories, the testing dates were scheduled to be on the estimated sixth or seventh day before the next menstrual period. After the EEG, each subject was given the Moos MDQ (Menstrual Distress Questionnaire) and afterwards told the actual purpose of the study. Researchers later contacted subjects to learn the date of menstrual period onset. Women who had been told that they were premenstrual reported more premenstrual physical symptoms than women who thought that they were intermenstrual. Women who were told they were premenstrual did not report negative moods any more frequently than did women who were told they were not premenstrual. Ruble deduced that one of two things is probably happening here: what a woman has learned to associate with or think about the menstrual cycle may influence her to overstate her real experience; or, when she thinks she is premenstrual, a woman's perception of normal cyclical changes may be magnified.<sup>137</sup>

Other studies have reflected the pervasiveness of negative stereotypical beliefs about the menstrual cycle. One survey of college students found that three-quarters of the men and one-third of the women thought that female cognition was influenced by menstruation; the majority of women and men assumed that menstruation impairs women's ability to function well.<sup>138</sup> Sommer noted that the results of many studies based on self-reports indicate that women frequently assume that the biology of the menstrual cycle lessens cognitive abilities, including concentration.<sup>139</sup>

Koeske is the foremost researcher in the field of attribution research. Her work, and that of most others interested in this topic, is strongly influenced by the 1962 study by Schachter and Singer, summarized in Chapter Four.<sup>140</sup> Koeske's results support the notion that there is a "premenstrual increase in arousability or sensitivity."<sup>141</sup> She argues that awareness of menstrual cycle phase--particularly the paramenstruum--provides an explanatory label for disturbing feelings of anger, tension, insecurity which might otherwise be seen as unexplainable or given a different explanation.

Koeske's study of premenstrual emotionality found that negative premenstrual experiences are attributed to biology whereas positive ones are attributed to the situation or to personal factors:

when premenstrual negative behavior is ascribed to the influence of biology, the situational factors simultaneously influencing it are discounted in importance and the behavior is judged more extreme. . . . more unreasonable and unjustifiable, and more indicative of a changeable (i.e., temperamental, irrational, and immature) personality than identical behavior displayed by either a non-premenstrual female or a male. . . . [This] attribution pattern points to a mechanism assuring the persistence of a negative stereotype in the face of disconfirming evidence and it isolates a belief system capable of construing not-so-uncommon behavior as unusual, inexplicable, and somehow less tied to the situation at hand.<sup>142</sup>

In other words, behavior perceived negatively is seen as proof of negative stereotypes of female emotionality; positive behavior is seen as unrelated to biology. Koeske considers two possible explanations for this finding.

First, negative behaviors such as aggression and hostility are viewed as abnormal for women and therefore best explained by influences other than the situational context. "Nice" behaviors are perceived as normal for women and unremarkable. Second, women may cite PMS to explain their negative behaviors: "I wasn't myself," "I was out of control." (Koeske points out that excuse behavior is common in men and women describing their own negative behavior.) Of course, using biology in this way tends to support the negative stereotype of women.

Koeske has found preliminary support for a hypothesis that positive or negative emotions are heightened in the premenstrual phase, depending upon the existing situational cues. Moods during the premenstruum were "more strongly related to the

situation than moods occurring at other cycle phases for women or for men" and "premenstrual negative moods occur only in stressful environments."<sup>143</sup> Koeske suggests that because of increased sensitivity to emotional responses, a woman's body can become more of a helpful indicator of her state than her head alone can be.

## SUMMARY

PMS made headlines in the 1980s, in popular and professional venues. Newspapers, magazines, talk shows, standup comics, novelty vendors, clinics, researchers, and writers partook in the creation of a trend. The widely publicized lists of symptoms convinced many women--and/or their partners--that premenstrual changes, whether occasional or monthly, minor or severe, constituted a medical problem. A large self-help industry grew up alongside, and sometimes in league with, the medical profession and dispensed aid in the forms of literature, pharmaceuticals, and support groups.

In the early to mid-eighties as the floodlights of media attention peaked, PMS was being cited as the cause of lowered cognitive and work performance, increased absenteeism, and erratic, violent, and criminal behaviors. Destroyer of families,crippler of industry, PMS sounded like a perfect rationale for limiting women's participation in the public sphere. Such concerns had long appeared in the medical literature; now popular media joined in sounding the alarm.

Medical science pursued PMS from every etiological and treatment angle, but the endocrine system was most frequently implicated by researchers. Eventually, the medical profession began curbing its exuberance and more carefully scrutinizing its data, without necessarily questioning its underlying assumptions. Numerous researchers began making clearer distinctions between the common experience of some premenstrual changes and the rarer problem of frequent, severe, painful premenstrual symptoms. Explanatory models have become more and more complicated with no single one gaining widespread acceptance from the medical community at this time. Dalton, however, remained confident in her analysis of cause and cure.

Alternative treatments of the subject examined the connection between the negative meanings this culture holds for menstruation, the history of discrimination against

women, and the premenstrual expression of strong emotion, especially anger. Feminists have derided and debunked the raging hormones theory but some are looking toward a biology less predicated on sex difference and more interested in life cycles.

Attributional approaches to premenstrual experience may do the best job, at this point, in representing human symbolicity and biology enmeshed in a social network. It may also be the most hopeful direction in the research, though not in terms of easily erasing painful, discordant feelings. Proponents of attribution theory are open to the premenstrual time as a potentiality not yet understood. If it is a period of greater sensitivity and arousability for women, the Menstrual Joy Questionnaire is as cogent as all the measurements of distress. Is it possible to exchange being "on the rag" for having "windows of sensitivity" without placing women back on the pedestal of purity? If the legitimacy of women's anger at injustices were acknowledged, would it fuel more needed social change instead of becoming, turned inward, guilt, depression, and self-hatred?

From its inception as a medical phenomenon in the 1930s to its peak in the 1980s, PMS has been discussed in terms of purported negative social consequences from premenstrual women, who have been frequently portrayed as victims of powerful female hormones who then victimize those around them. Most of the women's voices heard in the debate thus far have represented distinct points of view: medical and social science researchers, consumer activists, feminist critics. In the next three chapters, more women's voices are brought into the discussion, both the voices of women who identify their experience with PMS, and the voices of those who do not.

## NOTES

<sup>1</sup> P. M. Shaughn O'Brien, Premenstrual Syndrome (Oxford: Blackwell Scientific Publications, 1987) 32-3. See Linda R. Chait, "Premenstrual Syndrome & Our Sisters in Crime: A Feminist Dilemma," Women's Rights Law Reporter 9 (1986): 267-293, for details on the two British trials. Chait also describes the 1982 U.S. case in which Shirley Santos' attorney filed a motion to dismiss charges against Santos because Santos suffered from premenstrual syndrome.

<sup>2</sup> Also see writings by Dalton regarding the use of PMS as a legal defense, "Cyclical Criminal Acts in Premenstrual Syndrome," Lancet 2 (1980): 1070-71; "Should Premenstrual Syndrome Be a Legal Defense?," ed. Benson E. Ginsburg and Bonnie Frank Carter, Premenstrual Syndrome: Ethical and Legal Implications in a Biomedical Perspective (New York: Plenum Press, 1987) 287-300.

<sup>3</sup> See Amanda Rittenhouse on the popularity of articles about the trials: The Emergence of Premenstrual Syndrome: The Social History of a Women's Health "Problem," diss., U of California at San Francisco, 1989.

<sup>4</sup> Susan Jacoby points out that, as of 1983, the PMS defense has only been proposed in cases where women have attacked husbands, children, or boyfriends. See Susan Jacoby, Wild Justice: The Evolution of Revenge (New York: Harper & Row, Publishers, 1983).

<sup>5</sup> There were few popular articles on PMS before 1981. A search of The Readers' Guide to Periodical Literature from 1931 to 1980 produced only 24 references, beginning in 1954.

<sup>6</sup> Carol Tavris, The Mismeasure of Woman, (New York: Simon & Schuster, 1992) 135.

<sup>7</sup> Janice Delaney, Mary Jane Lupton, and Emily Toth, The Curse: A Cultural History of Menstruation (New York: E.P. Dutton & Co., Inc., 1976).

<sup>8</sup> For example, I picked up this book in a game store in San Francisco: Florence Schlots, The PMS Book (Watertown: Ivory Tower Publishing Company, Inc., 1988). It is also available in Canada, Australia, New Zealand, and the United Kingdom. I found the door sign in a "new age" variety shop (herbs, books, trinkets, etc.) in a Maryland suburb. The sign reads, "Warning! PMS Attack" and features an old-looking photo of a crying woman.

<sup>9</sup> It also brings to mind the old idea that women are closer to animals than men are.

<sup>10</sup> Marie Annette Brown and Phyllis Arn Zimmer, "Help-Seeking for Premenstrual Symptomatology: A Description of Women's Experiences," Culture, Society, and Menstruation, ed. Virginia L. Olesen and Nancy Fugate Woods (Washington, D.C.: Hemisphere Publishing Corporation, 1986) 173-84.

<sup>11</sup> Deborah Levitt, Ellen W. Freeman, Steven J. Sondheimer, and Karl Rickels, "Group Support in the Treatment of PMS," Journal of Psychosocial Nursing 26.1 (1986): 23-27; Diana Taylor and Laura Bledsoe, "Peer Support, PMS, and Stress: A Pilot Study," Olesen and Woods, 159-71.

<sup>12</sup> Andrea Eagan, "The Selling of Premenstrual Syndrome: Who Profits from Making PMS 'the Disease of the 1980's?'" Sophie Laws, Valerie Hey, and Andrea Eagan, Seeing Red: The Politics of Premenstrual Tension (London: Hutchinson and Co., 1985) 87. In the same article, Eagan discusses the questionable qualifications and ethics of the man who opened the first PMS clinic in the U.S.

<sup>13</sup> A phone call to their 800 number in 1993 yielded a lengthy recorded message with information on how to order their "ProCycle" vitamin/mineral supplements which allow "millions of women" to control their premenstrual symptoms.

<sup>14</sup> Jo Ann Cutler Friedrich, The Premenstrual Solution: How to Tame the Shrew in You (San Jose: Arrow Press, 1987); Judy Lever, Pre-Menstrual Tension (New York: McGraw-Hill Book Co., 1981); Katharina Dalton, Once a Month, 2nd rev. ed. (Claremont: Hunter House, 1983); Ronald V. Norris, "Clinical Management of the Premenstrual Tension Syndrome," Premenstrual Syndrome and Dysmenorrhea, ed. M. Yusoff Dawood, John L. McGuire, and Laurence M. Demers (Baltimore and Munich: Urban & Schwarzenberg, 1985) 67-75.

<sup>15</sup> Wendy Kaminer points out the political function self-help literature serves by encouraging readers to make themselves more "socially congenial." See Wendy Kaminer, I'm Dysfunctional. You're Dysfunctional: The Recovery Movement and Other Self-Help Fashions (Reading, Mass.: Addison-Wesley Publishing Company, Inc., 1992) 164.

<sup>16</sup> Dalton, 1983, xiii.

<sup>17</sup> Dalton, 1983, 167.

<sup>18</sup> Dalton, 1983, 213.

<sup>19</sup> Coventry Evening Telegram, July 15, 1982; cited in Esther Rome, "Premenstrual Syndrome (PMS) Examined through a Feminist Lens," Olesen and Woods, 147.

<sup>20</sup> Norris, 119-22; 257-68. Norris's list is the longest. Queen Victoria and Lizzie Borden are most frequently mentioned. See David Stannard's critique of the reductionism of much psychohistory in Shrinking History: On Freud and the Failure of Psychotherapy (New York: Oxford University Press, 1980).



<sup>21</sup> Norris, 123.

<sup>22</sup> See Catherine A. MacKinnon's review of Ann Jones' book, Women Who Kill, in "Toward a Feminist Jurisprudence," Stanford Law Review 34 (1982): 734, on the subject of women who break stereotype and kill men, usually men who have been abusive to them over time: "how do you excuse an act as a rational response consistent with women's condition when the act itself is not only exceptional among women, but directly inconsistent with women's conditioning? Any person under these conditions would react this way--but Ann Jones shows how women are not permitted to become persons, or to see themselves as persons, or to act."

<sup>23</sup> Friedrich; Caroline Shreeve, The Premenstrual Syndrome (Wellingborough: Thorsons Publishing Group, 1983). Other books endorsing Evening Primrose oil include Ann Nazzaro, Donald Lombard, and David Horrobin, The PMS Solution: Premenstrual Syndrome: The Nutritional Approach (Montreal: Eden Press, 1985); Linda Ojeda, Exclusively Female: A Nutrition Guide for Better Menstrual Health, 2nd. rev. ed. (Claremont: Hunter House, Inc., Publishers, 1983); and Stella Weller, Pain-Free Periods: Natural Ways to Overcome Menstrual Problems (Rochester: Thorsons Publishers, Inc., 1987).

<sup>24</sup> Beryl Kingston, You Can Relieve Menstrual Problems: A Modern Woman's Guide, rev. Am. ed. (Englewood Cliffs: Prentice-Hall, Inc., 1982).

<sup>25</sup> Susan M. Lark, Dr. Susan Lark's Premenstrual Syndrome Self-Help Book (Los Angeles: Forman Publishing, Inc., 1984).

<sup>26</sup> Michelle Harrison, Self-Help for Premenstrual Syndrome, rev.ed. (New York: Random House, 1982); Reni L. Witt, PMS: What Every Woman Should Know About Premenstrual Syndrome (New York: Stein and Day, 1984).

27 Dalton 1983; Lever; Ronald V. Norris with Colleen Sullivan, PMS: Premenstrual Syndrome (New York: Berkley Books, 1984).

28 See Lawrence Sanders' best-selling novel about a violent murderer who kills during her premenstruum: The Thirdly Deadly Sin (New York: Berkley Books, 1981).

29 Media images of women's roles continue to be limiting and trivializing. See, e.g., Gaye Tuchman, Arlene Kaplan Daniels, and James Benet, ed., Hearth and Home: Images of Women in the Mass Media (New York: Oxford University Press, 1978); and Kathryn Weibel, Mirror, Mirror: Images of Women Reflected in Popular Culture (Garden City: Anchor Press, 1977).

30 Rittenhouse used Index Medicus. Tavis reports the results of a computer search: medical journals articles on PMS, Premenstrual Syndrome, and Premenstrual Tension, 1970s: 549; 1980s: 1118; psychological journals: 1970s: 66; 1980s: 365.

31 Virginia Cassara, "A View from the Top of a Consumer Organization," Ginsburg and Carter, 207-12.

32 Rittenhouse points this out; see Robert L. Reid and S. S. C. Yen, "Premenstrual Syndrome," American Journal of Obstetrics and Gynecology 139 (1981): 921-26.

33 E. Gonzalez, "Premenstrual Syndrome: An Ancient Woe Deserving of Modern Scrutiny," Journal of the American Medical Association 245(1981): 1393; cited by Mary Roth Walsh, The Psychology of Women: Ongoing Debates (New Haven: Yale University Press, 1987) 129.

34 Linford Rees, "The Premenstrual Tension Syndrome and its Treatment," British Medical Journal 5/9/53: 1014-16.

35 H. Sutherland and I. Stewart, "A Critical Analysis of Premenstrual Syndrome," Lancet 2 (1965): 1180-83.

<sup>36</sup> See Dawn Mills, Premenstrual Syndrome: A Comparison of Diagnostic Methods, diss., U of California at Berkeley, 1992, for a discussion of the problems in separating PMS from normal fluctuations and stress-related changes.

<sup>37</sup> Linda Gannon, Menstrual Disorders and Menopause: Biological, Psychological and Cultural Research (New York: Praeger Publishers, 1985).

<sup>38</sup> See Penny Budoff, No More Menstrual Cramps and Other Good News (New York: Putnam, 1980). Also see K. J. Lennane and J. R. Lennane's article on the sexism involved in psychosomatic diagnoses of dysmenorrhea: "Alleged Psychogenic Disorders in Women: Possible Manifestation of Sexual Prejudice," New England Journal of Medicine 288 (1973): 288-92.

<sup>39</sup> It is interesting to note a difference in the way menstrual cramps and premenstrual symptoms are treated in the medical and popular literature of recent years. Cramps are a common experience for many women but dysmenorrhea, severe, painful cramping, is understood to be a problem afflicting a small percentage of women. See Barbara Sommer, "Menstrual Distress," The Complete Book of Women's Health, ed. Gail Hongladarom, Ruther McCorkle, and Nancy Woods (New Jersey: Prentice Hall, 1982). Unlike PMS, dysmenorrhea is not regularly depicted as incapacitating or hampering the majority of women.

<sup>40</sup> Louise Lander, Images of Bleeding: Menstruation as Ideology (New York: Orlando Press, 1988).

<sup>41</sup> Sally K. Severino and Margaret L. Moline, Premenstrual Syndrome: A Clinician's Guide (New York: The Guildford Press, 1989) 94-131. The evolutionary theory is based on the idea that PMS has survival value. Hostility expressed by females premenstrually would stymie mating during that phase, increasing male desire during the next fertile period and improving likelihood of conception. Or, the same hostility would

tend to terminate infertile relationships, creating opportunities for new fertile relationships to develop (because fertile females would not experience enough menstrual cycles for PMS to be noticeable).

<sup>42</sup> See Ablanap's concise overview of the literature through the mid 1980s: Judith M. Ablanap, "Premenstrual Syndrome: A Selective Review," Lifting the Curse of Menstruation: A Feminist Appraisal of the Influence of Menstruation in Women's Lives, ed. Sharon Golub (New York: Harrington Park Press, Inc., 1985) 107-23.

<sup>43</sup> O'Brien, 197.

<sup>44</sup> American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 3rd ed., rev. (Washington, DC: American Psychiatric Association, 1987) 367. For the distinction between LLPDD and PMS, see Severino and Moline.

<sup>45</sup> Severino and Moline, 261.

<sup>46</sup> Severino and Moline, 138.

<sup>47</sup> In the last several years, Rubinow has proposed three psychological models of PMS: sensitization, learned helplessness, and state regulation. See B. L. Frankel and David R. Rubinow, "The Premenstrual Syndromes," Modern Perspectives in Clinical Psychiatry, ed. J. Howells (New York: Brunner/Mazel, 1988) 170-86; David R. Rubinow and Peter J. Schmidt, "Models for Development and Expression of Symptoms in Premenstrual Syndrome," Psychiatric Clinics of North America 12.1 (1989): 53-68..

<sup>48</sup> Malkah T. Notman, "The Psychoanalytic Approach," Premenstrual Tension: A Multidisciplinary Approach, ed. Charles H. Debrovner (New York: Human Sciences Press, Inc., 1982) 51-69.

<sup>49</sup> Locus of control refers to "a generalized expectancy that events are either more under personal control (internal) or controlled by external forces, such as fate, luck, or others (external)." See Severino and Moline, 81.

<sup>50</sup> Severino and Moline, 81. Also see Gandelman's study which "somewhat supported" the hypothesis that women with PMS are more likely to have an external locus of control. Her study found a stronger correlation between high self esteem and low incidence of PMS. Alice Gandelman, Locus of Control and Premenstrual Syndrome, thesis, San Jose State U, 1985.

<sup>51</sup> Severino and Moline, 132-35. Also see Nancy Fugate Woods, Gretchen Kramer Dery, and Ada Most, "Stressful Life Events and Premenstrual Symptoms," Journal of Human Stress 8 (1982a): 23-31.

<sup>52</sup> Georgia Witkin-Lanoil, "All in Your Head," Health July 1985: 6.

<sup>53</sup> Dalton, 1984, 228-33. In her review of nine studies of menstrual cycle influences on higher level intellectual functions, Barbara Sommer reported that only Dalton found lowered performance during the paramenstruum; the rest of the studies found no differences across the phases of the menstrual cycle (cited in Severino and Moline, 90). In a later review article, Sommer determined that "Taking all of the reviewed studies in their entirety, the conclusion is that among the general population of women, menstrual cycle variables do not interfere with cognitive abilities." See "How does Menstruation Affect Cognitive Competence and Psychophysiological Response?" Women & Health 8 (1983): 86.

<sup>54</sup> Joan Chrisler, "The Effect of Premenstrual Symptoms on Creative Thinking," Menstruation, Health, and Illness, ed. Diana Taylor and Nancy F. Woods (New York: Hemisphere Publishing Corporation, 1991) 74.

<sup>55</sup> Mary Brown Parlee, "Positive Changes in Moods and Activation Levels during the Menstrual Cycle in Experimentally Naive Subjects." The Menstrual Cycle, Volume 1, ed. Alice J. Dan, Effie A. Graham, and Carol P. Beecher (New York: Springer Publishing Company, 1980) 247-63.

<sup>56</sup> Chrisler.

<sup>57</sup> In much of the literature on prevalence of negative social side effects, the significance of the statistics used are not measured. Apparently it is presumed that increased incidence rates around the time of the premenstruum do not require further analysis. Results based on women who have had accidents are used to demonstrate *all* women's accident proneness premenstrually.

<sup>58</sup> Dalton, 1984, 238

<sup>59</sup> Dalton, 1984, 233-35.

<sup>60</sup> Paula Englander-Golden, Frank J. Sonleitner, Mary R. Whitmore, and Gail J. M. Corbley, "Social and Menstrual Cycles: Methodological and Substantive Findings," Olesen and Woods, 77. They state that the results of their work demonstrate that "childcare, rather than personal illness mediates sex differences in absence from work."

<sup>61</sup> Dalton, 1984, 236-38.

<sup>62</sup> Dalton, 1984, 240. Concern about PMS having a negative impact on the family has appeared in the literature from the beginning. For examples, see Robert T. Frank, "The Hormonal Causes of PMT," Archives of Neurological Psychiatry 26 (1931): 1052; S. Leon Israel, "Premenstrual Tension," Journal of the American Medical Association 110 (1938): 1721-23; Katharina Dalton and Raymond Greene, "The Premenstrual Syndrome" British Medical Journal 1 (1953) 1007-1014.

<sup>63</sup> Dalton, 1984, 241.

<sup>64</sup> Dalton, 1984, 243-45.

<sup>65</sup> J. Robert Willson, Elsie Reid Carrington, and William J. Ledger, Obstetrics and Gynecology, 7th ed (St. Louis: The C.V. Mosby Company, 1983).

<sup>66</sup> Dalton, 1979, 179.

<sup>67</sup> The first American edition of Dalton's Once a Month was published by Hunter House in 1979.

<sup>68</sup> Mary Brown Parlee, "The Premenstrual Syndrome," Psychological Bulletin 80 (1973): 454-65, pointed out several weaknesses in Dalton's use of correlational statistics; Gwyneth A. Sampson's article, "Premenstrual Syndrome: A Double-Blind Controlled Trial of Progesterone and Placebo," British Journal of Psychiatry 135 (1979): 209, found "no significant difference between progesterone and placebo in reducing symptoms of premenstrual syndrome, and in the majority of cases placebo was more effective, although never significantly so."

<sup>69</sup> Ellen Freeman, Karl Rickels, Steven J. Sondheimer, and Marcia Polansky, "Ineffectiveness of Progesterone Suppository Treatment for Premenstrual Syndrome," Journal of the American Medical Association 264 (1990): 349-53.

<sup>70</sup> Peter J. Schmidt, Lynnette K. Nieman, Gay N. Grover, Kari L. Muller, George R. Merriam, and David R. Rubinow, "Lack of Effect of Induced Menses on Symptoms in Women with Premenstrual Syndrome," New England Journal of Medicine 324 (1991): 1179.

<sup>71</sup> Tavris, 346.

<sup>72</sup> Mary Ellen Robertson, "A Survey of Multidimensional and Interdisciplinary Approaches to Premenstrual Syndrome," Menstruation, Health, and Illness, Taylor and Woods, 129-42.

<sup>73</sup> Studies disproving studies that make front page stories often receive a fraction of the media coverage, if any.

<sup>74</sup> A few people offered critiques and posed serious questions about the research before the mid-eighties. A 1973 article by Mary Brown Parlee focused primarily on weakness in the psychological studies of PMS but also critiqued the work of Katharina

Dalton. From all of the work she reviewed, Parlee found no well-founded proof for the existence of a measurable premenstrual syndrome. The next year she wrote a critique of Moos' widely used Menstrual Distress Questionnaire, concluding that there is "no strong reason to suppose that a woman's responses on the MDQ do in fact represent reports of her direct personal experience of psychological changes throughout the menstrual cycle." Randi Daimon Koeske, "Theoretical and Conceptual Complexities in the Design and Analysis of Menstrual Cycle Research," The Menstrual Cycle, Vol. 2: Research and Implications for Women's Health, ed. Pauline Komnenich, Maryellen McSweeney, Janice A. Noack, and Nathalie Elder (New York: Springer, 1981), stressed that there is a dynamic interaction of variables often ignored by menstrual cycle researchers, leading to significant conceptualizing, measuring, and analyzing errors. She recommended more emphasis on positive and negative behaviors in normal samples. Parlee (same volume) is critical of psychological research on the menstrual cycle that ignores the life contexts of the women and events studied. Parlee advised more cross-disciplinary research as a means of examining assumptions, and more research on the process and emotional concomitants of women acquiring information and experience of the menstrual cycle; see Parlee, "Gaps in Behavioral Research on the Menstrual Cycle," Komnenich, et al, 1981, 45-53.

<sup>75</sup> Robert L. Reid, "Premenstrual Syndrome: A Time for Introspection," American Journal of Obstetrics and Gynecology 155 (1986): 921-26.

<sup>76</sup> Jeanne Brooks-Gunn, "Editorial: Differentiating Premenstrual Symptoms and Syndromes," Psychosomatic Medicine 48 (1986): 386.

<sup>77</sup> Reid, 922.

<sup>78</sup> Margie Ripper, "A Comparison of the Effect of the Menstrual Cycle and the Social Week on Mood, Sexual Interest, and Self-Assessed Performance," Taylor and



Woods, 20. Concentrating on the severity of symptoms during the premenstrual phase will not identify chronic problems lasting throughout the cycle or what has been referred to as premenstrual magnification, the intensification of existing symptoms premenstrually. See Michelle Harrison's explanation of premenstrual magnification, 30-32.

<sup>79</sup> Ripper, 21.

<sup>80</sup> See discussion of attribution theory, below.

<sup>81</sup> Mary Brown Parlee, "Stereotypic Beliefs about Menstruation: A Methodological Note on the Moos Menstrual Distress Questionnaire and Some New Data," Psychosomatic Medicine 36 (1974): 229-40; Diane N. Ruble and Jeanne Brooks-Gunn, "Menstrual Symptoms: A Social Cognitive Analysis," Journal of Behavioral Medicine 12.2 (1979): 171-94; Nancy Fugate Woods, Ada Most, and Gretchen Kramer Dery, "Prevalence of Perimenstrual Symptoms," American Journal of Public Health 72 (1982): 1257-64.

<sup>82</sup> Randi Daimon Koeske and G. F. Koeske, "An Attributional Approach to Moods and the Menstrual Cycle," Journal of Personality and Social Psychology 31 (1975): 473-78; Diane N. Ruble and Jeanne Brooks-Gunn, "A Developmental Analysis of Menstrual Distress in Adolescence," Behavior and the Menstrual Cycle, ed. Richard C. Friedman (New York: Marcel Dekker, 1982); Parlee, 1980. See a more detailed discussion, below.

<sup>83</sup> O'Brien, 202.

<sup>84</sup> Doreen Asso, The Real Menstrual Cycle (New York: John Wiley & Sons, 1983) 144.

<sup>85</sup> Asso, 151.

<sup>86</sup> Severino and Moline. See also Peg Miota, Mary Hahle, and Carole Bartz, "Premenstrual Syndrome: A Bio-Psycho-Social Approach to Treatment," Taylor and Woods, 143-52. The 1986 book Culture, Society, and Menstruation, edited by Olesen and Woods, dubs women "socio-bio-cultural actors," xi.

<sup>87</sup> Severino and Moline, 91.

<sup>88</sup> For example, see Chapter Three on early days of Obstetrics and Gynecology.

<sup>89</sup> There are exceptions in the popular literature, e.g., Kaaren A. Nichols' article, "PMS: Premenstrual Syndrome or Strength?," EastWest Journal January 1987: 50-51.

<sup>90</sup> A wonderful editorial by Gloria Steinem posits that "if men could menstruate," "Boys would mark the onset of menses, that longed-for proof of manhood, with religious ritual and stag parties." See "If Men Could Menstruate: A Political Fantasy," Ms Oct. 1978: 110.

<sup>91</sup> Janice Delaney, Mary Jane Lupton, and Emily Toth, The Curse: A Cultural History of Menstruation (New York: E.P. Dutton & Co., Inc., 1976) 237-242. See also, C. Matria and Patricia Mullen, "Reclaiming Menstruation: A Study of Alienation and Repossession," Women and Health 3.3 (1978): 23-30; Penelope Washbourn, "Becoming Woman: Menstruation as Spiritual Experience," Womanspirit Rising, ed. Carol P. Christ and Judith Plaskow (San Francisco: Harper & Row, Publishers, 1979) 246-58; Emily Culpepper, "Exploring Menstrual Attitudes," Women Look at Biology Looking at Women ed. Ruth Hubbard, Mary Sue Henefrin, and Barbara Fried (Cambridge: Schenkman Publishing Co., 1979) 135-61. For a critical view, see Lander's analysis of "feminist glorifiers," 122-25, and my discussion in note 102 below.

<sup>92</sup> Other authors who discuss positive aspects of the cycle include Penelope Shuttle and Peter Redgrove, The Wise Wound: Eve's Curse and Everywoman (New

York: Richard Marek Publishers, 1978) and Emily Martin, The Woman in the Body: A Cultural Analysis of Reproduction (Boston: Beacon Press, 1987).

93 Paula Weideger, Menstruation & Menopause: The Physiology and Psychology, the Myth and the Reality (New York: Alfred A. Knopf, 1976) 5.

94 Shuttle and Redgrove, 13.

95 Shuttle and Redgrove, 41.

96 Shuttle and Redgrove, 44.

97 Shuttle and Redgrove, 46-47.

98 Shuttle and Redgrove, 56-57. In my interviews with women, described in the three chapters which follow, I found that the issues that women cited as the source of marital and relationship conflicts during the paramenstruum were usually related to feelings of dissatisfaction and unfairness in their lives, as in the examples offered by Shuttle and Redgrove.

99 Shuttle and Redgrove, 83-89.

100 Shuttle and Redgrove, 84.

101 For example, see Martin, 1987, and "Premenstrual Syndrome: Discipline, Work, and Anger in Late Industrial Societies," Blood Magic: The Anthropology of Menstruation, ed. and intr. Thomas Buckley and Alma Gottlieb (Berkeley: University of California Press, 1988) 161-81; Dena Taylor, Red Flower: Rethinking Menstruation (Freedom: The Crossing Press, 1988).

102 Lander groups Shuttle and Redgrove with other "menstrual glorifiers" whom she sees as falling into an apolitical, ahistorical, biological determinist trap. Lander fails to consider their argument about the politics of paramenstrual symptomatology as representing repressed anger at social inequities. See also Haunani-Kay Trask's response to accusations that the work of "cultural feminists" such as Adrienne Rich and Susan

Griffin idealizes female sexuality and nurturance without advocating structural change. Trask points to the important role of the "critical consciousness" linked to female physicality and the experience of mothering that these authors bring to their analyses of the power imbalance between women and men. Haunani-Kay Trask, Eros and Power: The Promise of Feminist Theory (Philadelphia: University of Pennsylvania Press, 1986).

<sup>103</sup> Martin, 1987, 175.

<sup>104</sup> Martin, 1987, 177.

<sup>105</sup> Martin, 1987, 178. Also see Lander, 8.

<sup>106</sup> Also see Siobhan D. Harlow's analysis of the persistent myth that menstruation makes women inferior workers and leads to large losses of work time: "Function and Dysfunction: A Historical Critique of the Literature on Menstruation and Work," Olesen and Woods, 39-50. Harlow demonstrates that the little literature available on the subject of menstruation and work does not support the popular belief that menstruation hinders women's work.

<sup>107</sup> See also anthropologist Thomas Johnson's excellent analysis of PMS as "an appropriate symbolic representation of conflicting societal expectations that women be both productive and reproductive" in "Premenstrual Syndrome as a Western Culture-Specific Disorder," Culture, Medicine and Psychiatry 11 (1987): 337.

<sup>108</sup> Martin, 1987, 165.

<sup>109</sup> Martin, 1987, 138.

<sup>110</sup> Taylor.

<sup>111</sup> Laws, Hey, and Eagan; Lander.

<sup>112</sup> Sophie Laws, "Who Needs PMT? A Feminist Approach to the Politics of Premenstrual Tension," Laws, Hey, and Eagan, 59. The authors used the term PMT rather than PMS because they felt it was recognized by more people.

113 Valerie Hey, "Getting Away With Murder: PMT and the Press," Laws, Hay, and Eagan, 65.

114 Andrea Eagan, "The Selling of Premenstrual Syndrome: Who Profits From Making PMS 'The Disease of the 1980s?'," Laws, Hay, and Eagan, 80-89.

115 Lander, 9.

116 Lander, 101-102.

117 Shulamith Firestone, The Dialectic of Sex (New York: Bantam Books, 1970); Germaine Greer, The Female Eunuch (New York: McGraw-Hill, 1971); see, for example, Ellen Frankfort, Vaginal Politics (New York: Bantam Books, 1973).

118 Lander, 121.

119 See note 12.

120 Lander, 127.

121 Carol Tavris makes the point more effectively in The Mismeasure of Woman, 92. Also see her chapter in the same book on "Misdiagnosing the Body: Premenstrual Syndrome, Postmenstrual Syndrome, and Other Normal 'Diseases,'" 131-69.

122 Lander, 175. Her review of the research in these areas is very good; see 133-74.

123 Jacquelyn N. Zita, "The Premenstrual Syndrome: 'Dis-easing' the Female Cycle," Feminism and Science, ed. Nancy Tuana (Bloomington: Indiana University Press, 1989) 189.

124 Zita, 192.

125 Zita, 196.

126 Zita, 197.

127 Zita, 197.

128 Zita, 201.

129 Zita, 200.

130 See Elissa Koff, Jill Rierdan, and Margaret L. Stubbs, "Conceptions and Misconceptions of the Menstrual Cycle," Women & Health 16.3-4 (1990) 119-36, on the pervasiveness of misinformation and negative stereotypes about the menstrual cycle.

131 For example, see Parlee, 1974.

132 For example, see Ruble and Brooks-Gunn, 1979.

133 For example, see Koeske and Koeske, 1975; Koeske, "Theoretical Perspectives on Menstrual Cycle Research: The Relevance of Attributional Approaches for the Perception and Explanation of Premenstrual Emotionality," The Menstrual Cycle. 1: A Synthesis of Interdisciplinary Research, ed. Alice J. Dan, Effie A. Graham, and Carol P. Beecher (New York: Springer Publishing Company, 1980) 8-25; and Koeske, "Premenstrual Emotionality: Is Biology Destiny?" The Psychology of Women: Ongoing Debates, Walsh, 137-46. Koeske uses the term attribution in reference to looking at popular beliefs and explanations of the menstrual cycle which women apply to comprehend their own and others' behavior. In describing the research in this area, I use the term attribution for simplicity's sake.

134 Is any experience unmediated?

135 Karen E. Paige, "Women Learn to Sing the Menstrual Blues," Psychology Today Sept. 1973: 41-46.

136 Severino & Moline, 72. See also Brooks-Gunn & Ruble, 1980; Sharon Golub, ed., Menarche (Lexington: Lexington Books, 1983); Sharon Golub, "A Developmental Perspective," The Premenstrual Syndromes, ed. L. H. Gise (New York: Churchill Livingstone, 1988).

137 Diane N. Ruble, "Premenstrual Symptoms: A Reinterpretation," Science 197 (1977): 291-92.

138 Sharon Golub and D.S. Harrington, "Premenstrual and Menstrual Mood Changes in Adolescent Women," Journal of Personality and Social Psychology 41 (1981): 961-65.

139 Barbara Sommer, "The Effect of Menstruation on Cognitive and Perceptual-Motor Behavior: A Review," Psychosomatic Medicine 35 (1973): 515-34; and "How Does Menstruation Affect Cognitive Competence and Psychophysiological Response?" Women & Health 8 (1983): 53-90. Also see studies on the important role of expectations by Barbara Olasov and Joan Jackson, "Effects of Expectancies on Women's Reports of Moods During the Menstrual Cycle," Psychosomatic Medicine 49.1 (1987): 65-78; Diane N. Ruble and Jeanne Brooks-Gunn, "Expectations Regarding Menstrual Symptoms: Effects on Evaluation and Behavior of Women," Changing Perspectives on Menopause, ed. Ann M. Voda, Myra Dinnerstein, and Sheryl R. O'Donnell (Austin: University of Texas Press, 1982) 209-19.

140 See pages 62-63 of this dissertation.

141 Koeske, 1987, 142.

142 Koeske, 1987, 139-40.

143 Koeske, 1987, 142-43.

## CHAPTER SEVEN

### HOW WOMEN INTERPRET PMS

When we lack direct experience of others' pain or misery, it is easy to dismiss their distress as trivial or blame them for in some way bringing the distress upon themselves. Unlike the menstrual cramps which most women now understand to be "real," physiological, and untainted by the designation "psychosomatic,"<sup>1</sup> many of the women I interviewed believe that the severity of physical and psychological premenstrual symptoms is influenced by the way in which sensations and emotions are attended to and labeled. It is as difficult to ascertain why women without severe premenstrual symptoms do not have those symptoms as it is, at least at this point in time, to determine why many women do. Are they lucky or unlucky in their inherited traits? Do they take better or worse care of themselves? Are they responding differently to the same stimuli? Do they think differently about their bodies, menstrual cycles, gender? As the last chapter demonstrated, there is no consensus among medical or social scientists on the nature of PMS. Not surprisingly, women outside of those communities also express a variety of opinions about what PMS is and where it comes from.

This chapter has three sections. First, the groups of women from whom the information was gathered for this research are described. Second, women's ideas on the subject of PMS are examined, looking at the responses of women who participated in PMS workshops separately from, third, those of women from the women's health club and the gynecology clinic.<sup>2</sup> Twenty-two of the forty-five women interviewed describe themselves as having PMS. The focus of discussion is their descriptions and beliefs about the premenstrual syndrome. Specific subjects included are definitions and causes of PMS and the role of attitudes in the experience of the menstrual cycle. It is interesting



to note that whether or not they experience disturbing premenstrual symptoms, women expressed concerns about some of the ways in which PMS is exploited.

## DESCRIPTION OF THE GROUPS STUDIED

Information was gathered in the form of questionnaires and interviews through the following three organizations in Northern California: The Menstrual Health Foundation, The Women's Needs Center, and Piedmont Women's Fitness Center, described below.

### Menstrual Health Foundation (MHF)

MHF is a non-profit organization in Santa Rosa, California, about an hour and a half north of San Francisco. The area is becoming increasingly populated as more and more people brave the daily commute to the Bay Area, but it still has a slower pace of life and a semi-rural feeling compared to the metropolitan area.

MHF has offered PMS workshops of varying length in Sonoma and Marin Counties since the early 1980s. Promotional materials describe the workshop as "a unique opportunity to address the discomforts (PMS) associated with menstruation and discover how to have a pleasurable and empowering relationship with your Cycle."

Like the Bay Area, Sonoma and Marin are known as generally liberal communities with many residents practicing alternative lifestyles. The term "New Age" is used widely, usually not pejoratively, by many members of these communities. Many of the women in attendance knew of these workshops through an acquaintance with member/s of the organization's Board of Directors, or through word of mouth. A few mentioned seeing flyers about coming workshops; one woman had won the workshop through a drawing at a holistic health fair.

The women ranged from teenagers accompanied by a parent--usually her mother--to women in their forties. Occasionally a woman was accompanied by her boyfriend or husband. Most of the women in attendance were White; I met one Latina and one

African American woman at the workshops. Additional demographic information was gathered only from the fifteen women interviewed for this study. Of the interviewees, fourteen were White women in their thirties and forties, one was a nineteen year old Latina. Eleven of the fifteen women had family incomes in the middle-class range.

### Women's Needs Center (WNC)

The Women's Needs Center (WNC) of San Francisco is located on Haight Street, near the Panhandle portion of Golden Gate Park. The neighborhood is renowned--and infamous--for being a key countercultural center of the 1960s. The street has retained some of that ambience. It is an interesting mix, combining one of the greatest concentrations of street people in the city with stylish boutiques and refurbished Victorians.

WNC dates from the early 1970's and is part of the Haight Ashbury Free Medical Clinic. It refers to itself as "San Francisco's ONLY free women's clinic." WNC's stated goal is:

to provide high quality, free health care especially accessible to low income women, but responsive to the unique needs of all women regardless of age, ethnic group, socioeconomic status or political ideology.

The poverty rate income level was about \$447 per month in 1988; during the month questionnaires were gathered at WNC, their records showed that 45% of visits to the clinic were made by women citing a monthly income at or below that level. Only 10% of them listed monthly incomes over \$1117. 75% of the visits were made by women in their twenties and thirties. In terms of ethnicity, 89% of the women indicated they were White, 6.8% African American, and 2.2% Latina. Of the fifteen interviewees,

fourteen were White, one was African American. Two-thirds of them were in their twenties and the other third were in their thirties and forties.

Most of the women who come to WNC live nearby, have heard about it from other women, or were referred there by agencies or other sources. I sometimes spoke with women who no longer lived in the vicinity or who could afford private health care but preferred the quality of care and the informal, nonintimidating atmosphere at WNC.

#### Piedmont Women's Fitness Club (PWFC)

Piedmont Women's Fitness Club (PWFC) was located in a small, downscale shopping center near working, middle and upper class neighborhoods in Oakland. Membership fees were by far the lowest of the area's health clubs. Members walked, biked, took the bus, or arrived in old Pontiacs or new Mercedes to use the club.

Some of the women tried out the club briefly and disappeared, but others went faithfully for years. There was more camaraderie than competition as far as I could see. Typical classes were attended by young women in their twenties up to older women in their 60s or even 70s. The majority were White or African American, but there are also quite a few Asians and Latinas. Among the fifteen women I interviewed, nine were White, five were African American, and one was Latina.

## HOW MHF PARTICIPANTS VIEW PMS

Question: What do you think causes PMS?

Answer: The way I understand it . . . is that it's a total imbalance of your system. I think it controls your whole system, not just your hormones. Your whole body--my whole body--is just completely out of whack during that time. . . . Once the period starts and the body starts functioning on the level that it should, then things get into balance again and then you can look at the world.

The workshops on PMS offered by MHF included an examination of negative societal messages about the menstrual cycle; an explanation of the cycle from a perspective combining mainstream and alternative medicine; stress reduction techniques; nutritional advice; and discussions of alternative ways "honoring" the female fertility cycle. Although medical practitioners were castigated by workshop presenters for their approach to treating PMS, the ideas of researchers such as Katharina Dalton on the hormonal causes and social consequences of PMS were repeated uncritically during the sessions.

One of the opening remarks of the first workshop I attended was "If we had all been differently introduced to fertility, we wouldn't be together in this room today." A perspective reinforced throughout was that the experience of negative premenstrual symptoms is both real (as opposed to "all in one's mind") and preventable, if one improves one's knowledge of and attitudes about the menstrual cycle, and practices health habits which workshop organizers recommend. During the workshop, the facilitators encouraged participants to concentrate on their strongest desires and commitments in life, in order to motivate themselves to make needed changes in feelings

and beliefs about the menstrual cycle and poor health habits. These messages were added to women's existing information about PMS, garnered from the media, doctors, and other sources and interpreted in ways that made the most sense to each woman.

Thirteen of the fifteen women I interviewed identified themselves as suffering from premenstrual syndrome. Of the other two, one woman came to the workshop hoping to find ways of reducing her severe menstrual cramps and the other came because she had won a drawing at a health fair that entitled her to attend at no cost.

### Realizing You Are Not Alone

Attending a workshop in which a woman talked with other women about her premenstrual symptoms and how PMS interacts with other areas of her life had the effect of suggesting a new perspective on the menstrual cycle for most of the women. Perhaps most significantly, the recognition that she was not the only person troubled by emotional and physical changes during the premenstrual phase clearly lessened many women's prior feelings of being isolated, crazy, and bad. For example, Leslie said she would like to let other women know that "they aren't going crazy. . . . They're not alone in this." Helen told me she was reassured by attending: "You can read all you want but until you experience other people going through the same things, having the same feelings [pause]. I truly had suspicions that I was a little 'off.'"

Premenstrual changes were described by workshop leaders as common and familiar. Participants talked about how they were affected by various symptoms and what strategies they were using to cope with them. Helen was surprised at "seeing others becoming emotional and crying during the workshop when I felt like crying right at the start but thought, "that's horrible to lose control in front of others." To realize others get emotional like I do and it's OK" was a relief to her. Martha said the greatest advantage

of the workshop format was "coming together with [our] stories and discovering commonality. I wasn't the only one there wanting to make changes in my life."

The sense of relief this sharing of similar experience brought was frequently visible, audible, and palpable during the workshop sessions and the subsequent interviews. Its importance should not be underestimated. Every woman I spoke with who had attended one of these workshops made reference to how much more valuable it had been to discuss the menstrual cycle with other women than to rely on reading materials and medical professionals. In spite of confessional TV talk shows and a plethora of self-help books, many women apparently have little opportunity to discover they have "private" ailments and concerns in common with other women. What is perceived as personal abnormality and inadequacy often becomes normal, human, and manageable when brought out into the open. Nora said that there were a number of things she already knew on an intellectual level before the workshop "but feeling it on the inside is something else." In addition, she found spending a day with other women, away from work and home, beneficial:

It empowered me in a way, just hanging out with women. I got more out of it about things other than PMS. . . . We [women] are neat people. . . . When you get caught up in the rat race you forget there are sisters out there who want to help you.

#### Accepting Cyclical Changes as Normal

If it is therapeutic to learn that one is not alone, it also helps to know that the experience of various changes across the menstrual cycle is not abnormal. One of the most valuable aspects of the workshop for many women was accepting that cyclic changes are normal events, as Terry said, "to be recognized, accepted, worked with, used." Terry used an analogy to make the point that people are not static, but experience

fluctuations in many aspects of life: "my days vary, not one better than the other, just different--like the weather." What matters is how she responds to these changes:

A lot of my stress is self-imposed, my way of looking at things. For example, I'm approaching my period and I notice some symptoms accompanying hormonal changes. If I accept that, then I'm fine, whereas if I fight it, then I create a stressful situation. . . . A lot is internal and has to do with fighting the flow. Everything happens in its time: buying a house, my husband's rehabilitation, my hormones and my cycle, and it's a matter of me adapting to that. If I don't, I'm cranky and tired and wired.

Helen said much the same thing. She found she could remind herself that moods change, "I'll feel different tomorrow or the next day, maybe even tonight," and by so doing she would "not get too wrapped up in this" or "let myself get carried away with it." Helen continued to use charting of her cycle without setting herself up to feel badly, as she says she used to do:

I still write down some things in the chart once in a while. But it's not every morning, "How am I feeling?" [mimicking distress]. It's becoming more second nature, more like, "Oh, that's how I'm feeling, what day is it today?" It's been very interesting to learn so much about the cycle.

Carol told me her PMS had lessened in the several months since the workshop, and that she had more emotional clarity and perspective in the week before her period. She said she had told her husband:

You know, there's a lesson we need to be learning through this. It's [premenstrual mood changes] just happening, we don't have to be sucked into it and get so overwhelmed and jump and make reactions from an emotional place rather than a place of really knowing what to do.



### Understanding PMS as an Imbalance

In describing their understanding of what PMS is, one of the terms that the women who participated in PMS workshops used most frequently was "imbalance." PMS was referred to as the result of various kinds of imbalances: of the body as a whole; between different hormone levels; between good and poor health habits; between the physical and the cognitive; between the amount an individual gives to her world and the amount she receives from it.

Leslie understands PMS as a "total imbalance of your system. . . not just your hormones." She believes that during the premenstrual phase her body is "just completely out of whack." She contrasted what happens premenstrually with what she calls "homeostasis:" "that's not there, it's just out the window. Once the period starts and the body starts functioning on the level that it should, then things get into balance again." I asked Leslie what she thinks brings on this state of imbalance and she said what she had heard about changing hormone levels "made more sense to me than anything else." To Leslie, and many other women who believe they have PMS, the rest of the menstrual cycle is normal, a state of equilibrium; in contrast, the premenstrual phase is marked by instability precipitated by hormonal imbalance.

Commonly cited as factors in PMS are matters of lifestyle and environmental conditions. Martha believes poor health habits contribute to her negative premenstrual symptoms: "When I'm doing what I need to do to take care of myself, I don't have those symptoms. . . . When I'm out of balance--not eating right, sleeping enough--I will." Health habits are an area in which many women see themselves as having considerable control. Debra added some elements over which we often have less control, such as toxins in foods and the environment. If we exercise our bodies and are able to avoid these toxins, she believes women need not and will not experience premenstrual symptoms. To Hallie, the notion, raised by workshop presenters, that negative social and

familial messages about the menstrual cycle may play a role in the causation of menstrual problems is surprising and unclear. In her own situation, she sees a more important role for diet, stress, heredity, and exercise.

To other women, negative feelings and beliefs about the menstrual cycle are significant factors in the experience of symptoms. Alice said she thinks PMS is the result of an "attitude imbalance." She was interested in the impact of attitudes on physical experience: "I think a lot of this [PMS] is subconscious beliefs we've been taught and are acting out. Maybe part of a pattern from generations ago that we've been taught on some level." Alice said a state of balance is recognizable

when you don't feel overwhelmed, you feel capable of whatever comes up. . . . It's largely a state of mind, feeling at peace with your life. . . . Maybe it's that thing of what's brought in and how much you give out to the world. A feeling that there's enough of each.<sup>3</sup>

For Alice, the idea that there is a connection between attitudes and health is positive: "I think it's in our hands. . . . Also, it makes you feel powerful to know that you can make something different."<sup>4</sup>

Carol, who discussed fertility problems as well as negative premenstrual symptoms, talked about both these experiences as situations she has inherited and created, a reflection of her biology and her personal choices. She sees relationships between reproductive difficulties and earlier events in her life, including her careful avoidance of pregnancy for many years: "Your body may lag far behind your mind--you can get what you ask for and then have a hard time undoing it." Helen believes that physical changes and ways of thinking are "interrelated:" "If you're fearful it causes chemical changes that can upset your body." But she and most other workshop participants are exasperated when doctors and other people propose that PMS is

"psychosomatic," a message Helen interpreted as meaning it was "all in the mind" or not real.

### Giving Priority to Self-Respect and One's Own Needs

As the preceding passages indicate, women frequently told me that what made the greatest difference in terms of lessening negative premenstrual symptoms were shifts in their attitudes. They said they believed that changing how they thought and what kinds of things they believed had made a positive difference in what they experienced. A decision to recognize their own needs as important and deserving of greater priority was assessed as more significant than any specific behavioral changes--such as diet change and increased exercise--following such a decision.

This belief that one's attitude significantly affects one's experience was also reflected in answers to a question about what advice they would give other women about PMS. Gail said she would advise other women to "be conscious" of their physical needs and "make that OK. . . Take care of yourself." Beth has learned what is important is that "at the center I have to feel good. . . . Instead of always trying to take care of everyone else." Helen wants to tell other women

Learn to ask, "Is this important? Now? What are the big things in my life?" Try to avoid guilty suffering over small things so that you can deal with what's important in your life and get in touch with the good that also happens. Start taking good care of yourself, especially not allowing yourself to be put down. You have to start somewhere and once you do, other actions become easier, other things follow.

She has begun looking more critically at her acceptance of women's stereotypical role as primary caregiver and angel of mercy:

I have to take the time I need--and a lot of women don't--rather than trying to be everything to everybody and wanting them to worship you. You do sacrifice a lot when you become a mother but you still have rights. You think you're supposed to be this smiling, patient little person; that's not life or people!

Along the same lines, Abigail talked about letting go of the idea that she was required to maintain a "cheerful front for the world," and adapting an attitude of "I can be however I want, however I feel, and I can be honest with people."

Leslie explained that her attitude had changed from one of determination to endure her symptoms to willingness to adjust her schedule to give herself some less demanding time premenstrually:

Before I was kind of like a bulldozer effect: "I've got to get through this. I've got to do it." Grit my teeth and bear it. But now I'm much more relaxed about it. . . . I make a conscious effort to pace myself, shift gears. Try not to force more on myself that I think I can handle.

Changing your "frame of mind" and reaching "the point where you can listen to your body" is "very beneficial" according to Leslie. She expressed a wish that she would always be "smart enough" to remember that.

For one woman, the workshop was the beginning of a process of leaving her husband. Husbands, as well as boyfriends or children, occasionally accompanied women to the workshops. Nancy's husband came to the workshop with her. Nancy was mostly quiet during the session, often sitting with her face averted; however her husband spoke up several times. He stated his strong aversion to the fact of his wife's menstruation, using words like "disgusting" and "repulsive" to describe her during menstruation. I was shocked that a man would sit next to his wife in a room surrounded by women and discuss her, and by extension all the women present, in such terms.

When I called Nancy a couple months later to set up a time for our interview, she told me in an animated voice that she had since separated from her husband. During our interview, she said that although she was already aware of her husband's attitudes, hearing them stated aloud in the setting of the workshop had affected her differently. She had begun to wonder if she could effectively work to lessen the menstrual cycle difficulties she experienced within the context of this marriage. Furthermore, she wondered what their father's attitudes about the female body would mean for her two young daughters and their experience of menstruation. Nancy talked about her hopes that the process of standing up for herself which she had recently begun--including the ending of her marriage--would have positive implications for her daughters' lives: "And if I grow, they're going to grow. They're going to be great when they're my age. I see so much I didn't do, so much I couldn't do, wouldn't do." After her breakup with her husband, Nancy described herself as "much stronger," with a "higher opinion" of herself. She said she was discovering she was "not as bad a person" as she had often been told and had come to believe.

Helen spoke quite eloquently on the subject of insecurity. She said she tended to see herself as "different," "flawed." She had trouble with things like taking credit for her accomplishments or accepting the validity of her own logic. Listening to other women say similar things about themselves at the workshop had been quite unexpected for Helen; their personal insecurities seemed "so unnecessary." Helen began to realize that she often didn't "stand up" for her rights on many "small issues," such as the sharing of household and childcare tasks: "Just realizing that I wasn't crazy gave me the OK to start saying what I want to do." She said that "all women should get more confidence and recognize that men aren't perfect and have many emotional upsets." However, she sees the work of improving her self-regard as far from finished: "I think that my overall opinion [of myself] still has a long ways to go."

Though many women spoke of a need to adapt themselves to their cyclical changes, there was also an awareness of the difficulty of adjusting work and family schedules when the organization of the work world does not take many such human factors into account. Gail suggested that as a society we should "make room for women and men to live their lives more in tune with cycles rather than pretending they don't exist, going on blindly at great speed always."

### Seeing the Positive Potential of the Menstrual Cycle

The workshop also suggested viewing the menstrual cycle as a positive resource in women's lives. This is an extremely original concept for women inculcated with societal messages suggesting that considerable stealth and secrecy are appropriate means of handling an essentially embarrassing subject. Aside from notions of menses as fetid and unsanitary, the association of cyclically volatile emotions with women in connection with the cycle create an impression of a repugnant, dangerous, unstable being. Combined with a regular reminder of the potential for becoming pregnant, a capacity that women face with a range of perspectives from dread to delight at any given time in the fertile years of their lives, the menstrual cycle often serves as a repository for women's ambivalent feelings about being female in this society.

Several women described an ongoing struggle to replace old habits of mind. Alice, referring to negative social images of the menstrual cycle, said that she will sometimes "buy into that, too, how horrible it is." For Nancy, the most important idea she took from the workshop was that "you shouldn't feel guilty about having your period," an idea which she said was "not yet a reality for me."

Olivia, who has extremely painful menstrual cramps nearly every cycle, said she was amazed to hear a workshop leader describe menstruation as something she "gets happy about!" Olivia had given the idea some thought and said she "tried to have a

positive attitude but it doesn't always help the pain." I do not recall that anyone had suggested to her that by sheer dint of will or positive thinking she should be able to eliminate her pain.

Most of the women I spoke with expressed great interest in the idea of the menstrual cycle as something to explore in order to better understand and take advantage of its unique characteristics. Some women find it helpful to keep track of cyclical changes on a chart. Not doing so creates a "lost feeling," Nora told me, adding, "knowledge is power. When you know what's going on, it doesn't make you feel as crazy." Gail was "amazed" to find that some women knew when they ovulated. When she started keeping track of her own menstrual cycle, "I found out that my body runs on a twenty-seven or twenty-eight day cycle, and I am amazed by this clockwork-like system going on in my body."

Helen described how "charting" had allowed her to recognize beneficial patterns of temperament as well as more problematic moods: "I didn't realize the introspective and 'too beautiful' times occurred in a pattern, too" (Helen used "too beautiful" to describe moments when she was deeply touched by an aesthetic or emotional experience.) A number of women felt, like Helen, that attending the workshop had validated their own sense of wanting private time alone when they didn't have to be responsible for taking care of others' needs. In solitude, the experience of turbulent emotions often changed. Similarly, Abigail suggested women can "use the feelings that often make us feel buffeted around to, instead, learn who we are."<sup>5</sup>

I was struck by how women responded to the workshop's suggestion that "their power" is greater premenstrually. Alice liked the idea of the premenstrual phase as a "powerful, intuitive time." She felt that this idea validated her own desire to "withdraw and go inward" at that time and said she was "trying not to think of [the menstrual cycle] as a weakness but as a powerful thing."

Alice mentioned the negative social images of menstruation as a "misnaming of what's going on" and an obstacle to exploring a more positive approach to the menstrual cycle. She said she sees PMS as "a powerful feminist issue of looking at women as whole people, including that part. Before I saw it as a feminist issue in terms of playing it down, now I see ways of playing it up." Martha echoed the sentiment that society ignores or misunderstands the menstrual cycle and wondered "what does it mean to be a woman, to claim this part? . . . To claim what I've denied for many years?" Debra, who was volunteering some of her time to assist the workshop organizers, described herself as "giving myself permission to feel the real changes that [are] occurring and to honor them."

The most vivid images of premenstrual power came from Abigail. Abigail described a mental image of herself during the premenstrual phase as a panther ready to spring. Then she related an unusual experience that occurred one night under a full moon. Abigail said she had demanded of the moon why she must endure these distressing premenstrual feelings and the moon had responded that she was "not owning her power."

#### Recognizing the Negative Repercussions of PMS

Women attending workshops on PMS generally expressed strong appreciation for the increased attention being given PMS in the media and by the medical profession. Similarly, most said they considered paying attention to their own cyclic changes, pleasant and unpleasant, a positive action. However some women saw the attention as also having potentially negative effects. Changes previously perceived as neutral, neither good nor bad implications, can become "symptoms." Alice referred to this possibility that attention to PMS could "bring out symptoms for people looking for seeing it as a negative thing. A lot of people who never saw their periods in a negative way might start



to see it that way." Nora said she saw "nothing negative about having knowledge behind you" but recognized that there are people who will use PMS to say things like, 'there's one more reason a woman shouldn't be president.'"

Hallie agreed that the media focus "may put it out there for some male chauvinists to laugh at" but felt that "generally, attention is what we need to get something done." Personally, she prefers not to "dwell on it or worry about the next one." Hallie thinks that paying attention to her cycle "puts a spotlight on it" in a way that is not always beneficial:

In some ways, I wish I didn't know some parts. I don't like to allow myself an excuse for slowing down. It's almost like you want to give yourself permission for not feeling so well. You might succumb to it. . . . We can do a lot to ourselves emotionally just by thinking about something too much.

Carol said that a possible negative effect of the increased attention focused on PMS could be the use of PMS as an excuse to explain one's own actions or to discount the legitimacy of others' actions.

Helen, who had initially been extremely relieved to hear about PMS because it seemed to help explain her frequent feelings of depression, surprised me with her later assessment of PMS:

I don't like the term. There's not a premenstrual anything. There is a continuum of moods and emotions at differing times of the cycle and varying reactivity to stress and sensitivity to stimuli, which isn't positive or negative.

The PMS workshops women attended served to reassure them that they were neither insane nor alone in their experiences of premenstrual problems. Information

provided at the workshop defined premenstrual syndrome as a significant problem caused primarily by an improper diet and lifestyles and by beliefs that are not supportive of a woman's reproductive cycle. Hormonal imbalance was explained as as a consequence of these factors that in turn causes a variety of other physical and emotional symptoms.

In the course of the interviews with workshop participants, other ideas about PMS that apparently resonated with many women came up repeatedly. Most of them relate to the influence of thoughts and perceptions on experience. First, accepting the normalcy of premenstrual changes ("going with the flow"?) is advocated by the women from this population. Different emotional states can be noticed without getting "sucked into" them. Second, is the idea of "imbalance." "Hormonal imbalance," being "out of balance," and "attitude imbalance," are examples of the language used to describe PMS. Hormones are most often referred to in this way, but diet, sleep habits, and beliefs can also result in imbalances. Third, women recognized the importance of giving their own needs greater priority. A healthy self-regard and re-examination of limiting social roles was seen as valuable. Fourth, women have the option of better understanding the menstrual cycle and regarding it in a more positive light. This requires overturning the negativity and shame with which it is associated in this culture. The idea of enhanced personal power during premenstrual days was very appealing to those interviewed. Finally, while women are pleased that PMS is getting attention, they are concerned about some negative consequences of that attention: women may begin to label neutrally perceived changes as negative symptoms; PMS can be used as a rationale for gender discrimination; and, PMS can become a self-fulfilling prophecy.

## HOW WOMEN FROM WNC AND PWFC VIEW PMS

I feel like they're naming an illness that's not an illness but just a state of being. Not that women are always premenstrual with those negative connotations. It's cyclical and these are the things that are going to happen in your body and why would you call that a sickness? (Veronica)

This section of the chapter discusses comments on PMS from the thirty interviewees from the gynecology clinic and the women's health club. None of them were aware that PMS was the research focus until near the end of the interview. The discussion is divided into three parts: the premenstrual changes women reported; their definitions and explanations of PMS; and social and individual uses of PMS.

### Premenstrual Changes Reported

The premenstrual changes brought up by these women are similar to symptom lists appearing in articles and popular books on PMS. The physical and psychological changes are presented in two lists; each list begins with the changes most often mentioned. Physical changes cited were: weight gain/ bloating/water retention; breast tenderness; increased breast size/breast swelling; appetite increase; lower back pain; cramps; headaches; slowing down/tiredness, feeling lazier; clumsiness; acne; a pleasant sensation; and increased energy. Psychological changes cited were: irritability/ bitchiness/tension; anger/rage; emotional intensity; depression/ despair/hopelessness/ sadness/the blues; moodiness/mood swings; less ability to cope/more out of control; less concentration; more creativity; and a different point of view.

When women told me about their typical menstrual cycles, most included descriptions of a few premenstrual changes or symptoms. With some exceptions, the

changes were described as negative. Generally, physical and psychological changes were both mentioned. For example, Wanda told me she gains water weight, her breasts become tender, and she has some lower back pain; she cries more easily, becomes irritable and has a harder time concentrating (she mentioned more symptoms than anyone else). A few women referred only to psychological or physiological changes. Two women, Shirley and Louise, did not describe any events unique to the premenstrual phase. Both have the impression from media coverage that PMS is extremely common and therefore their experience must be exceedingly rare. Louise finds the idea of PMS very puzzling:

I don't have problems with mood swings or anything like that. It's weird because a lot of my friends act crazy. And I'm going, "why?" I can never understand the concept of PMS either. How can something like that even control your emotional state?

Wanda and Arlene are two women who also find positive attributes in the premenstrual phase. Wanda has noticed that she is more able to "come up with new ideas then. Things fall into place or become settled at that time." Arlene referred to premenstrual emotional sensitivity she experiences positively:

It's good to be more sensitive, it's OK to feel more emotional. It's fine if you feel more irritable. It's the sand in the pearl, something to motivate you to adjust, to get what your body, your self, needs.

### Causes and Definitions of Premenstrual Syndrome

Whether or not they associated their experience with PMS, a majority of the women had heard and accepted the idea that PMS is a significant illness caused by hormones. Holly told me PMS is "a result of chemical changes" and is "physiological,

not emotional." Fran relates PMS to the idea of "hormonal balance": "it must be somehow scientifically related to whatever hormone makes your period start."

Two women voiced a psychological explanation of PMS espoused earlier in the century and still common. Shirley reasons that when the body does not conceive, "it's a traumatic thing" for a woman. Cindy thinks that "PMS is a time when your body's confused." When a woman does not become pregnant in a given month "your body's not really sure of what's going on" and hormones "are produced."

Some women assume there is a connection between hormonal changes and premenstrual symptoms but are not comfortable labeling PMS as an illness. Eve defines PMS as a "group of symptoms that vary from woman to woman, some of which are incapacitating and others which just make your life uncomfortable." The cause is "probably sensitivities to the changes in the hormones in the blood." To Faith and Veronica, PMS is neither imaginary nor a disease. Cyclical physical and emotional changes are natural, common events; severe changes are both avoidable and treatable. Veronica sees the medical recognition of PMS as a positive sign that the medical establishment is listening to women. On the other hand, she thinks the label PMS has "become a catchall for a lot of women's health issues:"

I feel like they're naming an illness that's not an illness but just a state of being. Not that women are always premenstrual with those negative connotations. It's cyclical and these are the things that are going to happen in your body and why would you call that a sickness?

Sally is not sure the "hormonal imbalance" theory makes sense and does not think that anyone truly knows what PMS is. Sally thinks other women are "ruled by emotions" and theorizes that PMS is essentially "an emotional state." However she does not know "if I believe it for me."

Rose, Arlene, and Darlene all understand premenstrual syndrome as a combination of hormonal changes and other factors. Rose believes that because of the misogyny in our society, there is a "trauma of being female." Specifically, she is curious to know if her father's attitudes affect the way she feels:

The older I get, the more I realize how misogynist my father is. I'm wondering how much effect that has had. . . . I know a lot of it's hormonal and there are physical reasons why it happens but I'm interested in exploring the connections with misogyny in society in general.

Rose described the expression of emotions as taboo within families like hers. She believes this may carry over to the experience of premenstrual mood changes: "We start thinking, 'Oh, this is awful, I shouldn't be feeling this way.'" Whether the causes are societal, physical, or psychological, Rose does not think that women's premenstrual pains are "discountable."

Arlene mentioned PMS early in our interview in the context of saying that she thinks the role of mother is denigrated in our culture. She sees relationships between that denigration and "my clients with serious PMS stuff" and wonders "where the other links are." Arlene does not associate her experience of cyclical changes with PMS because that is "put in the context of pathology."

In her explanation of premenstrual changes, Darlene cited hormones, personal circumstances, and ways of thinking as instrumental factors. More than any other woman interviewed, Darlene discussed her cycle in terms of variability rather than characterizing it as a consistent experience:

Depending on everything happening to me--mood, how things are going with myself, my family, people nearby--I might become more creative at that time. If things are pressing on me, some unresolved issues, I can become more depressed at that time. There's the feeling that I can't cope

as well, I'm getting more out of control. . . . Eventually, I'll ask "what time of the month is it?" It's become that common of an occurrence that I can say, "OK, it seems overwhelming this time because my period's coming and my hormones are doing their thing."

Simultaneously, Darlene says she will be "aware of what my thought processes are." She notices that "exercise and creative processes can counterbalance" other impulses:

In a way, it's like fighting an instinct or it may be a matter of habit. I tend to look at it as a habitual way of responding to a physiological event. Or I can push away to some extent and try to redirect that energy.

From the way Maria interprets the articles she has read on the subject, PMS is "the body's reaction to unhealthy things we do to our bodies with toxins, diet, and mental stresses." Although she does not have any "real evidence" to support her hypothesis, she asks herself "why the body would evolve with PMS." She finds more persuasive the idea that the "big changes" in the last one hundred years have made our lives increasingly stressful, especially women's lives "because we bear children." Like Maria, Belinda emphasizes a "man-made" component to PMS. She argues that PMS is "a major problem but an unnecessary one, just the way sexism is. A lot of it's enforced on us by the man-made world. . . , pollution, the food."

Finally, it was refreshing to talk with one woman who said she had seen something about PMS on TV but could not remember what the acronym stands for, what causes it, or what the symptoms are. When informed of the popularly cited definition and symptoms, she said, "Oh, I'm glad I don't have that!"

#### Uses Of PMS: Issues Of Responsibility And Media Hype

Everyone I interviewed had been exposed to media coverage of PMS and is acquainted with the way trends in social problems, health concerns, and commercial

products come and go. As discussed below, a number of women expressed specific concerns about PMS as exculpating women in the legal arena, providing an excuse for missing work or self-pity, and as a marketing tool.

### PMS As Legal Defense

The British murder trials in which a PMS defense figured were a familiar news item for most of the women I interviewed, who expressed misgivings about PMS as a legal or ethical defense for violent crime. Fran remembers reading about the trials and commented that there is a wide spectrum of experience of premenstrual symptoms, "from some irritability to people so irritable that they'll kill." Nevertheless, she believes PMS does not prevent women from having "a choice" in the actions they take. Allie agrees. She called the news reports on the trials some "crazy stories about women getting off murder raps because they pled PMS."

Wendy has seen television talk shows that emphasize women affected by PMS "to even a violent degree," and she remembers a Lawrence Sanders book about a premenstrual "murderess."<sup>6</sup> Wendy's concern is the effect of such sensational images. She thinks they make it easier for men to "blame things on PMS."

In contrast with these views, Wanda thinks that a woman with PMS is not "in control" or "responsible" for her actions and should be given help in gaining control of her emotions, "through therapy or medication." She related seeing "something on TV about a woman throwing her baby off a bridge because she had PMS:"

I know and have tried to explain to my boyfriend, that absolutely uncontrollable surge that will come at certain times. I could believe, though I've never felt it that overwhelmingly, that people are driven to do odd things like throw their baby off the bridge or something. He doesn't understand it because I do think it's something unique to women.<sup>7</sup>



## PMS as Excuse

Both women who do and who do not specify premenstrual symptoms discussed PMS as a means of avoiding work or other responsibilities. Neither Nadine nor Louise cited any negative premenstrual experiences. Nadine described PMS as a fad many women have jumped onto:

Since it's something new people be saying they have it but they probably don't know, you know, they say, "Oh, I got PMS, leave me alone." . . . To me, I really don't know what it means. But it's like, you know how things go in fads and it's the fashion thing now to have PMS. . . . Or call into work, "Oh, I've got PMS, I can't come in," stuff like that. People do that. I have friends that talk like that, too. And they probably don't know what it means either. 'Cause it just came out, it's like the now word for women to use.

Louise agrees that women can use PMS as an excuse to "get out of" things, for example, cooking or work: "'Cause I would use that, knowing that if I don't feel like coming to work, the first thing a woman can say is, 'Cramps? Oh, that's it.' I still use that." She says the reason something related to menstruation works effectively as an excuse is that it is "acceptable," "it's that mysterious thing that only women can deal with."

Both Allie and Cindy regularly experience premenstrual symptoms. Yet both referred to a potential for giving oneself permission to be a "bitch." Allie said just that: recently PMS is "more publicized and it's just an excuse for being a bitch every now and then." Cindy described herself as using PMS as an excuse in the past:

For a long time, I just sat around and said, "hey, I'm a bitch because I have PMS." And I don't think that's really a valid thing to do that. I think that of course you're responsible for your actions. Even if you may have more

stress at certain times of the month, that's the time that you just have to exert a little more control.

Several women offered an explanation of how someone might come to experience premenstrual changes as more severe or disruptive than need be. In different words, each suggested that there is a way in which an individual has a choice about whether or not to highlight negative feelings by becoming engrossed in them. Kathleen spoke in terms of giving symptoms "power." She cited the example of a woman she worked with who believed she was "heavily influenced by PMS" and whom Kathleen thinks did not need to be a "victim" of PMS:

I don't think this woman I'm talking about needed to be as out of control as she was. . . . It really did feel like it took over. And so I think there's a way, like with anything, you can then allow things, . . . give them power and so that there's almost this built-in excuse that for like two weeks or a week you kind of get to be really out there and crazy. So I think that's a piece of it, and not to say that it wasn't real, but what else is she going to do about it than just kinda be a victim to it?

Darlene told me about a roommate "who believed she had PMS, or was a PMS victim or patient or whatever." The woman would become emotionally "explosive" premenstrually and it appeared to Darlene that "the more she was dealing with it and becoming aware of it, the more intense it became." Darlene says she believes "many things are that way. The desire to know "what is this about?" . . . consumes you."

Gloria talked about people who have a tendency to focus on problems without working to change them. "You can look at this [PMS] as a big scapegoat and problem." She thinks it is too easy to feel sorry for oneself and "wallow in it." Sally also focused on accepting the PMS label as an easy alternative to trying to better understand oneself:

Women are looking for a category to explain why sometimes they feel horrible and sometimes they don't. If they can pigeonhole it somewhere, that's fine. If I can say it's PMS and shake it off and not worry about it, I'd much rather do that than go to therapy.

Most of what Lynne has heard about PMS comes from television "and from women whose orientations towards their periods I had no respect for." Like Gloria, Lynne sees PMS as an opportunity for self-pity: "It just sounds like the handkerchief to the forehead or the violin." She explained that she thinks some women use PMS as a way of "not being responsible" for themselves and what is going on around them. She is concerned that people dwell on PMS, and many use it as an "excuse to totally indulge in some very negative feelings." Beyond that, she feels it "fosters a bad relationship to yourself."

Veronica wonders if "maybe women exaggerate" PMS because the attention on cyclical changes arises in a social context in which people are expected to be even and consistent:

I think we're always so concerned with smoothing everything out and making sure there's no bumps and lumps. That's why it's so prevalent now because we like to put everybody in a little package. If you're gonna go through the cycle then you're not quite so smooth and bumpless.

Veronica suggests that the best response is to "take it [cyclical changes] in stride."

### PMS as Marketing Tool

Many women, particularly those with troubling premenstrual symptoms, are grateful that attention has been focused on PMS. However, even some of the women who identify themselves as having PMS began to feel at some point, as Dorothy did, that the media focus on PMS had "kind of gotten out of hand." Arlene is glad that PMS has

been acknowledged but complained "there's a lot of hype." When I asked Nadine what she knew about the subject, she replied that she had seen a humorous skit on TV about PMS, then asked me, "PMS just came out, didn't it?"

Several people surmised that PMS provides a golden opportunity for market forces to exaggerate or create a need, then fulfill it with an array of profitable remedies. Gloria's first response to hearing and reading about PMS was anger. She thought it was "ridiculous:" "it became like the whole *month* was occupied" with problems to be smoothed out. Lynne believes that some kind of premenstrual "condition" exists but is "amplified," capitalized on, and constructed as a "product." Arlene thinks that it will probably be treated as "another illness to be dealt with with more pills" instead of "organically," as she would like to see it treated.

Molly does not know anyone with PMS and thinks it is a "rare thing" at least "in my group." She thinks the reason PMS is in the limelight is

probably another gimmick. I mean, I don't know if this stuff like really helps them. I mean, if it helps them then it's good that science discovered it. But if it doesn't and they could do something else for it, then you don't really hear the alternatives besides taking a pill. And what are those pills going to do to you thirty years down the line?

## SUMMARY

The premenstrual changes cited by women from the health club and clinic were similar to those that appear in the PMS literature. Most of the women mentioned some negative physical and psychological changes. A number of theories about what causes or increases premenstrual symptoms were described, including hormonal, societal, environmental, and situational explanations. Regardless of whether or not they associated their experience with PMS, women were concerned about the potential uses of PMS as a legal defense, individual excuse, and manufactured industry.

The ways in which women from all three groups talked about PMS bear many similarities. Because everyone had been exposed to the construction of PMS in popular culture, most of them were familiar with, and gave some credence to, the idea that hormones "cause" PMS. Some women went no further in explaining menstrual cycle changes, but more often, they described a more complex interaction of factors related to personal traits and circumstances and the social and physical environments.

Not surprisingly, women who do not associate their menstrual cycle experience with PMS were less likely to believe that PMS is an illness. But regardless of whether or not they believe their premenstrual changes constitute a pathological "syndrome," many women express concern with the negative potential of how PMS is used at both the individual and societal levels. In the next chapter, many women describe themselves as having less control of their emotions and actions before and during menses. However, as we have seen here, only one woman expressed the belief that women with PMS periodically have no control and therefore limited or no responsibility for their actions.

## NOTES

<sup>1</sup> See discussion of medical validation of menstrual cramps in Chapter Six.

<sup>2</sup> The women who attended MHF workshops are discussed separately from the women at the clinic and health club sites in this chapter for a couple of reasons. First, the former group knew from the start that the focus of my research was the premenstrual syndrome. Second, nearly all of them identified themselves as suffering from PMS. However, in the two discussion chapters which follow, responses from all three groups are examined as a whole because of the overall similarities in their exposure to the public discourse on PMS and the similarities in their attitudes about the primary issues being examined in this research. For example, on the questionnaires, all groups were asked if they agreed with the statement that they are more easily upset or angered prior to their periods; 81.1% of the women from the clinic and health club and 88.9% of those from the PMS workshops indicated that the statement was accurate for them. For a more complete description of the methodology, see Appendix B. For a summary of the questionnaire results, see Appendix G.

<sup>3</sup> See discussion of PMS and stress in the next chapter.

<sup>4</sup> See discussion of control and PMS in the next chapter.

<sup>5</sup> See discussion of PMS and emotions in the next chapter.

<sup>6</sup> Lawrence Sanders, The Thirdly Deadly Sin (NY: Berkley Books, 1981).

<sup>7</sup> Wanda is the only woman with whom I have spoken to express this view.

## CHAPTER EIGHT

### WAGING HORMONES, Part I: Control and Hormones

Sometimes I'm really angry at them (hormones) for the changes they bring about that I can't really control. Like when I get my period. And sometimes when I get depressed, I think, "Why does this have to happen?" This insignificant amount of this substance in me can cause such dramatic change in my outlook on myself and life. (Nina)

PMS is popularly understood as a common ailment related to cyclical changes in female sex hormone levels. The phrase "raging hormones" has been used to suggest that, in women, hormones exert considerable influence or control over behavior, making them less stable and reliable at times; it is an idea which supports women's exclusion from positions of power in society.<sup>1</sup> One of the most commonly cited symptoms of PMS is irritability or "bitchiness," a mood state clearly at odds with the stereotype of the ideal woman. To ascribe inappropriate emotions and behaviors to temporary menstrual phase disturbances reinforces the image of women as more ruled by biological imperatives than are men, while ignoring stressful and inequitable social conditions women face in this culture.<sup>2</sup> Women may tend to assign the lack of control that they have over various aspects of their lives to hormonal action rather than social status because it is safer to do so than to challenge the gender status quo. Most of the research on PMS ignores the evidence that women's social circumstances are linked to their experience of stress and expression of anger.

Four interrelated issues--control, hormones, stress, and emotions--came up repeatedly in the interviews of forty-five women discussing their menstrual cycles. The

subjects of control and hormones are examined in the current chapter and stress and emotions are discussed in the chapter that follows. This chapter focuses on women's concerns and views on the subject of where control of their feelings and behaviors is located: in their minds, their health habits, or their sex hormones.



## CONTROL

In these interviews, women had a great deal to say about themselves and their relationships to their bodies. The ideas they expressed reflect the ongoing scientific and philosophical debates about the role of biology vs. culture in human personality and behavior, and perhaps, in a larger sense, what it means to be human. We seem to be able to hold numerous, sometimes conflicting beliefs about who or what is "in charge" in human action.

When women talk about their menstrual cycle, they reveal a mixture of beliefs about what it is to be human and female. Perhaps we generally operate under an assumption of being in charge of the direction and activities of our daily lives. We decide to do a thing and do it. Some things we do become sufficiently habituated that the behavior is accomplished with little or no conscious effort; tying shoe laces or replacing the gas cap after refueling the car are examples. From the way we talk, many of us assume there is another part of ourselves that is an instinctual, biological substratum over which we have no conscious control and which is capable of manipulating us, against our will, like a puppeteer pulling the strings of a marionette.

Women may believe themselves to be, simultaneously, in and out of control of their bodies. Gloria told me about her decision to take the birth control pill, at a particularly demanding time in her life, as a "form of control over my ability to work." Yet she described the decision as "sacrificing control over my hormones and self in exchange for increased productivity." In other words, she said she had taken control by relinquishing control.

Many women experience the premenstrual phase of the menstrual cycle as presenting a special challenge to the need to feel in control:<sup>3</sup>

I just don't think--well, I should speak for myself because I don't know to what extent other people have pain or what not--but for myself, it's like, yeah, I could get real nasty during this time but it's like I need to have that control. And maybe it's a lot more control than I normally have to have, but I think it's real important (Cindy).

How do these individual dialogues fit into the societal picture? Why is need for control and the fear of loss of control so important? As we saw in Chapter Two, a mechanistic model of the body has distinct economic and political advantages: the more disciplined and controllable people are, the more interchangeable and useful they are in the labor force, and the more manipulable they are as consumers of products and discourse. In a modern society such as ours, the practice of power requires "increasingly invasive apparatuses."<sup>4</sup> Attempts to control bodies and minds become ever more sophisticated.

The first section of this chapter looks at the ways women talk about the issue of having control over their premenstrual feelings and behaviors. Examples of their remarks are grouped by whether they express the belief that women are "out of control" premenstrually or a belief that, by careful scrutiny and adjustment of thought and action, women can exercise control over their premenstrual experiences.

### Out of Control

Many of the women I interviewed portrayed themselves as being "different" people before their menstrual periods. Women who believe they have PMS were more likely to refer to themselves as unlike their usual selves premenstrually than are those who do not identify themselves as having PMS. The majority of the women who attended PMS workshops expressed the fear that they were sometimes "crazy," or that others--usually their husbands--would think them crazy. Martha summed up how she feels premenstrually with the phrase "generally insane."

In the days leading up to their periods, some women consider their own behaviors irrational, describing themselves as "crying for no reason" and "irritable for no reason." These behaviors were assumed to indicate that something was "wrong" with them. Gail talked about a particularly bad day when it "seemed like I didn't fit in the universe at all."

Many women from all three groups referred to the days before their periods as a time of "abnormal" behavior. Nina spoke of being able to "step back and see myself" behave differently than "the way I see myself most of the time." Eve said she was more likely to cry at "something that wouldn't normally make me cry." To Kim, "little things" that she "normally. . . can pretty much handle. . . don't seem as bearable" premenstrually. Laura told me she would sometimes "say things that I would never say on a normal day." She said it is as if there is "nothing I can do" about the way she feels premenstrually: "it's in my body. I feel trapped by it." The week to ten days before her period begins, "things really get intense":

I feel like I could be subject to a PMS attack at any time. If I'm working, I feel it's really hard to control. I'm in a completely differently work mode, I bicker at everyone, I say things that I would never say on a normal day, just speak off the top of my head.

Along with the fear of being crazy is the feeling of being unable to do anything to change one's behavior. Eve said "I sometimes feel like I just don't have the control that I usually do and. . . control is very important to me. Carol described the sensation of having "no reins" during an argument: .

Sometimes it's almost like a feeling of going crazy. I'll say something to someone, and then I'll say something else, and then I'll say something else. And it's like I can't stop myself.

Nora remembered a stressful situation in which she was with her four year old son while she was sick with a high fever. If she were ever capable of being "a child abuser," she

said, "that would have been it." Nora compared the feelings she had in that situation with a premenstrual state of mind she frequently experiences:

Like you're at the end of your rope and if one more thing happens, you're going to let go of that rope and fall off. It's involuntary and that's part of the scare. While you're in it, you don't feel like you have any control over it.

Recognizing which cycle phase she is in does not necessarily increase the amount of control a woman feels she has. Ginny talked about an ongoing conflict between her will and her body during the premenstrual phase. She says preparations she makes in order to avoid losing control are to no avail:

I'd say, "I know it's getting to be that time. I'm aware of it, I'm not going to let it get to me, and it's nothing to be concerned with." But when it comes, it's like you can't control yourself, it's like your body takes over. It's really strange. I'll know why, but emotionally it's hard to control.

Holly said that realizing that strong premenstrual emotions are temporary is helpful, though it makes them no more controllable:

I would like to think that I can control it. I keep track of ovulation, notice the mucus and sometimes have pain. When I start feeling irritable it always surprises me, and at first I'll think maybe it's because I had a hard day or I ate too much sugar. Then I realize it's two weeks before. And because it catches me by surprise I know that it's not that I'm thinking, "it's two weeks before, I'm supposed to be irritable." Every month I go, "maybe I'll skip it this month." But I hardly ever do.

Darlene said she is particularly likely to feel less in control when she is both in a stressful situation and premenstrual. She described the feeling as being unable to "cope as well," finding difficulties "more of a burden" or "more out of my control." Knowing

where she is in her cycle provides a meaningful context for the feeling of having less control but Darlene did not describe this awareness as a means to regain control: "to some extent, women can't control themselves." She believes she and other women she knows, college educated, career-oriented women, experience a conflict between realizing that "they had to become more controlled if they wanted to be in that [professional] part of society," and finding "at the time of your period, you let it down, you can't do it."<sup>5</sup>

This idea that the premenstrual phase is a time when the usual limits or boundaries cannot be maintained was mentioned by other women. One particular description of the different state some women experience between premenstrual days and the remainder of the cycle, has stuck with me ever since our interview. Leslie said that in trying to explain PMS to her husband, she had recently found a way to put it into words:

I think the best way I can describe it is that the week before I start my period it's like an inhibition within me has been lifted. . . . I have the same feelings all the time, but the other three weeks I guess it's I have better judgment and control.

Nora suggested "it's almost like these shifting hormones are bringing down your guard."

### In Control

Women from all three groups expressed the view that both attitudes and "lifestyle" factors such as diet, stress, and exercise can affect one's menstrual health. Alice told me: "I think it's in our hands. And I think that with a lot of diseases. It's a lot of lifestyle stuff. And we create this with our thoughts and attitudes." The nature of the relationships between these factors was generally uncertain. For example, do hormones cause food cravings or does eating the wrong foods wreak havoc with one's hormones? If one could only achieve the right lifestyle and attitudes, would menstrual cycle pains and changes disappear making each day of the month just like every other? Alice acknowledged her

fear that all one's efforts might not be enough: "You know what I'm really afraid of? If I really do everything right [diet, etc.] and that doesn't work."

Prior to realizing that her symptoms corresponded to a cycle phase, Martha was afraid that the way she felt premenstrually would be "my whole life now. I'm never going to get out of it, I'm never going to feel good again." She said she now has a better idea of "how to handle" it and has "made many changes." If she were offering advice to other women, Martha would tell them about her own experience in

lessening symptoms by becoming aware and making changes. We're not powerless. We can make a difference, make a choice. There's a big difference between feeling out of control and making a difference.

The kinds of choices Martha, and many other women I interviewed, described as making a difference were in areas such as what to eat, the amount and kind of exercise they get, and the use of stress reduction and relaxation techniques. Martha said that when she falls "off the wagon" of various regimens that help her to feel healthy, she does not feel that she has "as much control":

It's more like I'm a victim. I've been a victim most of my life and this way I can take charge of my life. I'm not being run by someone else. I really can decide and make choices.

Eve expressed a strong desire to control her appetite and reduce her weight, especially through exercise. She said that when she was exercising several times a week she found

I didn't have the mood swings, I didn't have the food cravings. It really, really helped control it. I never thought it would happen but I'm a big advocate of exercise against PMS! I'm sure it doesn't work for everyone but it's been working for me.

She has also observed that changes in diet affect her premenstrual symptoms:

I've been dieting for the last couple months as well, being real careful, eating a lot of whole grains and fruits and vegetables. I try to keep my calories under 1500 a day. I use very little dairy: milk on cereal and in coffee. . . . Prior to that time, I'd start feeling bloated and cranky and having food cravings for crunchy, salty things: pretzels or tortilla chips and salsa. On a bad day I could eat a whole bag of them. I'd be a little more easily upset. . . . A lot more sensitive. I still am; the past couple months I find that I still am somewhat more sensitive before my period, but I feel that I have more control.<sup>6</sup>

Nancy articulated an interesting paradox contained in some ways of thinking about control of one's health. She supports the idea of medical self-help as a way of "taking some of the power out of doctors' hands," especially the power over women. She and other women she knows are interested in "alternative options:"

But because there's a lot of emphasis in holistic health practices on healing yourself, if you have a health problem, you start feeling, "oh my god, I don't have the perfect diet, exercise plan, whatever it is." That can result in the opposite of what holistic healing is trying to do. It can result in complete alienation from your body, where I am over here and my body is this uncontrollable thing over there.

Nancy wonders where the line is between encouraging people to take control of their health and blaming them for any instances of ill health deemed preventable by others.<sup>7</sup>

Some women focused their attention more on their thinking than on their physical health as a key to lessening premenstrual symptoms.<sup>8</sup> For example, Alice believes PMS may represent an "acting out" of outdated stereotypical beliefs about womanhood that have been passed on from generation to generation. The process can be counteracted, she

suggested, by "feeding" ourselves "new information" that challenges and corrects those beliefs.

Abigail described having a mental image of herself premenstrually as a panther, pouncing at the slightest provocation. She initially spoke of this as a negative, predatory image but when I visited her a year after the workshop, she had transformed the meaning of the imagery:

I'd walk down the hall at work sometimes and suddenly have that image of the panther ready to spring, I'd get that feeling in my haunches. But I would start feeling more in control instead of being controlled by my feelings.

Abigail said learning to deal with "feelings of being overpowered and controlled by something outside of myself has helped me in other situations where I feel overpowered" by helping "me to get in touch with my own powerfulness." A change of attitude allows you to "welcome [premenstrual feelings] as your power."

Lynne was very interested in the issue of whether or not a person controls events in her life. Lynne thinks control is possible at a certain "stage of enlightenment," and in the meantime, there are ways to expand the realm of choice. This is her approach to responding to premenstrual symptoms as well as other life events:

A lot of times in life it's like that: You have a reaction and you become so identified with it, you think you have no choice. But I'm lucky, a lot of the time I can remember, you know, you just remember yourself. There's somebody here who can decide whether they want to get totally identified with that or whether they can see that as something that's happening but that they can take in stride. That's my technique, I guess. I'd like to be in control, but I'm not to that stage of enlightenment yet [laughs].



## HORMONES

Our menstrual cycles, we have been told, are the rhythmic signs of our reproductive ability. Under the level of our consciousness, something called hormones direct our organs in preparation for the big event: pregnancy. Some of us have understood this to be the case since our introductory briefing on menstruation in elementary school; others picked up our ideas about the role of hormones in more recent years from popular media. In any case, it is now a popular belief that a woman's hormonal fluctuations have a major influence on her experience of daily life.

Endocrinology is a young science, which, like genetics, is enthusiastically studied and often hailed as providing essential answers to human functioning.<sup>9</sup> As the terminology of Freudian psychology has filtered into common usage, so the languages of genetics and endocrinology have also entered everyday conversations. In each case, many of the people using terms such as ego, genes, and hormones, may have only the most general understanding of the words' meanings. The important thing is they have come to accept the referent as real: the women I interviewed believed in their hormones.<sup>10</sup>

What are hormones to us? In some uses, they appear to have replaced the term "nerves" in popular vernacular.<sup>11</sup> Instead of referring to things "getting on" our nerves or how our nerves are "acting up," we say our hormones are "raging" or "imbalanced" or "out of whack." There is a more amorphous sense of physical location and causation when we substitute hormones for nerves as the reason for a "charged" feeling. What women had heard about hormones--particularly in relation to PMS--generally had to do with a "chemical imbalance." Hormones are depicted as both extremely potent and delicate; a slight shift or missed signal could throw everything--one's body, mental state, control of one's life--into disarray. Interestingly, whether or not women had a specific

sense of hormones, many believe in hormones as powerful, ruling elements in their lives over which they have little or no control.

The rest of this chapter discusses women's ideas of what hormones are, what they do, what they are influenced by, the imagery women used to describe hormones, and their feelings on the subject of hormones and menopause.

### What Hormones Are

Women expressed a variety of opinions about what hormones are and how they function. Some women were far more familiar with the scientific definition of the endocrine system than were others. Nina, who has had some medical schooling, defined hormones as:

chemical messengers that regulate certain glands in your body. I know the physiology of menstruation, which hormones do what. I see them as a fluid in my blood that causes changes in me, mental as well as physical.

A fairly specific description was also given by Lynne:

I guess I think of them as little globule things that are manufactured by the body and secreted and get absorbed into your bloodstream or some stream, and influence behavior. I guess they come from one part of you, like your glands, and end up influencing your brain. That's the picture I have.

Rose said she thinks hormones are "incredibly important" and she's "not exactly sure what they are," although she followed that statement with a more detailed interpretation of the role of estrogen and progesterone in the menstrual cycle than others gave:

It seems like the brain releases estrogen and then when estrogen levels get to a certain point it triggers ovulation. Then after ovulation, the

progesterone gets to a certain level and triggers menstruation. And then estrogen- -That's pretty much what I know.

When I asked Rose where hormones are she said:

I know they're produced in the brain, the pituitary gland, somewhere around in here [pointing to own head]. I guess they're produced in the bloodstream, and when the blood gets saturated with certain ones, it causes certain reactions. But I'm not totally clear.

Some definitions were more succinct than others. Gloria remembered that hormone levels fluctuate across the menstrual cycle: "I don't remember their names or the phases. Some peter out and some build up over the month. There are different phases intersecting each other." Veronica described hormones as "coming out of very small glands in enormously powerful small amounts--which can wreak havoc on your system! [laughs]." Eve was even briefer: "Let's just break it down: hormones are chemicals and chemicals in your body do things to you."

Other women were less sure about what hormones are. Kathleen's initial response to the question of what she understands hormones to be was, "Ha! I don't." When she later referred to fluctuating levels of chemicals that "produce physiological and emotional responses in the body," I asked her how and where this takes place: "Where is it? Hmm. That's interesting, I don't know." Faith said she thought hormonal changes are linked to the occurrence of PMS. When I asked her what hormones were, she paused, then said, laughing, "Well, you got me there!"

Shirley answered simply, "I don't know." She had heard the phrase "raging hormones" and said she guessed it is used in reference to emotions. She also thought of hormones in relation to men's "sexual urges," which she thought would probably apply to women, too. Shirley had no image of where or how hormones function in the body: "I think of little cells, I guess." She believes she is not alone in being unfamiliar with the

topic: "In general, I think people know very little about their bodies. It's different to know about muscles, that kind of thing. Hormones are like black or blank."

To Molly, hormones are associated with male puberty: "Ummm. For women I really don't know. I just know for my brother [in adolescence] they just said his hormones were going crazy." Kim's knowledge of hormones is primarily associated with prescriptions her mother has been given for a variety of conditions:

My mother was taking all sorts of hormones for [pause] I've lost track. At one point, they said she was going into menopause and they started giving her hormones. Then she stopped that and now she's taking hormones and I can't remember what the reason is now. She had her gall bladder removed so she's had a number of things that I think they said needed hormonal additives for. I don't know a lot about it.

### What Hormones Do

Women's explanations of the impact of hormones ranged from sexual characteristics to emotions and behaviors to "everything." Odetta associates hormones with development of sexual characteristics: "It helps people's bodies develop. I know a girl who took hormones so she could have a big chest." Cindy listed a few things she thinks hormones do:

I know if you have a low estrogen level you'll like grow a moustache or something [chuckle]. . . . Anyway, so the hormone goes from the pituitary gland through your body and goes and tells your uterus [to] contract. And I'm sure it does other things as well. . . . But there are other hormones that do other things. Hormones are really important. I know sexually, how your body gets aroused is through hormones. I know they're very important.

The issue of control, especially of emotions, came up frequently as we discussed hormones. "I guess for me, they control my moods and stuff like that," Molly told me. Helen believes hormones are the key to understanding emotions: "It's been a revelation that my emotions aren't caused by external things and that they [hormones] cause a lot of physical sensations and changes." Helen gave this list of associations with the word hormones: "Emotions, control of and lack of; they control me; out of control; out of whack." Allie ascribes dramatic mood changes from one part of the cycle to another to hormones. After her period

it's almost like I'm high. I can walk around giggling, you couldn't peel the smile off my face. And everything makes me happy and I'm just on top of the world. And boy, when I crash, I crash. And that seems cyclic and that's why I attribute a lot of it to my hormones. I'm sure all of it isn't but a lot of it is. . . . They make me do crazy things.

Later Allie said of hormones: "I feel like they take control of me."

Women from all three groups talked about hormones as controlling major areas of women's lives. Lynne asked me, "Isn't that where behavior comes from?" Cheryl believes that "hormones are the key" to understanding our "very complex" bodies: "I would like to understand the network. I think hormones control everything." Sally said she thinks that "most people do not understand hormones" but described herself as "a real hormone person." Before I had finished asking a question about whether or not she believes that hormones control mood changes, Sally had answered. Question: "Do they control. . . ?" Answer: "Yeah."

In telling me how she would explain PMS to someone who asked her about it, Nora said she would "get real basic and talk about the hormones. . . . Hormones rule our lives, basically." Nora has "a lot of respect" for hormones "'cause they do their job, that's for sure." She believes that hormones affect women

all the time, with the premenstrual and the pre-ovulatory, wanting to have sex more. Or when they're on their period. And postpartum women--their hormones are just zinging all over the place. Postpartum blues, milk letdown. We're just one big group of hormones, you know.

### What Hormones Are Influenced By

Two theories of what influences hormonal changes were advanced: heredity and consciousness. In the first case, again, no individual control is involved. During our interview, Allie told me some of her mother's gynecological history as well as her own. Allie believes that she has inherited the same gynecological problems her mother has had:

If she gets real cranky, I'll say, "Mom, are you off your old lady pills right now?" and she'll say, "Yes, how can you tell?" And I'll say, "Well, get on them because I don't want to talk to you until you do." And the minute she goes on the hormones she's fine, a real likable person, but otherwise she's terrible. So I'm sure a lot of that is inherited. I tend to feel a lot like her anyway: Physically, emotionally. It seems our bodies have followed a lot of the same patterns.

Some women believe hormones can control someone who is not aware or "conscious" of hormonal action. I told one of the women who leads PMS workshops that many of the women I was interviewing were referring to hormones as controlling them. I asked her what she thought:

"Are women controlled by their hormones?" It's like a Zen koan. No, to the degree you're conscious, no. When I'm unconscious of my physiological processes, I'm at the mercy of them. It's like getting in a car, not knowing how to drive it, and racing down the road. . . . Consciousness is the key to whether or not you're controlled by your hormones.

Darlene thinks that if she "had a clearer understanding" of hormones "maybe things would run smoother:"

If I'm aware of things, it feels like I'm more attuned and less just an effect of it. As if just by the process of being tuned in, I'm more in harmony with it. . . . If I'm not, it's like this thing that keeps pricking me, "remember, I'm here." I'm just an effect of a thing that keeps bugging me and not so aware that it's integral to what I experience.

### Images of Hormones

As we have seen, a number of women did not have a sense of what hormones are or how they function. Others used intriguing language to describe hormones. Some images were negative, even menacing; others were neutral or positive. Most of the descriptions suggest that hormones are powerful. As Arlene said:

When you start messing with the hormones, you're really messing with something. It's a very, very delicate balance. Nobody knows much about it. . . . They seem very, very concentrated and specific which is why the balance is so delicate.

The picture in Cindy's mind is martial: "I feel like they're horrible, like they're mean, they're vicious hormones, they come down there in, like, rows." Maria called hormones "directors" and "master conductor switches." She pictured hormones in the brain, "oozing out." Allie said they are " Monsters. Monsters."

Eve supplied sound effects as she described a specific sensation she sometimes has: "I just feel hormones zipping around in me. It's really awful. It's like I can feel them going zzzzz, zzzzzzzzzzz, zzzzzzzzzzz, zzzzz."

Visual imagery was more common. Two women envisioned hormones coming in colors. Holly told me she sees hormones as "green liquids that pour into the blood; I'm

not actually sure where they enter the blood. . . . But when I think of hormones, I think of an actual substance. I don't know if they are." Fran laughed and pointed to various part of her body while saying: "Some come out of here and are probably blue ones, some from here and these are the green ones. There are some red ones, too."

Others focused on shape or substance. Cheryl's description reveals her feelings about specific hormones:

Hormones are like little things with happy or mean faces that run around in my body. Progesterone is a happy face. Estrogen has a mean face because in the pill it makes me vomit.

Darlene and Nina used interesting analogies to describe the material of hormones. Darlene imagines them "as either like blood cells or drops. Or, when I consider how many of these there are, like impulses, almost an electrical kind of current." Nina said she sees them "as something maybe not entirely physical as blood. Humor is a good word. I see them as something between a flow of air and fluid."

Images from Belinda and Arlene had a more positive tone, while also connoting a sense of significant power. Belinda said she imagines hormones as "round, maybe because of the ovaries, and in numbers that are uncountable, ever producing, ever moving. They are my vim and vigor":

From what I've been reading, it's [the endocrine system] almost like the spiritual aspect of your physical body; it's the little tiny subtle part. The heart, brain, et cetera, are all the robust things. The pituitary and the pineal gland--are supposedly synonymous with the third eye. It's the subtle, the subtle that's real important.

Arlene used several ways of representing the meaning and action of hormones:



Little balls bouncing around as in a pinball machine. . . . I guess they're like the jewels of the body. I think they're part of the chakra system, a real energetic thing. . . They seem to be little messengers to the brain.

### Hormones And Menopause

If hormones are disturbing to negotiate from puberty to the end of one's reproductive years, the prospect of no longer having them and therefore being urged to ingest them is frightening to women approaching menopause. The topic was usually raised by women in their early forties. Alice worries that she will move directly from problems with PMS to problems with menopause:

My cycles are changing lately. . . and I wonder if this is early menopause. And I think, what if I have *that* whole hormone thing and I haven't even gotten *this* one down? I don't want to do the gynecological thing with the hormones [hormone replacement therapy].

Several women's concerns are heightened by memories of their mothers' experiences with menopause. Belinda is worried about having an experience of menopause similar to what she has heard about and what she remembered of her mother's:

I heard about it [hormones] in terms of women, especially menopausal women. It was something frightening, something that you lose and are therefore no longer whole or vital. . . . When my mother had her menopause she went crazy, literally. She was literally wild. And maybe I'm afraid of that.

Fran expressed stronger fears about menopause than she remembers having of menstruation. She is also hoping to avoid her mother's experience, which she says is all she knows of menopause:

My mother was very sexy, especially in her younger days. . . . She had an image of herself as a sexual person. And I think menopause meant for her not being that anymore. . . . Sort of like this, "this is the end of your life feeling," and I've picked that up.

Fran said she knows that "it's not true but I feel that." "It's like telling a kid there's no reason to be afraid of the dark. And the kid knows it's dark in there!" She said she had never discussed the subject with anyone before.

One younger woman, Molly, also has a negative impression based on her mother's menopause:

Yeah, god, I remember when my mom went through menopause, I swear I thought it was never going to be over. It's like, how many years do we have to, like, go through this? Oh, it was, like, horrible. Then as you get older, you feel sorry for her, you think, oh, god, her whole body was like totally, totally changing and she was like, probably had no control.

Debra, who is involved with the organization offering the PMS workshops, imagines that soon she will have graduated to an organization for menopausal women and will spend "several years trying to figure out what *this* one is all about": "Menopause is more awesome. I have heard all my life about taking a little fix of estrogen to keep you young." She "might be more open to considering hormone therapy for bad menopause symptoms" than she is to hormonal therapy for PMS, but she is hopeful that with "proper diet and attitude and being in tune with the *natural* changes," menopause will not be "a big issue either."

None of the women who brought up the subject of menopause conveyed any positive associations with it. Hormones are generally described as something to struggle with during your reproductive years which then abate, abandoning you to old age in a

culture that does not value age, particularly in women. "What a plan, whoever thought it up" was Fran's final comment on the subject of hormones.

## SUMMARY

For women who notice specific cycle phases, the paramenstrual (premenstrual and early menstrual) phase is often experienced as a different state of mind than other times of the menstrual cycle. It is as if a part of them were standing by noticing and judging the difference as inappropriate if not appalling. Some of the women whose responses are excerpted here describe themselves as having diminished or no control of their emotions and behaviors premenstrually; others say they are able to increase or maintain control by careful monitoring of their thoughts and actions. The desire for increased control was almost always expressed in terms of the personal sphere (occasionally the sphere of interpersonal relationships), and rarely in terms of influence on a larger scale, such as the community, the society.<sup>12</sup> Thus women spoke primarily of striving to improve their health habits and increase control of their emotional responses. With the correct diet, exercise, and attitudes, women hoped to gain greater control of menstrual cycle related changes.

More often than not, women gave uncertain responses to questions about hormones. For some body organs and systems there are clearer visual images: a heart, a stomach, circulating blood, muscles, bones. But what do hormones look like? Where are they? Most women spoke assuredly about the importance of hormones, whether or not they had any specific sense of what they are or how they function. No one described them as insignificant. Those who offered mental pictures of hormones presented an interesting variety of images.

If an excess of hormones or imbalanced hormones is frightening, so is the approach of decreasing hormone levels in menopause. Many women are afraid of experiencing bizarre changes during menopause and are ambivalent about the idea of taking hormone supplements as a way of treating those changes.

Questions that need to be asked are: under what circumstances do women gain greater control by imposing ever more strenuous disciplines of emotional suppression, diet, and exercise upon ourselves? When do these practices bring us within easier reach of a system of social control? When women speak of the premenstrual phase as a time when a wall is let down or a lid lifted, how do we decide if that represents the loss of a positive form of self-control or a positive form of resistance to externally imposed, confining gender norms? Perhaps, as Darlene proposed, "when there's suppression of women's realities, they might unavoidably spill out at those times."

## NOTES

<sup>1</sup> Physician Edgar Berman's notorious quote about women being ill suited for the position of bank president or President of the United States is cited by Karen Paige in "Women Learn to Sing the Menstrual Blues," Psychology Today Sept. 1973, 44.

<sup>2</sup> See the results of the study by Koeske discussed on page 142 in Chapter 6.

<sup>3</sup> See discussion of research on locus of control and PMS in Chapter Six.

<sup>4</sup> Sandra Lee Bartky, "Foucault, Femininity, and Patriarchal Power," in Feminism & Foucault: Reflections on Resistance, ed. Irene Diamond and Lee Quinby (Boston: Northeastern University Press, 1988) 79. See also Jacques Ellul, The Technological Society (New York: Vintage Books/Random House, 1964).

<sup>5</sup> See Emily Martin, "Premenstrual Syndrome: Discipline, Work, and Anger in Late Industrial Societies," in Blood Magic: The Anthropology of Menstruation, ed. and intr. by Thomas Buckley and Alma Gottlieb (Berkeley: University of California Press, 1988) 161-81. Her argument is briefly discussed in Chapter Six of this dissertation.

<sup>6</sup> See discussion of the stressfulness of dieting in Chapter Nine.

<sup>7</sup> See Susan Sontag, Illness as Metaphor (New York: Farrar, Strauss and Giroux, 1977).

<sup>8</sup> Because the first section of Chapter Seven examined PMS workshop participants' views on the importance of one's attitudes in lessening premenstrual distress in some detail, I have kept this section very brief.

<sup>9</sup> See discussion of sex hormones research in Chapter Three.

<sup>10</sup> It should be plain that I am not suggesting that our bodies do not include elements such as hormones and genes. However, the most thorough scientific knowledge of hormones would not yield a satisfactory explanation of human experience and action.

See discussions of the social construction of illness and the mind/body split in Chapter Two.

<sup>11</sup> See an interesting look at terms, including nerves, that women use in discussing menopause in Dona Lee Davis, Blood and Nerves: An Ethnographic Focus on Menopause (Newfoundland: Institute of Social and Economic Research, Memorial University of Newfoundland, 1983).

<sup>12</sup> When women talked about making needed social changes--during the interviews with women from PMS workshops in particular--it often involved ideas about a shift in global consciousness toward a new, or renewed, appreciation of "the feminine."

## CHAPTER NINE

### WAGING HORMONES, Part II: Stress, Shame and Anger

They wonder what she will do if they enclose her in the room with them. One of them shuts the door. She backs her way toward the closed doorway and then roars. "Be still," the men say. She continues to roar. "Why does she roar?" they ask. The roaring must be inside her, they conclude. They decide they must see the roaring inside her. . . . She swings at one of the men. His own blood runs over him. "Why did she do that?" the men question.<sup>1</sup>

This chapter attempts to provide some answers to the question of what makes American women in the late twentieth century angry. What are the common experiences of their lives that might engender a time of strong, often negative emotion during the paramenstrual days of the menstrual cycle?<sup>2</sup> We will take a look at the stresses and emotions women experience in relation to the reporting of PMS.

The term "stress" is liberally sprinkled throughout our daily conversations. We often talk of being "under a lot of stress" or feeling "stressed out." What is stress? The working definition of stress for this discussion is "the pressure upon an individual which stems from the discrepancy between role demands and [her] willingness or capacity to fulfill them. . . ., the tension with which the individual is left after [her] coping devices and support resources have been used."<sup>3</sup> Stressful events "involve threats to an individual's well-being."<sup>4</sup> Chapter Six included a brief discussion of the research examining the relationship between stress and premenstrual symptoms, noting that stress seems to play a significant role in women's reports of premenstrual symptoms. The first half of this



chapter focuses on three aspects of gender and stress: what women say about stress in their lives generally; the stress resulting from women's concerns about achieving an "ideal" physical appearance; and stress related to intimate relationship conflicts.

In this culture, emotion is viewed as something that interferes with rational thought, something less reliable than thought but frequently offered as an acceptable justification for behavior generally considered inappropriate. Chapter One briefly referred to the fact that despite the absence of a good understanding of the nature of human emotions, women are widely considered to be more emotional beings than are men. Part of a woman's stereotypical social role is to provide emotional support to the members of her family. In the workplace as well, women are expected to be more nurturing and emotionally expressive. The second half of the chapter deals with the subject of emotions, beginning with women's ideas about whether women are more emotional than men. Next, the specific emotions of shame and anger are considered in relation to the menstrual cycle and the reporting of premenstrual symptoms in particular. Finally, there is a brief discussion of why some women value their premenstrual experience of emotions.

## STRESS

[Stress] seems to be a symptom of a mental process of intense concentration. Like having three projects going and working on them all intensely at the same time. Like having five children. It demands a certain kind of attention, an awareness that seems to take all your energy. It can fatigue you. (Darlene)

There is a growing body of research on the subject of gender and stress. Gender affects stress in various ways: whether or not a situation is perceived as stressful, what response options are available, and what the health consequences of stress are. The more traditional one is, in terms of internalization of gender role stereotypes, the greater the impact of gender on stress.<sup>5</sup> Different gender expectations create different stresses for each gender. For example, women are supposed to be nurturing, supportive, and pretty; if a woman perceives that she does not fit those norms and struggles to conform to them, it is stressful for her.

In the conclusion of their book Gender and Stress, authors Barnett, Biener, and Baruch summarize the research on stress in women's lives. A primary factor in stress is the degree to which a person has control over a situation and "in both occupational and family domains, women's roles are more likely than men's to be associated with low control over outcomes."<sup>6</sup> In the arena of paid employment, women are paid less, are more likely to exit and re-enter the work force, and typically have positions with little authority.<sup>7</sup> Traditionally, motherhood is high in demands and low in control; wives are usually more affected by events in their husbands' lives (for example, job transfers, military relocations).<sup>8</sup> It appears that women are particularly vulnerable to negative effects from non-work related stresses; they "undergo more life event changes, interpret those changes

as more stressful, and are affected more intensely by events they cannot control than are men."<sup>9</sup> If the growing evidence that women are more prone to depression is correct, it "may be due both to socialization into a gender role that encourages relinquishing of control to others and to their occupancy of social roles that provide less opportunity for control."<sup>10</sup>

How do women respond to stress? Overall, the perception that one possesses sufficient resources to combat a threat produces less stress than the perception that one's resources are insufficient. Barnett, Biener, and Baruch cite research that defines three types of responses: one can change the situation, change the meaning of the situation, or manage the emotional pain from the situation. Women tend to use the latter two, which are more emotion-based strategies than the response of changing the situation. When women perceive that they cannot change a stressful situation, they may use "self-consoling" behaviors (such as eating and shopping) or "self-changing" behaviors (such as dieting and exercising).<sup>11</sup> Some researchers have found that use of emotion-based responses which often involves "selective ignoring of problems in response to the strains of marriage and parenting tended to exacerbate psychological distress."<sup>12</sup> Thus, how women often respond to stresses in their lives--which are compounded by the lack of control they have over many circumstances--does nothing to alter the source of the stress or prevent it from reoccurring.

### Life Stresses and PMS

In interviews, women described stress as anything that causes increased mental, emotional, and/or physical tension. The imagery of physical and psychological weight, burden, or pressure was often used, in word choice and pantomime. Common examples of stress were: disturbing interactions with other people in various settings; time constraints; heavy work loads; and major changes such as moving or starting a new job.

For Laura, having long cycles (thirty-four to thirty-six days) used to be very stressful because she was frequently worried about being pregnant. When she found out that her mother's cycle was thirty-six days long, that source of stress was diminished.

Darlene and Wendy talked about the stress of changing the way women express themselves in order to fit into the male professional world. Darlene referred to a greater need to suppress one's emotions:

It seems like maybe there's not as much pressure in other parts of society where there's more acceptance of the traditional expectations of women: you're a woman, you're expected to be feeling-oriented. Which in some ways is chauvinistic; again, you and your feelings are trivialized rather than appreciated.

Wendy thinks that women have to learn to communicate in two different styles: "I think women are able to perceive how to communicate even if it means changing your methods so you're communicating as a male person does." We discussed the dilemma of trying to fit into male culture without being seen as too aggressive, a situation she described as "a very fine line you walk all the time."

Many women say they experience stress differently before their menstrual periods. Issues or concerns seem to weigh more heavily. Debra commented that with PMS, life's stresses "seem to loom much larger."<sup>13</sup> How they respond to events that might be aggravating at other times is different: they described themselves as likely to be stronger, angrier, less measured or accommodating in dealing with stress. Women also talked about times they believed that significant stress influenced their cycles by altering the length (for example, delaying their periods) or increasing menstrual cramps.

Individual methods for reducing stress were similar to those mentioned for lessening premenstrual symptoms.<sup>14</sup> Nora believes that stress exacerbates premenstrual symptoms and premenstrual symptoms can be lessened through stress management

techniques (for example, relaxation, meditation, and hypnotherapy). Another frequently mentioned antidote for stress was exercise. Some women suggest that physical exercise works by distracting them from repeatedly replaying a problem in their minds without actively looking for constructive ways to resolve it.

Helen had some ideas about how social institutions would need to change for women's lives to be less stressful at all times of the month:

There are many problems in the world such as the organization of the workforce and how that at present affects women's lives. Men would need to stay home for some twenty-four hour periods to learn to become good primary caregivers. They can do it and can bring a new and worthwhile perspective to it. Men love the babies but they expect the child to fit their needs. They want to be with the child when it's convenient.

### Stress From Concerns About Physical Appearance

Part of it [premenstrual symptoms] is my head is all caught up in this nasty body image that I have of myself. So when I start to gain weight and my breasts get huge that affects my head, too (Eve).

As discussed in Chapter Five, industries related to dieting and exercise have expanded tremendously since the 1970s. In this culture, women face much higher requirements for physical attractiveness than men; perhaps most significantly, in terms of the effort required to conform, women are supposed to be thin in order to be considered attractive. Many women have internalized this message and for some women, dieting is "an important chronic source of stress."<sup>15</sup>

In contrast to popular notions of dieting as healthy, research suggests that dieting is both ineffectual and unhealthy:

Dieting typically does not result in lower weight, but in fatigue, irritability, chronic hunger, greater reliance on external guidelines for the regulation of food intake, and "counterregulatory" behavior, characterized by uncontrollable urges to binge eat.<sup>16,17</sup>

Diet and weight were not issues that were focused on in the questionnaires or interview questions used in this research (diet was mentioned in one interview question), yet the subject came up in many of the interviews. The topics of food cravings, a desire to lose weight, and dissatisfaction with body size and shape were often raised. Many women mentioned changes in appetite over the menstrual cycle, particularly an overall increase in appetite, or cravings for specific foods, premenstrually. The foods usually craved were chocolate, sweets generally, and salty foods. The women who brought up the subject of food often asserted the importance of a good diet in reducing PMS. A number of women see correlations between eating certain items--caffeine, salt, and sugar were most frequently mentioned--and specific symptoms. The women from PMS workshops and the fitness club referred to issues of food and weight more frequently than the women from the women's health clinic.

Women of various body types expressed concern about their weight and displeasure or depression with premenstrual weight gain. They provide additional evidence that the cultural ideal of thinness engrosses a large percentage of the female population in an endeavor in which it is extremely difficult to succeed. Premenstrual weight gain and bloating are frustrating and depressing to women already unhappy with their appearance. In describing themselves in relation to their eating habits, women often used exaggerated and demeaning terms, for example: "I'm bad," "I'm terrible," "I eat like a pig," "I'm a pig," "I pigged out," "I'm a slob," "my rolls of fat."

A number of the women described a complex cycle of attraction and revulsion to food. Some foods, for example, sweets and salty snack foods, are associated with a form

of reward or a treat. One woman described eating chocolate as a way of "nurturing" herself. Another spoke of how deprived she feels when sweets and special treat foods are present on holidays and she feels she must carefully ration the amount she eats. Eating too much food or "bad" foods leads to guilty feelings. Alice ignores the "voice saying no" to particular types or quantities of food, which she says she knows she should not ignore. She keeps telling herself that she will do better in the future. Laura says she has given up on trying to reduce symptoms by being careful of what she eats premenstrually. She has also stopped feeling guilty about it because guilt only "adds insult to injury" (injury meaning the other pains and difficulties she associates with the paramenstruum).

Several women conveyed awareness of a cycle of eating, weight gain, and depression, with apparent links to the menstrual cycle and cultural expectations. Eve said "part of it is my head is all caught up in this nasty body image that I have of myself. So when I start to gain weight and my breasts get huge that affects my head, too." Weight is "a real issue" for Maria. She described her pattern in more detail. She notices "mood shifts" about a week prior to her period, but when her cycle is longer, she seems to gain more weight, resulting in lowered self esteem: "the more depressed I get about weight, the more I eat." The larger her additional weight gain, the harder it is for her to bring her weight back down to closer to where she wants it to be. I asked her where her sense of weight as a problem comes from. Maria's mother "always complained about her weight but she wasn't that heavy." When Maria entered high school, she thought of herself as "big and strong." Soon after high school, she married a man who "wanted this little thing, which I wasn't." She said that is when she became "very self-conscious." She has one sister who is bulimic and another who is "medium size, average weight, and thinks she's fat."

Maria and Nancy both see weight as a "cultural issue" for women. As Nancy said, the issue of PMS "gets more complicated. . . when you get all the messages women are getting about food:"

Then you start to really wonder about depression because if you're feeling really hungry and you're eating everything in sight, you've picked up five pounds in a week. Then you might very well kick off a serious depression because you're not supposed to be eating like that and shit! You've just gained five pounds! That is a whole other factor. Or feeling fat because you're bloated or your breasts are too big. Or feeling bitchy. And all these are things you're not supposed to be feeling or doing. That throws a whole 'nother wrench in the gears.

### Relationship Stresses

When women talked about strong emotions they experience premenstrually, I asked about the kinds of issues that came up for them at those times and whether they were recurring concerns. The answers most often dealt with relationship stresses and feelings of resentment, irritation, and insecurity in connection with those relationships. As we saw in Chapter Six, the most frequently cited source of stress reported in studies of premenstrual symptoms and stress results from conflicts with a significant partner.

Two women said that they have difficulty distinguishing menstrual cycle related effects from responses to stressful events in their relationships. Sally had been trying to ascertain whether some strong emotions were due to a recent breakup or cyclic moodswings:

The last two months I've been very teary off and on. . . . I don't whether to blame it on premenstrual or where I am emotionally. . . . And no one has ever said anything, or pointed out mood swings until this break-up, which



they attribute to that and not some cyclic thing. I attribute part of the depression to cyclic. . . . I tell myself it's premenstrual and that it'll go away because I don't want to think this is the way it's going to be.

Eve described some strong feelings she had during a time of upheaval in her relationship with her boyfriend: "Part of it is we *were* going through a really hard time, and we *were* on the verge of breaking up sometimes, so it's hard to separate that out [from premenstrual state]."

Women with husbands and children often mentioned issues of sharing childcare and household responsibilities. Helen is disgruntled about the differences between her parental role and her husband's. She is trying to decide if she wants to have a second child, under the present circumstances:

I'm main caregiver *definitely*. He's a good father but he wants to come in and do it when he wants to be. I think he should be whether he feels like it or not. I get real tired and he should, too. His attitude is common, basically, it's lucky if he changes diapers. On a good day, I say why not, on bad days, it's god, I can't deal with one [child].

Helen remembers how hard it was when their child was younger and "waking up every forty minutes. I was feeling like a basketcase." They had "some bad times, lots of arguments" then. She said her husband "went so far as to say 'I'm going to commit you to Sonoma Mental Hosp, you're driving me nuts.'"

Household chores are most likely to make Leslie feel irritated premenstrually:

The little things seem to bother me a lot more. Little things I've asked my husband to do or not to do. And the rest of the month, it's "ok, so he didn't do it." But at that time, it's like, "now I've asked you not to *do* that! "Don't pile dishes in the sink." . . . Just little things like that, that are totally unimportant.

As discussed in Chapter Five, many women are increasingly resentful of inequities in the household division of labor. Leslie spends much more time in the home than her husband and is the primary caretaker of the house and the children. Her husband's job relocations have directed their moves within and outside of the United States. In terms of possessing the factors contributing to stress, Leslie's life would score high marks.

Problems in her relationship with her husband also come to the surface for Nora. She has been considering leaving her husband for sometime and had recently communicated her decision to him. She spoke of the stress involved in making that decision:

Sometimes the stressed feeling is that you just can't make a decision. Two weeks ago I wrote a letter to my husband and said I was leaving. That was rather stressful. It had been on the verge for a long time. The decisionmaking process was hard. It's hard to really think through what you want. . . . I couldn't even say it to him, so I had to write a letter, you know? And then he read it while I was at work and we talked about it when I came home. So there's been a lot of stress in my life about that.

Nora said that when a woman with PMS has a partner who "isn't sensitive to that it can be devastating." She described her husband as

not really very supportive. But then it's not like he is or he isn't. It's just nothingness [laughs]. It does make a difference to have an understanding partner. . . . Lots of things do come up at that time (premenstrual). And it's really curious why they come up then.

Nora also told me about a friend whose husband writes "danger zone" on the calendar to indicate his wife's premenstrual phase, which Nora said her friend did not find amusing or helpful.

Some of the unmarried heterosexual women spoke of feelings of insecurity about their significant relationships. Ginny almost cancelled our first interview because she "had been waiting to hear what he [her boyfriend] had planned for the weekend" but she decided to go ahead with the interview after her boyfriend had "encouraged" her to do it. Ginny talked at length about her concerns in their relationship, which seem to be heightened premenstrually: "I would start feeling sorry for myself and lonely. I'd doubt he loved me and wanted to be with me. I felt empty, lousy, . . ." Most of the issues involved had to do with her desire for the relationship to progress in the direction of becoming engaged, renovating the house in preparation for living together, getting married, and having children with him. Her partner had not said "no to family but he hasn't really decided yet."<sup>18</sup> Ginny described them as "doing real good" as a couple: "No house improvements, no step in the relationship, like an engagement or anything, but fine."

Ginny said she does not want to "pick a fight but it's like I'll start bringing up things":

[He] doesn't talk a lot. . . . I'll talk to him and I know he's listening but he doesn't give me much feedback, which is kind of hard. So then constantly I'll nag more because I want feedback. And then he gets pissed off.<sup>19</sup>

She repeatedly used phrases that convey the idea that there are no genuine issues involved, only her propensity for creating problems: "like asking for a fight though I didn't want a fight"; "I'd usually pick a big fight with [him] at that time;" "'cause I've got to find *something* to be negative about." She locates the source of all conflicts she has with her friend within herself. His feelings are legitimate responses to her actions; her feelings are invalid.

## EMOTIONS

Women went to PMS workshops seeking solutions. Often those solutions had to do with controlling or limiting emotional responses. In describing the premenstrual feelings they would like to change, women frequently mentioned being more unhappy, tearful, depressed, irritable, and angry. Helen wanted "to lose my irritability, be more patient. I wanted all calm 'yes, dear' days." Leslie was particularly concerned about her strong feelings of anger and wanted to do away with them entirely.

Are women innately more emotional than men? A thorough examination of the science of human emotions is beyond the scope of this dissertation. The evidence from the research to date on emotional expressiveness and gender is not what many people would expect to find. People believe women are more emotionally expressive than men; women report more emotional expressiveness for themselves; and in researcher-controlled settings, women express more emotions. In naturalistic settings, however, there is no overall difference between female and male expression of emotion.<sup>20</sup> This suggests that cultural expectations of female emotionalism influence both subjects and researchers.<sup>21</sup>

There is a longstanding belief, demonstrated in much of the research cited in this dissertation, that the female reproductive system is responsible for female emotionality; the reverse is not said of males. Thus, in today's parlance, many attribute the source of women's feelings to sex hormones. Yet, as psychologist Donald Nathanson points out, people are "gripped by emotions that oscillate far too swiftly for any substance that must flow through something as sluggish as the circulatory system."<sup>22</sup> In the case of depression, which appears to be twice as likely in women as in men, a three year study concluded that culture rather than biology was the primary factor. The woman who chaired the research group stated "women truly are more depressed than men, primarily due to their experience of being female in our contemporary culture."<sup>23</sup>

### Comparison of Women's and Men's Emotionality

Five of the women with whom I spoke explicitly stated a belief that women are, by biology or socialization, more emotional than men. Two of them believe women are inherently more emotional. For example, Paula associates women's emotions with cyclical physiological changes:

Women have a lot happening with their bodies. Hormones and a lot of changes every month. I think that can affect your moods. Naturally, it would stand to reason that men don't have as much happening every month as women who are constantly in a cycle or getting ready to go into a cycle. To me, that can affect one's moods. . . . For the most part, I think women are more justified in having moods, more clearly defined moods.

To Belinda, women are constitutionally superior to men because women are more emotional and more intuitive:

I like to link emotion with intuition, which I think is more powerful than logic. And more healthy. We need logic certainly but we're overrun with it and I think women's intuition and emotion is more real, or stronger. I think it's a superior way of being.

Men's "greatest problem," Belinda believes, is that "they don't express emotion:"

It could be a bottom line to annihilation, that great rage that they have. Yet women have it, too, because we're oppressed. Having that stereotype of being emotional, we're allowed to be emotional but we're not allowed to be angry really.

Two other women think that whatever the source of the difference, women and men are

totally different people. I find it curious that my gay male friends are much more able to discuss feelings. Is it hormonal, temperamental, environment?

I don't know. But there's an absolute difference. (Sally)

Overall, Sally says her "male friends are absolute zombies as far as emotions go." Faith believes the reason men are less sensitive emotionally is "a matter of training but it's also a matter of inclination." She considers men's moods "more selfish" than women's:

I think women have always been trained to be in tune with other people's moods and relate to and try to help somebody if they're in a bad mood. Whereas men, I think, are totally selfish, they have no idea of it. I mean, when they're pissed, they're pissed, or when they're angry, they're angry. And they want to be taken care of, I think. They don't have much [pause] compassion.

Finally, Eve sees cultural conditioning as the source of differences in female and male emotionality:

I think women *feel* more than men. I wouldn't say that it's biological; I think we're raised that way. I don't think it's valid to say men are analytical, women are emotional. Men have feelings. I think they've been trained to control their feelings and that may make them seem like they're rational. And women have more been told it's OK to cry, because women are weak and they're supposed to do that.

Like Sally, Eve exempts her gay male friends from this description.

Far more often, women view men and women as equally feeling beings. Carol is not at all convinced that men are more reasonable and logical than women. She said she sometimes thinks "that when women have PMS, they're like men are all the time in their irrationality." Sometimes, like Dorothy, a woman revised her assessment of how women and men compare in terms of emotionality in the process of discussing the matter:

I basically think women are more emotional than men. Or they show more emotion than men. But on the other hand, I'm seeing a guy who's very emotional and he's very moody, too. I tend to think that women show more feeling toward different things. They're all different, so it's hard to say, but the guy I'm seeing now is very emotional, he shows a lot of feeling. He's very sensitive. He's right up there with me [laugh]. We're emotional together.

Many women expressed the view that the experience of emotions and changing moods is human and that social conditioning influences emotional expressiveness by each gender. Shirley thinks "Society says it's not OK for men to feel that way so they don't show it as easily," whereas women are "allowed" to express their feelings more openly. Maria argues that physiological differences are "not enough" to account for the "tremendous variation between and within culture." She thinks that "even when we're feeling the same thing, different labels are used for it," depending on one's gender.

Other women suggested that the difference is in the way men and women express their emotions. Nancy believes men "may not cry but they get hurt, sad, defensive. I don't think they're any less emotional." Nadine gave the example of a man "watching a football game and somebody lost and it [his mood] just went down." Other ways in which men may exhibit their emotions are "yelling, lots of drinking, lots of things that women don't necessarily do," according to Wendy.

To what do women attribute the differences they see in how emotions are expressed by each gender? They assumed the way men handle emotions is primarily a function of gender roles. Veronica said "It's not cool to be emotional so they're going to deny that across the board." Fran described it as "part of being macho."

Helen thinks it is difficult for her husband to acknowledge his own periods of irritability and anger. She was surprised to notice that in some arguments, he is the person whose anger is "out of control:"

In a recent "discussion," I was very calm and he was flying off the handle. "Now the calmer I get, the more outrageous you get, pounding your fist. I see the fire in your eyes. You'd never admit to that, it was always the flames in mine." It's hard for him to deal with.

Rather than being a matter of greater emotional expressiveness by women, Darlene proposes that women simply discuss their emotions more than men do: "The only difference I'd begin to entertain would be that women verbalize it more. Which doesn't mean they *show* it more, just they might talk about it more." Darlene believes the stereotypical norms of emotional behavior by women and men diverge from a more complex and "much broader" reality in which both genders are capable of a wide range of emotional expression.

If the sexes are equally emotional, I asked Louise, why does the stereotype of the emotional woman persist?

I think it's just the past. People are so used to it. That's the way it's always been. You know, once everything's set in someone's mind that way, especially in society as a whole, it's just gonna stay that way and that's it. [pause] My husband has real bad mood swings.

One woman told me that in her experience, men are more emotional than women:

A lot of men I know seem to say, "you poor women have such wild mood changes and can't control your emotions. You cry over everything." And I've been saying all of my boyfriends have been *much* more tempestuous than I am. Their moods go this way and that way and they blow up over nothing. And they're out of control. . . . It's interesting. Once a month I



feel on edge. But I don't ever get as out of control as a lot of men I know do. (Holly)

I asked her the same question I asked Louise. Holly thinks the image of the emotional woman persists because "some men like to have a reason to categorize women as unstable and untrustworthy and just weaker."

### Shame, Guilt, and PMS

Definition of shame: A painful emotion caused by a strong sense of guilt, embarrassment, unworthiness, or disgrace.<sup>24</sup>

There were many painful stories and bittersweet memories in these interviews. Though the focus of the research was not menarche, almost all women seem to remember their first menstruation and a number of the women with whom I spoke told me about theirs. Memories of any adolescence, male or female, may be dotted with moments of shame and embarrassment; certainly these stories were.

In a couple of the PMS workshops I attended, women discussed ritual celebrations of their daughters' menarches; they themselves typically did not have happy initiations into womanhood. In fact, I have heard many more stories of women horrified to discover themselves bleeding unexpectedly than I have of women well prepared for menarche and proud to share their new status with family members.

Why is menstruation permeated with shame in this culture? One factor is that control of bodily functions is treated as critical to social acceptability at an early age in this culture. Nathanson points out that

The self-disgust and self-dissmell associated with excretory dyscontrol are so powerful a stimulus for shame, triggers that come to matter so much to the growing child, that excretory competence becomes a kind of reference point within our construct of shame as an emotion. . . . In the moment of

embarrassment we feel infantile, weak, dirty, and unable to control our bodily functions.<sup>25</sup>

Think of the timing of menarche in terms of its impact on a young woman's self-esteem in the context of this account of shame and what has been said about women's role and status within society throughout this dissertation. Years after she has learned bladder and bowel control comes a new source of effluence, uncontrollable, often unforeseen, and peculiar to her sex. If it is talked about at all, it is in whispers, euphemisms, or strange technical terms.

Sally had "zero preparation" for menarche:

I was in the bathroom at school and this hemorrhage occurred. I mean, I didn't know what it was. I pulled my pants up, went out to the playground and got my friend Judy, who had started her period three weeks before. I dragged her into the bathroom and said, "What is this?". . . And what happened is I cried. And I went home, ill. . . . I remember feeling every boy in all of Berkeley knew and was pointing and staring at me. My mother wouldn't let me play touch football anymore and that made me really angry because I didn't think [pause]. I felt I was ill rather than this was a normal phenomenon. . . . To this day, I'm sure that if I asked Billy O'Connell, my next door neighbor, if he knew when I started my period, he would say yes. I mean, I have this stigma from this experience. And of course my mother told my father and I cried for weeks over that. How could she betray me? It's so funny. But isn't it interesting that we really remember that?

Fortunately, not all women have experiences like Sally's (or worse). But everyone I spoke with remembered menarche.

How do women feel about their menstrual cycles? Besides their personal introduction to menstruation and the range of physical sensations experienced with cyclical changes, the majority of women probably receive many negative messages from those around them over time. What follows is a short summary of the kinds of experiences described to me.

Arlene remembers a "snide remark" her father made when she was twelve about her "breasts getting bigger." Menstruation "wasn't a joyous thing. The body was something you fought against." When her brother asked her whether or not she had begun menstruating, she lied and said no "because I was trying to preserve my independence for another few months or a year." Gloria said she learned that when grocery shopping, "the [sanitary]-napkins were supposed to be completely hidden in the bottom of the basket from men." Eve's father would "always tease me about did I want him to go to the store and buy me some Kotex" and "he'd always say it in front of people." Eve continues to be ill at ease talking about the menstruation with male friends because "I was raised with the suspicion that it's something you don't talk about, something to be ashamed of. It's dirty, disgusting, . . ." She remembers the rules she had to follow for carefully wrapping used pads in thick wads of toilet paper before disposing of them. Some women are still too embarrassed to go to the store to purchase their own menstrual pads or tampons and persuade their husbands or boyfriends to do it for them.

A few women said they had been told to abstain from sex during menstruation. Odetta's grandmother told her "'Do not have sex while your period is on.' So I don't. No matter what. It's something bad that went into your mind." Louise was told the same thing; she has heard that some people do have sex during a woman's menses which she thinks is "the most gross thing somebody could do!" Even without a specific prohibition against menstrual sex or any negative comments from lovers, several women told me they were always afraid that a man would be "disgusted" by them during their period. I asked

Darlene where she thinks her fear came from if a man had never made a negative comment to her about menstruation. She believes it is the silence: "I mean, if you can't talk about it, there must be something wrong with it." Sally's ex-husband was not silent on the subject. He "used to make some sleazy comment. . . 'my god, she's on the rag.'" Sally's husband also made her sleep in another room when she was menstruating.

Perhaps the oddest thing I heard in all the interviews was that one young woman had recently learned that her father did not know about menstruation until he married her mother when he was forty years old. "And apparently it just blew his mind. He just lost it. He thought it was disgusting." Her father grew up in Czechoslovakia which is not, after all, a different planet. I have spoken with numerous women, both in connection with and outside of the research for this dissertation, who knew nothing about menstruation until their periods started; that is startling enough. It is a sign of how much secrecy has surrounded this subject that any man, living within the human community and without severe mental illness, could reach the age of forty without knowing that women of reproductive age regularly bleed.

Some women told me they have shed negative stereotypes about the menstrual cycle. Maria summed up her sense of men's attitudes towards the menstrual cycle with two words: "disgusted, dirty." Until recently, she said she had "carried that," along with a negative body image. Now she realizes "it's bullshit." Gloria believes the "intense moodiness" she used to have was more related to "unhappiness with myself" than with her menstrual cycle.

I see now that I'm an accomplished designer, I'm much happier with myself.

. . . I was a more difficult person to be with when I had these mood swings.

The whole cycle was rougher.

She also notices that her current male housemate is "just the biggest grouchy thing," which she attributes to the fact that "he's not happy with his work" rather than his hormones.

As we talked about our menstrual cycles, a few women expressed surprise that the men they knew had never seemed interested or curious about the subject. "No man's ever asked me the things you're asking me," Fran said. In Shirley's opinion, men "aren't interested. And when you think about it, it's really a pretty incredible thing. They're like, 'you bleed, so what?' . . . They don't know what it's about or care to." "Bleeding doesn't have to be bad," Nora told me; "men can't bleed for a week and stay alive." Gloria decided to increase some men's direct knowledge of menstruation by using her diaphragm to collect her menstrual blood:

Occasionally I would educate the boyfriend I was with by showing them this amazing amount of blood that we give out every month. And they would go, "wow" Some of them would say, "gee, I associate blood with pain."

Is there any relationship between such experiences and premenstrual symptoms? The evidence from research<sup>26</sup> suggests that stereotypical beliefs and expectations affect a woman's reporting of cyclical changes. We have already seen that there is a correlation between high stress levels and the severity of premenstrual symptoms. If stressful events "involve threats to an individual's well-being," strong feelings of shame and embarrassment should qualify. In addition, some studies indicate that low self esteem is "significantly correlated to frequency and intensity of PMS."<sup>27</sup> Since "a large part of one's self esteem is dependent upon others' valuation of oneself," the knowledge that others perceive this aspect of one's womanness as disgusting could have a negative impact on a woman's self esteem. Conversely, the higher a woman's self esteem, "the less likely" she is "to experience PMS, and with less severity."<sup>28</sup>

According to Nathanson, the emotion of guilt is a combination of shame and fear. Shame is related to the inner self, but guilt comes from an awareness that our behavior or actions has been harmful or has violated an important code.<sup>29</sup> Many of the women who

identified themselves as suffering from PMS, described a cycle of premenstrual expressions of anger, followed by strong feelings of guilt and remorse. Nancy and Helen are two women who have broken this pattern.

Nancy told me about interactions with her husband:

I'd get teary, fall apart. He couldn't deal with it so he'd want a divorce which would make me fall apart more. I'd just go into hysterics of, "I'm sorry," and "I'll try harder, what do you want me to do?" I can just see myself on the ground begging, it makes me sick. When I'd speak my piece, really come up and say something, be aggressive--he'd threaten divorce and I'd have to cower down then, too. Which bothers me because I'm not a person who normally cowers. There are times during my cycle that I feel strong and want something and I should ask for it, but that threat of divorce bothered me so much, that I wouldn't. Inside I'm just this thing needing to explode but I can't. That would really work on my pride.

In the course of their marriage, Nancy says she

left myself completely to help him. He asked me to quit work when we got married, so I did. Then he asked me to work part-time while he did something else, so I did. Then he asked me to quit so I did. That sort of thing. I always did. It's so sick to hear it come out of my mouth, that I would do something like that.

She eventually persuaded her husband to go "to counselling to work on *my* problem." When the counsellor "found it to be his problem, that was the end of counselling." Her husband said he "couldn't communicate with that man." Nancy describes the situation in her family as having gotten "so bad, the three of us [she and her daughters] were so low into the ground to make him feel good. It was just sick."

Now that she and her husband have separated, Nancy says she still has PMS,

but I can deal with it better. I'd like to have somebody there but at least I don't have that letdown. And that's nice. And not to feel awful because I've got my period and he doesn't like it.

Helen spoke eloquently about a recurring pattern of having emotional fights with her husband when she was premenstrual, then feeling terribly guilty and attempting to atone for it. She sees herself as starting to break the pattern by learning to "calmly express anger":

Not that we're not fighting--we have these "discussions." And now I'm not apologizing for a week, crawling on the floor, making fabulous dinners to make up for what a witch I was. . . . The guilt was almost worse than going out of control. Guilt, I'll mourn for a long time.

Helen has come to feel that "all women should get more confidence and recognize that men aren't perfect and have many emotional upsets." When I asked Helen what she most wanted or needed for herself at this point, she answered:

Amnesia for my husband so we can outlive the past. . . . Now I wish my husband had never heard of PMS. I am no longer grateful for his "support" for me in having PMS. Now it's just a scapegoat for him. Too many men read about this and only see what they want to see. Too many women don't bother looking any further.

### PMS and Women's Anger

Question: If you were going to do a study of PMS, what do you think would be important to look at?

Answer: What bothers me most about PMS is the anger. That's what I'd like to look at. The uncontrollable rage that comes out. (Leslie)

Leslie's way of defining PMS was "it's like an inhibition within me has been lifted. . . I have the same feelings inside me all the time. . . but during that week, I just go off like a firecracker." What does Leslie's anger mean? As she told me about her life and I tried to place myself in her circumstances, I could imagine that she had plenty to be angry about. She is a strong intelligent woman trying very hard to be a good military wife and mother to two sons. Where they live, how she spends her time, how she comports herself, many of the details of her life have been and are decided by the fact of her husband's position in the military. Her sphere of control is very limited. Leslie did not express dissatisfaction with these arrangements but she related many difficult situations she has navigated. She ridiculed, as many of the women I interviewed did, the kind of matters that precipitated her furious responses: household routines not followed correctly, items out of order. Leslie has been horrified by the anger that she cannot always squelch and said she would like, more than anything else, for that anger to simply go away.

When these stories are related, whether in PMS workshops, popular media, social gatherings, or conversations, the point often being made is how absurd we are as women. The stories are presented as certain evidence that PMS has a biological basis. The analysis rarely goes any further. But underlying their examples were some significant issues. As we saw in the beginning of the chapter, many examples of premenstrual concerns related to a sense of what is fair in a relationship, such as division of household labor, sharing of child care responsibilities. Others involved personal needs for affection, trust, security in the relationship. With few exceptions, when anger and conflict arose premenstrually, women were likely to later discount the validity of their concerns and express guilt over having raised them. Helen told me:

I used to turn all my guilt and anger inward. I couldn't get angry at my husband, so I'd get angry at myself. It was the source of suicidal feelings, a feeling of "I'm so bad I need to die, I need to be gone." Yet it was directly



in proportion to the rage I felt that he wasn't helping me, understanding me, or supporting me. Now sometimes I see when I'm angry at [my daughter], I'm angry at him.

In the last thirty years, books like Betty Friedan's The Feminine Mystique, Phyllis Chesler's Women & Madness, Lillian Rubin's Worlds of Pain, and Arlie Hochschild's The Second Shift,<sup>30</sup> have posited real sources for women's rage and suggested that because of definite social rules about anger as inappropriate feminine behavior, women may repress or redirect anger. As Phyllis Chesler pointed out twenty-one years ago, this is particularly likely to be true of traditional women, who are economically dependent on their husbands:

Open expressions of rage are too dangerous and too ineffective for the isolated and economically dependent women. Most often, such "kitchen" declarations end in tears, self-blame, and in the husband graciously agreeing with his wife that she was "not herself."<sup>31</sup>

When it expresses dissatisfaction with unacceptable aspects of one's life--and is not immediately followed by guilt--anger is an "instrumental" emotion: "anger, with its tremendous expenditure of energy, can be the instrument of change."<sup>32</sup>

Who is this angry woman and why is she inhabiting this nice woman's body? Emily Martin's list of possible sources of contemporary American women's anger was given in Chapter Six. Some of the stressful situations discussed in this first part of the chapter could also provoke women's anger. The kinds of situations women told me they are likely to feel and express anger towards are summarized below.

Issues in relationships with other people--especially with husbands, boyfriends, lovers (most of interviewees were heterosexual)--were most frequently mentioned as sources of premenstrual anger. One of Wanda's comments brought together two common issues: relationships and household tasks. She said that she and her boyfriend had been together for three years and "it's pet peeves that have developed that come up more. I just

don't want to deal with them. . . . The attitude is, 'just never mind, I'll do it.'" Nina's anger is usually directed at her male partner: "Most of my reactions are with Matthew. He'll be really good at finding that little trigger that will set me off and make me [brief pause] bite."

Their young children also can annoy women more premenstrually, especially when they are trying to concentrate on something and the child interrupts. Sometimes a woman's child was present, or nearby, during an interview. Nora's pre-school aged son interrupted one of our conversations several times and Nora indicated her annoyance with such interruptions: "It's always something. I think that's part of my PMS, too." At one point, she said to him, "No, not right now, I'm on a roll here, let me think."

Sometimes women acknowledge that their anger towards one person or situation will be redirected at someone else, usually nearby. Nora said she will sometimes "vent" her anger on her son, "because he's easy to get mad at, especially at that time, besides being frustrating in general." She thinks the anger expressed toward her son is actually anger at her husband. Another woman said she realized she had been harboring tremendous anger towards her mother and expressing it at others premenstrually:

I see exactly why I have reason to be so angry. After forty-five years, I've refined it down. I know exactly why I screamed for eight and a half years of marriage. I got it completely. It had to do with my mother. (Abigail)

The role of nurturing others at her own expense can become oppressive for women premenstrually. One of the PMS workshop leaders told me that she thinks the reason why PMS captured considerable attention in recent years is that "women can't deny their anger any more about being overcommitted to nurturing." Nora said her "anger and the displaced anger comes up" when she is exhausted and wants "to be left alone but nobody does leave you alone." Nina told me she becomes "a lot more selfish with my emotional needs as well. I'm more apt to show my anger or disappointment or happiness in those two days [before my period]."

Women with stressful jobs described their work as harder to manage calmly during the premenstrual phase. For Dorothy, work involves dealing with "a lot of angry people. . . listening to them cussing me out." There are days, particularly before her period, when she becomes very angry in response and tells her boss, "I can't deal with this today."

Some women expressed a feeling of being violently angry about everything and at everyone. Nina said "I get very volatile. And something. . . triggers this almost violent [growling sound]. I'd like to smash a glass or hit someone. I never act out them. I'll just be angry towards the world." Nora said, "I don't get angry a lot, and a few days before my period, I could just about kill. Nobody can do anything right, everybody's an idiot."

In her poem "This Morning," Muriel Rukeyser says "today once more I will try to be non-violent. . . in the violent day."<sup>33</sup> While women speak of violent emotions, those with whom I have spoken did not speak of crossing the line from feeling like smashing or hitting to taking the action. Clearly many women are concerned about their potential for violence. Crime statistics consistently indicate that while violent crimes by women have increased, the number is still far below that of violent crimes committed by men.

Another source of women's anger is news reports on social problems and politics. Cheryl mentioned a number of recent events in the news which made her angry, including a story about a young woman in the Bay Area who had been killed and raped. The accused perpetrator was out on relatively low bail. Cheryl says her anger becomes a "rage state" and a "vehicle" premenstrually; it's a time she has to "acknowledge the anger" about "this normal everyday stuff that we should all be mad about."

It was interesting how often women expressed anger about how menstruation and PMS are discussed and treated in this culture. Some women are angry about the cost of menstrual pads and tampons: "I get angry when I have to pay five or six bucks for a box of napkins, and it makes me furious because . . . I feel like they're capitalizing on women's menstrual periods." (Eve) Laura is angry at the cost of menstrual supplies and the lack of

medical help for menstrual and premenstrual pains and problems. There are times she would like to address

the medical profession and the pharmaceutical industry and whoever makes tampons and Kotex and say, "it's all your fault, you don't find out what'll cure cramps, and why don't you just give us protection instead of making us pay so much money for it?"

Many women mentioned their anger at doctors, and anyone else, who assume their pains are psychosomatic. This term was understood to mean "all in your head," "made-up," or "exaggerated." These interviews convinced me that women are very concerned, for good reason, by the suggestion of being weak or ill psychologically. Belinda related an incident on public transportation in which a male passenger overheard her conversation with a female acquaintance about how they tend to feel during different times of the menstrual cycle:

And he started saying something like, "oh, women and their periods. I don't know why they make a big deal about it." And laughed in this irritating way. . . . So I got mad at him: "You men just make me sick. You can make these casual, flippant comments. You try bleeding for seven days and see how you feel, just try it sometime." And he looked at me very surprised. He looked like he was in that sheltered environment where men were the macho people and spoke loud and women just didn't do it and if they did their voices went very high [mimicking higher voice] and my voice remained very low and I *zoomed* in.

Women are also angry about much of the media coverage and advertising about PMS. Gloria is angered by the "ridiculous" impression given by commercials that with the addition of PMS to the list, women should be preoccupied with menstrual cycle issues throughout the month. Carol hates to see PMS

getting all blown up, people getting off of murder cases. . . . To make it as a debilitating disease that says a woman can't be president because of PMS is a like a swing back. . . . It's like these raving females with PMS and all these hormonal problems.

Many women feel they are discounted, particularly by men, before and during their periods. Darlene is "annoyed by men saying, 'she's on the rag.' It can trivialize real confrontational issues." She thinks men say "'she's on the rag' because she [a woman] is not complacent." Lynne says she has

noticed a lot of men will ask women if they're on their periods if women get a little [pause] "persnickety." . . . I just continue with my subject, I don't answer that. The truth is, yes, I am on my period. And yes, maybe I am a little more uptight, but so what? How does that change the conversation we're having? So I don't get into that one.

When Helen and her husband argue she says "he will get defensive and deny whatever I say, whatever truth is in it. Which infuriates me. Or he'll say it's just PMS, which fans the fire."

After Kathleen told me how much she liked menstruation I told her that her positive response to the subject was rare in my research to date. And I told her how one young woman had cried during our interview as she described her surprise at an item on my questionnaire about "positive aspects of the menstrual cycle;" she had never considered the possibility of the cycle as anything other than horrible. Kathleen responded:

That's so sad to me. I think it's this whole bigger thing of the way women have been denigrated in the society and there so clearly that's [the menstrual cycle is] the woman's thing and so there's all this shit around it that *women* have taken in. And just bought. . . . It's more that the right

way of looking at it is that men should be having *menstrual* envy. It's like, fuck penis envy.

### Positive aspects of premenstrual emotional expressiveness

I love being bitchy. I find it's a release for me. There are certain difficult things in our relationship and on those days when he says little things that irk me the rest of the month, I can snap back "goddam it, that's not true," and really vent what I feel at that moment. For me, that's a tremendous release. (Nina)

Some women conveyed both a concern about the *ways* in which they sometimes expressed their anger premenstrually and a sense that a premenstrual tendency to express feelings, especially anger, is a positive thing. From these interviews, I have the impression that many women allow themselves, or are better able, to express negative and critical responses to their circumstances when they are in that portion of the cycle; I have also found it to be true for myself.

A woman assisting at the first workshop I attended told us that she liked her anger, honesty, and directness before her period and "would like to have those qualities more often." In the story mentioned above of the confrontation on a bus between one interviewee and a male passenger, the woman spoke proudly of the clarity and strength with which she expressed her anger about his comment.

Nora was concerned about the way she sometimes expressed anger toward her son but also saw value in having arguments with a spouse or partner premenstrually. She described friends who "always fight before her period. . . . I don't think there's anything wrong with it, you know, myself. A lot of things get cleared up in those times, too."

Anger is not the only emotion women notice premenstrually. Nina also talked about a "heightened sense of warmth and affection," premenstrually. She thinks

something about the premenstrual phase "really sharpens" all her emotions. Eve believes moods are simply part of life: "This is just the way I am right now and there are ups and downs in life, there are ups and downs in the month. Life is cycles." Eve described driving down the street and hearing a song on the radio

that just makes me cry. One that's so beautiful, or so sad, or brings back memories. I'm much more liable to get into my feelings at that time. . . . I think sensitivity is really important.

Helen used to berate herself for being emotional but said she had come to see the positive aspects of moods. She is not certain whether she could have had this insight at an earlier age:

Could I have learned this twenty years ago? Is some of it just a growing up process? When I sit with my daughter, I hope to help her understand something about emotions as changing and related to internal and external factors. It's wrong to teach that emotions are something not to be dealt with, to try to make "steel" persons.

Helen believes that the "volatility of emotions" is something to recognize and accept. "I know I love and hate deeply--what's wrong with that? Would I give up these depths? No."

## SUMMARY

The stresses that women reported as looming larger for them premenstrually have real roots; women's roles within the labor force and the home typically grant them low control over outcomes. Women mentioned the areas of stress in their lives frequently in the interviews, including situations at work, the struggle to reach an ideal physical weight, and conflicts in personal relationships. In addition to the external pressures, many women consequently have feelings of shame and self-doubt about not fitting into the "male" world, eating too much or being too heavy, and being dissatisfied or insecure in their significant relationships.

Women have a variety of opinions about the value of emotional expressiveness. Some women desire much greater evenness and control of their feelings. Others believe that women are fortunate in the range and depth of their emotions compared with men. The majority of women view the sexes as similar in their emotional makeup but different in the socially acceptable avenues of emotional expression.

Vivid memories of menarche and other experiences related to the menstrual cycle featured predominant feelings of shame and embarrassment in response to actual and feared comments by others. Some women have been more successful than others in shedding the accumulated messages of disgust and deficiency.

As we saw in the last chapter, many women are concerned about the different way they feel premenstrually; terms and phrases like "crazy" and "out of control" were used to describe that state. Yet women also spoke assertively about the things that anger them and seem to come more forcibly to their attention premenstrually. They are irate about aspects of their relationships, work, and gender role. There are times they feel furious at the state of the world and everyone in it. They are also mad about how they are treated because they have a menstrual cycle: paying the costs of "supplies," being discounted



because they are premenstrual or menstruating, being told that menstrual problems are psychosomatic.

Some women spoke with pleasure about the heightening or increased sensitivity of their emotions premenstrually. If their anger has a sharp clarity to it, so does their compassion for others, and their sense of aesthetic appreciation.

Ginny, Leslie, Helen and Nancy are four of the women who attended PMS workshops hoping to discover ways to lessen their premenstrual discomfort and anger. Ginny and Leslie are examples of women for whom PMS is serving as a kind of double bind. Both describe themselves as politically conservative and religious; both tend towards traditional women's roles. There are problems they experience in their lives which they often do not discuss with their partners. Premenstrually, they are more bothered by the problems and more likely to face the other person involved. Yet they are in agreement with their partners that premenstrual feelings and concerns are invalid.

Helen and Nancy are less conservative women who have spent some years of their lives in situations similar to Ginny and Leslie's but who came to see and deplore the extent to which they had allowed their needs and emotions to be discounted. For Nancy, it meant ending a marriage. Helen and her husband are negotiating a new definition of their marriage.

## NOTES

<sup>1</sup> Susan Griffin, Woman and Nature: The Roaring Inside Her (New York: Harper & Row, 1978) 187. The title of the short piece from which this excerpt is taken is "The Lion in the Den of the Prophets."

<sup>2</sup> The term paramenstrual is usually used to refer to the period of time approximately a week to ten days before menstruation through the first few days of bleeding.

<sup>3</sup> Uta E. Gerhardt, "Stress and Stigma Explanations of Illness," Stress and Stigma: Explanation and Evidence in the Sociology of Crime and Illness, ed. Uta E. Gerhardt and Michael E. J. Wadsworth (New York: St. Martin's Press, Inc., 1985) 163.

<sup>4</sup> Rosalind C. Barnett, Lois Biener and Grace K. Baruch, eds., Gender and Stress (New York: The Free Press, 1987) 350.

<sup>5</sup> Barnett, Biener, and Baruch, 350.

<sup>6</sup> Barnett, Biener, and Baruch, 351.

<sup>7</sup> There has been much discussion in recent years of the dangers of a "superwoman" syndrome, in which women experience stress from taking on too many roles. From the evidence thus far, multiple roles do not seem to adversely affect women's health. In fact, a long range study found that women with more roles showed better health trends. See Ingrid Waldron and Jerry A. Jacobs, "Effects of Multiple Roles on Women's Health: Evidence from a National Longitudinal Study," Women & Health 15.1 (1989): 3-19.

<sup>8</sup> Barnett, Biener, and Baruch.

<sup>9</sup> Jocelyn J. Johnson, "Female Clerical Workers' Perceived Work and Nonwork Stress and Dissatisfaction as Predictors of Psychological Distress," Women & Health 15.4 (1989): 71.

<sup>10</sup> Barnett, Biener, and Baruch, 358.

<sup>11</sup> Barnett, Biener, and Baruch, 354-55.

<sup>12</sup> Barnett, Biener, and Baruch, 355.

<sup>13</sup> Nathanson offers an explanation for why this may be the case:

. . . anything that can cause a minor degree of constant-density experience is capable of being added together with one or more low-grade stimuli that, when taken together, finally achieve the level necessary to trigger distress. We can handle a certain number of minor annoyances, but when the group of aches and pains that get to make up our day becomes large enough, we can unaccountably feel like crying. This is why the sort of thing that would never bother you on a good day is capable of driving you crazy when you are mildly ill. It probably is part of the reason women are more likely to cry when they are premenstrual. Some alteration of hormones, some change in the biochemical environment of the brain, may be producing the equivalent of a steady-stimulus or decreasing the threshold for distress; with the addition of some "minor" pressure we can cry. Much that people call "stress" or being "stressed out" is the affect distress either in pure form or with a little bit of the affect fear thrown in for good measure.

Donald L. Nathanson, Shame and Pride: Affect, Sex, and the Birth of the Self (New York: W. W. Norton & Company, 1992) 98-99.

<sup>14</sup> For example, see some of the comments in the section of Chapter Eight on controlling PMS.

<sup>15</sup> Barnett, Biener, and Baruch, 354.

<sup>16</sup> Ilana Attie and J. Brooks-Gunn, "Weight Concerns as Chronic Stressors in Women," Gender and Stress, eds. Rosalind C. Barnett, Lois Biener, and Grace K. Baruch

(New York: The Free Press, 1987) 219. Also see Naomi Wolf, The Beauty Myth: How Images of Beauty Are Used Against Women (New York: William Morrow and Company, Inc., 1991).

<sup>17</sup> Attie and Brooks-Gunn also report on a fascinating study done in 1950 in which thirty-six male conscientious objectors were put on a semistarvation diet for six months. Their usual food intake was cut in half, which Attie and Brooks-Gunn describe as "a typical weight reduction technique for women" (236). Physical, psychological, and behavioral changes were all noted. When the subjects had lost about one-fourth of their initial body weight, many effects were visible: they became obsessed with food, talking about it frequently, and reading cookbooks; they displayed emotional difficulties, "depression, hypochondriasis, hysteria, angry outbursts, and in some cases, psychotic levels of disorganization;" (237) they were incapable of working or interacting effectively on the job and in social situations; and they reported constant hunger.

<sup>18</sup> One of the last things Ginny told me, is that she had considered "accidentally" getting pregnant in order to force the issue of marriage and children with her partner.

<sup>19</sup> Tavis quotes from an interview with psychologist Andrew Christensen: "The one who has more power doesn't need to speak; the one who is one-down needs to demand or persuade to get information." Carol Tavis, The Mismeasure of Woman (New York: Simon & Schuster, 1992) 273.

<sup>20</sup> See, for example, Susan B. Shimanoff, "Handouts and Readings for Speech 503: Sex Roles and Communication," unpublished course materials, (San Francisco State University, 1992); Deborah Tannen, You Just Don't Understand: Women and Men in Conversation (New York: William Morrow & Company, Inc., 1990).

<sup>21</sup> See Stephanie A. Shields, "Are Women 'Emotional'?" EveryWoman's Emotional Well-Being, ed. Carol Tavris (Garden City: Doubleday & Company, Inc., 1986) 131-47.

<sup>22</sup> Nathanson, 42. Nathanson argues that the system of emotions or affect works in two directions: "events trigger the neurobiology of affect, and disturbances of neurobiology that resemble the biology of normal affect can make us think of the kind of event that normally triggers affect." 66.

<sup>23</sup> Quotation comes from the Los Angeles Times, December 6, 1990. For the study itself, see Ellen McGrath, Gwendolyn P. Strickland, and Nancy F. Russo, eds., Women and Depression: Risk Factors and Treatment Issues (Washington, D.C.: American Psychological Association, 1990).

<sup>24</sup> "Shame," The American Heritage Dictionary of the English Language, 1980 ed.

<sup>25</sup> Nathanson, 178.

<sup>26</sup> See the review of contemporary research in Chapter Six.

<sup>27</sup> Fay Catlett, Self Esteem and Premenstrual Syndrome: A Descriptive Study, thesis, San Jose State U, 1985, 66.

<sup>28</sup> Catlett, 66. Also see Gandelman's study which found a correlation between high self esteem and low incidence of PMS: Alice Gandelman, Locus of Control and Premenstrual Syndrome, thesis, San Jose State U, 1985.

<sup>29</sup> Nathanson, 148, 19.

<sup>30</sup> Betty Friedan, The Feminine Mystique (New York: Dell Publishing Co., Inc., 1964); Phyllis Chesler, Women & Madness (New York: Avon Books, 1972); Lillian Breslow Rubin, Worlds of Pain: Life in the Working-Class Family (New York: Basic Books, Inc., Publishers, 1976); Arlie R. Hochschild, The Second Shift (New York: Avon Books, 1990).

31 Chesler, 109-110.

32 Nathanson, 105.

33 Muriel Rukeyser, "This Morning," No More Masks! An Anthology of Poems by Women, ed. Florence Howe and Ellen Bass (Garden City, New York: Anchor Press, 1973) 99.

## CHAPTER 10

### CONCLUSION

Institutionalized rejection of differences is an absolute necessity in a profit economy which needs outsiders as surplus people. . . . But we have no patterns for relating across our human differences as equals. As a result, those differences have been misnamed and misused in the service of separation and confusion.<sup>1</sup>

Sex is one of the key differences among people that our culture insists on distinguishing and emphasizing through specific gender norms. Perceived movements toward ending the use of gender as a means of discrimination are met with strong resistance, perhaps most effectively by reasserting those differences through the vaulted authority of science. That science, enmeshed in the culture of sexual inequality, tends to serve rather than challenge the existing power relations lending it legitimacy. The premenstrual syndrome is a contemporary example of the misnaming and misuse of difference between the sexes.

This study was informed by the assumption that the way the menstrual cycle is handled in this culture is often detrimental to woman's health and self-esteem. The sex education most women receive does not encourage an appreciation of being female. It does not prepare a young woman for the range of normal menstrual cycle experience--positive, neutral, and negative--she may have at various times in her life. It does not serve as a positive transition to a new stage of life with distinctive capacities and responsibilities.

More often than not, young women are imbued with a sense of shame and limitations about the fact that they menstruate.

One of the women I interviewed, Kathleen, contrasted how menstruation is viewed in this country with an experience she had in Jamaica. She was with a group of Rastafarians "smoking herb." The joint was not passed to women who were bleeding, which suggests that others would be aware when a woman was menstruating. A woman explained to Kathleen why the women had been excluded: "Hey, they couldn't tolerate the power." In a comparable setting in this country, would others be likely to know which women were bleeding? How many American women would analyze the situation in terms of male fear of female power?

Apparently, PMS is primarily a Western phenomenon. As we saw in Chapter One, the cross-cultural research thus far suggests that the largest number of reports of premenstrual symptoms come from the West, particularly the U.S.<sup>2</sup> Considering core American values such as efficiency and rationality, as well as the specific historical conditions we have discussed, it is not surprising that a cyclical female function should be the object of attempts to regulate it. The requirements of capitalism do not mesh well with all human traits.

In order to understand PMS as a social phenomenon, we have looked behind it in time and around it in context. A review of the historical and contemporary literature on PMS in its social context reveals connections between the status of PMS research and other sociopolitical realities and ideologies of the respective times. The assumption of female weakness and pathology linked to reproductive biology has been a recurring theme in American culture. The transformation of normal female functions into disease exemplifies and is a consequence of efforts to socially define and control women. It ties in



neatly with parallel cultural themes idealizing a specific set of physical and behavioral attributes constraining and preoccupying women.

There is a clear ideological thread linking 19th century disease constructions such as hysteria and neurasthenia with the premenstrual syndrome. The Victorian ideal of feminine weakness served as an effective form of social control which also allowed women who did not want to participate in the public sphere to remain in the home. In the early twentieth century, concurrently with the discovery and ability to isolate and measure the reproductive hormones, the premenstrual phase was marked off as a separate area of specific concern to industry and society at large, requiring the attention of medical authority. As we have seen, research interest in paramenstrual pathology decreased during war time when women's wage labor was needed, resurfaced in the conservative 1950s, and peaked with the PMS frenzy of the 1980s during the backlash against feminism.

Research stressing menstrual cycle-linked pathology occurs at times of demographic opportuneness, medical expansion, and economic and sociopolitical advantage. Despite the failure of medical science to validate the cultural belief that biological functions determine women's capabilities and shape her appropriate social roles, the efforts to do so continue. Studies succeeding in showing any sign of cyclical variability in women's skills and faculties are heralded; studies challenging such findings or demonstrating gender symmetry are not.

PMS as a social issue coincides with cultural trends toward scientific authority and the increasing medicalization of experience. Physicians are granted an expanding role to observe and regulate lifestyle issues, and given access to intimate aspects of people's lives, physical and mental. Consider the invasion of privacy involved in PMS therapies in which family members are engaged in regularly monitoring and recording one's moods and behaviors for signs of pathology. Yet, in the context of trends toward spending more time

thinking about the self, refining control of one's body, and attending to increasingly minor symptoms, the relinquishing of personal autonomy to greater social control often goes unnoticed.

PMS clearly struck chords in the American psyche in the 1980s. Public attention to PMS was catalyzed by the dramatic news coverage of the British trials involving a PMS defense. In the midst of a conservative swing in reaction to the women's movement, which stirred fears about changing gender roles and women's potential political power, the media reports of the trials conjured up images of violent, vengeful women killing their men. Issues of power and control are intimately related to PMS as a topic of public interest.

The title of this dissertation, "Waging Hormones," refers to a strategic focus at the biochemical level to define the female role in politically expedient ways. The effectiveness of PMS as a political strategy is greatly enhanced by its flexibility. Like co-dependency, the description and catalog of PMS symptoms can be read to apply to large numbers of people, male and female.<sup>3</sup>

PMS works as a metaphor for woman's cultural image, evoking her dangerousness and innocence. It provides a means of simultaneously blaming and exonerating her; it offers a way to explain and discount her strongest feelings as unintentional and uncontrollable (without medical intervention). PMS can seduce women as a socially sanctioned explanation for discontent in their lives. Because participation in PMS treatment is usually voluntary,<sup>4</sup> the elements of social control may be less conspicuous.

PMS is widely understood as a disruption of the "delicate" balance of hormones coordinating the workings of a woman's reproductive system. Hormones, like genes, represent a relatively new field of medical study and evoke powerful images. Sex hormones in particular appear to provide a simpler explanation for such complexities as

human emotions than does gender socialization or the poor fit between human cyclicality and the demands of a capitalist economy. In contrast with the hormones associated with maleness, the female sex hormones are less linked with potency than with mental and emotional instability and lack of control. Estrogen and progesterone have come to be seen as a determining factor in women's capabilities, state of mind, and affect.

An interesting paradox in the popular culture of PMS is the contradictory way in which the issue of self-control is discussed. On one hand, female sex hormones are understood to be incredibly powerful elements in determining feeling and action. An excess amount or imbalance in hormone levels is understood to result in a volatile and treacherous state of being during the paramenstrual phase of the menstrual cycle. Women are hapless victims of the female reproductive system. On the other hand, and in concert with trends emphasizing the role of positive attitude in health and the total control of the individual over her or his destiny, one may be perceived as personally at fault for not creating perfect menstrual health. In both cases, the individual is separated from the social contexts of dis-ease and healing. Medical and/or self-help remedies are the only solutions proffered.

There is no doubt that changes in some hormone levels can have noticeable influences on one's physical and emotional states. It is certainly better to understand that physiological events can affect emotional states and that emotions produce physical changes than it is to assume that every physical difficulty and negative feeling is indicative of mental illness. We are born with the ability to experience a wide range of affects, and hormonally stimulated or heightened emotions are often difficult--or impossible--to untangle from the effects of other personal patterns and responses to external events. Louise Lander says it well:

Just as the human hypothalamus unites the hormonal and the neural, so human feeling and action unite biology, psychology, and sociology. Hormones alone, . . . , do not explain anything. For hormones alone do not exist. Hormonal events merge with brain events and social events; . . . no single ingredient determines the end result. Hormones do not rage, they insinuate.<sup>5</sup>

A specific belief in PMS has entered the mainstream of assumed truths, held to be real, widespread, a matter of raging hormones or hormonal imbalance, again, despite strong evidence to the contrary. Many women who initially resisted the label as stigmatizing to many women came to use the term to describe a range of their own experiences, frequent or infrequent, minor to severe, whether or not medical treatment has ever been sought. In fact, a common assumption is that if one does not have severe premenstrual and menstrual symptoms, one is "lucky." PMS is supposed to describe the norm of women's paramenstrual experience.

The primary conclusion of this research is that the phenomenon of PMS has been two-edged in terms both of what it represents and its consequences. On the positive side, women with severe cyclical symptoms whose concerns were often previously dismissed gained confirmation that they were neither alone nor crazy. Viewing women's pains as psychosomatic has been a way to invalidate them. As better research on premenstrual symptoms is done, the chances for efficacious treatment improves. Women have been active participants in the debate over PMS, in asserting their health needs, critiquing the inadequacies of the medical and psychological research, and challenging the classification of "premenstrual syndrome." Some PMS support groups and non-profit organizations, of which MHF is an excellent example, provide an opportunity for raising women's consciousness about the cultural denigration of the menstrual cycle and their shared

experience of gender discrimination as women. Many women are apparently more able to express interpersonal and social concerns premenstrually that they may suppress at other times. In fact, some women may use PMS as an opportunity to vent their anger and frustrations.

The negative aspects of PMS are significant. Though medical attention to PMS is in part a result of organized pressure on the institution of medicine, it is also a consequence of the fact that when remedies (purported or real) for female problems become profitable, interest grows. PMS propaganda has successfully persuaded many women--even without stepping into a doctor's office--to pathologize cyclical changes they had considered normal; the same women then contribute to the dissemination of the belief in PMS as a common ailment. Some of the groups organized to assist women with PMS have lent uncritical support to the use of ineffective and sometimes hazardous treatments. The medical profession has largely studied PMS outside of the context of women's lives, thus entirely ignoring social causes of women's distress in a sexist society. Women's justifiable anger about inequitable conditions are easily discounted by women themselves, their families, their employers, and society at large when women are medically designated irritable and "bitchy" due to raging hormones. This in turn lessens the chances for structural changes to improve the conditions of women's lives.

Several interesting and unexpected findings emerged from the original research for this dissertation. A number of women expressed a surprisingly strong belief in the power of hormones to control their behavior and emotional responses, often in the absence of a clear understanding of the nature and function of hormones. However, in spite of this conviction, almost all of the women interviewed said that PMS does not eliminate a woman's ethical or legal responsibility for her actions.

There appears to be a strong connection between issues of weight, diet, body image and PMS. The cultural obsession with thinness has persuaded many women that they will never be acceptable, competent, or attractive unless they achieve a body shape unrealistic for most women. The ongoing struggle in which these women are engaged is often heightened by the common premenstrual symptom of water retention and weight gain; the results are more stress, depression, and guilt.

Striking similarities appeared in the responses on questionnaires and to interview questions regarding the premenstrual presence of heightened anger or emotional upset and the specific kinds of issues that are most likely to arise for women at that time: dissatisfaction about the household division of labor and childcare responsibilities, and relational concerns (whether the women were heterosexual or lesbian). It can not be coincidental that these are traditional areas for defining woman's role and are also arenas in which many women are currently trying to achieve equality.

Many words and images from these interviews made lasting impressions. Here are a few of them: Helen's wish for her husband to forget ever hearing the term PMS; Sally's belief that everyone in her old neighborhood knew the day of her first period; Nora's comments about the "neatness" of being with women; Allie's desire to have all her reproductive organs removed, like her mother did; Nadine's efforts to keep her boyfriend from ever knowing anything about her cycle, especially her period, vs. Gloria's habit of showing her boyfriends a diaphragm full of menstrual blood--and their impressed response; Ginny's desperation to marry her lover; and Nancy's husband's comments about her as "disgusting" and her own high spirits after leaving him. Overall I was moved by the amount of sadness and difficulty in these women's lives, their willingness to talk with me about intimate subjects, their strength, generosity, curiosity, and support. I was left

with visions of how life might have been different and better for all of us, and how it might still be better for our daughters.

Chapter Six included a number of alternative ways of viewing the premenstrual phase, as "windows of sensitivity" or a "moment of truth," for example. This excerpt from an essay by Audre Lorde does not explicitly deal with women's menstrual cycle experience but offers a similar explanation for the kind of strong emotions women may experience premenstrually:

We have been raised to fear the yes within ourselves, our deepest cravings. But, once recognized, those which do not enhance our future lose their power and can be altered. The fear of our desires keeps them suspect and indiscriminately powerful, for to suppress any truth is to give it strength beyond endurance. The fear that we cannot grow beyond whatever distortions we may find within ourselves keeps us docile and loyal and obedient, externally defined, and leads us to accept many facets of our oppression as women.<sup>6</sup>

Feminist constructions of the paramenstruum incorporate the positive "symptoms" women report--such as bursts of energy, creativity, heightened compassion and sexuality--and validate the real roots of their anger.

If we are serious about wanting to reduce women's negative premenstrual symptoms, we need to do more than search for wonder drugs or send women to psychologists: we need to improve the conditions of their lives and lessen the sources of their distress. As Susan Faludi has cataloged, women in the U.S. have recently constituted two-thirds of the poor adult population. Women still receive significantly lower salaries than men. Women's reproductive rights are not secure. Coming home is the start of many women's second work shift; the home is also the most dangerous place for a woman in this society.<sup>7</sup>

There are many examples of women in our culture who are resisting oppression and challenging the restrictive aspects of their social roles which PMS as a social construction supports. Women entering jobs, careers, and political posts typically reserved for men challenge stereotypes about women's capacity for all kinds of endeavors. Women openly loving other women, choosing celibacy, leaving bad relationships, and developing new models of family and community defy the social requirement that they be married to men or cast as unloveable. Women participating in sports and building physical strength challenge old ideals of women's bodies as weak and soft. Women's movements toward acceptance of fat women and aging women challenge the aesthetics of thinness and youth as the only models of beauty.

Rejecting cultural beliefs about the menstrual cycle is another form of political resistance. Women consistently told me that they would like to see girls being better prepared for and educated about the menstrual cycle; specifically, they would like to see an end to ideas about menstruation as shameful, dirty, and unnatural: a woman's curse. Overturning persistent cultural notions about women as debilitated and irrational due to the menstrual cycle is a major, long-term process. But each woman moving in that direction is a start.

In Chapter Seven I suggested that the menstrual cycle functions as a "repository for women's ambivalent feelings about being female in this society." In our interview, Laura spoke candidly about her habit of "dumping" on her period: "I kind of scapegoat it. It always seems to come at a time where I can really knock it down and have a fit about it." The vehemence with which Laura said "I can really knock it down" made me catch my breath. I want to close with what she then told me about why she had agreed to be interviewed on the subject of the menstrual cycle:



When I filled out that questionnaire, I just had emotional surges all over. It made me think all kinds of things. . . . One of the questions on there was "What do you like about your period?" And I want to tell you, I just had the strangest reaction to that. At first, it was like, "Ha! What do you mean what do I *like* about it? I like when it's *finished*." But you know what? It really jerked something inside of my body, inside of my emotional self, that said, "Well, gosh, if things were different [pause]." And I started thinking, well, I want to be comfortable with my period, it's a time where I really realize about womanhood and I can be really close to my thoughts about life and spiritual things and all of these things. . . . And that question just made me realize that, yeah, I can really get back to base with myself and my cycle. And I can actually even like it, never mind just be neutral with it. . . . Yeah, it just brings chills to my arms, it gives me that "whoa" feeling just to think about it.

It's coming to me now that there's not a lot of support; I feel like a lot of times I'm out there fighting my own battle. . . . It would just be so important to me to have someone who really cared that I was bleeding. Besides just myself. You know. I can't tell you how excited I was to just be able to talk about it. Because it's the first time in my life.

## NOTES

<sup>1</sup> Audre Lorde, "Age, Race, Class, and Sex: Women Redefining Difference," Sister, Outsider (Trumansburg: The Crossing Press, 1984) 115.

<sup>2</sup> See Chapter One. In summarizing cross-cultural research on the menstrual cycle, Karen Ericksen notes that the most significant contrast in reports coming from various cultures is "the relative uniqueness of the "premenstrual syndrome" in the West." Karen P. Ericksen, "Menstrual Patterns and Menstrual Beliefs: National and Cross-National Patterns," Premenstrual Syndrome: Ethical and Legal Implications in a Biomedical Perspective, ed. Benson E. Ginsburg and Bonnie Frank Carter (New York: Plenum Press, 1987) 186. For earlier assessments, see Oscar Janziger, Ralph Riffenburgh, and Ronald Kersh, "Cross Cultural Study of Premenstrual Symptoms," Psychosomatics 13 (1972): 226-35; and Robert Snowden and Barbara Christian, Patterns and Perceptions of Menstruation (New York: St. Martin's Press, 1983).

<sup>3</sup> See Wendy Kaminer's critique of the self-help industry in I'm Dysfunctional, You're Dysfunctional: The Recovery Movement and Other Self-Help Fashions (Reading, Mass.: Addison-Wesley Publishing Company, Inc., 1992).

<sup>4</sup> See the example of Helen's husband warning her that he would have her committed in Chapter Nine.

<sup>5</sup> Louise Lander, Images of Bleeding: Menstruation as Ideology (New York: Orlando Press, 1988) 162.

<sup>6</sup> Audre Lorde, "Uses of the Erotic: The Erotic as Power," Sister, Outsider (Trumansburg, NY: The Crossing Press, 1984) 57-58.

<sup>7</sup> Susan Faludi, Backlash: The Undeclared War Against American Women (New York: Crown Publishers, Inc., 1991) xiii-xiv.

**APPENDIX A**  
**SYMPTOM LIST<sup>1</sup>**

Abdominal bloating	Irritability
Abdominal cramping	Joint swelling and pain
Absentmindedness	Lack of coordination
Accident-proneness	Lactation difficulties
Acne	Lethargy
Alcohol intolerance	Muscle aches
Anger	Nausea
Anxiety	Noise sensitivity
Asthma	Palpitations (heart pounding)
Back pain	Panic states
Breast swelling and pain	Paranoia
Cardiac arrhythmias (irregular heartbeats)	Pimple eruptions
Confusion	Rashes
Crying	Salt cravings
Depression	Seizures
Dizziness	Self-esteem (lack thereof)
Eating disorders	Sex-drive changes
Edema	Slurred speech
Eye difficulties	Smell sensitivity
Fainting	Spaciness
Fatigue	Stiff neck
	Styes

Food binges	Suicidal thoughts
Hand tingling and numbness	Sweet cravings
Headaches	Tension
Hemorrhoids (flare-ups)	Tiredness
Herpes (oral, skin, genital)	Touch sensitivity
Hives	Urinary difficulties
Indecisiveness	Violence
Infections	Weight gain
Insomnia	Withdrawal

<sup>1</sup>Michelle Harrison, Self-Help for Premenstrual Syndrome, rev. ed. (New York: Random House, Inc., 1982) 11.

## APPENDIX B

### METHODS USED IN THIS DISSERTATION

This appendix outlines the beginning assumptions of the researcher, specific procedures used in gathering and analyzing the original data, and the limitations of the study.

#### ASSUMPTIONS

In researching the emergence of PMS as a widely recognized disease and a popular media topic, I speculated that two major trends had been influential in the development of PMS as a medical construct, one conservative, the other progressive. First, I expected to find a continuation of trends from earlier uses of menstruation to define and control the female body, disqualifying women from full and equal social status. This would support a finding of PMS as a useful means for reinforcing gender role stereotypes. Second, I suspected that the emergence and growth of the women's health movement has encouraged women to be 1) more insistent about their health concerns being taken seriously by the medical profession and 2) more willing to speak out about issues related to fertility and the menstrual cycle specifically. This suggests a more positive interpretation of the PMS phenomenon as an educational movement serving women's needs.

Women have acted as agents in both these trends according to their personal experience, level of awareness, and individual and group interests (for example, class). Public discourse mediates private experience, in ways that potentially alienate, confirm, illuminate, pathologize, or liberate. How women interpret the cultural phenomenon of

PMS is influenced by how they perceive it as serving or harming their interests. Therefore it makes sense to examine the social construction of the PMS phenomenon from the twin perspectives of women's consciousness and cultural prescription. Marcia Westcott makes this point in expressing the critical lesson of Nancy Cott's important article on 'passionlessness' in Victorian sexual ideology:

the meaning which women ascribe to their own behavior is reducible to neither the behavior itself nor to the dominant ideology. It is derived from women's consciousness which is influenced by the ideas and values of men, but is nevertheless uniquely situated, reflective of women's concrete position within the patriarchal power structure.<sup>1</sup>

Both the experience of negative premenstrual symptoms and the decision to identify oneself with having PMS are probably the result of many interwoven physical, situational, ideological, and idiosyncratic aspects of individual women's lives. These include general life circumstances; overall state of health; individual and shared attitudes, beliefs, and values. One overarching assumption was that attitudes affect experience and experience affects attitudes.

By "general life circumstances" I mean demographic and situational factors such as one's age, race, community, education, socioeconomic status (SES), working conditions, household composition, and network of social relationships. Each of these may at different times offer special advantages or stressors (for example, it seems likely that the lower a woman's SES and education levels, and/or the more stressful her work, home, and relationships, the worse her general health will be).

The area of greatest interest in this study was women's attitudes about menstruation and PMS. Information was gathered in the interviews and questionnaires about women's:

formal and informal menstrual health education (or lack thereof)  
experience of menarche  
family members' and peers' attitudes  
beliefs of own (cultural, ethnic) community about the menstrual cycle  
personal religious and political beliefs  
awareness and attitudes about public discourse on PMS, menstruation, female and male emotionality, hormones, etc.

I assumed that all of these factors might influence a woman's tendency to perceive and label her experience of pre- or paramenstrual changes as PMS. Assembling this information produced a picture of women's attitudes toward their own menstrual cycle experience and towards the public phenomenon of PMS.

## DATA GATHERING

### Interviews

The decision to make interviews the heart of the research was made after attending a small workshop on PMS put on by the Menstrual Health Foundation where I was struck by four things:

1). The number of times "crazy," "out of control" feelings occurring premenstrually were described, typically accompanied by examples of self-blaming and guiltiness. I assume that most women are not "crazy"--though they often experience crazy-making situations in their public and private lives--whether or not they experience distressing premenstrual changes. The participating women appeared to be intelligent, likeable, and socially adept. Several of them said that they were in their premenstrual phase at the time.

2). The verbal and nonverbal evidence of a tremendous sense of relief discovered in the process of hearing other women's stories. Participants were reassured that perhaps since other women shared their feelings, they were not crazy or bad after all.

3). The apparent effectiveness of the workshop approach, as gauged by comments during and after the session as well as written evaluations I later saw. I believe this was due to several factors, including the relief experienced, a sense of having taken an important step toward resolving problems, and the motivating encouragement from the workshop's leaders and other participants.

4). The workshop's multi-faceted approach to menstrual cycle problems and solutions stressed situational and sociocultural aspects as well as current biomedical explanations of the menstrual cycle and invited women to re-frame the way they view their experiences. Facilitators demonstrated the built-in negativity of common descriptions of the menstrual cycle and challenged participants to look for other--neutral or positive--ways of approaching their cyclical changes. Women offered and gathered new information, questioned old assumptions, and found areas of common ground with each other. In short, although the term was not used, consciousness raising was taking place.

I believe that a familiar, co-oriented relationship between the researcher and the respondents is preferable to a brief appearance by an outsider for the latter's primary benefit. Participant/observation at the sites of the three sample populations included in the study, which are described in Chapter Seven, contributed to my sense of how women view issues such as health and PMS but was not been formally included and analyzed.

I attended six MHF workshops over the course of one and a half years. I had access to evaluations of workshops done by participants and copies of videotaped material from two of the workshops. (I also attended PMS workshops offered by Planned Parenthood and Kaiser Hospital for the sake of comparison.)



I initially planned to interview only women attending workshops on PMS. But as the work progressed I became interested in having a more diverse and representative cross section of women. Therefore I added women from the two other settings.

I was a volunteer at WNC for one year, working as health educator and pregnancy counselor. This gave me the opportunity to observe what kinds of health problems brought women to the clinic and to discuss the experience of PMS with clients who raised that concern.

I was a member of Piedmont Women's Fitness Club for almost three years, exercising several mornings a week, and made numerous casual acquaintanceships and a few friendships among the members.

The interview questions are in Appendix C. Each participant also filled out consent and demographic information forms. See Appendices D and E.

Women agreeable to being interviewed on the subject of their menstrual cycle were solicited via the questionnaires. At MHF women were asked to indicate their willingness to be interviewed by writing their names and phone numbers on the back of the questionnaire. Women from WNC indicated their interest by filling in that portion at bottom of questionnaire; of the thirty who did so, I selected the first fifteen women I was able to contact and schedule for an interview. At PWFC I placed a sign-up sheet for interviews next to the questionnaires. Of the thirteen women leaving a name and phone number, I was able to schedule interviews with nine; I then selectively asked six more women, including four African American women, and all six agreed to participate.

WNC and PWFC participants did not know that PMS was the specific focus of study until the end of the interview. I was particularly interested to see how often they would bring up the subject of PMS and how they would discuss it. I explained at the

beginning of the interview that I would tell them more about the research at the interview's end.

Each interview was held at the time and place of the respondent's preference. Most of the MHF interviews took place at the woman's home; two were in restaurants, one at the interviewee's office. Ten of the women were interviewed twice, about three months and again six months after the workshop. The remaining five were interviewed one time only, approximately one year after the workshop in which they had participated. The individual interviews ranged in length from forty-five minutes to three hours.

Most of the WNC interviews also took place at the woman's home; a few times we met in available rooms at the clinic. The interviews were usually between one and two hours in length. Unlike MHF and WNC, the women at PWFC lived only a short distance from me and generally they preferred coming to my apartment. A few were held in an unoccupied office at the health club. These interviews also tended to be the shortest, ranging from forty-five minutes to an hour and a half.

Earning the respondents' trust was important. Because I had reached them through a particular place--a PMS workshop, a women's clinic, a women's health club--we shared at least that connection. I emphasized that there were no right or wrong, good or bad answers, rather that all of their opinions and experiences were of great interest. I was very grateful for each woman's willingness to spend time meeting and discussing intimate aspects of her life with me.

The list of questions and topics for all three groups began with background information on current activities and life changes of the last few years. The next sets of questions dealt with overall health, menstrual health history, and recent menstrual cycle experiences. The questions for the MHF group then dealt specifically with PMS and the workshop they had attended. When I spoke with the women from WNC and PWFC, I asked about PMS near the end of the interview unless they had introduced the subject

earlier. Many of the questions for all three groups pertained to their individual experience but I also included questions about how they perceived the public portrayal of PMS and how they thought other men and women perceived some of the same issues.

I attempted to structure the interviews to allow for long narratives as well as some more focused responses, both on issues they raised in the interviews and on my own specific areas of curiosity.

The style and structure of the interviews changed as work progressed. My initial concerns about standardizing the questions to promote comparability among the interviews, were increasingly abandoned in favor of involved dialogue. The first set of interviews (MHF) was with women I had met in a setting that fostered intimacy. The women were very interested in the fact that I was doing my dissertation on PMS, and with most of them it was appropriate, and ethical to be more conversational and self disclosing. I became more flexible with the questions, rewording, dropping, adding and combining them as it made sense to do so while making better use of interesting material surfacing in the interview itself. In one extremely emotional interview with a young woman from WNC, I dropped the prepared list of questions almost entirely.

### Questionnaires

Questionnaires were used to gain a general impression of the range of menstrual cycle experience and attitudes in the sample populations and ideas for interview topics and questions. The objective and subjective responses do not have the depth of the interviews but because of the much larger number of women involved (288 vs. 45 participants) there is some value in the information gathered from them. Copies of the questionnaires are found in Appendix F.

Two questionnaires were used, one for MHF, the other for WNC and PWFC (there is slight difference in format between the latter two that does not involve the

questions themselves). All of the questionnaires were distributed, filled out, and collected on site; they were made available to anyone willing to participate. I handed out the MHF questionnaire at the beginning of three PMS workshops after introducing myself so workshop participants knew something about who I was and what I was studying. The MHF questionnaire had ten objective questions adapted from the twenty-two item Brooks-Gunn and Ruble Menstrual Attitude Questionnaire (1984). The Menstrual Attitude Questionnaire measures responses in five areas of attitudes about menstruation: whether or not menstruation is debilitating, bothersome, natural, an anticipated event, or without effect. Five open-ended subjective questions were devised to discover more about the reasons for attending a workshop on PMS.

At WNC the questionnaires were distributed and collected by the receptionist during a one month period; at PWFC they were placed on a small table outside the locker room for one week, under a sign calling attention to them. Aside from the few participating staff and volunteers with whom I was acquainted at the time, the women at WNC and PWFC knew only that the study dealt with the menstrual cycle in filling out the questionnaire. The one page form used both places had five objective questions, three of which were adapted from the Menstrual Attitude Questionnaire. The idea to incorporate questions dealing with positive aspects of menstrual cycle experience was inspired by Delaney, Lupton, and Toth's Menstrual Joy Questionnaire.<sup>2</sup> I also inserted a question regarding whether or not women felt they had been adequately prepared for menarche by others. The subjective portion of the questionnaire consisted of five sentence completions.

In all 288 questionnaires were collected: 22 from MHF (15 interviewees, 7 other workshop participants); 175 from WNC (15 interviewees, 14 WNC staff and volunteers, 146 other WNC clients); and 91 from PWFC (15 interviewees, 76 other PWFC members). The PWFC questionnaire was the only one of the three to ask for any

demographic information. (Demographic information was obtained from all 45 interviewees.) PWFC was the last group I surveyed and I had less demographic information about them than the other groups. For a summary of the questionnaire results, see Appendix G.

## ANALYSIS

### Interviews

The recorded experiences, conversation transcripts, pieces of information are compiled, reduced and examined for their interactions (patterns) and basic themes. The more significant is extracted from the less significant within a system of meaning. Parts are strung together to make new wholes--simplicity is sought beneath the complexity. . .

. . . As interpretations are made and recorded, the remaining data are examined to see if and how they corroborate or refute the ongoing analysis. There are not rules for data analysis except one--that the analysis draw heavily on the language of the persons studied. <sup>3</sup>

The tapes were all transcribed, almost verbatim, and entered into my computer. I began the analysis by summarizing the common, emphasized, and unusual aspects of each individual interview. I then summarized each sample group's range of responses on recurring themes.

Using Magellan computer indexing software, I searched the interviews, all three groups of women and one group at a time, for key terms and themes. The following are the clusters of significant, recurring issues noted in conducting the searches:

Emotions. Anger, bitchiness, irritability, tears, depression, moodswings.

Issue of control. Perceived roles of attitude and hormones in one's experience of premenstrual symptoms.

Amount of stress and relationship to premenstrual symptoms.

Relationships with men.

View (largely negative) of medical profession.

Eating, weight issues.

View of PMS. Hype. Use as excuse. Expressed view of PMS prior to knowledge that it was the focus of study (1st part of WNC, PWFC interviews)

Positive aspects of cycle experience.

Excerpts from all of the interviews were grouped in new files by theme. When the differences between the group of women who attended PMS workshops and the other groups are significant and relevant, I wrote separate analyses of their responses. The contents of each file were summarized, and care was taken to show the range of responses as well as to explore common strains of thought. These thematic summaries were then grouped to produce meaningful chapter content and the findings were linked to the contemporary issues in the preceding chapters.

### Questionnaires

The Statistical Package for the Social Sciences/PC+ Studentware (SPSS/PC+)<sup>4</sup> was used to analyze the questionnaire data. The responses to objective and subjective questions were coded and frequency tables were run. Results were verified by manual count by the researcher and a colleague.<sup>5</sup>

## LIMITATIONS

Forty-five women were interviewed; optimally, more women would be included. They would also be interviewed in greater depth than researcher, financial, and interviewee constraints allowed.

The quantitative information is not the result of carefully controlled scientific methods, in terms of sampling or instruments. The questionnaire data come from an opportunity sample rather than a true random sample. They were used for my own curiosity and preparation, more than anything else.

## NOTES

<sup>1</sup>Marcia Westcott, "Feminist Criticism of the Social Sciences," Feminist Research Methods: Exemplary Readings in the Social Sciences, ed. Joyce McCarl Nielsen (Boulder: Westview Press, 1990) 65; Nancy F. Cott, "Passionlessness: An Interpretation of Victorian Sexual Ideology, 1790-1850," Signs 4 (1978): 219-36.

<sup>2</sup>Janice Delaney, Mary Jane Lupton, and Emily Toth, The Curse: A Cultural History of Menstruation (New York: E. P. Dutton & Co., Inc., 1976) 88.

<sup>3</sup>Shulamith Reinharz, "Experiential Analysis: A Contribution to Feminist Research Methodology," Theories of Women's Studies II, ed. Gloria Bowles and Renate Duelli-Klein (Berkeley: University of California, 1981) 86.

<sup>4</sup>Marija J. Norusis, SPSS/PC+ Studentware (Chicago: SPSS Inc., 1988).

<sup>5</sup>Computer coding and analysis were performed by Karen Lovaas and Dawn Mills.



## APPENDIX C

### INTERVIEW QUESTIONS

[MHF interviewees]

#### A. BACKGROUND

1. What do you do?
2. How has your life changed in the last 5 years?
3. How do you see yourself now as opposed to 5 years ago?
4. What do you see yourself doing in the future? Any major changes envisioned?

#### B. HEALTH/MENSTRUAL CYCLE

5. How have your health habits and awareness changed, if much at all, in recent years?
6. Please describe what your experience of your menstrual cycle has been like.

#### C. PMS/MHF WORKSHOP

7. When, how did you come to see yourself as having PMS? (symptoms experienced, hearing of syndrome in news) bWhat else was happening at the time in your life? Do you see it as connected to any other events?
8. What did you do about this realization? (before coming to the MHF workshop)
9. What, if anything, has been different since you attended the workshop? To what do you attribute the difference?
10. What was the most significant thing about the workshop to you, at the time and since?
11. What do you most remember, what stood/stands out about it?
12. What do you see as the advantages and disadvantages to the workshop approach? (at MHF and generally--as opposed to individual self-help, medical intervention, other approaches)
13. How did you see, what did you think about PMS prior to the workshop?
14. How do you see PMS now?

15. What do you think causes and exacerbates PMS?
16. What do you think is the best way to deal with PMS: as an individual? As a family?  
As women? As a society?
17. What is the single most important thing you would tell someone asking you for  
advice about PMS?
18. Are there any possible negative aspects to the current attention being focussed on  
PMS? What? Why?
19. Is PMS a feminist issue? Why or why not?
20. Are there any positive aspects to the cycle for you, especially during the time before  
your period?
21. Do you have any specific goal now in terms of PMS? What would you most like to  
see happen for yourself at this point?
22. If you were going to do a study of this subject, what do you think would be most  
important for you to look at?
23. Is there anything you would like to ask me?

**2nd set of MHF interviews**  
(Approx. 6 mos. after workshop)

Roughly 8 - 10 questions were asked, based in part upon listening to tape of initial interview.

1. We last spoke about 3 1/2 months ago. What's been going on since then? (specifics about holidays, jobs, etc.)
2. Any plans, changes coming up for you?
3. How have your last few cycles been? Any new associations made between cycle phases and other experiences? Anything notable during the premenstrual time, positive or negative?
4. Here are some of the terms that have come up often in these interviews. Please give me your definitions or associations for them: stress or stressed out; concepts of balance and imbalance; the "feminine;" and hormones--what do you understand them to be and do, do you have any visual images of them?
5. In terms of the premenstrual concerns you have had, what kinds of things, if any, have been helpful to you? How do you feel about this issue now? How does the cycle(including premenstrual time) figure in your life now, e.g., is it relatively important, unimportant; enhancing, detracting?
6. In the future, should the negative symptoms increase, what would you be likely to do about it?

## INTERVIEW QUESTIONS

[WNC, PWFC participants]

1. Background: What do you do? What kind of things have been going on in the last few years [changes in living conditions, relationships, jobs)? What are your future plans?
2. How would you describe your overall health, now and in the past?
3. What about your menstrual health? Would you sum up your experience of your cycle from adolescence to the present?
4. Do you experience any regular changes during your cycle?  
Or, would you walk me through a typical cycle starting on the first day of bleeding?
5. Are there any connections you see between your cycle and what is going on in your relationships and job and other situations in your life? [in either direction]
6. Do you see connections between things like your activity level, amount of exercise, and diet and your cycle?
7. Have you ever consulted anyone--professionals, family, friends--with menstrual concerns?
8. How did you learn about menstruation?
9. What would be a good way to learn about menstruation? For example, if you had a daughter or a little sister how might you tell them about the menstrual cycle?
10. How do you think most women feel about their periods and cycles?
11. How do you think most men feel about women's periods and cycles?
12. Do women's and men's moods and mood shifts seem alike or different to you? In what way/s?
13. What do you know about what's known as "PMS"? How did you hear about it? Do you have the impression that it is major/minor, rare/common? Do you associate it with what you experience?
14. What do you understand hormones to be, do? How do you imagine or visualize them?

**APPENDIX D**

**DEMOGRAPHIC INFORMATION FORM**

**KAREN ELIZABETH LOVAAS**  
local address and phone

I want to thank you again for your willingness to discuss your menstrual cycle with me. The analysis of all those hours of tapes will take a long time but as I said before, you will hear from me later about the progress of the work.

I would like to ask another favor of you now, which is that you to fill in the information below and return it to me in the enclosed, stamped, pre-addressed envelope. I am asking for this information in order to get a clearer overall view of the range of similarities and differences in the group of women with whom I have spoken. It should only take a few minutes to do and will be very helpful. The information will all be kept confidential and no real names will appear in my dissertation or any other writings that may come from this research (unless you have given me your explicit permission to use your name).

NAME \_\_\_\_\_ RACE/ETHNICITY \_\_\_\_\_

AGE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

SEXUAL PREFERENCE(circle one) heterosexual lesbian bisexual

YOUR LAST YEAR OF FORMAL EDUCATION COMPLETED(e.g., 10th grade h.s., college Junior, Master's degree, etc.) \_\_\_\_\_

PLACE/S WHERE YOU GREW UP \_\_\_\_\_

YOUR FAMILY'S ECONOMIC LEVEL WHEN YOU WERE GROWING UP (e.g., poor, working class, middle class, upper class) \_\_\_\_\_

YOUR FAMILY'S RELIGIOUS AFFILIATION \_\_\_\_\_

CITY OR COMMUNITY IN WHICH YOU NOW LIVE \_\_\_\_\_

APPROXIMATE ANNUAL INCOME( individual or your immediate family if you live with or are supported by them) \_\_\_\_\_

YOUR OWN RELIGIOUS AFFILIATION \_\_\_\_\_

YOUR OWN POLITICAL TENDENCY(e.g., conservative, moderate, liberal, radical, etc.) \_\_\_\_\_

\*\*\*\*\*

IS THERE ANY OTHER INFORMATION THAT YOU THINK WOULD BE  
RELEVANT TO THIS RESEARCH? THANKS AGAIN!

**APPENDIX E**

**CONSENT FORMS**

[MHF participants]

KAREN ELIZABETH LOVAAS  
local address and phone number

Thank you again for your willingness to contribute to the study of PMS I am doing for my dissertation. Consent forms are a standard part of studies with human participants and I am writing to you now to obtain your written consent for use of your contributions. Please return one signed copy of this form in the enclosed pre-addressed, stamped envelope as soon as you can.

The interviews of you, women attending MHF workshops, and women drawn from two other populations, are a wonderful source of information about American women's lives today. They document the ingenuity we bring to the challenging situations we face, the lessons we learn and share with others. Besides summarizing these materials, I will be looking at recurring or striking images and exploring common and divergent themes emerging from the workshops and interviews. Doing justice to your thoughts and language requires use of quotations. It is up to you whether or not you want to be specifically mentioned by name when I refer to information and quotes given by you. E.g., you might instead be referred to as a MHF leader or participant.

You have already been most gracious in allowing me access to your workshops and making time to be involved in my work; it is important to me that the results be accurate. It has been my intent throughout that this project be truthful, meaningful and useful for all of us. Hopefully, it will also contribute to larger ongoing debates and developments.

Spaces are provided below for three signatures. Please read each line carefully. Your signature at the end of the line will indicate that you have read, understood, and agreed to the stated conditions. Please call me if you have any questions.

1. General consent. Information obtained from MHF activities, written materials, and interviews may be utilized in this study.

Signed \_\_\_\_\_ Date \_\_\_\_\_

2. Permission to quote. Quotations may be used as long as my identity is not revealed.

Signed \_\_\_\_\_ Date \_\_\_\_\_

3. Permission to quote with attribution. Quotations attributed to me by name may be used after being checked by me for accuracy and correct context.

Signed \_\_\_\_\_ Date \_\_\_\_\_

[WNC and PWFC Participants]

KAREN ELIZABETH LOVAAS  
local address and phone

Thank you again for your willingness to participate in the study I am doing for my dissertation that is related to women's menstrual cycles. Consent forms are a standard part of studies involving human beings as participants and I need your written consent for my use of your contributions to the study.

All the information I receive from you will remain confidential and anonymous. No names or other identifiable information about you individually will appear in the study.

Spaces are provided below for two signatures. Please read each line carefully. Your signature at the end of the line will indicate that you have read, understood, and agreed to the stated conditions. Please call me at the number listed above if you have any questions.

1. The information obtained from me may be utilized in this study under the conditions described above, that is, total confidentiality and anonymity.

Signed \_\_\_\_\_ Date \_\_\_\_\_

2. Quotations may be used as long as my identity is not in any way revealed.

Signed \_\_\_\_\_ Date \_\_\_\_\_



**APPENDIX F**  
**QUESTIONNAIRES**

[MHF]

KAREN ELIZABETH LOVAAS  
local address and phone

Warm greetings

I want to ask a favor of you in connection with this workshop on PMS and some research I am doing. I would appreciate it if you would answer the questions below and on the next page and return them to me before the end of the day. I will be glad to tell you more about this project and if you would be willing to talk privately with me at some time, please write your name, phone number and best times to be reached on the back of this sheet.

All of the information will remain confidential.

Many thanks.

Sincerely,

**Please read the following sentences and tell how much you agree or disagree with each one by circling the number that best suits your response.**

1 = strongly disagree  
2 = disagree  
3 = slightly disagree  
4 = slightly agree

5 = agree  
6 = strongly agree  
X = don't know

- |  |   |   |   |   |   |   |   |
|--|---|---|---|---|---|---|---|
| 1. When I am premenstrual or having my menstrual period I am worried that someone will know. | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 2. Menstruation is something I would prefer not to have.                                     | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 3. The menstrual cycle gives women a way to keep in touch with their bodies.                 | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 4. Women are more tired than usual before they menstruate.                                   | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 5. I feel as fit before my period as I do during any other time.                             | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 6. I can tell my period is coming because of breast soreness, weight gain or other signs.    | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 7. Most women make too much of the minor physical changes with menstruation.                 | 1 | 2 | 3 | 4 | 5 | 6 | X |

8. Menstruating regularly is a sign of a woman's general good health. 1 2 3 4 5 6 X
9. I am more easily upset just before my period than at other times of the month. 1 2 3 4 5 6 X
10. Others should not be critical of women who are more easily upset before their periods. 1 2 3 4 5 6 X

**Please use the back of this page if you would like more space for answering these last 5 questions.**

A. What led to your decision to come to this workshop?

B. What changes, symptoms, problems seem to regularly occur before you menstruate?

C. What kinds of effects do these experiences have on you and your overall situations(e.g., work, relationships, self-confidence)?

D. Have you previously and/or are you currently consulting others about any of these issues?

E. What kinds of things did you consider in making your decision to attend this workshop(for example, location, cost, a friend's recommendation, curiosity, dissatisfaction with other treatments tried, etc.)?

Thanks again!

WNC

KAREN ELIZABETH LOVAAS  
local address and phone number

Hello. I'm a volunteer here and am also doing research on women's menstrual cycles. Please take a few minutes to answer the questions below; it will be very helpful to my work. When you are finished, please return this form to the receptionist.

All of the information given will remain confidential.

Thanks very much for your help.

**Please read sentences 1 - 5 and tell how much you agree or disagree with each one by circling the number to the left that best shows how you feel.**

- 1 = strongly disagree
- 2 = disagree
- 3 = slightly disagree
- 4 = slightly agree

- 5 = agree
- 6 = strongly agree
- X = don't know

- |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| 1. The menstrual cycle gives us a way to keep in touch with what's happening inside our bodies. | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 2. Menstruation is something I wish I did not have.   | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 3. I feel more energetic and creative before my period begins.                                  | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 4. I can become angry or upset more easily before my period than at other times.                | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 5. Others helped me to be well prepared for my first menstruation.                              | 1 | 2 | 3 | 4 | 5 | 6 | X |

Please complete sentences 6 - 10 in your own words. Use the back of this sheet for more room to write.

6. My favorite time during my menstrual cycle is \_\_\_\_\_  
\_\_\_\_\_

7. Other people may know I'm about to have my period by \_\_\_\_\_  
\_\_\_\_\_

8. I can tell my period is coming by \_\_\_\_\_

\_\_\_\_\_

9. What I don't understand about my menstrual cycle is \_\_\_\_\_

\_\_\_\_\_

10. I would like to change my menstrual cycle by \_\_\_\_\_

\_\_\_\_\_

**Please provide the following information if you would be interested in being interviewed for this research.**

NAME \_\_\_\_\_ PHONE [home] \_\_\_\_\_ [work] \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THANKS AGAIN!**

PWFC

KAREN ELIZABETH LOVAAS  
local address and phone

Hello. I am a member here and am doing research related to women's menstrual cycles. If you will take a few minutes to answer the questions below and return this form to the front desk, it would be very helpful to me. Thank you very much.

**Please read sentences 1 - 5 and tell how much you agree or disagree with each one by circling the number to the left that best shows how you feel.**

1 = strongly disagree  
2 = disagree  
3 = slightly disagree  
4 = slightly agree

5 = agree  
6 = strongly agree  
X = don't know

- |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| 1. The menstrual cycle gives us a way to keep in touch with what's happening inside our bodies. | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 2. Menstruation is something I wish I did not have.   | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 3. I feel more energetic and creative before my period begins.                                  | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 4. I can become angry or upset more easily before my period than at other times.                | 1 | 2 | 3 | 4 | 5 | 6 | X |
| 5. Others helped me to be well prepared for my first menstruation.                              | 1 | 2 | 3 | 4 | 5 | 6 | X |

**Please complete sentences 6 - 10 in your own words. Use the back of this sheet for more room to write.**

6. My favorite time during my menstrual cycle is \_\_\_\_\_

\_\_\_\_\_

7. Other people may know I'm about to have my period by \_\_\_\_\_

\_\_\_\_\_

8. I can tell my period is coming by \_\_\_\_\_

\_\_\_\_\_

9. What I don't understand about my menstrual cycle is \_\_\_\_\_

\_\_\_\_\_

10. I would like to change my menstrual cycle by \_\_\_\_\_

\_\_\_\_\_

**These answers are anonymous. But please fill in the following information to give me a better idea of who the participants are.**

AGE \_\_\_ OCCUPATION \_\_\_\_\_ RACE/ETHNICITY \_\_\_\_\_

(If you want to know more about this project, call me at the number at the top of the first page)

THANKS AGAIN!

## APPENDIX G

### SUMMARY OF QUANTITATIVE RESULTS

#### 1. Demographic (interviewees only)

Family Religion: Protestant 39%; Catholic 26.8%; None 14.6%; Other Christian 9.8%; Jewish 7.3%

Sexual Preference: Heterosexual (37) 86%; Lesbian 9.3% (4); Bisexual 4.7% (2) [2 declined to answer]

Education: Some college (17) 40.5%; B.A. (14) 33.3%; Graduate school (5) 11.9%; A.A. (2) 4.8%; high school (2) 4.8%; professional (2) 4.8%

Family economic level: Working class (18) 42.9%; middle class (17) 40.5%; upper-middle class (5) 11.9%; Poor (1) 2.4%; other or missing (4).

Political ideology: Liberal (23) 56.1%; Moderate (6) 14.6%; Conservative (5) 12.2%; Radical (4) 9.8%, Democrat (2) 4.9%; Independent (1) 2.4%

Marital status: Single (21) 47.7%; Married (16) 36.4%; Divorced/separated (7) 15.9%

#### 2. Answers to objective questions

##### A. PWFC, WNC

1. "The menstrual cycle gives us a way to keep in touch with what's happening inside our bodies" (89.2% agree; 6.9% disagree; 3.9% don't know)
2. "Menstruation is something I wish I did not have." (57.5% agree; 39.4% disagree; 3.1% don't know)
3. "I feel more energetic and creative before my period begins" (66.4% disagree; 20.9% agree; 12.7% don't know)
4. "I can become angry or upset more easily before my period than at other times." (81.1% agree; 15.8% disagree; 3.1% don't know)
5. "Others helped me to be well prepared for my first menstruation." (52.5% disagree; 44.4% agree; 3.1% don't know.)

##### B. MHF

1. "When I am premenstrual or having my menstrual period I am worried that someone will know." (58.8% disagree; 41.2% agree)
2. "Menstruation is something I would prefer not to have." (61.1% disagree; 38.8% agree)

3. "The menstrual cycle gives women a way to keep in touch with their bodies." (82.2% agree; 12% don't know; 5.9% disagree)
4. "Women are more tired than usual before they menstruate." (76.5% agree; 23.5% disagree)
5. "I feel as fit before my period as I do during any other time." (94.1% disagree; 5.9% agree)
6. "I can tell my period is coming because of breast soreness, weight gain or other signs." (100% agree)
7. "Most women make too much of the minor physical changes with menstruation." (70.6% disagree; 17.7% agree; 11.8% don't know)
8. "Menstruating regularly is a sign of a woman's general good health." (76.5% agree; 11.8% disagree; 11.8% don't know)
9. "I am more easily upset just before my period than at other times of the month." (88.9% agree; 5.5% disagree, 5.5% don't know)
10. "Others should not be critical of women who are more easily upset before their periods." (88.2% agree; 11.8% don't know)

### 3. Answers to subjective questions

#### A. WNC,PWFC

1. My favorite time during my menstrual cycle is
 

end of bleeding	43.3%
week after bleeding	15.1%
other	12.7%
midcycle	6.3%
start of bleeding	5.6%
midst of bleeding	4.0%
premenstrual	2.4%
  
2. Other people may know I'm about to have my period by
 

psychological (esp. mood) changes	45.6%
physiological changes	17.4%
combination of psych & phys	13.7%
my telling them	7.9%
  
3. I can tell my period is coming by
 

physiological	47.9%
combination of psych and phys	33.9%
psychological	8.6%
calendar	6.2%



4. What I don't understand about my menstrual cycle is	
fluctuations	17.3%
cramps	8.7%
other physiol	7.7%
why	6.1%
emotional changes	4.6%
5. I would like to change my menstrual cycle by	
physiological	40.1%
none	19.8%
elimination	11.3%
combination of physiol & psych	7.7%
PMS	5.0%
 B. MHF	
2. Regular changes, symptoms, problems occurring before menstruation	
Both psych & physiol	82.4%
psych	11.8%
physiol	5.9%
3. Effects of above	
combination	47.1%
own feelings, behaviors	23.5%
relationships	17.6%
work	11.8%
4. Previously or currently consulting others about menstrual cycle related concerns	
family/friends, self help, combination of sources, alternative medicine, traditional medicine	70.6%:
none	29.4%

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