MEDITATIONS ON THE PREMENSTRUAL SELF: THE CONCEPTUALIZATION OF SELF IN THE ORIGINS AND DEVELOPMENT OF THE PMS DISCOURSE

by

Helen Loshny

B.Sc., University of Manchester, 1982

PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in the

GRADUATE LIBERAL STUDIES PROGRAM

OF THE FACULTY OF ARTS

SIMON FRASER UNIVERSITY

April 2004

APPROVAL

Name: Helen Loshny

Degree: Master of Arts (Graduate Liberal Studies)

Title of Project: Meditations on the Premenstrual Self: the Conceptualization of Self in the Origins and Development of the PMS Discourse

Examining Committee:

Chair: Dr. June Sturrock
Graduate Chair, Liberal Studies
Professor, Dept. of English
Simon Fraser University

Dr. Mary Lynn Stewart
Supervisory Committee
Professor, Dept. of Women's Studies & History
Simon Fraser University

Dr. Heesoon Bai
Supervisory Committee
Associate Professor, Faculty of Education
Simon Fraser University

Dr. Jerilynn Prior
External Examiner
Professor, Dept. of Endocrinology
University of British Columbia

Date Approved: April 2, 2004

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Abstract

The phenomenon of PMS – Premenstrual Syndrome has received a significant amount of attention in the last 30 years both in the public discourse and as a subject of research in the social scientific and medical communities. A founding representation and a central narrative theme of the PMS discourse is women's experience of an altered or different sense of self – a 'PMS self'. The split personality of the legendary Victorian character, 'Jekyll and Hyde' has been frequently invoked by the 'experts' and by women themselves to describe this different and, with the Hyde persona intended to represent their PMS self, mostly negatively construed sense of self that they experience in the post-ovulatory/premenstrual phase of their monthly cycles.

Incorporating a sociohistorical critique and the results of a narrative analysis which I undertook, the work of this project is to explore the origins and development of the phenomenon of PMS and the 'PMS self/real self' characterization of the PMS experience in relation to theories and ideas that have been put forward in order to critique and posit alternative explanations for the sociocultural and historical sources of the contemporary notions of self, subjectivity, identity and the body. Using the theoretical and exploratory constructs of the *Modern* and *Postmodern PMS Self* I examine the ways in which women's understanding of themselves is interpreted through and within the hegemonic discourses and practices of the PMS discourse, which rest on static and dualistic notions of the self. I suggest that some of these interpretations can be read as a challenge to such notions in their positioning both as coping strategies for resisting the split-self identification and as a way of deriving insight and strength from the shifts in feeling and emotion that take place over the course of natural, normal womanly cycles.

Quotation

"Nothing but myself? .... My selves.
After so long this answer...

Anger and tenderness: my selves.
And now I can believe they breathe in me
as angels, not polarities.
Anger and tenderness: the spider's genius
to spin and weave in the same action
from her own body, anywhere –
even from a broken web."

from 'Integrity' by Adrienne Rich (1978)

Acknowledgments

To Greg, my partner and best friend, whose patience and support just barely outlasted the most frequently repeated question of the last few months, "Mum, when are you going to be finished?"

And to Emma, the source of the question and my joy and inspiration

Many thanks to Mary Lynn Stewart and Heesoon Bai for their clear and consistent guidance and support and to Jerilynn Prior for her long standing contribution to the area of women's reproductive health and in her role as external examiner for this project.

To Shauna and Amber for their timely and encouraging words of wisdom.

To the women who participated in the study for sharing their feelings and reflections about their experience.

To my mum and sisters, Catherine and Therese, for their wonderful pragmatism and capacity to love.

Table of Contents

Preface

The origins of this project lie in a simple statement contained in the introductory materials for a course on Autobiography, which I took a couple of years ago. The statement was among a list of phrases, which was intended to generate some reflection and discussion on the nature of self and it's representation in the various genres of Autobiography. As I was glancing through this, one in particular stood out from the rest, which was the phrase "I just don't feel like myself". While I have heard the statement used many times by others and have used it a few times to describe my own state in a variety of situations, its use in this context gave rise to a series of loosely connected thoughts to do with the assumptions about the constitution of self on which a statement like this rests. I began to do some exploratory thinking centred around questions regarding the nature of the 'self' to which this feeling of 'not myself' was being compared, which included looking at the source of the distress, dis-ease and disorientation which is often implied in the tone in which the statement is made. The related idea, which could also be read from the statement, that individuals experience more than one version of self and that certain versions are more acceptable than others, spurred my thinking further.

Unwittingly at first and then more deliberately as my thoughts progressed I used as my reference point in this exploration, the periods throughout my life when I have made avail of this statement to express the way I feel, in particular, the few days before my monthly menstruation during which I have experienced a range of 'symptoms', which vary in degree and intensity and are collectively labeled by the modern medical establishment and known in common parlance in contemporary Anglo American society as PMS (Premenstrual Syndrome). While concerning myself about PMS, its symptoms, its causes and its affect on my life and the lives of others is not new for me – I have been doing it since my early 20's when I recognized that 'I did not feel like myself' for a portion of each month – it started to occur to me that to explore its place in relation to the deeply complex, profoundly embedded notion of the self, in this particular way, offered an interesting, if challenging, proposition. Up until shortly before this time most of my concerns had centred on my mostly unquestioned identification as a PMS sufferer and how I might be able to eliminate this 'problem' from my life or at least be able to 'manage it' more effectively. Consequently my interest in this area was almost wholly focused on finding 'cures', 'remedies' and 'symptom alleviators' for PMS. As time went by however, and as I experienced less than unqualified success in this search, I started to expand my exploration of the work in this area and, as a result, I have increasingly started to question the paradigms, which have informed my thinking and approach to PMS. This process of reframing PMS, while still driven by personal motivations, has been shaped by an interest in the development of PMS as a cultural discourse. It was

at the juncture of my increasing awareness of this perspective and my preliminary thoughts on the conceptualization of self that the idea for this thesis started to take form.

What follows then is a series of essays, which explore the ideas of self that are found in the PMS discourse. Incorporating a mix of literature review and analysis and accounts of women's subjective experience of this phenomenon, I will attempt to interrogate the notion of self from the perspective of the 'not self' of the premenstrual syndrome experience.

The PMS Self

Introduction

"Are you a Jekyll and Hyde? That is, do you feel like an entirely different person once you ovulate and again once you start menstruating?"

(Martorano 1993, 189)

The phenomenon of PMS – Premenstrual Syndrome has received a significant amount of attention in the last 30 years both in the public discourse and as a subject of research in the social scientific and medical communities. A founding representation and a central narrative theme of the PMS discourse is women's experience of an altered or different sense of self – a 'PMS self'. In 1931, the year in which a name and a clinical designation was first given to the physiological and psychological changes experienced by large numbers of Anglo American women in the premenstrual phase of their monthly cycles, feminist psychoanalyst, Karen Horney discussed the "intensities of feeling of self-deprecation to the point of pronounced feelings of oppression and being severely depressed" (Horney 1931, 2) when describing the condition of many of her female patients who were diagnosed as suffering from what Horney and others then labeled as PMT- Premenstrual Tension (Horney 1931). Similar terms,

including the expression 'self deprecation', were later used as part of the mandatory diagnostic criteria in the description of the clinical form of PMS, which under the name of PMDD – Premenstrual Dysphoric Disorder, was included in the 4th of edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (APA 1994). Discourse analysis of narrative accounts given by women participating in studies in the past few years reveals prominent themes along the lines of a 'PMS-self/real-self' dichotomy (Swann 1997; Ussher 2000; Ussher 2002; Cosgrove 2003; Ussher 2003), parallel to and most probably influenced by the 'me/not me' presentation, which has been a central feature of the numerous articles and publications on PMS, that have appeared in the popular press and media since the early 1980's (Chrisler 1990; Markens 1996; Chrisler 2002). The split personality of the legendary Victorian character, Dr. Jekyll – the upstanding citizen and physician who undergoes nocturnal transformations into a madman murderer, Hyde - is emblematically typical of the metaphors frequently invoked by the 'experts' and by women themselves to describe this different and, with the Hyde persona intended to represent their PMS self, mostly negatively construed sense of self that they experience in the post-ovulatory/premenstrual phase of their monthly cycles.

Prompted by an exercise in a class on Autobiography in which the participants were asked to reflect on a set of statements about the self, including the phrase, 'I just don't feel like myself', I began to do some exploratory thinking about how this particular interpretation and description of the PMS experience

shapes and is shaped by contemporary Anglo American women's conceptualization and understanding of themselves. Influenced in part by feminist, postmodern and social construction theories which view the self and the interrelated 'entities' of the subject, the person, the body and identity as sociocultural and historical productions, my thinking has centred on questions that have roots in my own experience and are to do with the nature of the self to which this feeling of 'not myself' is compared, as well as the source of the distress, dis-ease and disorientation which is often implied in the tone and by the context in which the statement is made. The related idea, which could also be read from the statement, that people experience more than one version of self and that certain versions are more acceptable and privileged than others, has also directed my exploration of this phenomenon.

Discursive Selves

I chart this exploration through a series of essays, which, in the first part of this project, comprise a sociohistorical perspective of PMS and, in the second part are centred on the question themes that were developed for a survey and interview form, which was to used to conduct the qualitative study for this project. The focus is on the various analyses of the discourses surrounding PMS and the self where the term discourse "implies sets of shared cultural beliefs and practices that are utilized in everyday life in order to construct meaning, identity and subjective experience," (Ussher 1995, 360) as well as in the sense in which discourse reflects the underlying assumptions and metaphors which constitute

different epistemological systems. A full explanation of the methodology and technique used to conduct the study and analyze the study results can be found in the *Study Methodology and Approach* section in this introduction.

As a basis for this exploration, the first part of the project – *The PMS Self, Part I,* provides an overview of the origins and development of the phenomenon of PMS, looking critically at the historical and social forces, which have given it shape and meaning. One of the central themes of this outline is an examination of the ways in which the interrelated discourses of PMS and the approach to PMS research have been situated within a broader critical examination of the epistemological assumptions underlying the biomedical and social science theories and methods, which have dominated our understanding of it. With this background in place I then go on, in *Part II* of *The PMS Self,* to discuss the subjective accounts provided by the women in the study from the perspective of theories and ideas found in contemporary academic analyses of discourses surrounding the self, particularly those theories and ideas that interrogate "the hierarchical dualism at the foundation of Western thought." (Lee and Sasser-Coen 1996, 7) Drawing comparisons with the outcomes from other similar studies, I use the construct of the *Modern PMS Self* as a framework to examine the ways in which the women in this study interpret and make meaning of their experience of PMS through the dominant discourses that derive from what many scholars regard as the founding ethos of the modern era – the mind:culture/body:nature split. This involves an exploration of the role of the hegemonic discourses of normality and femininity in the 'self/not self'

interpretation of the PMS experience. Not to imply that these are exhaustive categories in terms of ways of thinking about the self; rather, they encompass the main themes of self, which have emerged in the aforementioned studies and around which the study survey instrument is structured.

In the following and concluding section of this project, *The Postmodern PMS Self,* I address the body of theory, which suggests that even a critical analysis such as the preceding one is undermined by the fact that it rests on a stable and static notion of the self, which is a concept that many of the same scholars have called into question as the fundamental misconception at the basis of dualistic thinking. Again, using the construction suggested in the title as a framework for exploration rather than an evaluative description, I look at how the study findings can be read in relation to the findings of some of the more recent research and clinical approaches to PMS, which are motivated, in part, by attempts to put forward an alternative conceptualization to this unitary and fixed notion of the self, subjectivity and identity. Contemporary theories relating to the idea of 'self as process', which emphasize a "changing notion of identity that recognizes material and discursive contexts within which individuals are constituted and constitute themselves" (Lee and Sasser-Coen 1996, 9) and approaches found in Eastern practices, including those based on the Buddhist ethos of 'mindfulness', have been proposed - within a wider critique of the model of selfhood which underpins late twentieth century Anglo American theory and practice in this area - as alternate models to understanding and dealing with the PMS experience. I will look at how a number of women in this study, mostly

without awareness of the specifics of these models and their theoretical and practical origins, have adopted what appear to be versions of them, not only as coping strategies for resisting the split-self identification but as a way of deriving insight and strength from the shifts in feeling and emotion that take place over the course of their monthly cycles.

Study Methodology and Approach

The ideas alluded to in the previous paragraph to do with the productive, regulative and meaning-making effects of discourse on identity and subjectivity are at the basis of the methodology and approach that I used in the qualitative study on which the project is based. This approach draws on contemporary theoretical and methodological propositions in its assumption that narratives act to construct subjectivity and that the meaning of objects and events are inseparable from the way they are constituted within particular discourses (Potter 1986; Young 1989). It is one of a number of alternative methodologies which are premised on the recognition of the "the impossibility of any method as guarantor of truth in that methods construct and produce knowledges and thus privilege certain realities and marginalize others." (Cosgrove 2003) These methodologies are the outcome of various critiques, which seem to share a common purpose in their challenge of the "realist/positivist epistemology that has dominated science since the seventeenth century" (Ussher 1999, 209) and which, in turn, has been the model for the social science enterprise. Much of the challenge to this 'realist/positivist epistemology' has come from feminist scholars including Sandra

Harding who establishes this challenge with a definition of epistemology as a theory of knowledge which sets out who may legitimately be deemed a 'knower', what requirements information or beliefs must meet in order to be legitimated as 'knowledge' and what kinds of 'facts' may be known (Harding 1987). Working also with definitions of positivism and realism which assert, in the former case, that knowledge is only possible through homogenous means of observation using the senses and that causality is governed by antecedent conditions and general laws of nature, and, in the latter case, that objects have a real existence independent of any observer, or of any cultural knowledge and practices, these scholars have endeavoured to expose the limitations of such a realist/positivist epistemological approach to our understanding and engagement with the world. They claim that, amongst other things, that it has led to the marginalization and devaluation of indigenous and lay knowledge(s) and to a privileging of theories of biomedical and psychosocial causation premised, as it is, on the assumptions, which follow from the above definition, that 'observers' or researchers have a privileged status by which they are 'authorized', through their use of theories and methodologies that rely on standardization, replicability and statistical and qualitative analyses, to uncover truths about the world.

I will discuss the particulars of some of these alternative methodologies that have been proposed to overcome the limitations of the positive/realist approach in relation to the development of the PMS discourse in the last section of Part I but suffice it to say here that as part of the attempt to move beyond the empiricism of this perspective they constitute what has been called a 'material-

discursive' approach (Ussher 1996; Yardley 1996; Swann 1997; Ussher 1999). As was alluded to in the previous paragraph this approach rests on the understanding that the material and discursive – the world and the words, practices, behaviours and relationships by which we engage and make meaning of the world - are irrevocably connected and cannot be understood without reference to the other.

The acceptance and legitimacy of lay knowledge is one of the most radical implications of the adoption of a material-discursive perspective and one, which, as mentioned, underlies this project and other recent work in the social sciences. In relation to the effects of this approach on the potential direction and focus of PMS research, feminist psychologist Jane Ussher has this to say:

> This allows for the voice and views of women who have premenstrual symptoms to be a legitimate part of the research agenda; it explicitly welcomes an acknowledgement of subjectivity, hitherto marginalized or ignored in PMS research. For example the way in which women construct their understanding of PMS in relation to both medical and media accounts of female reproduction can be seen as a fruitful avenue of research, shedding light on the perception of symptoms, the course of PMS and mechanisms of coping adopted by individual women. (Ussher 1996, 231)

Thus it was with the goal of 'shedding light' on the PMS-self/real-self representation and interpretation of the PMS experience that I undertook the study for this project. As mentioned, I drew on the main themes, which have emerged in recent narrative analyses in this area, to develop a questionnaire (Appendix I), which could be distributed and posted via email and regular mail and also be used to conduct an in-person, semi-structured interview of approximately 45 minutes duration. I felt that it was necessary to use two data

gathering techniques in order to address women's needs and concerns regarding participation in such a study. For personal and practical reasons some of the women who agreed to be involved preferred to complete the questionnaire only. Four of the women indicated a preference to participate in an interview only and the remainder completed a questionnaire and agreed to an interview in which to explore their questionnaire responses in more detail. Although the interviews, by their very nature, yielded fuller and more nuanced accounts, this was not to the detriment of the questionnaire responses, which seemed to capture the participant's reflections and feelings about their experience in a candid and succinct manner. I approached the interviews with some awareness of the various critiques of and approaches to interviewing formats and style, particularly the deconstruction of the 'masculine paradigm' of interviewing (Oakley 2000), which rejects the prohibition on self-disclosure in the interview (Bloom 1998) on the basis that "finding out about people through interviewing is best achieved when the relationship of the interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship." (Oakley 1981, 41) Thus I decided to talk briefly, at the beginning of the interview, about the ways in which my own experience of PMS had provided the motivation for this project and to draw on this experience, in a timely and appropriate manner during the interview, in order to clarify and validate the interviewee's responses. I was also sensitive to the issues raised in these critiques about the advantages and challenges of having a relationship with the study participants and while I had a pre-existing relationship with five of the

women who participated in the survey, two of which are close relationships, it seemed that employing a reflective, exploring approach throughout the interview stage helped to ensure that the process was one of mutual discovery for all the participants no matter what the nature of our relationship.

The study questions are centred around the various ways PMS affects women's experience of themselves, including their understanding of what it means to be a woman; their major life roles as mother, partner, work colleague, friend; their conception of their bodies and their health; as well as how these experiences affect their overall understanding of the idea of self. In recognition of the fact that the content and length of the responses and narratives might be constrained by the particular focus of the questions the women were encouraged to respond at any length and to include information indirectly or not related to the study questions. The questionnaire, which was approved for use by the Simon Fraser Ethics Board was sent and given to participants along with a notice explaining the purposes of the study and providing assurance of informed consent for general participation in the study, and specifically for audiotaping, as well as providing assurance of anonymity and notice of freedom to withdraw at any point (Appendices I - IV). Also, in order to protect their desire for confidentiality the women were assigned or assigned themselves pseudonyms.

Twelve women participated in the study. Prospective participants were encouraged to respond by telephone and email via word of mouth referrals and notices, which were posted in a variety of venues throughout the Lower Mainland of British Columbia, including women's centres and organizations, clinics and

doctor's offices and post-secondary institutions, as well as via electronic list-serves. Although it was not a random sample the participants were from a relatively broad range of socioeconomic, ethnic and educational backgrounds and they were a diverse group in terms of age, which ranged from 20 to 49 years, with nine of the women aged between 35 and 45 years, three in their low to mid twenties and one woman who was 49. With the exception of two students all of the women were wage earners, holding one or two part-time jobs or in full time employment, including one part-time self employed woman and one who was full-time self-employed. Their incomes ranged from below $10,000 to over $50,000 with two women in the former range, two in the latter and the rest in-between. All of the women had received some form of post-secondary education. There were three Asian Canadian women and one Afro-Canadian woman in the group, with the remainder being Euro-Canadian. There were two women from the lesbian community and one from the bisexual community and there was a wide range of domestic and relationship arrangements represented amongst the group.

Once the questionnaire responses and interview transcripts were collected and compiled, the data was analyzed using a method that has been referred to as 'thematic composition'. Following Hollway (1989), Stenner (1993), and Ussher, Hunter and Browne (2000), among others, this method involves a number of readings of the responses and transcripts in order to identify and group narrative themes, which are then analyzed in terms of their function and effects and the implicit assumptions that are used to warrant them. It is a method

of narrative analysis that includes careful and reflective listening with the aim of exploring the meanings women ascribe to their experiences of PMS, in contrast to what Ussher suggests is the primary goal of research conducted using the aforementioned positivist methods, namely the search for a explanation of the phenomenon (Ussher 1996). In that the study questions were structured around previously identified themes, the analytic lens was on the rhetorical strategies and discursive positioning used by the women to describe and make sense of how their PMS experience affected their understanding of themselves. These results are discussed in Part II of this project but in order to get a sense of why the women might interpret and express their experience of PMS as they do, following, in Part I, is a sociohistoric critique of the PMS discourse.

The PMS Self, Part I

A Critical Sociohistorical Perspective

"Tell me, Doctor, why does my wonderful wife, with her perfect figure and her lovely nature suddenly spit with rage for no obvious reason once a month?"

(Dalton 1979, 11)

The association between the menstrual cycle and disease and disorder has a long history going back to Plato and Hippocrates, who documented the deleterious influence of the "wandering womb" recommending "passion and love" followed by pregnancy as the cure for all "manner of diseases" the womb "provoked." (Veith 1964, 7) Nineteenth century commentators described menstruation as the moral and physical barometer of the female constitution (Burrows 1828, 147), or a source of "moral and physical derangement" (Maudsley 1873, 88) and in the last century the British psychiatrist Wickham wrote of the "physical disturbance" of menstruation, where towards the end of the cycle, "the destructive forces are in control and they culminate in the menstrual period." (Wickham 1958)

It could be argued that the phenomenon of premenstrual syndrome or PMS is one of the most broadly recognized and potent current manifestations of this association in contemporary Anglo American society. This is not to discount women's experience of PMS as a set of very real 'symptoms' or, as many feminist researchers, clinicians and therapists prefer to say, physical and psychological changes, which vary in degree and intensity amongst women and from cycle to cycle in individual women, and which can have effects ranging from mild discomfort all the way through to severe physical and psychological distress. Rather it provides a framework for understanding better what it means for and about women, including myself and the participants in this project, who define themselves as PMS sufferers.

In situating PMS as the most recent of a long line of maladies, which position women as diseased and disabled by their reproductive capacities (Showalter 1985; Chesler 1989; Ussher 1992), Ussher is among a number of feminist theorists who suggest that it was this genealogy that was at the basis of the 'discovery' of the syndrome in 1931. However, despite this shared genealogy, PMS or PMT, as it was initially labeled by US Physician, Dr. Robert Frank (Frank 1931), was different in form and function from its immediate foremothers, 'hysteria' and 'neurasthenia' due, in part, to emerging medical technologies and the newly developing theories and practices of psychiatry and psychology. With the recent 'discovery' of the sex hormones, which was one outcome of a broader shift within scientific research towards biochemical and molecular causation (Oudshoorn 1994), and which is described in more detail in

a later section, as well as the increasing reliance on psychoanalytic theory to account for all manner of dis-ease and distress, the age old problem of 'women's problems' found a new cause in theories of hormonal imbalance, the effect of which was expressed in the Freudian inspired lexicon of sexual drives, desires and dream fantasies. (Horney 1931; Benedek. T 1939). According to Dr. Frank it was the effect of "accumulations of the sex hormone", estrogen that gave rise to the "indescribable tension from ten to seven days preceding menstruation," (Frank 1931, 1054) experienced by many of the women attending his clinic, whereas aforementioned feminist psychoanalyst, Karen Horney would assert that the premenstrual "intensities of feelings of self-deprecation to the point of pronounced feelings of oppression and of being severely depressed" that occurred in "otherwise healthy women", was a psychological response to the anxieties and fantasies associated with pregnancy, combined with frustration caused by the cultural restrictions surrounding the expression of female sexuality (Horney 1931, 2). Ussher also points to the fact that these formative descriptions diverge along themes, which become central to her and other's critiques of the work and research in this area. She distinguishes between Frank's reliance on a biomedical model of hormonal causation, which pathologizes women's cyclicity, and Horney's view that the process was not pathological because it "occurred in otherwise healthy women." (Ussher 2003)

The Naming of a Syndrome

> "PMS (I hate the name, because "syndrome" of course means a collection of symptoms, so seems to hint at illness) is really just what I think of how I am two weeks post ovulation."

Study participant, Karen

When interest in the phenomenon of premenstrual tension picked up again, after an interval of some 20 years, the theme and theories of biomedical causation seemed to hold sway. In 1953 the British physician Dr. Katharina Dalton, who has since been acclaimed the 'guru' of PMS (Houppert 1999, 146) began to pursue what would come to be a life-long interest in this area of women's health, resulting in, amongst other things, the coining of the term "premenstrual syndrome," (Dalton 1964) a name which she felt better captured the array of premenstrual physical and psychological symptoms and changes experienced by the many women she treated in her practice. The most common of these were bloating, weight gain, headache, backaches, irritability, depression, breast swelling or tenderness, loss of libido, and fatigue (Dalton 1979). Along with Dalton's work in general practice, it was her own experience in pregnancy, during which she experienced a complete cessation of migraine headaches, that directed her efforts in this area and was the basis for her claim that a deficiency of the female sex hormone progesterone was the root cause of PMS. Dalton began to treat her patients - who, she claims, numbered more than fifty thousand by 1999 - with a regimen of natural progesterone, which, while she no longer

practices, remains the cornerstone of a course of therapy that also includes advice about diet and lifestyle and which she promulgates in the very popular book, *Once a Month* (Dalton 1979), first released in 1979 and currently in its sixth printing. Often vilified by feminist critics, who accuse her of, amongst other things, hyperbole (Houppert 1999, 147) and misogyny (Zita 1989, 191) Dalton has become one of the more problematic figures on the PMS scene, a personification of the dilemma at the heart of the PMS discourse. The dilemma was becoming increasingly transparent by the mid-1970's and is articulated by Delaney, Lupton and Toth in the 1979 edition of their book on menstruation entitled *The Curse* in which they ask; "how far can medicine go to recognize, treat and 'legalize' PMS as an exclusively female condition without endangering the extremely tenuous position of women in the economy and the political arena of the 1980's and beyond." (Delaney, Lupton et al. 1988, 101) Lauded by many 'ordinary' women for giving validation to their experiences by naming and describing them, as well as further substantiating the idea of a material (hormonal) cause for PMS, rather than one that was 'all in a woman's head', Dalton began to be subject to growing criticism, starting in the early 1970's, from within the medical and feminist communities, for using unsubstantiated numbers and anecdotal evidence to make her argument, such as the figure of 8% which, she claims, is the cost of PMS to the total annual wage bill in the US (Houppert 1999, 147).

Critics have also pointed to her use of flawed research methodology (to be discussed in more detail later in Part I), which, among other things, relies too

heavily on the biomedical causation model, as well as pre-existing assumptions of women's cyclicity as a pathology that needs to be 'cured' (Zita 1989). Such assumptions are vividly depicted in her early publications in which premenstrual women are often painted as potentially dangerous and dysfunctional actors in all spheres of their lives, unable to meet expectations and to fulfill their myriad, demanding and often conflicting responsibilities as wives, mothers, consumers, workers etc:

> However, sudden mood changes, irrational behaviour and bursting into tears for no apparent reason are bewildering, while sudden aggression and violence are deeply disturbing when with little warning and no justification, his darling little lovebird becomes an angry, argumentative, shouting, abusive, bitch. (Dalton 1977, 80)

> ...the usually tidy house is not picked up, the beds aren't made, dirty dishes sit on the kitchen table, and there is probably a burned cake by the sink. Perhaps the children went off to school late in yesterday's clothes, and chances are that the meals won't be ready on time. (Dalton 1979, 107)

> ...she may buy totally inappropriate dresses that are the wrong colour, and which she will never wear. It is possible that her appreciation of shape and size deteriorate during this phase of the cycle. (Dalton 1979,124)

> ...more than one secretary has been referred for treatment when her boss could no longer put up with those few days every month when letters had to be repeatedly returned for retyping. (Dalton 1979, 115)

It seems, however, that Dalton has been largely able to resist these criticisms and has had a significant influence on the PMS discourse partly because of her willingness to acknowledge and respond to what women were telling her about their experience. As some commentators have observed this is

despite, and possibly because of, the fact that her response to them is comprised of not just one but two masculine voices of objective authority – "the voice of medical 'objectivity' which systematically belittles and ridicules female behaviours and the subjective voice of the male victim who suffers these behaviours. " (Zita 1989, 191)

Cyclicity as Pathology in the 19th and 20th Centuries

"... now on the more negative side I think PMS is used as a way of pathologizing women and I think it's used to dismiss very important things that they are saying..."

Study Participant, Andrea

So it was that as articles and discussions on PMS began to take a more prominent place in women's magazines and gynecological clinics and also started to appear in the popular discourse and the mainstream media, Dalton's and others assumptions and theories about the existence of PMS, as well as the cause and treatment for it, took centre stage. According to feminist anthropologist Emily Martin, the particular trajectory and timing of this updated version of the age old story of cyclicity as pathology should come as no surprise, emerging as it did in the time immediately preceding and during the peak years of the women's movement of the 1970's and 80's. In her 1987 book, *The Woman in the Body* (Martin 1987) Martin draws on her own research and that of other feminist historians and social scientists including Barbara Ehrenreich and Dierdre English (Ehrenreich and English 1978) to support her thesis that this

framing of women as temporarily or, in some views, permanently unfit for their domestic and care taking roles, and most definitely for engagement in higher education, professional work and political life, is part of a larger pattern that has been repeated at other times in recent history in periods of broad economic and social upheaval. Among these is the period which straddles the last part of the nineteenth century and first years of the twentieth century, during which the entry of women into higher education in historically unprecedented numbers and the activities of the early suffragettes and related groups provoked the release of a flurry of studies and publications, including the aforementioned Henry Maudsley's *Sex in Mind and Education* (Maudsley 1883), which asserted that women's cycling constitutions rendered them unfit for sustained mental and physical labour. While it seemed that all women were considered incapacitated to some extent – the phenomenon has been described as the "cult of invalidism," (Martin 1987, 109) Ehrenreich and English point out that the more severely 'afflicted' were often the subject of treatments and therapies that were representative of the central place of anatomy and physiology in the medical system and mostly consisted of variations on the 'rest cure'. This was a treatment pioneered by the famous nineteenth century physician, Dr. S. Weir Mitchell and was only really suitable for middle and upper class women who could afford to partake in the weeks of bed rest and minimal activity, which the cure prescribed. Less frequently but more radically, afflicted women were subject to operations known as ovariectomies, which, as the name implies, involved the removal of the

ovaries, the malfunctioning of which was widely believed to be the root cause of 'women's problems'.

The fact that such maladies and their respective treatments might be, in part, a response to women's attempts to change their status and power in society did not get lost on some of the commentators of the time, as can be seen in the following excerpt from an article, which appeared in the New York Times of March 28, 1912:

> No doctor can ever lose sight of the fact that the mind of a woman is always threatened with danger from the reverberations of her physiological emergencies [menstruation]. It is with such thoughts that the doctor lets his eyes rest upon the militant suffragist. He cannot shut them to the fact that there is mixed up in the women's movement such mental disorder, and he cannot conceal from himself the physiological emergencies which lie behind.

Also, although they were few in number and not widely publicized, there were study results and theories put forward that challenged these dominant ideas. These include the work of the famous physician and founder of the Association for the Advancement of Medical Education for Women, Mary Putnam Jacobi (Martin 1987), as well as a 1914 book by Leta Hollingworth, Ph.D., entitled *Functional periodicity; an experimental study of the mental and motor abilities of women during menstruation* (Hollingworth 1914). In the latter, Hollingworth calls into question Maudsley's and other's theories about the debilitating effects of menstruation, basing her objections on the results of a series of tests that she conducted on twenty-three women over several menstrual cycles and which showed no significant impact on women's cognitive and motor functions across the cycle.

In a continuation of this argument about the relationship between social and economic conditions and the effect of women's reproductive physiology on their abilities and role suitability, Ehrenreich and English, Martin and others point out that in the succeeding interval during and between the two world wars, the need for women's direct and indirect participation in the war effort was accompanied by the publication of studies and commentaries, which painted quite a different picture from those of the previous era, extolling the virtues of women workers and soldiers and down playing the impact of menstruation. In her 1999 book *The Curse*, the journalist and author Karen Houppert quotes extensively from a training film put out by the US War Department in 1940 in which a male Army Doctor scoffs at the idea that "some twentieth-century girls still believe that lavender-and-old-lace hokum about no activity and no bathing during menstruation. That's Victorian stuff", he suggests, as is "that trash about nerves and sensibility during this period." (Houppert 1999, 157). This was followed, in the post WWII period and the time at which Dalton started to practice, by the revival of what Ehrenreich and English call the ideology of 'sexual romanticism', which, with its roots in nineteenth century ideas about woman's 'natural' place in the domestic sphere and her inherent pathological condition, played an important part in the large scale redeployment of women out of the workplace and back to the home (Ehrenreich and English 1978). And then came the period in question -the late 70's and 80's, during which time coverage of PMS and its debilitating effects on women's abilities and potential became much more prominent in the popular discourse, a development which these and

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other commentators suggest was part of a broader 'backlash' generated in response to the resurgence of the women's movement, when significant numbers of women in Anglo American society started to push back against and move out beyond the limits of their culturally and socially proscribed roles and responsibilities (Faludi 1991). The beliefs about, and representations of women contained in, the literature and discussions about PMS at this time, which influenced and were in turn influenced by the theoretical and methodological assumptions underlying the growing number of studies on the subject, did not go unnoticed by members of the feminist and medical communities who began to voice their objections even as the discourse was taking shape in the public arena. I will outline the details of these objections in a later section but as a prelude to this I will look at perhaps the most central of these assumptions – that of hormonal causation.

'Raging Hormones'

> "...so, I call them my hormone swirls, I'm having a swirl and it's going to set in for a while and then it's going to go..."

Study Participant, Jane

Central to the acceptance and dissemination of ideas about the cause and treatment of PMS at this time and to a large extent now was the relatively new science of sex endocrinology with its star players, the powerful and mysterious female sex hormones. In her excavation of the history of sex hormone research, *Beyond the Natural Body: The Archeology of the Sex Hormone*, Nelly Oudshoorn

contends that the 'discovery' of the female sex hormones in European and US laboratories, which took place over first three decades of the twentieth century, came about, in part, as a result of a long standing search for the "essence of femininity." (Oudshoorn 1994, 6) In examining the motivations for and circumstances of this search, Oudshoorn draws on the work of other historians of science and medicine, such as the aforementioned Sandra Harding, Anne Fausto-Sterling and Michel Foucault, who take or incorporate a social constructionist viewpoint in their examination of the circumstances and conditions in which, they argue, scientists 'construct' as opposed to 'discover' reality. Oudshoorn suggests that the idea of an essence of femininity is based on an understanding of the body as a universal, physiological, natural reality, an idea that she counters with her argument that "the naturalistic reality of the body as such does not exist, it is created by scientists as the object of scientific investigation." (Oudshoorn 1994, 6) She elaborates on this proposition, picking up on a number of themes, which, she claims, run through the history of the biomedical sciences and which have also been described by Emily Martin and the feminist science historian, Nancy Tuana (Tuana 1993) and others, in relation to the ways in which the development of medical/technological approaches and systems influences and is influenced by broader social and economic movements. This has contributed, among other things, to an understanding of the body, the female body in particular, as a fragmented entity whose parts 'operate' in line with the dominant business metaphors of a small business, industrial process or technological communication system. Drawing on the work

of Foucault, Oudshoorn goes on to examine how, in Anglo European and American nineteenth century society, theories of sex moved away from the centuries old 'one sex model' to a focus on sex difference, which, in step with the fragmented body paradigm, sexualize every part of the body and, Foucault proposes, make the female body the medical object *par excellence,* further coding 'it' as defective and inferior to the male body. In line with the aforementioned theories of Ussher and others, Oudshoorn argues that this search for the essence of femininity was not a new one. Rather, she suggests, with the emergence of the aforementioned medical technologies and disciplines, such as biochemistry and gynecology, the location of the pursuit changed over time from the womb in early ages, to the ovaries in the nineteenth century and eventually to the hormones in the early twentieth century.

Oudshoorn's thesis is also a response to the question of how "the concrete, often very mundane, human activities that go into the discourse building of scientific claims, achieve the status of universal, natural facts." (Oudshoorn 1994, 10) This line of enquiry leads her to look at the notion of 'networks' put forward by social scientists, and alternately proposed by Foucault in his ideas on the multiplicity and mobility of power relations, to support their theories that knowledge claims can become established as scientific facts only if they become linked to relevant groups. In this case it is the structural relationships and interactions of the three-member network of laboratory scientists, clinicians and pharmaceutical companies in conjunction with the 'material authority' of their research enterprise, manifest in the form of research

material, diagnostic tools, screening tests, drugs and other regulatory devices, that has been instrumental in creating the universally accepted facts about hormones and the female body, which are also integral to the PMS discourse. A particular outcome of this dynamic, which is also illustrative of another of Oudshoorn's key arguments - that rather than just being a passive readout of cultural ideas, science often transforms pre-scientific ideas in ways which are consistent with the particular style or 'signature' of the disciplines in which they are taken up - was the creation of conditions which led to the generation of a quantitative theory of sex, which posited that "men and women differ only in the relative amounts of their sex hormones," (Oudshoorn 1994, 60) as well as the tests and tools to specify this quantitative theory. Oudshoorn proposes that these were among a number of developments in which pre-existing or newly created circumstances contributed to a more favourable climate for female sex hormone research and which was to have a significant effect in 'naturalizing' and reinforcing pre-scientific theories about women's cyclicity:

> Based on the female sex hormone blood test, gynecologists now suggested that men and women could be characterized by the specific nature of their hormone regulation, emphasizing the cyclic nature of female sex hormone production in women and the continuous stable nature of male sex hormone production in men. Sex endocrinology thus attached the quality of cyclicity to femininity, and stability to masculinity. (Oudshoorn 1994, 60)

Thus it was in the context of the discovery of the sex hormones that hormonal theories of cyclicity as pathology or what Ussher calls "women's madness" (Ussher 1999, 212) evolved. Although evidence for the presence and effect of the female sex hormones rested on an ideologically inspired and

specifically contrived quantitative theory that relied for its proof on tests and tools expressly created for this purpose (and, as mentioned elsewhere, is only a clue to a broadly complex interactive process), hormones, or more particularly, imbalances and deficiencies in the sex hormones came to be understood and represented as the source of all the physiological and psychological changes related, and even unrelated to women's cycles. According to Zita, Chrisler and others such an understanding has contributed to the creation and legitimization of the notion of women as victims of their 'raging hormones', the term that emerged in popular culture in the late 70's and has since become ubiquitous and synonymous with PMS. It is also the underlying premise for many of the studies in this area, which began to accumulate rapidly from the early 70's onwards and supposedly provided the medical and scientific proof for the existence of PMS. However, as mentioned previously, it was not too long before researchers within the medical and feminist communities began to uncover problems with these studies, related to their theoretical and methodological presuppositions. The studies and the critiques are the topic of the next section.

PMS Research, Theory and Methodology

"...the experts were for me I guess in a lot of ways frustrating, they didn't have any solutions and I think there really isn't much of a solution out there, there aren't any magical drugs that take it away, it's a very complicated set of processes that go on in a women's body..."

Study Participant, Jane

The supposition, on which Oudshoorn thesis partly rests, that cultural or prescientific notions of gender and sex have explicitly and implicitly influenced the scientific process, often from the hypothesis stage right through to application phase, is shared by a number of other scholars including the embryologist and social scientist, Anne Fausto-Sterling. She makes this argument in her book *Myths of Gender* by analyzing a variety of theories including ideas about brain lateralization, the 'intelligence gene' and sexual dimorphism, to support her claim that the social embeddedness of scientific knowledge is most overtly manifest in the construction of research hypotheses and experimental designs which often reflect the sexist and gender biased but non-conscious and, therefore, unarticulated agendas of even the most careful and capable of scientists.

Looking specifically at studies and theories on PMS Fausto-Sterling proposes that the belief in cyclicity as pathology, expressed by Behavourial Psychologist, Frank Beach in the remark, "women have a physiological abnormal status," (Fausto-Sterling 1992, 96) underlies much of the research and studies that were being done on PMS by Dalton and others throughout the period from the 1960's to the late 80's. As with many others who have undertaken a critical analysis of the PMS discourse Fausto-Sterling draws on the work of Mary Parlee and Randi Koeske, who are among a number of researchers who, in the mid 1970's as founding and early members of the Society for Menstrual Cycle Research, a US based non-profit organization that has held biennial conferences since its establishment in 1971, began to call into question many of the

theoretical and methodological assumptions of the past and current work in the area.

These researchers have raised issues and concerns with, amongst other things, the quality and type of observations and explanatory frameworks used in PMS research, which are mostly directed towards the description and depiction of negatively evaluated changes in women. Parlee has pointed out that the Moos Menstrual Distress Questionnaire, which is the most commonly used survey instrument used to collect data from self declared PMS sufferers not only has a name that reflects emphasis on the negative aspects of the syndrome in the popular literature (Lever 1981) but contains only five out of the forty-seven items which predict positive results (Parlee 1974). As well as directing attention away from the premenstrual and mid-cycle surges in energy, productivity and feelings of well-being which many women have reported experiencing (Martin 1987), this focus on 'what goes wrong with women' once a month makes easier the transition from simple descriptive language to disease-model theorizing. Implicit in this model, which rests on a definition of 'disease' as an "undesirable deviation from the norms of physical and psychological well-functioning," (Zita 1989, 192) are what Parlee and others have argued are questionable norms of relatively non-cyclic male physiology and benign femininity. A continuation of this discussion, as well as that from preceding sections, regarding the source and meaning of these norms will be undertaken in Part II of this project but suffice it to say here that their presupposition in much PMS research has led to a number of methodological issues. For instance, in that they support the presumption that

cyclicity is a problem caused by hormonal imbalance/deficiency, and a problem for menstruating women only, the use of non-menstruating control groups such as those from anovulatory, amenorrheic, pre-menarcheal, postmenopausal or male populations, as a means to measure the extent and amount of deviation from an actual as opposed to a presupposed baseline as well as to look at the influence of non-hormonal factors, has been seldom undertaken. A related issue raised in these critical analyses is the fact that some researchers have based their conclusions about PMS on data collected in studies on psychiatric patients or prisoners and/or participants who have not been screened to detect the presence of underlying medical and psychiatric disorders that may influence their symptom profile (Chrisler 2002).

Furthermore, these critics claim, the absence of or inadequate measurements of statistical significance in all of Dalton's and many other studies, which has resulted in an over rating of PMS symptoms suggests a questionable use of disease-model theorizing that assumes any deviation is abnormal, disabling and deserving of medical attention. In a continuation of this argument Koeske, Abplanalp (Koeske 1983) (Abplanalp 1983) and others look at how these issues have been further compounded by complications encountered in the collection of data used to confirm the existence of PMS. As well as the bias that results from the fact that the majority of study participants were drawn from PMS clinics and support groups, therefore self-selecting themselves as having problems and needing help, there is also a skew as a result of the reliance on retrospective reporting as the main data collection method. When compared

with other methods such as daily self-reports it seems that study subjects tend to overestimate their condition when working from memory, leading them to conclude that retrospective reports may be measuring the 'subjects' attitudes and assumptions about premenstrual conditions rather than what is actually experienced. Furthermore, not only has memory been shown to be faulty in assessing the impact and timing of symptoms but also with regard to the timing of the actual onset of menstruation. These are all also directly and indirectly related to what these critics, some of their contemporaries and many others since then have put forward as the central methodological issue in PMS research, which is the fact that menstrual cycle length and the number and intensity of associated physiological and psychological changes varies between women and from cycle to cycle in individual women thus making it extremely difficult to measure and standardize what actually constitutes premenstrual syndrome (Chrisler 2002).

However, it seems that these critiques were somewhat overshadowed by the findings from these early studies, which, generated and disseminated as they have been under the appearance of what their detractors define as 'science as usual' - "a legitimating activity driven by questions that are never considered a contrivance" (Zita 1989, 190) - have contributed in a formative manner to the growth of the PMS discourse as "a collection of negative facts about women's nature, a nature which in turn is seen as requiring medical surveillance and management." (Cosgrove 2003) This construction of PMS as a female gender trait, a syndrome which is universal to and variably present in all women, has,

say these same critics, given rise to the rapid multiplication of competing etiologies, the constant shifting of symptomologies and the conflicting definitions of the syndrome, which are contained in the literature and the study findings on PMS and which are the focus of the next section.

The Growth of a Syndrome

> "...I guess I think about the way that PMS is used in the public setting as trivializing both to those women who struggle with severe symptoms and in its reduction of the body - and all its amazing processes – to a syndrome..."

Study participant, Lorraine

As part of the growth of (mis)information about PMS, the syndrome had grown in stature. By the early 80's, the over 150 symptoms described by the clinician who created the Menstrual Distress Questionnaire in 1968 (Moos 1969) and the prevalence rate amongst women of nearly 100%, according to some studies (Seagull 1974), were increasingly portrayed as concrete facts in media articles and discussions about the syndrome (Chrisler 1990). Also, as the journalist Karen Houppert comments in rather colourful language, as well as "collecting victims", PMS was beginning to "gobble up" more of menstruating women's time with its "eminently mutable definition oozing out over the edges" of the premenstrual week right into the next such that the term 'PMS-ing' was increasingly becoming a "euphemism for bleeding itself." (Houppert 1999, 143) An example of the main symptom categories described in the clinical literature is

followed below by an overview of the most common themes that appeared in the popular literature of the time:

> *Affective*: sadness, anxiety, anger, irritability, labile mood.
> *Cognitive*: decreased concentration, indecision, paranoia, "rejection sensitive",suicidal ideation.
> *Behavourial*: decreased motivation, poor impulse control, decreased efficiency, social isolation.
> *Neurovegetative*: insomnia, hypersomnia, anorexia, craving of certain foods, fatigue, lethargy, agitation, libido change
> *CNS*: clumsiness, seizures, dizziness, vertigo, tremors (Zita 1989, 191)

> PMS was described as the blahs, consisting of snapping, irritability, anxiety, crying jags, bloating, anger, sudden bouts of tearfulness, headaches, aching joints, constipation and feeling out of sorts and bitchy. Women with PMS are nervy and moody, have frayed nerves and mood swings and experience an emotional dive premenstrually. PMS can cause strained relationships, feelings of despair and worthlessness and total loss of control. PMS is disabling and can interfere with daily routines, lead to bizarre behaviour, impair ability to function at work or in social situations and affect quality of life. (Markens 1996, 45)

Undertaking critical reviews of these descriptions, a relatively small number of scholars and researchers joined Parlee et al in continuing to press their claim that the construct of PMS 'essentially' symptomatizes every aspect of what it is to be a woman. Among the observations made in these reviews and one which will be explored more fully later in this chapter and in Part II is that although the syndrome description includes a wide range of physical symptoms it is the ones to do with the so-called negative effects on mood, behaviour and ability that seem to rate the most discussion and coverage in the literature and as a subject of research.

Along with the issue of growing symptomatology the reviewers also examined the resulting proliferation of etiologies, which, as has been noted earlier, demonstrate a trend towards clinical and scientific reductionism locating

causal variables within the individual or within correlative pathophysiological events (Ussher 1996). Although there was some exploration of the founding ideas from psychoanalytic theory about PMS causation put forward by Horney and others, this pyschogenic model ultimately relied on the dominant organic causation model. Consisting initially of extrapolations and variations on the original thesis of hormonal imbalance/deficiency the explanatory framework for the organic model has rapidly expanded, maintaining the hormone theory at its core while incorporating hypotheses on a range of related causes including, among others, vitamin and mineral deficiencies, blood sugar levels, fluid retention, elevated prolactin levels, increased prostaglandins and endogenous opiates. The fact that the resulting multitude of etiologies generated by these two models does not seem to adequately explain all manifestations of premenstrual syndrome should, say critics, call into question the disease model theorizing which underlies the research and therapies in this area. Instead, as Chrisler and others have noted in their analyses, the vague, idiosyncratic and all-encompassing nature of the syndrome worked to fuel a PMS industry in which private for-profit health clinics and pharmaceutical companies in North American and Anglo European society began and continue to benefit from the positioning of PMS as a disease in need of a cure (Chrisler 2002).

Variations on Dalton's progesterone therapy were the mainstay of the treatment regimes offered at the early-established PMS clinics. As the clinic system began to rapidly expand to number around 130 in North America by 2002 (Chrisler 2002) in tandem with the growing number of self-help publications on

the subject (Markens 1996), the treatment regimen also broadened. Included in the treatments and therapies available at clinics and documented in self help books are vitamin and mineral supplements such as vitamins E, B_6 and C and magnesium, calcium and zinc; light – natural and artificial; carbohydrates and carbohydrate beverages such as PMS Escape; gonadotrophin releasing hormone; thyroid pills; lithium; birth control pills; tranquilizers; diuretics; and essential fatty acids such as those found in oil of evening primrose. The clinics, many of which now have websites, also began to recommend a combination of exercise and nutrition regimes as a standard accompaniment to some of the more specific remedies listed above and a number have begun to incorporate so-called alternate treatments such as acupuncture, herbal supplements, meditation, yoga and breathwork, as well as various psychotherapeutic therapies and counseling programs. Over time, due to the work and efforts of many of the women cited in this thesis, a lot of the clinics have come to adopt woman-centred practices and approaches and more will be said about these in Part II. Also, while other therapies have come and gone, it seems that the ones that address basic lifestyle issues for women, related to the effects of proper nutrition (Rittenhouse 1991), increasing exercise or exercise training (Prior 1987), and methods to reduce stress (Maddocks 1985), have persisted because they have benefits for women's lives in general as well as for the symptoms of PMS. More recently, as part of a development much discussed and analyzed within the feminist medical and social science community and which will be reviewed in more detail later in this chapter, a large number of clinics have added the

relatively new family of antidepressants – the selective serotonin reuptake inhibitors or SSRI's, which go by their more notorious brand names of prozac, zoloft and paxil etc., to their treatment alternatives for PMS (Chrisler 2002; Caplan in press).

However a number of the same critics who have taken issue with many of the above named symptoms, etiologies and treatments that are a consequence of the domination of disease model theorizing in the research approach to PMS, as well as the corresponding 'magic pill' approach that seems to have held sway in mainstream clinical practice, have also included in their critiques an appeal to replace the simplistic, unilinear, reductionist thinking that characterizes the PMS discourse with a more broadly disciplinary and multifaceted approach that will be examined in the following section.

Biopsychosocial Studies – a broader look

> "...The feelings of discomfort and distress were compounded by traditional messages that I received about what it meant to be a woman: that I would undoubtedly have children, that I would go to university but it didn't really matter what I studied because I would give it all up to stay with my children anyway, that being a woman meant learning to sacrifice my own needs and desires, being economically dependent, etc..."
>
> Study participant, Morgan

Perhaps the most compelling argument and motivation for these scholars and researchers to look beyond theories of biomedical causation and one that will be examined in greater detail in Part II was the fact that PMS in both the

biomedical and public discourse was, and to a large extent still is, framed as a problem of biology of and for individual women as opposed to one that might also be related to issues of women's social and political status in society.

Their motive and methods were linked to a broader movement emerging in the mid-70's in which, influenced by growing body of critical theory and a search for alternate models of causation and remedy, the academic and research communities were attempting to move towards greater multidisciplinarity in diagnosing and treating both medical and social ills (Ussher 1996), resulting in increased efforts to consider the psychological and sociological, as well as biological factors implicated in PMS. Although acknowledging the limitations of such methods, based as they are in the positivist/realist tradition from which the biomedical approach has emerged and which will be the subject of further discussion in the second chapter, the members of the Society for Menstrual Cycle Research and other's critiques of the current status of PMS research included recommendations for the implementation of methods and studies that would examine more rigorously the impact of a wider range of psychological and social variables on women's experience of PMS (Prior 1997). Subsequently the impact of variables such as depression and disorders, negative attitudes towards menstruation, gender role conflicts, marital and family discord, psychological and social well being and support were increasingly included in or the object of research on PMS, in what came to be termed as biopsychosocial methodology. Also a wider range of physiological variables came under scrutiny including age

and reproductive life stage, genetic factors, pregnancy and problems during pregnancy and the use of oral contraceptives (Golub 1992).

These researchers also advocated for the use of feminist research methodology, which among other things, calls on researchers to be upfront and explicit about the motivations, assumptions and potential biases they bring to their work, as well as naming the funding sources and the research requirements of the funders. As previously mentioned they based their arguments on an interrogation of the underlying assumptions which equated cyclicity with pathology and abnormality, suggesting that these socially mediated beliefs and expectations played a large role in determining the incidence and reporting of premenstrual symptoms. Parlee suggested that these beliefs "may provide a set of cognitive categories for the (woman) to use in labeling what would, under other circumstances, be experienced as non-specific states of arousal." (Parlee 1989) According to Parlee, the interpretation of women's broad and varying response to, and expression of fluctuating states of physiological arousal related to their reproductive cycles, was cast in a mainly negative light of 'abnormal' and 'unacceptable' behaviour, for instance, the use of the somewhat disapproving and non-constructive term 'restlessness' to describe what, from another perspective and interpretation, might be seen and experienced as 'creative energy' (Walker 1995).

The 'menstrual joy questionnaire' (Delaney, Lupton et al. 1988), the 'tranquilizing effects of the post-menstrual and ovulatory hormonal milieu (Walker 1995)' and the redescription of PMS as a 'window of sensitivity (Zita 1989)' are

among the instrumental and theoretical devices employed by these feminist practitioners and researchers in an attempt to reframe women's experience in the premenstrual period in a way that was more positive and affirming than the all-pervasive disease and dysfunction model. Also the employment of more rigorous methods in the testing of physiological factors eventually leading up to the widespread use of what is considered the 'gold standard' of research methodology (Houppert 1999) - double blind, randomized placebo controlled studies, began to paint a more complex picture than the hormone imbalance/deficiency causation model. In fact Dalton's progesterone cure has been called into question by a series of such studies performed throughout the 80's and early 90's, which, similar to related studies on the effects of triphasic oral contraceptives (Graham 1991), found little correlation between these therapies and mood symptoms associated with PMS (Dennerstein 1985), and in other cases no statistically significant differences between the effect of placebos and the therapies (Freeman 1990; Rubinow 1991). Although Dalton has challenged these results with questions about the dosage levels and frequency as well as the differential effects of natural versus artificial progesterone used in these studies, the data from other more methodologically sound surveys began to accumulate, further challenging previous research findings and showing a lack of consistent measurable effects of the menstrual cycle on factors such as cognition, psychomotor skills and sexual response (Golub 1992). While these researchers acknowledge that it was debatable whether these findings had any impact on undermining the stereotypic representations of women in popular

culture as more illogical, emotional, generally incompetent and simultaneously nymphomaniacal and frigid in the premenstrual phase, they nevertheless raised questions about the standard and reliability of some of the research in this area (Parlee 1989).

Essentially what was emerging, albeit very much on the margins of the social scientific and medical communities, was an appreciation of the broadly complex and variably interactive range of factors involved in premenstrual syndrome. This was leading, in some quarters, to a questioning of the assumption underlying most of the research, that PMS, menstruation, or other aspects of biology, or mood, are independent variables. As Anne Walker has commented in discussing her research on premenstrual symptoms in ovulatory and an-ovulatory cycles "we assumed linearity between ovulation and symptoms occurrence – we also assumed that the direction of causality was from ovary to behaviour and not vice-versa... the possibility of more complex relationships was not systematically tested." (Walker 1995) This is the same argument made by Sharon Golub, past president of the Society for Menstrual Cycle Research and author of the 1992 book, *Periods: from Menarche to Menopause* (Golub 1992) in her analysis of the data from a number of the age and reproductive life stage studies of PMS which reveal, among other things, that the incidence of occurrence and reporting of PMS seems to peak in women between the ages of 35 and 44 years. Golub and others have pointed to role of physiological factors, citing a number of surveys which demonstrate this link including one which found that women between the ages of 20 and 24 are 30% less likely to ovulate every

cycle and are therefore less frequently exposed to the pre- and post-ovulatory variations in estrogen and progesterone than women between the ages of 30 to 39 (189). At the same time, they argue, psychological and age–related social factors such as those described below cannot be ruled out:

> Women in their thirties are more likely to be married and caring for small children than are younger women. These are often difficult years for women, who are stressed by the demands of childcare, housework and work outside of the home. They may be short of sleep, tired and irritable and therefore more vulnerable to shifts in mood occurring during the premenstruum. (Golub 1992, 190)

If this discussion was taking place only at the margins of mainstream research it is easy to understand why it barely registered in the public discourse. Instead, with biomedical studies outnumbering all others by a factor of 20:1 (Ussher 1996), and presumably being reported accordingly, and endorsements for self help books trumpeting the discovery that "PMS is not psychological but physical in origin" (Lauersen 1983) it was the compelling 'story' of cyclicity as pathology that held sway in the public arena. There was also a series of events and developments, which, critics have pointed out, both rested on and further reinforced this notion, and it is these that are the focus of the next section.

PMS as a legal defense and a psychiatric disorder

"...when I first had PMS I thought God I'm losing my mind, what if I'm losing my mind..."

Study Participant, Andrea

Results of a content analysis of articles and self-help publications on PMS that appeared in the popular press throughout the 80's conducted by Chrisler and Levy (Chrisler 1990) illustrated the prominence of biomedical causation theories along with the message that the most ubiquitous of these - the hormonal imbalance theory - was at the basis of the transformation of ordinary women into "the menstrual monster". This was one of a series of equally graphic, melodramatic metaphors, employed in the articles and self-help books in an unfailingly standard, albeit validating, format which, as previously described, incorporate first person accounts of 'out of control' women who, having heeded the advice of the so-called experts whose cures were being touted in articles and books, were able to tame their "inner beasts" and rid themselves of their 'madness' (Chrisler 2002, 286). It is no surprise that Markens (Markens 1996) and Rittenhouse (Rittenhouse 1991) in conducting a similar analysis of the literature reach a number of related conclusions as Chrisler and Levy including the observation that there were two related incidents at the beginning of the 80's, around which the tone of public discourse seemed to set the stage for the content and style of articles on PMS for the remainder of the decade and beyond. These incidents were two murder trials that took place in the UK in 1981 and 82 in which the courts accepted a diagnosis of PMS as a plea of diminished responsibility on behalf of the defendants. While Chrisler and Levy speculate about the link between the violence of the crimes and the violent language contained in the articles and Markens examines the extent to which experts are an "integral part of rhetorically establishing PMS as legitimate medical

phenomenon" (Markens 1996, 49) - Dr Dalton testified at both trials and, along with many other doctors, is quoted extensively in the literature – they all determine that the reporting of the trials and the accompanying commentary did a disservice to women in general. Most of the articles focused on the PMS defense, introducing many people to the concept and, by making liberal use of the terms 'Jekyll and Hide', 'hidden animal' and other tabloid-type descriptions, not only had the effect of downplaying some of the more crucial and tragic aspects of the case such as the fact that one of the defendants had a history of severe mental illness and the other had a alcohol problem and had suffered years of psychological and physical abuse, but also painted a picture of all women as potentially subject to premenstrual hormone fluctuations which could turn them from placid partners into dangerous criminals (Chrisler 2002).

The story of cyclicity as pathology was further realized in 1987 when, as described in feminist psychologist Paula Caplan's numerous publications on the issue, the American Psychiatric Association (APA) made a decision to list PMS under the clinical name, 'late luteal phase dysphoric disorder' as an example in the *Unspecified Mental Disorders* appendix of what some have termed the 'bible' of the APA – the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) (APA 1987). Accompanied by a protracted and volatile debate between supporters and detractors from within and outside the feminist community, a working committee of experts, which Caplan and others have pointed out was dominated by representatives from the pharmaceutical industry, undertook an enquiry with the goal of making a recommendation to include the disorder in the

main text of the subsequent edition. The debate centred on the dilemma defined years earlier by Delaney, Lupton and Toth (Delaney, Lupton et al. 1988) and reiterated many times since regarding how to acknowledge and deal with what women were saying about their experience of PMS without reifying PMS as "yet another step in the medicalization of women's experience." (Chrisler 2002, 300) In explaining the argument she made to fellow committee members in which she urged them to take into account gender roles in their assessment of the so-called symptoms of anger and aggression as signs of a disorder, Dr. Nada Stotland made the following observation:

> PMS is unique in so far as it's a syndrome that the whole society thinks exists and that the whole society thinks afflicts most women. Girls don't grow up thinking, 'if I'm female I will grow up and have schizophrenia. But they do think if I'm female I will grow up and have PMS'. Unlike any other syndrome in the manual more people will insist they have it than will turn out to have it. (Houppert 1999, 181)

Despite these objections and the findings of a *DSM-IV* subcommittee, which concluded that of the 400 studies they reviewed there were only a few preliminary and methodologically problematic ones that had any bearing on the question of PMS as a diagnostic category, the classification of 'Premenstrual Dysphoric Disorder - PMDD' was included in the main text of *DSM-IV* under depressive disorders (APA 1994). As well as the issue of inadequate and problematic research to warrant the listing, the objections were also based on a number of other concerns. More specific concerns related to the fact that although PMDD is listed under depressive disorders women need not be depressed in order to meet its diagnostic criteria and that the "criteria can be met *primarily* by the presence of physical symptoms which is unusual for an alleged

mental illness." (Chrisler 2002, 293) In addition, say Caplan and others, despite the intention of the psychiatrists who did the work in this area to distinguish the approximately 75% of women who they say report just minor or isolated premenstrual symptoms from the 3 – 5% of those who would qualify as suffering from the more severe PMDD, the virtual overlapping of the symptoms of PMS and PMDD largely undermines this goal (Caplan 1995). With the majority of women in the U.S. convinced that they suffered from PMS at least occasionally, Caplan claims that the psychiatrists had an irresistible economic incentive to develop a psychiatric diagnosis that would legitimize their profession as the experts best suited to assess and treat women's premenstrual complaints.

Caplan situates her analysis of this issue within a broader critique of the culture of psychiatry and the gendered approach to mental health, examining, amongst other things, the reasons behind the widely reported, albeit contested findings that women are four times more likely than men to be diagnosed with a depressive illness and treated with anti-psychotics (Ussher 1992; Caplan 1995; Stoppard 2000). Within this framework Caplan examines the direct link between the classification of PMS as the psychiatric disorder PMDD and the introduction of anti-depressants, which, as previously mentioned, mainly consisted of fluotexine (Prozac), as a means of treatment for PMS. Commenting on the fact that from the beginning of the diagnosis, anti-depressants were the only recommended psychiatric treatment for PMDD, Caplan goes on to discuss the series of events that in 2001 led to the repackaging of Prozac into Sarafem, a drug that is exactly the same as Prozac except that it is specifically marketed for

the treatment of PMDD. Caplan argues that this marketing of Sarafem was a cynical, profit motivated move on the part of its manufacturer Eli-Lilly whose patent on Prozac was about to expire and, in a similar fashion to the work that led to the classification of PMDD, is marked by a disregard for opposing voices, a reliance on inadequate, incomplete research and an unsubstantiated endorsement of Prozac as a treatment for PMDD. Based on, and further reinforcing the notion that the entire range of feeling, emotions and behaviours that women experience in the premenstrual phase of their cycles can be subsumed under an illness entity for which there is the possibility of cure, Caplan looks at how this decision paid little regard to the research findings, referenced by the report authors themselves, which show that calcium has the same therapeutic effect as Prozac.

An energetic marketing campaign trumpeted the release of Sarafem with a series of 'direct to consumer' TV and print advertisements showing images of women struggling to perform mundane tasks such as extricate a shopping cart and accompanied by voiceovers or commentary which suggested to women that "what they thought was PMS could actually be PMDD." (Chrisler 2002, 296) Despite the fact that the campaign - which capitalized on the 'PMS self/real self' presentation in the popular discourse, pitching Sarafem as the drug "to help you be more like the woman you are, every day of the month, even during your most difficult days" (Cosgrove 2003) - provoked complaints from individual women and women's groups there is good evidence from studies that have examined the response to direct to consumer advertising, to indicate that the campaign

probably made an impression on many women (Metzl 2003). As well as examining the effect of such advertising methods on the increasing tendency to self-diagnose pathologies and disorders, psychiatry professor, Jonathan Metzl looks at how they act to both relieve and stimulate women's (and men's) anxiety about a 'problem' by validating their 'suffering' while at the same time suggesting that it will only be relieved by taking a 'pill' or whatever type of cure is being proffered in the advertisement (Metzl 2003).

The preceding series of developments and events beginning with the genesis of the PMS discourse in the 1930's marks out a particular path for women, who, produced and engaged as 'PMS sufferers', steer through the 'revolving doors' of predominantly biomedical terrain with progesterone and evening primrose oil and calcium as the 'miracle' navigation tools needed to get them to their destination of "No More PMS. " (Laurence 1997) Now add Sarafem to the list of such tools. One of a family of drugs of which there is a basic lack of understanding about the long-term effects and documented evidence of a range of minor and major side-effects (Steiner 1995) including a number of the more common symptoms that women ascribe to PMS, as well as an increased risk of suicide – a finding reported by Eli Lilly themselves (O' Meara 2001; Chrisler 2002). The fact that thousands of women have taken such a path without calling into question its conditions and the nature of the destination that would dictate such conditions is, according to Jane Ussher whose work in this area will be the focus of the following chapter in this project, basically a culmination of a largely

reductionist, biomedical, ahistorical, individually focused and, ultimately, non-woman centred approach to PMS.

A Material-Discursive-Intrapsychic Woman Centred Approach

Although it is technically part of the sociohistorical critique I feel that this part of the analysis deserves a separate chapter. First, it serves as bridge to the second part of the project in that it focuses on Jane Ussher, who, along with others employing similar research methods in this and related areas, has laid a lot of the groundwork to enable women's voices to be witnessed and included in PMS research, including this study. Second, this chapter is also a bridge between the different styles that are used in Parts I and II, with an analytic style dominating in the former and the latter consisting of a mix of analysis, musings and opinion. Finally, most of Ussher's research on PMS has been undertaken in the past 10 years, which is a period that has received less coverage so far in this overview. While the scope of the project does not allow for in-depth analysis of the work in this period - there were over 900 studies between 1997 and 1999 alone (Houppert 1999, 143) - I will, partly through Ussher's critiques, examine the overall trends and direction of the research and discourse during this time.

Perhaps the key argument for this focus and one that speaks to the type of research methodology she advocates for and employs, is the prominence of the split-self theme that has emerged in the aforementioned narratives analyses on PMS (Swann 1997; Ussher 2000; Ussher 2003). I was simultaneously

encouraged and disappointed to discover them when I began to do the research and reading for this project. Encouraged by the way in which they resonated with my own and other women's experience and disappointed at the fact that, while the angle for my thesis may be novel, the thematic content was the subject of previous and ongoing analysis. It is thanks to the hindsight of research and reflection that my naïve supposition that this could be otherwise has been supplanted with the realization that, for a number of reasons to be explained in the following section, this outcome was and is inevitable. I have titled this section, *Notes from the Field*, in that, picking up on the tone and content of the preceding statements as well as the title of this chapter, it consists of reflections on how the material, discursive and intrapsychic have shaped my approach to and engagement with this project.

Notes from the field

In the larger scheme, a preoccupation with self is the luxury and burden of many people living in the industrial/information age in the developed world in the period spanning the late twentieth and early twenty-first centuries. This preoccupation is connected, to a varying extent, with a number of movements and developments, both large and small, in the social, political and cultural realms, including what US Sociology professor and editor of *Pathology and the Postmodern*, Dwight Fee, describes in the introduction to the book as a "linguistic or 'interpretive' turn in the social sciences and humanities" giving rise, among other things, to research approaches "that call attention to discursive or textual

underpinnings of mental life" and put "emphasis on how the life of the self is implicated in this knowledge centred struggle." (Fee 1999, 2) Situated as they are, within a wider critique of the positivist/realist methodology that dominates contemporary science and social science, it could be said that the PMS narrative analyses are an illustrative example such research approaches.

It could also be argued that, related to this 'turn' (and, in this case, some would say quite distantly), as well as part of this broader preoccupation with the self, are cultural moments and trends, which forefront the self and its 'inner life' and include, for the purpose of this analysis, the aforementioned self help industry. A reflection and product of the ethos of self-improvement, which permeates contemporary Anglo American society, this industry employs a wide variety of different methods and fora to disseminate advice about helping 'oneself', as well as providing a model for other types of popular literature such as women's and health magazines. I have previously described some of the arguments put forward by critics who claim that women's experience of PMS is mediated, often negatively, by the discursive content and format of the information provided in this segment of the literature. It should also be noted that self help advice is, for many women in Anglo American society, not only their sole source of information on this and other subjects, but, as Elaine Showalter has pointed out, their only means of accessing counseling and management advice due to their inability and/or unwillingness as a result of lack of resources and support, to avail themselves of the services of contemporary medical and health systems (Showalter 1997). With all this being said and given that, as

Chrisler (1990, 2002) and Rittenhouse (1991) and Markens (1996) have pointed out, personal accounts containing the 'me/not me' and 'normal/abnormal' presentation are a central feature of the self-help literature on PMS - literature of which I have made substantial use in my attempts to manage or cure this 'condition' - it becomes apparent, at least to me, as to why the similarity between my main focus of interest in this phenomenon and the theme of the split-self emerging from these narrative analyses is no mere coincidence.

On a continued personal note, Ussher's and other related critiques have also been important in sustaining my interest in and attention to this work. As part of her seminal contribution to the case for viewing PMS as a sociohistorical construct, Emily Martin, draws on some of the ideas brought forward by Ehrenreich and English, in persuading her readers to consider the extent to which ideological constructions of womanhood are framed within the dominant discourses of class, race and heterosexuality (Ehrenreich and English 1978; Martin 1987). Some of these arguments will be explored further in Part II but I wanted to raise them at this point as they are central to some of my pre-thesis and ongoing trepidation about pursuing this project, which has its source in the very same analyses and approaches, Ussher's included, that have helped to ease some of this trepidation. In the light of Martin's analysis, which showed, among other things, different attitudes and approaches to menstruation between middle class and working class women in the US, as well as international studies, whose findings seem to indicate that women in other regions of the world experience only a few of the physical symptoms of PMS (Chaturvedi 1994; Dan

1994), giving rise to the designation of PMS as a 'culture bound syndrome', my anxieties have centred on, to put it simply and bluntly, whether this is a white, middle class woman's pursuit of a white, middle class women's issue. To be sure an issue of importance for me and the women who took part in my study and for the many hundreds who have taken part in other studies and have sought help for this 'problem' but one that seems less significant when put in a broader context of the problems faced by millions women related to poverty, violence and oppression. In accompaniment to this internal dialogue, which has also played out between various feminist positions on the worth of this type of analysis that, on the one side frame it as question of, what should be, anxiety-free choice, and on the other side, call into question the notions of privilege and power implicit in such a choice, my anxieties have ebbed and flowed. They have ebbed in response to, amongst other things, Marken's insightful analysis, which show that, similar to the 19th-century 'cult of invalidism', whose 'members' were predominantly middle and upper class women, references to PMS in the popular discourse more often address the concerns of, and 'solutions' available to professional women and that the clientele at PMS clinics, who have historically been the target population of research studies, consist mostly of white, middle class women (Markens 1996). I will explore further some of the implications of these findings in Part II, including the suggestion that women who have experienced discrimination that is based on class, race, language, or sexual orientation both resist the need and are less willing to call attention to or believe that they can expect sympathy for this aspect of their 'femaleness'.

However, the very fact that these issues have been raised as part of broader critiques which explicitly and implicitly connect the roots of the problems of the PMS discourse with what could be conceived as the larger and wider problems of women's oppression and powerlessness throughout the world has helped sustained my energy and commitment to this project. I have also been energized by the women in the study, most of whom spontaneously voiced and sent messages of appreciation for being given the opportunity to give an account of some of their deeper thoughts, feelings and concerns on a topic that was normally addressed only at the level of an 'in-joke' amongst female colleagues or 'keep-away' signals amongst family members. An outline of these critiques and the arguments they have presented for the need to collect and include such accounts is the focus of the following and final sections of Part I

Women's Madness

As with the basis for many intellectual and academic pursuits, Jane Ussher's motivation for exploring the phenomenon of PMS, which she does within the framework of what she terms 'women's madness', has its roots in profound personal experience, which in this case was the diagnosis of mental illness and subsequent institutionalization and treatment of her mother when Ussher was a young girl. Citing this as the main reason for becoming a psychologist Ussher has made a career of examining the mental health field particularly relating to issues of women's sexuality and reproductivity. Much of her approach to these issues was laid out in a 1992 book entitled *Women's*

madness: misogyny or mental illness (Ussher 1992), which is essentially a critique of contemporary mainstream psychology and psychiatry theory and practice, drawing on the ideas of Chesler, Showalter, Laing, Szasz and others (Laing 1970; Szasz 1970; Chesler 1972; Showalter 1985), to show the ways in which madness is a sociohistoric and gendered construct. As one example of how women's 'abnormality', discontent and anger has historically been attributed to the body and treated as an illness with an organic cause, similar to other 'events' in the reproductive cycle such as Post Partum Depression and Menopause, PMS was included in this analysis and has received even more prominent attention in her subsequent work, in which, as mentioned in the introduction, she has used it as a lens to focus on the problems of the positivist/realist methodology that underpins contemporary science. Although Ussher was by no means the first to frame it as a psychological and mental health issue – this is established in the very origins and labeling of the condition – I think this particular analysis, which she shares with the aforementioned Caplan and other academic-practitioners cited in this thesis, reflects the extent to which it is viewed as a manifestation of emotional and psychological lability in women. As Houppert observes in a comment on the aspects of PMS that generate the most concern in the public and medical discourse, "it is the mood swings, not the physical discomforts associated with the ensuing cramps or headaches, that get the attention." (Houppert 1999, 141) However, Ussher's goal in framing it this way, within a broad critique that examines not only the limitations of empirical methods but also the constraints of the social

constructionist theories that have been put forward to counter these, is actually to deconstruct and destabilize this notion and posit alternative explanations.

Her analysis incorporates and elaborates on much of the critique outlined in the preceding sections, which themselves are parallel to and drawn from various other contemporary examinations of the limitations of positivist/realist methodology. The artificiality of the lab situation; the limited number of variables able to be studied at any one time; the limitations of quantitative analysis; the assumption that the individual should and can be studied separately from cultural or historical factors; the assumption that the individual should be the sole focus of attention at all; and the notion that objectivity is possible in either theory, analysis or the conduct of research, (Henriquez 1984) are amongst these and have been specifically addressed in relation to impact on PMS research in the preceding overview. Ussher looks at this impact in making the case for how a biomedically dominated, individually focused, unilinear cause and effect approach has led to an understanding and conception of PMS, which is highly problematic on a number of levels. Not the least of these problems is the fact that PMS' wide and shifting symptomatology and recent incidence figures from studies put it within statistically normal ranges, meaning that it does not even meet the basic criteria of a statistically abnormal condition with a "fixed group of symptoms or a common, but not invariant, group of symptoms'" (Ussher 2002, 309) which define a syndrome. This assessment is based on recent epidemiological surveys, which estimate that between 40 to 75% of women experience mild to moderate distress in the post-ovulation/premenstrual phase of their menstrual cycles

(Steiner 2000), and which have prompted a number of researchers to conclude that it is women without premenstrual symptoms who are 'statistically abnormal' (Sampson 1988). However, as Ussher repeatedly reminds us, we should be wary of any such data, as one of the consequences of the realist/positivist approach is the wide and often conflicting variability in study outcomes. This, she suggests, is an effect of the absence of reflexivity in this approach – the refusal to acknowledge the influence of factors such as values, politics and the constraints of disciplinary boundaries in the way in which the research questions are framed; the tools and methods used to collect the data; and the criteria used to make a diagnosis when using clinical or volunteer populations in the research. Resting on the devaluation and denial of women's knowledge of their own bodies and minds, as well as on the related implicit assumption that women with PMS symptoms are considered to be influenced by their subjective experience while researchers are not, the fact that reports of inconsistent symptomatology are taken as confirmatory evidence of the unreliability of subjective accounts is another such consequence (Ussher 1996; Ussher 2000).

There are other consequences for clinical practice and research, which Ussher claims, specifically relate to the positivist/realist epistemological desire for a uniform definition arrived at through the use of standardized, objective measures and instruments that are aimed at identifying a 'pure form' of PMS. With their reliance on static and observable measures that may have little bearing on how a woman evaluates her PMS experience, such definitions not only exclude women from research and potential treatment if she is 'observed'

and/or assessed not to meet the criteria but, as alluded to previously in this outline, they also contribute to a narrow and distorted picture of menstrual cycle changes. They are also at the heart of the problems entailed in making the distinction between PMS and PMDD, in that a diagnosis of PMDD, which would entail that a woman receives clinical recognition and treatment of her suffering, however problematic that treatment may be, is within the purview of the experts, who, with their careful methods of categorization, are the only people designated with the authority and knowledge to make such decisions (Caplan 1995). Framing it as an issue of 'who is PMS research for' also raises questions about the growing trend of making assumptions about causality on the basis of treatment effectiveness, a phenomenon which Peter Kramer calls "diagnostic bracket creep," (Zita 1998, 69) and one which has been identified in related areas of mental health research and discussed by, amongst others, Jacqueline Zita (Zita 1998) in her critique of Peter Kramer's 1992 book *Listening to Prozac.* (Kramer 1992). For instance, the presumptuousness of the conclusion, reached by Menkes et al in a study examining the positive benefits of fluotexine (Prozac) for PMS, that "these findings thus support the proposed role of serotonergic activity in the etiology of PMS," (Menkes 1996, 101) is highlighted by Ussher in the observation that while "aspirin is an effective cure for headache and inhalation of CO_2 an effective treatment for panic attacks, we would not propose that either aspirin or CO_2 are implicated in the etiology of either disorder." (Ussher 1996, 226)

While more receptive to the move towards a more multifactoral, multidisciplinary approach which is undertaken in biopyschosocial studies of PMS, Ussher sees related problems of misinterpreting correlational factors as causal ones and not accounting for the interactive influence of other indirectly related or non-related variables. Contrasting these studies to those in other areas, including a study examining the relationship between testosterone and violence in which testosterone was found to be an antecedent and a consequence of violent behaviour (Archer 1994), Ussher suggests that it is the positivist/realist goal of finding a general law which, in turn, rests on the assumption that the eventual accumulation of empirical findings will result in a progression of knowledge, that has also dominated the biopsychosocial approach to PMS. She does acknowledge that clinical practice lends itself to and requires greater multidisciplinarity, which was certainly my impression based on the interviews I did with the clinical and nurse practitioners in this area and which I will discuss further in the concluding sections of this thesis. And there have also been a number of more sophisticated studies done and models put forward that have attempted to address the dynamic and interactive nature of biological, personality, cognitive and life event and lifestyle factors (Walker 1995; Woods 1998; Sabin Farrell 1999). However Ussher cites the problems with crossing professional boundaries including professional rivalries; differences in epistemological and methodological training; and the pressure to locate research funding, as among the reasons why this approach has had little impact at the level of research practice in resolving the inconsistencies, contradictions and

disputes that, she claims, put PMS research at an impasse in the middle of the last decade of the twentieth century.

The Social Construction of PMS

It is in large part as a result of the limitations encountered by Ussher and others working in traditional methods of reproductive and mental health research, along with many other disciplines, that the theories and methods of social constructionism have arisen and been adopted and adapted to provide accounts of the world and our place in it and which have been used, in this project, as the dominant source in tracing the origins and development of the PMS discourse. Often working within the long shadow of one of the 'leading lights' of Social Constructionism, Michel Foucault - whose work in relation to the development of the self will be discussed in Part II, social constructionists challenge the realist assumptions of traditional biomedical and social science research, arguing instead that the subjectivity, behaviour and the very definition and meaning of what is health and what is illness is constructed within social practices and rules, language, relationships, and roles; it is always shaped by culture and history (Sedgewick 1987). In this view, which is reflected in the analyses of Oudshoorn, Fausto-Sterling and many others who have been cited in this outline, science is part of this constructive process, and as a consequence, theory, research and application cannot be seen as objective or value free. This does not mean, as Fausto-Sterling argues, that we act on the main implications of such a position and not undertake scientific research, rather we recognize that reflexivity in

theory and practice is an essential part of any and all theoretical and research undertakings in science, medicine and social science (Fausto-Sterling 1992).

The methods of social constructionism, as evidenced in this project, involve sociohistorical analysis, as well as discursive approaches, the latter being the outcome of the so-called 'discursive turn', which, in their assumption that language and practices are constitutive of subjectivity - of who we are and the way we understand and make meaning of the world - stand in direct contrast to much mainstream research such as psychosocial studies of PMS which conceptualize factors such as attitudes, beliefs, cognitions etc. as fixed entities that can be reliably measured (Potter 1986). While such approaches, which are drawn from principles of ethnology and poststructuralism, have only very recently begun to receive recognition as a viable method of qualitative analysis, Ussher and others argue that they are based on, and support a view of selfhood and identity which is more complex, fluid and actively engaged in meaning-making than the one that is assumed within the decontextualized environment of traditional research methods where study subjects are implicitly positioned as passive subjects, constrained by the a priori assumptions of data collection instruments (Henriquez 1984).

What has emerged from sociohistoric, discourse and narrative analysis studies of PMS, as this project attempts to demonstrate, is a more broad and, at the same time, more nuanced picture of the phenomenon than would come from laboratory and clinical analysis alone. In addition to the sociohistoric analyses already reviewed in this project the work of British sociologist, Sophie Laws who,

based on a series of interviews she did with men at the beginning of the 90's, argues that PMS is a social category that pathologizes women by placing a medical label on their rebellion and discontent (Laws 1991), has contributed to this picture. Versions of this argument have come together as one of the main themes in this outline, as well as put forward by another British academic, Paula Nicholson. Drawing on her background in psychology Nicholson picks up on claims advanced by other critical theorists in her examination of how the dominant patriarchal paradigm of pathological femininity has informed science theory and methodology including the work and practice of one of the most influential practitioners in this area and the founder of psychoanalytic therapy, Sigmund Freud. Noting how his theories, which rest on phallocentric notions of penis envy leading to inferiority of the feminine personality, have been widely criticized or ignored in academic psychology but have been given recognition in clinical practice and maintained resilience in popular culture, Nicholson draws similar conclusions to other scholars who, based on their analysis of Freud's most notorious case study, the 'hysteric', Dora, have suggested that Freud's focus on femininity and women's personality was tempered by his reading of women through a patriarchal, misogynist lens (Nicolson 1995).

As Fausto-Sterling had done before, Nicholson goes on to look at how sociobiological theories, which are premised on the increasingly disputed presupposition of the male-gatherer: female-hunter division of labour in prehistoric times, have incorporated a deterministic version of gene theory, which ignores or plays down the role of culture and socialization and reinforces ideas of

women's reproductive lability. Chrisler's and Rittenhouse's work is also reflected in her analysis in her examination of how contemporary media plays a significant role in the maintenance of hegemonic discourses and the ways in which people are positioned in and position themselves within them. Working from an understanding of hegemonic discourses as the languages, practices and behaviour of the dominant social groupings and powerful interests, Nicholson specifically focuses on the cyclical and tautologous connections between the reporting of scientific 'discoveries' in the popular press and how people come to assess and adjust their own behaviours in relation to the 'norms' implicit in these reports such that their response as subjects of research studies lend support to the 'common sense' positioning of the original claims. The consequences of all this for how women interpret their experience of PMS is described by Nicholson in the following comments:

> A medicalized concept such as PMS (and premenstrually related psychological and physiological vulnerabilities) represents an appealing explanation to women themselves and others, to justify women's oppression and relative lack of achievement, compared to men, under patriarchy... For women to confront the power imbalance in society in favour of men, demands their awareness of the need to change both self and the social context, while embracing the probability of failure. This contrasts with the apparent 'payoffs' for women who accept the patriarchal scientific explanations. The medicalized explanation requires that women recognize they have a 'condition' and can and should seek to cure it if it becomes 'out of hand'. This means that women can attribute their subordination and oppression to an 'objective', identifiable, predictable and potentially 'curable' state (while seeing their ill-temper and lack of achievement as not their fault) rather than to gender-power relations, and thus to an integral, and potentially enduring part, of their everyday lives. (Nicolson 1995, 782)

In a similar vein, recent narrative analyses have also contributed to an appreciation of the many dimensions of this phenomenon. Using the term

discourse in the sense in which has been previously described in the introduction and corresponding methods which approach PMS as an independent entity and permit women to give accounts of their experience, findings from such analyses demonstrate that self-diagnosis of PMS is a reflexive process consisting of active negotiation of symptoms and positioning within the dominant discourses of reproduction and femininity, as well as current life events and lifestyle and cognitions surrounding these (Swann 1997). There will be further discussion of the common themes, including the split-self theme or 'dualistic discourse', which emerge in these analyses in Part II but suffice it to say here that they contain changing and even contradictory descriptions of PMS, which, framed within a positivist perspective, would suggest unreliable data, but from a discursive perspective are taken to be evidence of the way in which meaning is multiple, fragmented, fluid and often contradictory (Potter 1986).

However, as potentially useful as they are, postulations such as these have been the subject of criticism, which, in the past few years, has been launched from many quarters at the entire social constructionist enterprise and its implicitly and explicitly stated conclusions that selfhood, subjectivity, identity and the body are 'merely' and only sociohistorical constructs or discursive formations. I will say more on this in relation to ideas of the self in Part II but as regards the PMS discourse Ussher argues that despite the fact that these approaches address previously neglected social and cultural aspects of PMS; that they assume that individual women are agentic; that they do not reify PMS as an illness or as an individual problem; and that they are not constrained by the

limitations of positivist/realist methodology, these approaches and methods contain other limitations, which undermine their potential as a replacement for all that has gone before (Ussher 1996). The most obvious of these is that implicit in the argument for PMS as a construct or product of discourse is a denial or disregard for the influence of biological factors such as menstruation and hormonal changes, which although produced and rendered meaningful by discourse themselves, have real and material status and effect in women's lives. In the same way the effects of psychological and social materialities like age, reproductive life stage and family and relationship circumstances may be negated. Also as Nicholson observes, in an echo of Parlee's comment that "many women now derive genuine benefits in their personal lives from an ideology that functions to explain and obscure social contradictions in their lives and the lives of other women," (Parlee 1989) social constructionist accounts may be of little use to women who feel they gain as individuals from positioning themselves within the dominant biomedical, illness discourse. Evidenced by, amongst other things, the sixth reprint of Dr. Dalton's, *Once a Month*, (Dalton 1999) it seems that, however problematic and limiting this explanation may be, it may be more helpful to women than the implied suggestion, from a social constructionist perspective, that it is 'all in a woman's head'. With reference to the challenges which she faced as both a researcher who was aware of and has contributed much to the preceding critique and a practitioner who, within the confines and constraints of the traditional medical system, was authorized and personally compelled to address women's needs, Ussher argues that many of

these difficulties arise from the dilemma, encountered by all of those who have undertaken radical critiques of sociocultural institutions and practices, of "how to reconcile a deconstructive critique at a macro level with the needs of an individual at a micro level." (Ussher 1996, 229)

Critical Realism and Feminist Standpoint Theory

An acknowledgement of this dilemma is at the heart of the epistemological and methodological framework – the Material-Discursive-Intrapsychic (MDI) model - that has been proposed by Ussher as a way of integrating positivist/realist and social constructionist and discursive approaches to arrive at the fullest possible understanding of PMS (Ussher 2002). As alluded to in the introduction this model is premised on the notion that the material and the discursive - the world and the words, practices, behaviours and relationships by which we engage and make meaning of the world - are irrevocably connected and cannot be understood without reference to the other. Ussher draws on concurrent work examining related mental health issues such as depression (Stoppard 2000) and chronic fatigue syndrome (Mostofsky 2000) to advance her argument that 'material' factors are those that exist at corporeal, societal and institutional levels: factors such as hormone theory and women's social and institutional status which are at the centre of the biomedical and sociohistoric accounts contained in this outline. The 'discursive' centres on the role of the social and linguistic domains – language, visual representation, ideology, culture and power, in producing, mediating and negotiating the material, 'lived' world.

Distinct from other material-discursive accounts, Ussher adds the 'intrapsychic' to this model in order to acknowledge factors that operate at the level of the individual such as perceptions and attributions for symptoms, as well as the psychological explanations for these, which include an analysis of the so-called defence mechanisms of repression, denial and splitting that are attendant in these perceptions and attributions (Ussher 2002).

While Ussher credits the material-discursive integration theories of Yardley (Yardley 1996) and others for this model, some scholars propose that the roots of such approaches go back to the theories and ideas of the existential phenomenologists, particularly those outlined by Merleau-Ponty in his 1962 *Phenomenology of Perception* (Merleau-Ponty 1962). Such ideas, which are centred around Merleau-Ponty's rejection of the research programs of empiricism and intellectualism and their basis in the dualism of the subject and the object, are also reflected in other contemporary epistemologies that are a source for Ussher's MDI model. These are the methods of *Critical Realism* and *Feminist Standpoint Theory*, described by Bhaskar (Bhaskar 1989) and Harding (Harding 1993) respectively, which taken together, Ussher suggests, provide the possibility of coming to an understanding of the world that affirms reality but recognizes that its representations are characterized and mediated by culture and language that have, amongst other things, provided incomplete and inadequate accounts of women's experience. Thus the argument that a less distorted view can emerge "through our participants' eyes" (Harding 1991; Harding 1993) is one of the central presuppositions of this model, which is also

premised on the understanding that such subjective accounts and the methods used to collect them, have a legitimate and equally privileged place as part of a variety of methods from the positivist/realist traditions and social constructionist and discursive perspectives, all of which could and should be used to understand and make meaning of our world, and, specific to this project, women's experience of PMS. The concomitant shift in focus of these approaches, away from research on women, to research for women and their acknowledgement of the difficulties, if not impossibility, of making accurate predictions relating to human behaviour and the social sphere, enables a reinterpretation of existing work in this area, as well as way of moving forward, both in research and practice, that is based on an ethos of mutual discovery and on methods which seek to explain, describe and understand. The descriptions and explanations put forward by such women/scholars/researchers in their attempt to understand one of the common and prominent themes in narrative analyses of PMS - the split-self representation, will be focus of the following and final chapter in this project.

The PMS Self, Part II

The Modern PMS Self

As described in the opening and later pages of this account, the motivation and inspiration for this project lies in the 'not feeling like myself' representation used by myself and other women to describe and explain the physiological and psychological changes experienced in the premenstrual phase of the menstrual cycle. As has also been discussed, this representation has been categorized by researchers and practitioners as the 'split-self' or 'dualistic' discourse and identified by them as one of the central features of popular literature on PMS, a factor which is implicated in the prominence of this theme in narrative analyses of women's experience of PMS. These same researchers and practitioners have discussed its use as a discursive strategy and positioning within the dominant and interrelated discourses of femininity and psychological health and normality (Swann 1997; Ussher 2000; Ussher 2003). While the details of this analyses and discussions will be explored later on in this chapter, I will give a rough outline of them at this point as a basis for the argument that will be established in the following section. In this section I will explore the proposition that the split-self discourse has its origins in a conception of the self,

which, according to scholars, is proscribed and prescribed in Hellenic code and gains its contemporary shape and meaning from the ideals and institutions of the enlightenment era (Kasulis, Ames et al. 1993; Lee and Sasser-Coen 1996; Fee 1999; Taylor 1999; Greene 2003) .

Common to women's subjective reports of 'PMS', both those given by the women who participated in this study and those documented in other studies, is the focus on the awareness of change. Women reported changes in such things as tolerance levels; sensitivity to others and life events; emotions and feelings; attitudes to and strategies for coping; energy levels, and related to all these, how they viewed themselves:

> I get very tense, I seem to feel every bit of flesh on my body, I can't sit because I feel that my breasts, everything is just disgusting... and then of course I can't concentrate on work and then if there's someone around I get very moody and tearful. (Ussher 2003, 312)

A central argument in the preceding sociohistorical critique and one that is certainly reflected in the above quote is the way in which women construe and interpret these changes in the premenstrual phase of their cycle as negative and unacceptable. Employing the PMS self/real self presentation, women describe themselves as experiencing higher levels of intolerance and irritability; feeling tearful and depressed for no reason; feeling over-sensitive and vulnerable; feeling unable to cope with levels of responsibility that could easily be coped with the rest of the month; and a general dislike of the self premenstrually (Ussher 2000; Ussher 2002). While the extent and degree of feelings and emotions vary from women to women and from cycle to cycle in individual women they can often be experienced quite intensely as the following comments illustrate:

> ... I want to sort of lock myself away. I mean I can function properly but I feel sad. Really sort of sad and sort of fed up with everything, instead of looking at the positive aspects of my life and all the good that I do and can do, it's just the negatives are highlighted to such a degree... (Ussher 2000, 95)

In light of findings such as Cosgrove's (Cosgrove 2003), which show that the PMS discourse has gained such cultural currency that women expect to have PMS and share the same basic interpretation of it, as well as the fact that such study findings were used to develop the questionnaire and interview instrument for my study, there were many similarities between these reports and the ones that I gathered. For instance one of the study participants, Karen, described how her PMS "*symptoms* vary in intensity but are usually the same – catastrophizing, reacting with intense emotion, feeling slighted by others, feeling mildly paranoid." (Karen, 9) Feelings of "abnormality" and "irrationality" come up a number of times, and one woman, Andrea talks about the "double distress" of her early experiences of PMS – the feeling of being "out of control", which, in turn, caused her to feel as though "she was losing her mind." (Andrea, 35) A number of the women echoed the desire expressed by Amy and Susan that they "wanted to be left alone" (Amy, 19) and did "not want to make meaningful conversation, make decisions or DO anything." (Susan, 15)

However, it should be said that, tempered as they were with comments and statements that reflected a more nuanced, constructive, and, what might be termed, imaginative interpretation of the PMS experience, which will be discussed in more detail in the following chapter, the degree and quantity of these negative descriptions and attributions seemed to figure less in the responses and accounts which I collected than in these other studies. I believe

there are number of reasons for this, which relate to the varying purposes and motivation for undertaking these studies resulting in, amongst other things, a different focus on the content of the subjective reports and different angles of analysis. To be sure they share a common purpose in their examination of how these descriptions and attributions are framed within the discourses of femininity and psychological health and normality. However, in that most of these other studies have been undertaken within a clinical, therapeutic environment, their study cohorts are drawn from clinical populations, who therefore might be expected to experience a higher degree of symptom severity and report it as such, compared to the participants in this study, which included only one representative from the clinical population. Also the intention with most of these other studies is to make recommendations and advocate for other treatment options such as cognitive-behavourial and narrative therapy, to be undertaken alongside, or as alternatives to the potentially more problematic 'Prozac/Sarafem' cure that might be the first and only treatment option offered to and requested by women who present with PMS. Therefore in order to make their case for the efficacy of these therapies, the clinicians and researchers focus on the worst, although no less real, aspects of women's reports, as well as on the ways in which women's symptoms are ameliorated by the methods and strategies entailed in these therapies. This approach is distinct from my focus, part of which is to account for the origins and shaping of the conception of self signified in the split-self representation and the discourses in and through which it is described and which is the goal of the following three sections.

Origins of the Self

There is a large and illustrious body of scholarly work and analysis examining the origins of the conception of the contemporary self, of which, due to the scope of this project, I can only provide a sketch and therefore do so at the risk of not crediting, misrepresenting and misconstruing the authors and creators of these theories and ideas. I am also going to trace these origins through one thesis in particular as the framework in which it is presented involves a examination of Western and Asian concepts of self and body (Kasulis, Ames et al. 1993), the comparison of which generates distinctions that are relevant to the concluding argument of this project. With this being said much of this analysis has been generated within a number of contemporary fields and disciplines as a critique of the ideals and institutions of the enlightenment era, which it is argued, took much of their shape and meaning from the theories and ideas put forward by the seventeenth century philosopher, René Descartes. To establish this critique, a number of these scholars have gone back further in time to the period of Greek Classicism, where they site the source of the metaphysical, ontological and epistemological beliefs and practices of contemporary Western society. Exemplifying the theories and ideals of Pythagoras, and Plato and Aristotle after him, they identify these most influential of Greek philosophers as the creators and authors of a model of human realization which, resting on a definition of the human being as a disembodied soul with a numerical essence that is eternal and unchanging, "celebrates permanence and denigrates change, individuates human beings, privileges the *psyche* over the somatic and devalues the practical

affairs of everyday life." (Ames 1993, 150) It has been suggested however that while these philosophers subscribed to various versions of this model and possibly situated their theories somewhat outside it, as has been proposed about Aristotle's theory of the 'four causes' (Aristotle and Ross 1924), it only really existed at the conceptual level until Descartes put forward his theories of the *res cogitans* and *res extensa*, which emphasize the distinctness of the mind and body (Descartes and Cress 1993). According to Kasulis, these theories made what was only previously conceptually distinguishable into something ontically distinct, and, illustrated in the infamous phrase attributed to Descartes, which translates as 'I am the thing that thinks', are at the heart of his legacy of the Western world's metaphysical and epistemological dualism of mind and body and the understanding that there is an objective world that is entirely separate from a disembodied *cogito* that attempts to represent it in consciousness (Kasulis 1993).

Prompting his readers to think about what is required in terms of the mind and body working together in the act of dancing, Kasulis uses this illustration to demonstrate the artificiality and nonsensicality of mind/body dualism in support of his argument that we took this dissimilarity, which is not derived from our commonsensical understanding of our everyday experience, and made it central to the intellectual tradition in the West because 'we' benefited from it in a variety of practical ways in, what were, the intricately related domains of religion, science, and scholasticism of seventeenth century Europe. Undermining the beliefs and practices that centred around the inseparability of theology and science – that the world was, and seen as, evidence of God's plan and intentions

- and the connection between the world of *is* (the world of facts in extended space) and world of *ought* (the world of psychological intentions, values and will), Descartes' theories paved the way for the empiricist methods on which modern science is based. They also provided a metaphysical prop for the Reformationist doctrine of justification by faith, in which it was argued that the primary relationship between God and humans was through the soul or the mind thus relegating the body to a secondary status in this relationship. Kasulis considers this 'desacralization' of the body also to be an important factor in the development of modern science, as well as in the establishment of disciplines and practices which make up the so-called psy-complex in that, with the mind-body dualism in place, the body came to be viewed as a "material mechanism to be studied as one would study any other machine consisting of hydraulic, electrical and filtering systems," (xvii) thus contributing to the understanding and study of the psyche as separate from these physical functions.

The 'Normal' Self

Although Kasulis et al do not advance this claim here, Descartes' theories are also implicated in the social, political and economic transformations centred around what was one of the most significant developments in the establishment of the modern era and the concomitant evolution of the 'individual' and contemporary notions of the self, which was the shift away from monarchical and feudal power. In taking up this argument, Foucault and others with a similar analysis (Foucalt 1980; Rose 1989; Burr 1999), assert that the demographic

changes and the changes in the mode of production in the eighteenth century, which were both a consequence and harbinger of the growing and increasingly mobile population and the development of a capitalist, market-based mode of production which required a vastly different style of organization and infrastructure than its pre-modern forerunners, could only be effectively managed by the broad adoption of *discipline* as a form of social control and practice in place of the existing cumbersome and inefficient feudal arrangements. Increasingly less subject to the more immediate and direct power of the sovereign, Foucault argues that control and regulation of the population began to be effected through the voluntary subjection of people to the proliferating rules governing required behaviour and their reciprocal punishments and rewards that are constitutive of the hierarchical institutions which they came to inhabit and by which they have become socially and culturally bound and produced (Foucalt 1977). Rose draws on Foucalt's analysis to show how these practices and behaviours of self-discipline and self-regulation, which have their roots in, and are perpetuated by the Middle Age custom of 'confession', played a central role in channeling the desires and sexual behaviour of the population in ways which were favourable to the effective management and regulation of society. Eventually, as the doctrine of Protestantism began to promote the practice of self-inspection, these have given rise to the ethos of the contemporary period, in which confession is seen as way of life and doctors, psychiatrists and other so–called health professionals are seen as gatekeepers of the bodies of knowledge

that prescribe and proscribe our languages and practices of confession (Rose 1989).

The fact that the effectiveness of this disciplinary power lies in people's willingness, even desire, to submit to it, makes its workings invisible, with the rewards for submitting oneself inherent in the system of hierarchical organization and regulation itself. These aspects of disciplinary power are described by Foucault as part of his argument for the development of the normalizing practices and expectations by which people have come to be ranked and accorded status and privilege in society depending on their willingness and ability to accept and meet such norms and expectations:

> Like surveillance and with it, normalization becomes one of the great instruments of power at the end of the classical age. For the marks that once indicated status, privilege and affiliation were increasingly replaced – or at least supplemented – by a whole range of degrees of normality indicating membership of a homogenous social body but also playing a part in classification, hierarchy and the distribution of rank. (Foucalt 1977, 184)

Developing this position further, Rose draws upon Foucault's key concept of the 'examination' to demonstrate the extent to which the factors of scrutiny, surveillance, judgement and normalization which it entails have, at the level of the physical institution, academic and public discourses and practices, behaviours and relationships, come to pervade every sphere of contemporary life. So it is, he argues, that the evolution of the modern individual is intimately connected with the processes of confession and normalization. Through the act of confessing to others – doctors, parents, lovers etc. – and in the presence of their consolation, understanding, judgement, the person *becomes* an individual.

The very act of describing and speaking of the self, Rose suggests, simultaneously *creates* it as an object for inspection and involves an incitement to self-regulation according to some moral code thus requiring that the self be monitored, tested and improved. However, in his assertion that "the self that is liberated is obliged to live its life tied to the project of its own identity," (Rose 1989) Rose argues that these moral obligations to inspect, regulate and improve one's self set us on a path that is probably impossible to achieve and at the same time have given rise to institutions and epistemologies all aimed at achieving this end. The languages, practices and techniques of these have infiltrated hitherto unexplored corners of our lives, which, according to Burr and Butt, he describes in four processes:

> ...the subjectification of work, whereby our working lives have become suffused with issues of identity and personal fulfillment; the psychologization of the mundane, whereby routine daily life has been transformed into a series of life events which need to be analyzed, understood, managed; a therapeutics of finitude, whereby all kinds of loss or frustration become reframed as healthy or potentially pathological; and a neuroticization of social intercourse, in which our relationships (and in their particular deficits) are seen as the roots of many personal and social ills. (Burr 1999, 151)

In their essay on the social construction of everyday pathology, Burr and Butt examine the effects of this rampant psychologization, suggesting that as more of our lives become psychologized in the way that Rose describes there is a correspondingly greater potential for distress and dissatisfaction in them. Some of these ideas have been alluded to in the previous discussion on PMDD and the use of anti-depressant treatment for PMS and are captured in the statement, released by the European drug regulator, explaining the request to

Lilly to drop PMDD as an indication for Prozac on the basis that it "was an invented illness and a strong example of the medicalisation of ordinary life." (Moynihan 2004) Related arguments have been developed elsewhere to account for how variations from the increasingly tightly defined and pervasive norms of psychological health and well-being have come within the province of diagnostics – self-generated and otherwise. A large number of contemporary studies and publications on everything from the prescribing of Ritalin to children (Leger 2003) to prescribing Prozac to adults (Zita 1998; Bradley 2003) have examined this trend towards the pathologization of the mundane and the developing continuum between normality and abnormality. In a similar vein it has been suggested that the modernist faith in cures and progress has led to a blurring of Freud's distinction between common unhappiness and neurotic misery (Burr 1999). Alternatively described as "part of modernity's project of turning people into individuals — in this case, a kind of US transcendence fantasy," (Leger 2003) the themes of control and self-control figure large in these analyses as they do in discourse and narrative analyses of PMS. Emily Martin has also explored the issue of control and self-discipline, specifically in relation to PMS and work. She draw's on the Foucaultian analysis outlined above, as well as on Marxist critiques on the alienating effects of work in capitalist, industrial societies, and speculates on the extent to which the PMS 'symptoms' of anger, anxiety, irritability etc. are an expression of resistance to the disciplining and creativity-suppressing routines and practices inherent in many contemporary workplaces. She also examines the practices and expectations enshrined within the institution

of motherhood from this perspective (Martin 1987). Martin addresses women's anger – the responses to it and the sources of it – as part of a larger argument on the effects of the norms, roles and expectations prescribed to women who are positioned in and by the discourse of femininity, the origins and nature of which will be discussed in the following section.

The 'Feminine' Self

Feminists scholars from a variety of disciplines have contributed to this analysis and critique on the origins of the individual and the contemporary notion of selfhood in Western civilization and their basis in the philosophical and practical opposition between mind and body, and its worldly and spiritual corollaries; culture and nature; flesh and spirit. According to this dualistic metaphysics, they say, human beings as embodied creatures are stuck in space and time and these temporal and spatial limitations – the "mucky, humbling limitations of the flesh" (de Beauvoir 1952) compromise the mind's projects of rationality, objectivity and self-realization, and, in practices and beliefs, which as mentioned, were established in Hellenic code and perpetuated beyond, have 'rendered' the body separate from and subordinate to the mind as a thing of culture. These scholars also support the argument outlined previously, and described by Susan Bordo below, that this dualism is deeply embedded in social institutions, behaviours and practices:

> ... mind/body dualism is no mere philosophical position to be defended or dispensed with by clever argument. Rather it is a practical metaphysics that has been deployed and socially embedded in medicine, science, law, literary and artistic representations, the psychological constructions of

> self, interpersonal relationships, popular culture and advertisements – a metaphysics which will be deconstructed only through concrete transformation of the institutions and practices that sustain it. (Bordo 1993, 11)

However while acknowledging that this philosophical and practical metaphysics underpins our sociocultural heritage and is thus shared at some level by us all, most of these scholars, by their very definition as feminists, take the position that women are differentially and more seriously affected by this cultural ideology. The fact of women's bodies' unique biological and reproductive capabilities, which place them closer to nature and the organic realm than male bodies, is at the basis of this argument. Bound to the body and its secondary status by these capabilities, they argue that 'woman' has been denigrated and subjugated along with and as part of nature (Merchant 1989), with this inferior status revealed in the bleeding, oozing and form-changing functions, which simultaneously signal the ability to give life and the inability to transcend the mundane toward abstract reason and the veneration of the mind (Tuana 1993). In fact, Highwater argues that the very 'progress' of Western civilization required "giving up the female gender – the material, passive, corporeal, and sense perceptible for the male – active, rationale and incorporeal." (Highwater 1991, 23) As described in the opening statements and alluded to numerous times in Part I, the result is that, throughout history, the bodies and bodily functions of women have been construed and represented negatively and women have become essentialized as bodies, seen at best as part of the natural world of disorderly, decaying matter and at worst slaves to sinister bodily impulses and excretions,

which remind humans of their vulnerability and mortality (Lee and Sasser-Coen 1996).

Along with the claim that male bodies are not so symbolically marked with such connotations, thus making it easier for men to imagine themselves free of these earthly 'constraints', Haug (Haug 1986) and others have invoked the ancient and deeply engrained representation of the feminine as reproductive mother or asexual 'madonna' versus the sexual being or 'whore', to make their case that while both women and men experience the material and discursive manifestations of mind-body dualism, women, unlike men, are told in countless subtle and not so subtle ways, that they are essentially only bodies – reproducers and (hetero)sex-objects. Partly in an attempt to reject or avoid criticism provoked by these and similar arguments, in which their proponents are accused of essentialist, monolithic portrayals of women and the female self (Butler 1990; Joy 1993), more contemporary analyses, as outlined in Part I, acknowledge that women's responses to these messages are as myriad as women themselves and depend upon many other factors including class, race, education, reproductive life stage, social support and so on. Nonetheless, there are messages, which are part and parcel of discourses, and which, Bordo and Bartky have argued, based on their interpretations of Foucault's above mentioned ideas which posit the individual and the body as practical, direct loci of social control, are internalized by women (and men) to a greater or lesser degree. The particular focus of their argument is on the disciplinary practices whereby the female body is transformed into a 'feminine' one, emphasizing how sexuality is produced

through power and hierarchical social relations are maintained (Bartky 1990; Bordo 1993). With specific regard to PMS, others have focused on the related issue of how the concrete and symbolic signs that mark women's reproductive capabilities are implicated in the problematizing and pathologizing of women's cyclicity. While for many women the nature of the cyclicity is different from that experienced by our pre-modern and modern foremothers – contemporary women spend much less time bearing and suckling infants and much more time bleeding (or not) than their foremothers (Asso 1983; Angier 1999) – its visibility and connotations, together with the questionable norms of relatively non-cyclic male physiology and the model of the culturally normative masculine subject (Burman 1997), have contributed to a disproportionate response to female reproductive cyclicity. This is especially so in the light of study findings which demonstrate the extent to which we are all creatures of cyclicity (McFarlane 1992; Golub 1992).

Following from this and the preceding discussion on the powerful and pervasive normative prescriptions around psychological health, the following section examines the ways in which women's split-self interpretation of their PMS experience takes place in and through these discourses of femininity and normality and the dualistic conception of being on which they rest.

Discourses of femininity and normality in PMS narratives

Narrative analyses of the real self/PMS self interpretation of PMS reveal a number of interrelated themes in which, it has been suggested, the real self characterization reflects an idealized notion of femininity in contrast with the

transgressive or non-perfect femininity of the PMS self. Mirrored in the splitting of 'woman' in popular culture representations in which the pervasive image is that of women who are positive, always in control, able to cope and juggling competing tasks and demands with hardly a hair out of place, the inability to match this image and to meet the expectations of the always calm, capable, tolerant and nice to live with woman implied in it, is one of the most common themes in women's accounts:

> It's like PMS knocks you. Your self-esteem and your self confidence and all that sorts of gets lowered. I think you just feel less worthy or less capable, because you are less capable, you're not coping with things as well as you could or should normally. (Ussher 2000, 90)

> I think for me it's the angry outbursts, the aggressiveness... the awful way I have of arguing and turning something that's quite normal and trivial into something that's an absolute nightmare. (Ussher 2003, 137)

Whereas feelings of frustration, anger and irritation might be considered to be understandable responses to the challenges faced by women from difficult or pressurized paid work, complex social relations, the demands of children and families, as well as attempts to be attractive, slim and happy, the loss of control of emotions that women typically report they experience during the premenstrual phase of their cycles is attributed to their hormone 'ruled' PMS selves. The transformation of the unhappy pre-pill women to the smiling post-pill women depicted in anti-depressant commercials (Vines 1992) is one example of the pervasive images and messages of our consumer culture that, in their portrayals of what is and what it takes to be the consistently perfect, positive and 'good' woman (Wolf 1992; Douglas 1994), present women with very little options, other

than to blame their inability to meet these mythical ideals on a pathology. These assessments are supported by study findings, in which the use of sex-role inventory instruments designed to measure the degree to which individuals describe their behaviour as consistent with stereotyped images of femininity and masculinity, point to a strong relationship between endorsement of the traditional feminine role and degree of menstrual distress (Heilbrun 1990; Cosgrove 2003). Ussher and others have also argued that these accounts of the idealized other, which draw on cultural discourses that act to isolate and divide women in their representations of women competing, comparing and looking for the flaws in each other, lead them to fantasize that *other* women, women without PMS, are the in-control positive selves they can't be (Ussher 1997):

> It feels different to everybody else. (These women) all seem to be getting on with their lives and doing things and I'm thinking I wish I could feel like that but I don't. I look at their lives as well and I think what's the point of it. (Ussher 2000, 92)

A second related split within which women position themselves in these analyses contrasts the idealized woman in the public sphere with the transgressive woman at home. Women describe attempting to and/or staying in control at work and then letting go, losing control at home:

> It often happens with my husband. I always manage to control it in work. I think it's almost as though because it's my husband I can let go. I can have a tantrum. Perhaps because I can't, it's weird that I can control it in work where you have to control it. I still feel tense and what will often happen then is that when I get home perhaps I let go." (Ussher 2002, 400)

From the perspective of newly emerging representations of rational and unemotional superwomen (Nicolson 1996) who can take up equal space with

men in the professional and public spheres, where femininity and emotionality have been traditionally aligned and positioned as alien or other (Ehrenreich and English 1978), this is seen as a strategy whereby a woman can maintain a sense of herself as public, coping and competent – it is her PMS self that lets her down. At the same time, the mantle of PMS gives women permission to express private, forbidden feelings in that they can simultaneously disown these feelings.

These observations and analyses have led Ussher and others to conclude that PMS is experienced and expressed primarily in relationships with close family members and closely tied to relationship difficulties and responsibilities. They suggest that women express grievances under the legitimizing rubric of PMS in the attempt to deal with perceived inequities in relationships or to make demands of children and partners that they would not otherwise make. However, the fact that these issues may only be raised in the premenstrual phase makes it easy for partners, families and for the women themselves to dismiss their feelings and behaviours as 'just PMS'. Defining this as 'self-silencing', Ussher argues that it results from the pressure and expectations that women experience within a family environment, where they are expected to subjugate their own needs and desires to the needs of others. It seems that the key feature that determines whether an emotion or behaviour is attributed to the PMS self is that it is at odds with idealized cultural and familial expectations of how a woman should feel or behave – being angry, rather than calm; losing patience rather than tolerating; confronting issues rather than letting things go; and being irrational, rather than in-control:

> I know I'm a good mother. I've got three very well-behaved balanced children. I've got their welfare at heart. I just want what's best for my children, my husband and all my family. I sort of look at myself when I'm premenstrual and I think that I don't like myself. I don't like what I've become. But rationally I think, 'Well it's not me. It's just not me. (Ussher 2003,398)

So the story of the modern PMS self might be summarized as follows: Our ontological heritage of the fixed, unitary self, later given realization in the subject/object, mind/body distinction that has affected women differentially, equips women with the conceptual means to say "it's just not me", or "it's like something takes over me". Immersed in the language and definitions of psychopathology, which rests on an epistemological tradition that enshrines this distinction, and constrained and produced by its normative prescriptions and ethos of self-discipline and self-surveillance, women's response to the limited range of affect and behaviours available to them within the realm of the isolating and individualizing discourse of idealized femininity, is to turn this invalidated and unrecognized self into a PMS self. However, the construct of the Postmodern PMS self permits and requires a retelling of this story.

The Postmodern PMS Self

As previously mentioned my intent in using the construct of the Postmodern PMS self is to use it to facilitate exploration as opposed to making an evaluative or prescriptive category. Therefore, in positing alternative explanations and possibilities for conceptualizing the self in the PMS discourse, which actually arise from critiques of postmodern ideas of the self, as well as theories that might be considered to be outside this epistemological framework, the construct is employed in the spirit of heterogeneity, multiplicity and reflexivity entailed in postmodern approach. As alluded to in the previous discussion, this approach is constitutive of and constituted by a broadly based critique, in which social constructionist and discursive theories and methods, among others, have been developed and employed to deconstruct the modernist project. While scantily referenced and outlined here, the work of those cited in this project and innumerable others has contributed to a critical understanding of the constraints and productive effects of the fixed and unitary concept of the self/individual and the subject/object, mind/body dualism underpinning the ideals and institutions of the modern era.

As has also been discussed, the postmodernist approach and its attendant epistemological methods has also been the object of criticism itself because of how it negates or minimizes the reality of lived experience. As with the critiques that have been previously outlined on the effects of such

approaches on the PMS experience, similar criticism has been leveled at others cited in this project, with regard to the anti-humanism implicit and explicit in their 'strong' constructionist and discursive perspectives. Such perspectives, it has been suggested, have not broached the issue of what our response, if any, should be at the level of the individual; have predicted, and pronounced on the 'death of the subject'; and have proposed the notion of a self that is invented and shaped through the medium of language. It is also argued that Foucault, who is the target of much of the preceding criticism, has paid little attention to gender, assuming that the regulatory practices of embodied femininity produce genderless, docile bodies involving little agency beyond the hold of the monolithic and deterministic force of the disciplinary power that produces such controlled and practiced subjects (Diamond and Quinby 1988). Related deconstructions, exemplified in Gergen's theory of the 'saturated self, which posit a view of selfhood as product of the technological age, in which the self becomes overpopulated, saturated with "multiple and disparate potentials for being" (Gergen 1991, 69) as a result of the ubiquity of technology and information, also come under fire in these critiques, from the perspective that, while they at least suggest alternate models to the unitary (albeit multifaceted), fixed and autonomous notion of the self enshrined in modernism, they rely on, and reinforce the anti-humanistic ideals, which see word and mind as entries in the discursive practices of culture (Greene 2003).

Treating the Postmodern PMS Self

One of the outcomes of these critiques is the epistemological theory and method on which this project is based – the Material-Discursive-Intrapsychic approach. A number of the ways offered by this approach for reinterpreting existing ideas about PMS, as well as developing new ones have been discussed and exemplified in this thesis and invite further possibilities to do with current and future research practice and treatment of PMS. While Ussher and others describe much of the following in their publications, I have been very encouraged to actually hear these approaches discussed and see them put into practice by self-described woman-centred reproductive health practitioners (CeMCOR 2004), as well as those working in more mainstream institutions in the local community. As mentioned they incorporate a woman-centred philosophy and have been proposed for, and been adopted not just in women's reproductive health clinics but also in family and relationship counseling environments where the goal is to come to an understanding of women's experience of PMS through a process of respectful, collaborative discovery between a woman and her family and practitioner. Methods such as narrative therapy, counseling and diarizing are used in order to enable women to both share their stories and empower themselves with strategies for coping and coming to terms with their experience. The feelings and behaviours that women report in such processes are not dismissed or denied on the basis of credible body of research and anecdotal evidence. This evidence supports and validates what women say about their increased vulnerability or sensitivity to stress during the premenstrual phase of

their cycle (Sabin Farrell 1999), possibility resulting from a combination of a complex interaction of physiological processes called a 'neuroendocrine cascade' (Parry 1994); sensitivity to changes in autonomic arousal (Kuczmierczyk 1996); and differential perceptions of stress premenstrually (Woods 1998), linked to cultural constructions of PMS as negative and debilitating (Chrisler 2002; Ussher 2003). Rather, there is a recognition that such sensitivity can lead to increased anxiety for a number of women, and, in the majority of cases, slightly diminished ability to cope with their multiple responsibilities and roles for a certain 'period' each month. This takes place within the context of a discussion where women are encouraged to accept normal human fallibility in themselves – variability in sensory responses, feelings and emotions; in reactivity; and in ability to cope – and to think critically about the cultural representations of idealized femininity and psychological health, which lead them to pathologize the changes they experience premenstrually. As well as education about the previously mentioned self-care strategies to do with nutrition, exercise and stress reduction, women are counseled and, in support groups, encouraged to share ideas about ways of receiving support and understanding from their families. Ideally, the discussion is focused not so much on how they can feel 'good' about themselves, but how women can integrate their PMS experience to arrive at an understanding of themselves, which is fuller, fluid and more dynamic than has been allowed within mainstream approaches. More recently, articles on PMS and publications in the self-help field, while still very much focused on PMS/PMDD as a problem for individual women for which they have the miracle cure, provide counsel and

advice that is less decontextualized. Along with basic self-care information they often prompt women to consider how potential external stressors, such as their roles in interpersonal relationships, domestic and caretaker arrangements and work environments might contribute to, and affect their PMS experience.

This shift in the popular discourse on PMS is probably partly why most of the women in this study were very aware of the need for and benefits of self-care, as well as the strategies that worked for them and the consequences for them if they didn't honour these needs:

> In coping with the day-to-day physical effects of PMS however, other strategies have proven more helpful. For example, the physical tension I feel with PMS is analogous to being an over-inflated balloon. Strategies such as visualization or exercise tend to release the tension in my body, and with it, the feeling that I am going to pop at any minute. (Morgan, 47)

> For me, it's more that I need to be away from my body in other areas of my life and so then, the music of it, and the care of it gets marginalized and sanitized... with mothering for example I need to look after myself so that I don't snap and get cranky. Just need to take it a little bit slower and if I blow that, then I try to let it be a time when I just don't engage with certain conflicts... as I'm writing I can feel that tightness in my end of the day head and teeth gritting in the presence of a request or demand that seems to me to be wholly unnecessary. (Lorraine, 4)

> If things go awry in the PMS period for me, that is, I don't take care of myself and instead suppress and frustrate the increased need for emotional connection, physical solace etc, the charge of frustration palpably remains for a subsequent period of time. Depending on how bad this charge is, it can even carry over into the next month's cycle and the next PMS can thus be already primed to be that much crankier, needier, and so on. In short: the consequences of lack of self-awareness and self-caring can escalate and be intensified by the "magnifying glass" effect at each PMS period. (Lianne, 45)

While a direct connection or reference is not made, the approaches described above incorporate an understanding of the possibility and potential of

the self, which is discussed in more detail below and which is implicit in the theories of George Kelly, whose ideas on the power of psychological constructs anticipate, and provide an antidote to, the 'victimizing' and pathologizing language and definitions of our psychologized culture (Kelly 1969). Arguing that the indicative mood in our language shapes our thinking and leads us to confuse things in the world with our constructions of them, they support Tavris' argument about the social labeling of PMS (Wartik & Tavris, 1998) and what many women, from Parlee through to Ussher have reiterated, about the effects of the negative construal of the premenstrual changes on women's interpretation of and ability to cope with PMS. In place of the emphasis on defining and labeling our experiences, Kelly proposes the use of an 'as if' approach, that would allow an 'invitational mood', which makes our constructions explicit and highlights their pragmatic value. For instance, I might describe myself as not wanting to be close with anyone during the premenstrual phase or, alternatively, wanting time alone for reflection and self care. Such casting of language in the invitational mood, Kelly suggests, leaves people open to extend themselves – elaborating possibilities, instead of being stuck in unhelpful definitions that make them impermeable to change and while not denying the fact that circumstances in the world force limits on us, it provides us with the possibility to reconfigure that which we cannot deny. Morgan's comments on the approach she takes to PMS capture the essence of this argument:

> Even though I might still feel frustration about feeling "wacky" at a certain time of the month, or conflicting feelings about others' expectations/judgments about me as a woman and now as a mother, I am generally able to respond more constructively. In other words, I ask

> myself what I can do about it instead of getting stuck in it without a more positive direction to go... (Morgan, 46)

With the discussion on ideas of the postmodern self that begins the following and final section serving as a framework, I employ Kelly's model to explore the ways in which the women in this study have been able to 'extend themselves' through and in their experience of PMS.

Inhabiting the Postmodern PMS Self

The concept of self on which the aforementioned material-discursive methods are based has been described by the feminist, critical psychologist, Sheila Greene in the following way:

> (It) is the idea of the self as a phenomenologically real mode of organizing experience that both derives from and makes possible self-awareness of existence in the world and continuity in time. This view places reflexivity at the centre of the theory of selfhood, personal identity and human personhood. Reflexivity generates the self and is the foundation for self and identity, but reflexivity can itself be sustained only by an enduring sense of self and personal identity. (Greene 2003, 93)

Greene argues that in contrast to the model of the natural, determined and essential self, which is embedded in Western culture and thought and underpins the dominant theories of psychoanalysis and psychological development and which posit the existence of an 'inner' self waiting to be discovered, it describes a concept of self that is more fluid and dynamic, addressing both the nature of constraint and the potential for change that constitutes the reality of lived experience. A number of the women in this study echoed these ideas in their accounts, reflecting on how they considered PMS to be a simultaneously

constraining and productive experience. Constraining because of the physiological effects, such as headache and fatigue, as well as the anxiety and tension that resulted from not being able to meet all the expectations of a partner, mother, worker etc., but productive in that it gave them more or less opportunity to step back from these roles and see them in a different light, as well as engage with others in ways that felt more 'real' and closer to the truth of things. The women describe it this way:

> It isn't that I think that I'm irrational at those times – as a matter of fact, I feel that I'm hyper-rational. It's just that things that bother me might bother me MORE then. I am also less capable of biting my tongue when I ought to, or of softening the truth where it might help to get along with others. I feel as though I see and say things more truthfully... I feel for me that that is my most real self and the rest of it is all just icing on the cake. (Karen, 9-10)

> These are physiological responses (that) have inextricably influenced who I believe I am, and my behaviour. For instance, the hormonal changes that characterize PMS are sometimes offset by finding it easier to say what is on my mind. Everything feels a little closer to the surface, a little more off the cuff, and less mediated by social norms. (Morgan, 47)

> Now, with my family and friends, I'm up front about exactly what's going on with me – I have a migraine, I've got no energy, I just feel like sitting down... When I stopped trying to be different than how I was feeling, it felt more honest. (Susan, 15)

A similar conception of the self has also been proposed by Morny Joy in response to what she considers to be the dangers of rushing to embrace postmodernist conceptions of the self (Joy 1993). Drawing on the work of Paul Ricoeur, who, in his efforts to reconcile the epistemologies of hermeneutics and phenomenology, is considered to have inserted a "space of reflexivity" into the heart of belonging," (Venema 2000) Morny advocates a hermeneutic approach to

understanding the self, which entails "the interpretation of the self against a wider social backdrop." (Joy 1993, 291) Reflected in the work of Martin and Sugarman (Martin 2000) who also propose a more hopeful and productive understanding of the self than other postmodern interpretations, Joy relies on Ricoeur's conception of the narrative conception of identity, where neither the self or the world is taken as a timeless ontological entity. Such a conception of self, according to Joy, allows a recovery of identity in the sense of a core identity, a distinctive self but in a form which is perpetually developing and changing as function of person's ongoing efforts to interpret and understand their engagement with the world. Morgan captures this in her account of how, from the perspective of a core identity in adulthood, she reinterprets her experience of PMS and menstruation as a girl and young woman:

> ...I have come to appreciate PMS and menstruation as fluctuations around a self that is consistent, not fractured, particularly as not experiencing it this way as a girl became a source of vulnerability for me. Although I may feel particularly tense or anxious as a result of PMS, I understand that this is myself under certain conditions. In a way, reminding myself of this (or my partner reminding me in a supportive way when I haven't clued in) helps to calm my anxiety and provide a sense of normalcy to the experience. (Morgan, 46-47)

Related to this notion of the changing, dynamic self are the theories and models advanced from both within and as critiques of postmodernism, as well as those that come from outside it, which are centred around the notion of the relational/polyphonic/plural self; the self as, or in community/complex/collective. Among these are Gergen's model of the 'situated' self, which he proposed partly in response to criticism of his ideas of the 'saturated' self (Gergen 1999). Echoing the ideas of a number of feminist scholars (see the contributors to, and

citations in *Feminists Rethink the Self* (Meyers 1997)), as well as those of Charles Taylor (Taylor 1999), who suggests that the self can exist only within what he terms 'webs of interlocution' such that the self only comes into being and has meaning through our relationship with others, and through the capacity for extended and extensive self-reflection granted to us through language, Gergen proposes that it is out of relational processes that concepts of both self and community emerge. However, referencing their historic and cross-cultural role as care providers and nurturers and the ways in which women are positioned in and through the discourse of femininity as always being in relation, it has been argued that women are defined and understood as only 'relational' selves with no "isolable core of selfhood." (Smith 1993, 6) While women's role in relationships and the effect of PMS on them is perhaps the most prominent theme in this and the other studies, most of the women's accounts, reflected in Andrea's comments below, indicate that they do not operate as a relational self at the expense of some enduring sense of self and personal identity:

> ...I don't know where I get it or where many women get it but there is such incredible ability to be selfless and I think that makes to world go round but I think it can be unhealthy and I think that PMS'ing is a time when I am completely selfish, I want things a certain way... (Andrea, 34)

> ... and yes I do say things and do things that hurt people, people that I'm close to but I strongly consider all those aspects of my self, definitely very different personalities. I mean I'm a completely different personality at that time but I don't separate the self in that way, it is just as me to fall apart or cry or yell or all those things, it's just a part of me that I very rarely let out and that's a hard thing to acknowledge, I think a lot of women dismiss the ideas that they have at that time because they think it somebody else or something else, some different part of them... (35)

Ideas of the polyphonic and plural self have a relatively long history. In his analysis of the contribution of Nietzsche to the field of psychology and beyond, Graham Parkes (Parkes 1995) brings together the ideas of American thinker, William James and the theories of Carl Jung, as well as those of Nietzsche, to propose a view of the self which is akin to a traditional acting troupe that is initially instructed by a director - the I, but over time, as the actors practice their art with discipline, get to know each others' style and broaden the repertoire, transforms into an improvisational theatre company where the appropriate character comes forward to play his or her part according to the occasion. Referring to Nietzsche's philosophy of life which was to "deal with things experimentally," (371) Parkes goes on to make the case for being open to the perspectives of many persons at once:

> It is not a case of abolishing the much maligned ego altogether: behind the mask of the I is usually the archetypal figure of the hero, whose muscular power and head-on approach is quite appropriate in certain situations. There is no need to dismiss the 'heroic ego' from the troupe; he is simply to be prevented from directing all the time or constantly upstaging the other characters. (Parkes 1995, 371)

This position is resonant with the ideas of Billig who, in his rhetorical model of humankind, shows how we take up positions in argument in response to the positions adopted by others (Billig 1987). This shifting of identity and position depending on circumstances and context is described by Lianne in her account of her PMS experience in which she draws on a concept and character from aboriginal traditions that captures the sense of the varying ways in which self can be experienced and enacted:

> ...I find that my writing changes a lot actually, I tend to make really clear analysis at the end of the month, I start to get the bones of what is important, it's a clarity, but at the same time a bit of lack of inventiveness and then after my period sometimes clarity is completely out of the question but there is a huge amount of inventiveness and creativity, which depending on how focused I am it does for better or for worse... I like being able to operate in those ways, they cross pollinate and I get to think clearly about this so I relish going back and forth. So definitely this is not so much a Jekyll and Hyde character but the Haida character, the Raven, although its true he is a trickster but just this sense of being comfortable with a multiplicity of masks because I think that would speak to everybody. Perhaps the idea of being comfortable would appeal to them once they realized that masks were inevitable as well, so live with them and enjoy them... (Lianne, 44)

Karen provides a similar interpretation:

> Expressing more than one self does not concern me in the slightest. It's a trick of an individual-centred culture to think we can function any other way. I would have a hard time getting along with others if I couldn't do this. It's sort of infantile to feel that others must always accept the "me" of me, even if it is unpleasant or upsetting to others. Sometimes, that's best kept in my head while I present my "social skills self" to the world. (Karen, 10)

The 'collective self' and 'selves in the collective' have also been posited as models for reconceptualizing the self in a way that gives credence to its alternative meanings and possibilities. A substantial body of anthropological and cross cultural studies have variously described these collectivist orientations often contrasting them to the "sense of strong individuality" (Smith 1994) that has emerged in Euro-American traditions. Some have made the argument that the Western self, particularly the female self, has always been more collectivist than received epistemological theory and practice would suggest but, as alluded to previously, Western philosophy, psychology and economics have shaped a common understanding and discourse of the self which posits it as natural, distinctive, unitary and independent (Greene 2003). Zita indirectly endorses this

distinctive, unitary and independent (Greene 2003). Zita indirectly endorses this argument in her critique of Peter Kramer's *Listening to Prozac*, in which, she claims, Kramer attempts to reassemble a unity of the self ('the true self') by "holding together the values of the middle class work ethic, efficient wifery hyperthymic heterosexuality and perhaps a special kind of whiteness." (Zita 1998, 78) While Kramer positions Prozac, as others have done, within a discourse that promotes, albeit cautiously, the promise that biotechnology holds in helping us realize the instabilities and fluidities enjoyed and enjoined in the so-called Postmodern self, Zita borrows from Donna Haraway's 'Cyborg' concept (Haraway) and Naomi's Scheman's analysis of emotions and their context-dependent articulation (Scheman 1993), to present a more feminist and political analysis, proposing the notion of the 'pharmorg' - the "Prozac-tipped but not Prozac-promised feminist." (Zita 1998, 78) This discursive positioning acknowledges the problems with the notion of the 'natural body', which is constantly invoked in arguments against the use of Prozac and the other biomedical technologies that are recrafting the bodies and selves of the twenty-first century, as well as allowing for the fact that some women may derive real benefits from their use. However, in that the pharmorg relies on and promotes a view of women as able to take responsibility for themselves and their bodies, 'to draw their own boundaries of domain and potency' and to reside in a political collective, Zita's pharmorg recognizes a more empowering and agential idea of female selfhood than is implied in Kramer's version:

> Kramer's attempt to recuperate white middle-class values in the production of female pharmorgs in effect works to discourage the

> liberating potentials of women's multiple identities and of our 'dysfunctional selves', our affinities with gossip and heteroglossia, and our monstrous joy in re/fusing the (ob)literation of radically and collectively spoken selves. Both Scheman and Haraway give us ways to embrace the body's postmodern physicality without surrendering to the way neurochemicals tell a flat story of the self and without the need for the 'natural body' or 'the plot of essential unity or origin'. (Zita 1998, 79)

A number of women in the study echoed these sentiments, both recognizing that dealing with PMS and related 'disorders' was more complex than the dominant discourses might allow and acknowledging the power and liberating potential of our collective selves in grounding and validating the changes associated with cyclicity:

> ...certainly we don't need to be silly about it, some women go through a really bad time, ok see your doctor and talk about that, do you need to take Prozac for a week at a time, maybe you do... (however) I think there is that message that if any little things are bothering you, don't waste time thinking about it - take a pill and you'll feel better, but what if there is something you really should be doing to change your life... (Jane, 29)

> ...I think the positive aspect of the PMS experience for me has come from being able and being part of the lesbian community where it was not treated as a crazy, aberrant behaviour, but rather something that women experience in different forms... To get comfortable with that and laugh and joke about it was certainly a liberating and a life affirming experience for me... I'll certainly carry on with that and now I share that by talking openly with other women about it... Being around people where it is not a big deal it certainly changes your attitude, you go out in the world and go this is not a big deal, now... (Jane, 27)

Similarly from Susan:

> I'm not a mom, but I've found that women – friends and work colleagues – need only say to each other "Excuse me, I'm PMS-ing," and there's an unspoken understanding that we can be excused for what we say or do. Women also ask other women for confirmation or validation of feelings with questions such as "Is this really that bad, or am I PMS-ing?" PMS makes you a member of an all-female club. (Susan, 7)

Acknowledging that the expression 'women's intuition' has become cliched to the point of redundancy I would like to use it to explore the idea of the 'extended self'. As mentioned, there is a credible, albeit contested, body of work generated by Chodorow (Chodorow 1978), Gilligan (Gilligan 1982) and others, which supports the argument that women, by virtue of their historic roles as caretakers and nurturers, are more in tune with and sensitive and responsive to the needs, emotions and feelings of others, both articulated and unarticulated. This ability to resonate and/or harmonize with others has corollaries in Asian traditions and theories, which recognize entities, beyond body and mind, that put individuals into a continuum with the external world, implying an extension of the boundaries of the mind-body field beyond what we normally consider the empirical self (Kasulis 1993). Similarly, a recent book by Rupert Sheldrake outlines an argument for the notion of the extended mind on the basis of a series of studies which show, among other things, that there is a greater probability than chance that people will correctly anticipate the identity of a person calling them on the telephone when that person is someone with whom they have a close relationship (Sheldrake 2003). In conjunction with the comments made by the women in the study about how their increased sensitivity in the premenstrual phase enables them to see beyond the masks to the "truth of things" (Karen, 10), some of them also report that they experience a greater sense of empathy with others, which Andrea describes as an ability to 'walk in people shoes' and arrive at a deeper understanding of what they might be going through:

> ... I definitely think that it confers wisdom, like I said, for people who experience it. I'm starting to think that any degree of instability, be it PMS

> or otherwise in people gives them that wisdom, especially if they come back to a place where they can interpret it within the confines of something a little more sane, as it were. I think the really big difference between sympathizing with somebody and empathizing with somebody and feeling sorry for somebody is very different from understanding what's it like to be in their space and giving them the space to be that way. I think that just in terms of having the experience of being devastated or just absolutely off my rocker allows me to understand more the complexity of being human and so, because I don't think I'm the only one who has that experience I definitely think that many women do have a vision into humanity that other people don't have. I would give the credit to PMS in a lot of those cases because I think that I learn a lot by having that change in my life... (Andrea, 33)

In a similar vein Lianne comments that her experience brings into awareness issues or feelings that she might otherwise dismiss or ignore:

> ...these emotions are not vastly different emotions from the ones I'd experience as part of the whole month's cycle, like my to day to day life, that they stem from similar behaviours, events, relationships, they stem out of the same context, they are reactions to familiar things. It's just that they may be reactions that are more intense; they reveal a side of something that I hadn't realized. It's not often I've become aware of where I was frustrating or repressing myself by seeing how violently it just shot out at that point, so it's sort of a good warning because it's like a rnagnifying glass so I can see things up close... (Lianne, 39)

From Dualism to Polarism to Angels

At the risk of over 'extending' my argument about the possibilities and potential of the PMS experience I would like to present one more component of it as a summary of sorts and a conclusion to this thesis. Jane Ussher recently encapsulated her proposals to shift to different theories and methods for researching and treating PMS within an appeal for an alternative framework for understanding premenstrual symptomatology that is based on Eastern models of mental health (Ussher 2003). Her argument goes beyond the growing and, what some might say, superficially imposed trend of incorporating Eastern practices of

regimes, and proposes a reconceptualization of the notions of self and mental health that underpin Western theory and practice. To make her case Ussher draws on the work of Western, Buddhist psychotherapist, Mark Epstein, who joins with others to confront the illusion of the core, consistent 'me', which is always positive and good (Epstein 1995) that is the ethos of Anglo American normative psychology:

> Rather than eradicate 'symptoms', this model would suggest that through the practice of mindfulness, an appreciation of the temporally based dimension of self is arrived at, by paying attention to bodily based experiences and sensations *as they occur* (Epstein 1995, 144). There is no reaction or judgement of these experiences or sensations, merely a witnessing of them, an awareness Epstein describes as "quite literally coming to one's senses." (144) What we discover in this awareness is that feelings are rarely constant. There is always fluctuation and change. (Ussher 2003, 142)

While acknowledging the somewhat troubling implications of Ussher's argument - that Buddhism is a universally homogenous set of beliefs and practices, of which she has gained knowledge about through the interpretation of a Western practitioner who is originally trained in psychotherapy - an exploration of them is beyond the scope of this project. With that being said it is interesting to see where she takes this argument in light of the interpretations of some of the women in this study and the theories with which I started this exploration into the origins of the self in the Western tradition.

This approach of mindfulness, suggests Ussher, doesn't encourage women to repress their feelings and/or to attribute them to an other unacceptable self, nor does it mean passive acceptance of them, rather, in acknowledging that difficult feelings and emotions arise in the normal course of life and cannot be

eliminated or ignored, it encourages women to feel these emotions and be with them in order that they can understand them and learn from them. Already hinted at in some of the previous quotes, this act of integrating the feelings and emotions of PMS and recognizing their part and role in a more complex, dynamic and fluid understanding of selfhood is explicitly acknowledged by a number of the women in this study and exemplified in the following comments:

> I always have found it utterly amazing to inhabit a woman's body and so...because I haven't been taxed heavily – I've just found it all like a really rich music that my body knows that is attuned to life giving and life affirming rhythms in the world around me and I feel – kinda cool. (Lorraine, 3)

> ...I have no concept of my body/self idea without menstruation or PMS – those ideas are pre-adult. It all works together. Everything is in order... I view my emotional cycles as part of my biological ones – without privileging the biological functions as the most important. (Karen, 10)

> PMS doesn't make me think of myself as any less normal or healthy. I feel that's its just one of those things that a lot of perfectly normal, healthy women experience. (Jas, 12)

> ... initially it felt like I was not giving myself a huge amount of leave to be drastically different so I had to recognize, look, this is not something you can wholly control, it's something that you need to calm down and look at instead of strangulating it, or worse things might result... (Lianne, 39)

From the perspective of the thesis which framed this particular exploration of the origins of the self, I would like to draw on the connection between these descriptions of women's integration of the PMS experience, Ussher's proposal and the arguments which posit that there are fundamentally different conceptions of self and body underpinning Western and Asian traditions. In outlining his argument about why the West has for so long "concentrated on the gestalt

emphasizing the abstracted distinctions between mind and body," (Kasulis 1993, xvii) Kasulis' intent is to draw a comparison with Asian traditions, which, while not homogenous, share recurrent themes exemplified in spiritual, medical and artistic practices, including the Buddhist discipline of mindfulness, that rest on the understanding of the psychosomatic field as a 'whole':

> The striking difference from most Western discussions of the mind-body relation is that the emphasis is on developing the integration between the two rather than looking for a constant unchanging form of interrelationship. In this regard, many Asian philosophers (as might many Western physicians) see the disconnection of mind from body as not a philosophical problem but as a practical dysfunction. The unity of mind and body is not to be discovered, but achieved. (Kasulis 1993, xix)

Ames elaborates on this thesis in his comparison of the source Western ontological beliefs and practices with those contained in Chinese classical philosophy. His argument centres on the notion of *Polarism*, the major principle of explanation in classical Chinese metaphysics and which he describes as a symbiosis; "the unity of two organismic processes which require each other as a necessary condition for being what they are." (Ames 1993, 159) He contrasts this ontological system, in which a human being is not conceived of as a sort of *being* at all but as human *doing* or *making*, with the dualistic ontology of the West, which he suggests is conducive of an essentialistic interpretation of the world:

> ... a world of 'things' characterized by discreteness, finality, closedness, determinateness, independence, a world in which one thing is related to the 'other' extrinsically. By contrast a polar explanation of relationships gives rise to an organismic interpretation of the world, a world of 'processes' characterized by interconnectedness, interdependence, openness, mutuality, indeterminateness, complementarity, correlativity, coextensiveness, a world in which continuous processes are related to each other intrinsically. (Ames 1993, 160)

Again at the risk of overdetermining PMS and these women's experiences of it, I would like to use this thesis of polarity to present one final interpretation of the conceptualization of the PMS self, which also brings us back to the lines from Adrienne Rich's poem at the beginning of this thesis. Seen from this perspective, the 'anger and tenderness' - the seemingly disparate emotions and feelings of the 'me' and 'not me' of PMS can, in the image of the spider's improvised spinning that makes and saves her life, be (re)conceived as not just part of the continuum that is self in the world but as constitutive of each other and of our selves.

Appendices

Appendix i-Survey Introduction

Helen Loshny
Student, Graduate Liberal Studies (GLS) Program
Simon Fraser University,
c/o 316 Simpson Street
New Westminster, BC, V3L 3J9
Phone: 604 520 1055
Fax: 604 520 1055
E Mail: hml@shaw.ca

GLS Acting Director: Stephen Duguid
GLS Graduate Chair: June Sturrock

For the attention of the prospective survey candidate:

I am currently undertaking a project for my Graduate course, which is looking at the self-concepts of women who experience premenstrual syndrome – PMS. I am analyzing the public debate on PMS as well as examining the various ways in which it has been researched and studied. In many women's accounts of this experience they report feelings of being 'out of control' and of not feeling like their 'normal self' during the premenstrual phase. I would like to hear from women directly about how these feelings affect their experience of themselves in the following ways; their understanding of what it means to be a woman; their major life roles as mother, partner, work colleague, friend; their conception of their bodies and their health; as well as how these experiences affect their overall understanding of the idea of 'self'.

If you are interested in contributing to this project I would very much appreciate if you could respond to the questions in section ii of this document and return it to me via email, regular mail or fax by the deadline noted in the survey notice or in the introductory email message. Your survey responses can be of any length and feel free to add in any information at any point in the questionnaire even if you feel it is indirectly or not related to the questions. Before doing this please read the consent notice in section i of this document. Also please be aware that all the survey responses will be kept confidential.

If you are also interested in participating in an in-person interview in order to explore your responses in more detail please indicate this at the bottom of the questionnaire. I would like to conduct these interviews at a mutually agreed time and place, ideally within a three week period after the completion the questionnaire (alternate arrangements can be made if this is not feasible). The survey and interview responses will be collected and compiled by the end of October 2003.

Thank you for your interest.

Appendix ii- Consent notice

Participant Name: _____

Participant E Mail Address: _____

I have been informed of the nature of this study and understand that I may withdraw my participation at any time. I understand that if I participate in an interview that the interview will be tape-recorded and that I may ask to stop the interview and/or have the tape turned off at any time. I understand that the questionnaire response and the interview materials will be kept confidential and that my anonymity will be protected. I will be given an opportunity to review a copy of the interview transcript, as well as any parts of the completed thesis that pertain to my interview and to make any changes that I see fit. The interview tapes will either be returned to me or destroyed once they are transcribed and none of the interview will be published in any other form than the thesis without my prior consent.

I also understand that I may register any complaint with the Director of the Office of Research Ethics or the researcher named above or with the Chair, Director or Dean of the Department, School or Faculty as shown below:

Stephen Duguid, Acting Director,
Graduate Liberal Studies Program
515 West Hastings Street, Vancouver,
BC, Canada, V6B 5K3

I may obtain copies of the results of this study, upon its completion by contacting:

Helen Loshny
Student, Graduate Liberal Studies (GLS) Program
Simon Fraser University,
Vancouver, BC, Canada
Phone: 604 520 1055
Fax: 604 520 1055
E Mail: hml@shaw.ca

I have been informed that the research will be confidential.

Appendix iii- PMS Questionnaire

1. For how long would you say you have experienced PMS and can you comment on its;

frequency - do you always experience it on a monthly basis?

intensity - do you experience it to the same degree each time?

variability - do you experience similar feelings and effects each time?

Response:

2. In what ways does PMS alter the way you think about yourself as feminine, as a woman?

Response:

3. How does PMS affect your experience of self in relation to your role(s) as a mother, partner, children, friend, work colleague etc?

Response:

4. How does PMS change your idea of self in relation to your body?

Response:

5. In what ways does PMS alter your idea of yourself as normal and healthy?

Response:

6. In what ways does PMS create or enhance the distinction between your public and private self?

Response:

7. How does the idea - which you may have elicited from your responses to the preceding questions - that you experience and express more than one self affect and concern you?

Response:

Please indicate with yes or no if you would like to participate in an in-person interview: ____

Appendix iv-SFU Ethics Board Approval

SIMON FRASER UNIVERSITY

OFFICE OF RESEARCH ETHICS

BURNABY, BRITISH COLUMBIA
CANADA V5A 1S6
Telephone: 604-291-3447
FAX: 604-268-6785

July 31, 2003

Ms. Helen Loshny
Graduate Student
Liberal Studies
Simon Fraser University

Dear Ms. Loshny:

Re: Meditations on the premenstrual self:
The conceptualization of the self in the origins and development of the PMS discourse

I am pleased to inform you that the above referenced Request for Ethical Approval of Research has been approved on behalf of the Research Ethics Board. This approval is in effect for twenty-four months from the above date. Any changes in the procedures affecting interaction with human subjects should be reported to the Research Ethics Board. Significant changes will require the submission of a revised Request for Ethical Approval of Research. This approval is in effect only while you are a registered SFU student.

Your application has been categorized as 'minimal risk" and approved by the Director, Office of Research Ethics, on behalf of the Research Ethics Board in accordance with University policy R20.0, http://www.sfu.ca/policies/research/r20-01.htm. The Board reviews and may amend decisions or subsequent amendments made independently by the Director, Chair or Deputy Chair at its regular monthly meetings.

"Minimal risk" occurs when potential subjects can reasonably be expected to regard the probability and magnitude of possible harms incurred by participating in the research to be no greater than those encountered by the subject in those aspects of his or her everyday life that relate to the research.

.../2

Appendix iv cont.

Please note that it is the responsibility of the researcher, or the responsibility of the Student Supervisor if the researcher is a graduate student or undergraduate student, to maintain written or other forms of documented consent for a period of 1 year after the research has been completed.

Best wishes for success in this research.

Sincerely,

Dr. Hal Weinberg, Director
Office of Research Ethics

c: Dr. June Sturrock, Supervisor

/jmy

Bibliography

Abplanalp, J. M. (1983). "Premenstrual Syndrome: A selective review." Women & Health **8**: 107-124.

Ames, R. T. (1993). The Body in Chinese Theory and Practice. Self as Body in Asian Theory and Practice. T. P. Kasulis, R. T. Ames and W. Dissanayake. Albany, New York, Suny.

Angier, N. (1999). Woman: an intimate geography. Boston, Houghton Mifflin Co.

APA (1987). Diagnostic and Statistical Manual of Mental Disorders (3rd ed. revised). Washington, DC., Author.

APA (1994). Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, DC., Author.

Archer, J. (1994). "Testosterone and Aggression." Journal of Offender Rehabilitation **21**: 3-25.

Aristotle and W. D. Ross (1924). Aristotle's Metaphysics: a revised text with introduction and commentary. Oxford, Clarendon Press.

Asso, D. (1983). The Real Menstrual Cycle. New York, Wiley.

Bartky, S. L. (1990). Femininity and domination: studies in the phenomenology of oppression. New York, Routledge.

Benedek, T. R. (1939). "The correlation between ovarian activity and psychodynamic processes." Psychomatic Medicine **1**: 245-270, 461-485.

Bhaskar, R. (1989). Reclaiming reality: A critical introduction to contemporary philosophy. London, Verso.

Billig, M. (1987). Arguing and thinking : a rhetorical approach to social psychology. Cambridge ; New York, Paris, Cambridge University Press.

Bloom, L. R. (1998). Under the sign of hope: feminist methodology and narrative interpretation. Albany, N.Y., State University of New York Press.

Bordo, S. (1993). Unbearable weight: feminism, Western culture, and the body. Berkeley, University of California Press.

Bradley, L. E. (2003). "Prozac and the post-human politics of cyborgs." Journal of Medical Humanities **24**((1-2)): 49-63.

Burman, E. (1997). Deconstructing Feminist Psychology. London, Sage.

Burr, V. & Butt, T. (1999). Psychological Distress and Postmodern Thought. Pathology and the postmodern. Inquiries in social construction. D. Fee. London, Sage.

Burrows, G. (1828). Commentaries on Insanity. London, Underwood.

Butler, J. (1990). Gender trouble: feminism and the subversion of identity. New York, Routledge.

Caplan, P. J. (1995). They say you're crazy: How the world's most powerful psychiatrists decide who's normal. Reading, MA, Addison Wesley.

Caplan, P. J. (in press). "The debate about PMDD and Sarafem: Suggestions for therapists." Women & Therapy.

Chaturvedi, S. K., Chandra, P. S., Gururaj, G., Beena, M. B., & Pandian, R. D. (1994). "Prevalence of premenstrual symptoms and syndromes: Preliminary observation." National Institutes of Mental Health and Neurosciences Journal **12**: 9-14.

Chesler, P. (1972). Women and madness. Garden City, NY, Doubleday.

Chesler, P. (1989). Women and madness. San Diego, Harcourt Brace Jovanovich.

Chodorow, N. (1978). The reproduction of mothering: psychoanalysis and the sociology of gender. Berkeley, University of California Press.

Chrisler, J. C., & Johnston-Robledo, I. (2002). Raging hormones?: Feminist perspectives on premenstrual syndrome and postpartum depression. Rethinking mental health and disorder: Feminist perspectives. M. Ballou, & Brown, L. S. (Eds). New York, NY, Guilford Press: pp. 174-197.

Chrisler, J. C., & Caplan, P. (2002). "The Strange Case of Dr. Jekyll and Ms. Hyde: How PMS Became a Cultural Phenomenon and a Psychiatric Disorder." Annual Review of Sex Research **13**: 274-306.

Chrisler, J. C., & Levy, K. B. (1990). "The media construct a menstrual monster: A content analysis of PMS articles in the popular press." Women & Health **16**: 89-104.

Cosgrove, L., & Riddle, B. (2003). "Constructions of Feminity and Experiences of Mental Distress." Women & Health **In Press**.

Dalton, K. (1964). The premenstrual syndrome. Springfield, IL., Charles C Thomas.

Dalton, K. (1977). The premenstual syndrome and progesterone therapy. Chicago, Yearbook Medical.

Dalton, K. (1979). Once a month. Ponoma, CA., Hunter House.

Dalton, K. H., W. (1999). Once a Month, Hunter House.

Dan, A. J. (1994). Socio-cultural influences on women's experiences of premenstrual symptoms. Premenstrual dysphoria: Myths and realities. J. H. Gold, & S. K. Severino. London, American Psychiatric Press: 201-211.

de Beauvoir, S. (1952). The Second Sex. New York, Vintage Books.

Delaney, J., M. J. Lupton, et al. (1988). The curse: a cultural history of menstruation. Urbana, University of Illinois Press.

Dennerstein, L., Spencer-Gardner, C., Cotts, G., Brown, J. B., Smith, M. A., Burrows, G. D. (1985). "Progesterone and premenstrual syndrome: A double blind cross-over trial." British Medical Journal **290**: 1617-1621.

Descartes, R. and D. A. Cress (1993). Discourse on method ; and, Meditations on first philosophy. Indianapolis, Hackett Pub. Co.

Diamond, I. and L. Quinby (1988). Feminism & Foucault: reflections on resistance. Boston, Northeastern University Press.

Douglas, S. J. (1994). Where the girls are: growing up female with the mass media. New York, Times Books.

Ehrenreich, B. and D. English (1978). For her own good: 150 years of the experts' advice to women. Garden City, N.Y., Anchor Press.

Epstein, M. (1995). Thoughts without a thinker: psychotherapy from a Buddhist perspectiv. New York, Basic Books.

Faludi, S. (1991). The Undeclared War Against American Women. New York, Crown.

Fausto-Sterling, A. (1992). Myths of gender: biological theories about women and men. New York, NY, Basic Books.

Fee, D., Ed. (1999). Pathology and the postmodern: Inquiries in social construction. London, Sage.

Foucalt, M. (1977). Discipline and Punish: The Birth of the Prison. London, Allen Lane.

Foucalt, M. (1980). Power/Knowledge: Selected interviews and other writings. C. Gordon. New York, Pantheon.

Frank, R. (1931). "The hormonal causes of premenstrual tension." Archives of Neurological Psychiatry **26**: 1053.

Freeman, E., Rickels, K., Sondheimer, S. J., & Polansky, M. (1990). "Ineffectiveness of progesterone suppository treatment for premenstrual syndrome." Journal of American Medical Association **264**(3): 349-353.

Gergen, K. J. (1991). The saturated self : dilemmas of identity in contemporary life. New York, N.Y., Basic Books.

Gergen, K. J. (1999). The Self: Transfiguration by Technology. Pathology and the Postmodern. D. Fee. London, Sage.

Gilligan, C. (1982). In a different voice : psychological theory and women's development. Cambridge, Mass., Harvard University Press.

Golub, S. (1992). Periods: from menarche to menopause. Newbury Park, Calif., Sage Publications.

Graham, C. A. (1991). Treatment of premenstrual syndrome with a triphasic oral contraceptive [microform]: a double-blind placebo-controlled trial. Ottawa: National Library of Canada.

Greene, S. (2003). The psychological development of girls and women : rethinking change in time. London, New York, Routledge.

Haraway, D. Manifesto for cyborgs: Science, Technology, and Socialist-Feminism in the Late Twentieth Century.

Harding, S. (1987). Feminism and Methodolgy. Indianapolis, Indiana University Press.

Harding, S. (1991). Whose Science? Whose Knowledge? Thinking from women's lives. Milton Keynes, Open University Press.

Harding, S. (1993). Rethinking standpoint epistemology: "What is strong objectivity?" Feminist Epistemologies. L. A. E. Potter. London, Routledge: 63-78.

Haug, F. (1986). Female sexualization : a collective work of memory. London, Verso.

Heilbrun, A. B. (1990). "The female role and menstrual distress: An exploration of inconsistent evidence." Psychology of Women Quarterly **14**: 403-417.

Henriquez, J. H., Urwin, C. Venn, C. & Walkerhouse, V. (1984). Changing the subject: Psychology, social regulation and subjectivity. London, Methuen.

Highwater, J. (1991). Myth and sexuality. New York, Meridian.

Hollingworth, L. (1914). Functional periodicity; an experimental study of the mental and motor abilities of women during menstruation. New York city, Teachers College Columbia university.

Horney, K. (1931). "Die Pramenstruellen Verstimmungen. *Zeitscher. f. psychoanalytique Padagogik,* 5, 1-7." (Reprinted in Horney, K. (1967). *Feminine Psychology,* 99-106.

Houppert, K. (1999). The curse: confronting the last unmentionable taboo: menstruation. New York, Farrar Straus and Giroux.

Joy, M. (1993). "Feminism and the self." Theory and Psychology **3**: 275-302.

Kasulis, T. P. (1993). The Body in Contemporary Western Philosophy and Social Thought. Self as Body in Asian Theory and Practice. T. P. Kasulis, R. T. Ames and W. Dissanayake. Albany, New York, Suny.

Kasulis, T. P., & Ames, R. T. et al. (1993). Self as body in Asian theory and practice. Albany, State University of New York Press.

Kelly, G. A. (1969). Clinical psychology and personality; the selected papers of George Kelly. New York, Wiley.

Koeske, R. D. (1983). "Lifting the Curse of Menstruation: Toward a Feminist Perspective on the Menstrual Cycle." Women & Health **8**(2-3): 1-16.

Kuczmierczyk, A. R. (1996). "Autonomic arousal and pain sensitivity in women with premenstrual syndrome at different phases of the menstrual cycle." Journal of Psychosomatic Research **30**: 421-428.

Laing, R. D. (1970). The divided self: an existential study in sanity and madness. London, Tavistock Publications.

Lauersen, N. H. (1983). Premenstrual Syndrome and You. New York, Simon & Schuster.

Laurence, A. L.(1997). 30 days to no more PMS. Ventura, CA, Allen Laurence, M.D.

Laws, S. (1991). Issues of blood: The politics of menstruation. London, Macmillan.

Lee, J. and J. Sasser-Coen (1996). Blood stories: menarche and the politics of the female body in contemporary U.S. society. New York, Routledge.

Leger, M. C. (2003). "A very childish moral panic: Ritalin." Journal of Medical Humanities **24**(1-2): 9-33.

Lever, J. (1981). Premenstrual Tension. New York, Bantam.

Maddocks, S. E., & Reid, R. L. (1985). The role of negative life stress and premenstrual syndrome: Some preliminary findings. Society for Menstrual Cycle Research, Galveston, Texas.

Markens, S. (1996). "The Problematic of "Experience": A Political and Cultural Critique of PMS." Gender & Society **10**(1): 42-58.

Martin, E. (1987). The woman in the body : a cultural analysis of reproduction. Boston, Beacon Press.

Martin, J., & Sugarman, J. (2000). "Between the modern and the postmodern: The possibility of self and progressive understanding in psychology." American Psychologist **55**: 397-406.

Martorano, J., Morgan, M., & Fryer, W. (1993). Unmasking PMS: The complete treatment plan. New York, Berkley Books.

Maudsley, H. (1873). Body and Mind. London, Macmillan.

Menkes, D. B., Taghavi, E., Mason, P. A., & Howard, R. C. (1996). "Fluotexine's spectrum of action in premenstrual syndrome." International Clinical Psychopharmacology **8**: 92-102.

Merchant, C. (1989). The death of nature : women, ecology, and the scientific revolution. New York, Harper Collins Publishers.

Merleau-Ponty, M. (1962). Phenomenology of Perception. London and New York, Routledge.

Metzl, J. M. (2003). "Selling Sanity Through Gender." Journal of Medical Humanities **24**(1/2): 79-10.

Meyers, D. T. (1997). Feminists rethink the self. Boulder, Colo.; Oxford, England, Westview Press.

Moos, R. H. (1969). "A typology of menstrual cycle symptoms." American Journal of Obstetrics and Gynecology **103**: 390-402.

Mostofsky, D. I., & Barlow, D. H., Ed. (2000). The management of stress and anxiety in medical disorders. Needham Heights, MA, Allyn and Bacon Inc.

Moynihan, R. (2004). "Controversial disease dropped from Prozac product information." BMJ. **328**: 7436.

Nicolson, P. (1995). "The Menstrual Cycle, Science and Femininity: Assumptions Underlying Menstrual Cycle Research." Social science and medicine **41**(6): 779-784.

Nicolson, P. (1996). Women, Power and Organizations. London, Routledge.

O' Meara, K. P. (2001). Misleading Medicine, *Insight on the News*. Washington Times Magazine**:** 10.

Oakley, A. (1981). Subject women. Oxford, Martin Robertson.

Oakley, A. (2000). Experiments in knowing: gender and method in the social sciences. Cambridge UK., Polity Press.

Oudshoorn, N. (1994). Beyond the natural body: an archaeology of sex hormones. London; New York, Routledge.

Parkes, G. (1995). Composing the soul: reaches of Nietzsche's psychology. Chicago, University of Chicago Press.

Parlee, M. (1989). The science and politics of PMS research. Annual research conference for the Association for Women in Psychology, Newport, RI.

Parlee, M. B. (1974). "Stereotypic beliefs about menstruation: A methodological note on the Moos menstrual distress questionnaire and some new data." Psychosomatic Medicine **36**(3): 229-240.

Parry, B. (1994). Biological correlates of premenstrual complaints. Premenstrual Dysphoria: Myths and Realities. J. H. Severino, & G. S. K. Gold. London, American Psychiatric Press: 47-66.

Potter, J. W., M. (1986). Discourse and social psychology. London, Sage.

Prior, J. C., Bishop, C., & Vigna, Y. M. (1997). Bio-Psycho-Social Aspects of the Menstrual Cycle. Looking Forward, Looking Back, The Place of Women's Everyday Lives in Health Research, Chicago.

Prior, J. C., Vigna, Y., Sciaretta, D., Alojado, N. & Schulzer, M. (1987). "Conditioning exercise decreases premenstrual symptoms: A prospective controlled 6-month trial." Fertility and Sterility **47**(3): 402-408.

Rittenhouse, C. A. (1991). "The emergence of premenstrual syndrome as a social problem." Social Problems **38**: 412-425.

Rittenhouse, C. A., & Lee, K. A. (1991). "Biopsychosocial factors that influence the experience of perimenstrual weight gain." Society for Menstrual Cycle Research.

Rose, N. (1989). Governing the Soul: The Shaping of the Private Self. London & New York, Routledge.

Rubinow, D. (1991). Models of PMS. Society for Menstrual Cycle Research, Seattle, WA.

Sabin Farrell, R. Slade, P. (1999). "Reconceptualizing premenstrual emotional symptoms as phasic differential responsiveness to stressors." Journal of Reproductive and Infant Psychology **17**: 381-390.

Sampson, E. (1988). Definition of premenstrual syndrome and related conditions. Definition of premenstrual syndrome and related conditions. M. G. Born, & E. M. Goudsmit. Chichester, England, Wiley.

Scheman, N. (1993). Engenderings : constructions of knowledge, authority, and privilege. New York, NY, Routledge.

Seagull, E. A. (1974). "An investigation of personality differences between women with high and low pre-menstrual tension." Dissertation Abstracts International **34**(9B): 4675.

Sedgewick, P. (1987). Psychopolitics. London, Pluto Press.

Sheldrake, R. (2003). The sense of being stared at: and other aspects of the extended mind. New York, Crown Publishers.

Showalter, E. (1985). The female malady : women, madness and English culture 1830-1980. New York, Pantheon Books.

Showalter, E. (1997). Hystories: hysterical epidemics and modern culture. New York ; Chichester, England, Columbia University Press.

Smith, M. B. (1994). "Selfhood at risk: postmodern perils and the perils of postmodernism." American Psychologist **49**: 405-411.

Smith, S. (1993). Subjectivity, identity, and the body: women's autobiographical practices in the twentieth century. Bloomington, Indiana University Press.

Steiner, M., & Born, L. (2000). "Diagnosis and treatment of premenstrual dysphoric disorder." International Clinical Psychopharmacology **15**: 5-17.

Steiner, M., Steinberg, S., Stewart, D., Carter, D., Berger, C., Reid, R. (1995). "Fluotexine in the treatment of premenstrual dysphoria: Canadian Fluotexine/Premenstrual Dysphoria Collaborative Study Group." The New England Journal of Medicine **332**(1529-1534).

Stoppard, J. (2000). Understanding Depression: Feminist Social Constructionist Approaches. New York, Routledge.

Swann, C. (1997). Reading the bleeding body: Discourses of premenstrual syndrome. Body talk : the material and discursive regulation of sexuality, madness and reproduction. J. M. Ussher. London; New York, Routledge.

Szasz, T. S. (1970). The manufacture of madness: a comparative study of the Inquisition and the mental health movement. New York, Harper & Row.

Taylor, C. (1999). Sources of the Self. Cambridge, MA, Harvard University Press.

Tuana, N. (1993). The less noble sex: scientific, religious, and philosophical conceptions of woman's nature. Bloomington, Indiana University Press.

Ussher, J. M. (1992). Women's madness: misogyny or mental illness? Amherst, University of Massachusetts Press.

Ussher, J. M. (1995). "A discourse analytic approach to women's experience of premenstrual syndrome." Journal of Mental Health **4**(4): 359-368.

Ussher, J. M. (1996). "Reconciling Disciplinary Divides through the adoption of a material-discursive epistemological standpoint." Annual Review of Sex Research **7**: 218, 34p.

Ussher, J. M. (1997). Fantasies of femininity: reframing the boundaries of sex. London, Penguin Books New Brunswick N.J.: Rutgers University Press 1997.

Ussher, J. M. (1999). Women's Madness: A Material-Discursive-Intrapsychic Approach. D. Fee, Ed. (1999). Pathology and the postmodern: Inquiries in social construction. London, Sage.

Ussher, J. M. (2002). "Processes of Appraisal and Coping in the Development and Maintenance of Premenstrual Dysphoric Disorder." Journal of Community & Applied Social Psychology **12**: 309-322.

Ussher, J. M. (2003). "The ongoing silencing of women in families: an analysis and rethinking of premenstrual syndrome therapy." Journal of Family Therapy **25**: 388-405.

Ussher, J. M. (2003). "The Role of Premenstrual Dysphoric Disorder in the Subjectification of Women." The Journal of medical humanities **24**(1/2): 131,16p.

Ussher, J. M., Hunter, M. & Browne, S. (2000). Good, bad or dangerous to know: Representations of femininity in narratives about PMS. Culture and psychology. C. Squire. New York, Routledge: 87-99.

Ussher, J. M., Hunter, M. & Cariss, M. (2002). "A Woman-Centered Psychological Intervention for Premenstrual Symptoms, Drawing on Cognitive-Behavourial and Narrative Therapy." Clinical Psychology and Psychotherapy **9**: 319-331.

Veith, I. (1964). Hysteria: The story of a disease. Chicago, University of Chicago Press.

Venema, H. I. (2000). Identifying selfhood : imagination, narrative, and hermeneutics in the thought of Paul Ricoeur. Albany, N.Y., State University of New York Press.

Vines, G. (1992). Raging Hormones. London, Macmillan.

Walker, A. (1995). "Theory and methodology in premenstrual syndrome research." Social science and medicine **41**(6): 793-800.

Wartik, N., & Tavris, C. (1998). Is premenstrual syndrome a medical disorder? Clashing views on abnormal psychology: A taking sides custom reader. S. Nolen-Hoeksema. Guildford, CT, Dushkin/McGraw Hill.

Wickham, M. (1958). "The effects of the menstrual cycle on test performance." British Journal of Psychiatry **49**: 34-41.

Wolf, N. (1992). The beauty myth : how images of beauty are used against women. New York. Anchor Books.

Woods, N. F., Lentz, M. J., Mitchell, E. S., Heitkemper, M., Shaver, J., and Henker, R. (1998). "Perceived stress, physiologic stress arousal, and premenstrual symptoms: group differences and intra-individual patterns." Research in Nursing and Health **21**(511-523).

Yardley, L. (1996). "Reconciling discursive and materialist perspectives on health and illness: A reconstruction of the biopsychosocial approach." Theory and Psychology **6**: 485-508.

Young, K. G. (1989). Narrative embodiments: enclaves of the self in the realm of medicine. Texts of Identity. J. S.Gergen & K. J. Gergen. London, Sage.

Zita, J. N. (1989). The Premenstrual Syndrome: 'Dis-easing' the Female Cycle. Feminism & science. N. E. Tuana. Bloomington, Indiana University Press.

Zita, J. N. (1998). Body talk: philosophical reflections on sex and gender. New York, Columbia University Press.