The Emergence of Premenstrual Syndrome
The Social History of a Women's Health "Problem"

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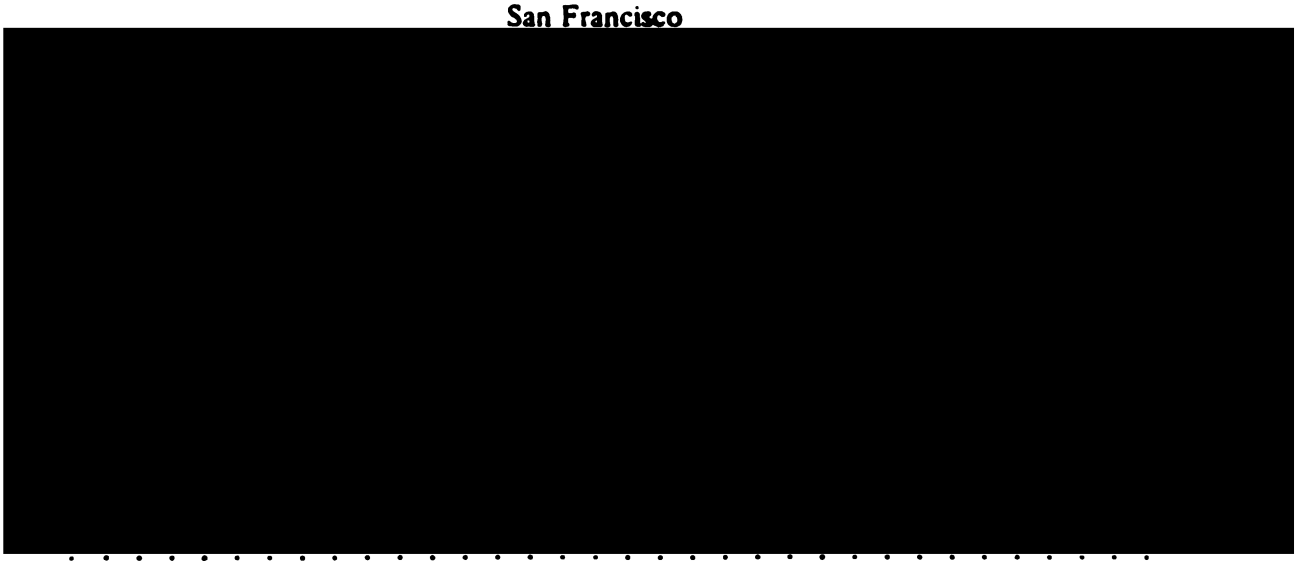

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Abstract

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Although premenstrual syndrome (PMS) has been a research concern for several decades, it did not capture public attention until the 1980's. Using the analytical framework of social constructionism and the conceptual categories of social problems and medicalization literature, I outline three eras in the emergence of premenstrual syndrome as a social problem. This discussion is grounded within a content analysis of three arenas of discourse: Medical, popular and feminist.

From this analysis, I conclude that issues, such as PMS, go through a process of emergence as social problems. This process involves both a cultural context, in this case changing views regarding the impact of women's biology upon their lives, and a specific tip-point or dramatic event after which an issue emerges as a social problem.

Early in the emergence process, debates over the nature of a given problem occur as contending yet interacting arenas of discourse debate its definition. In terms of PMS, part of this debate includes whether or not PMS is a medicalized issue as some authors within the feminist arena claim. I conclude that during the second era in the history of PMS part of the phenomenon, premenstrual symptoms, is medicalized within some arenas. Medicalization

in this analysis is not a monolithic, "all or nothing" process. When a health problem is emerging, parts of the phenomenon may be medicalized while others are not.

Finally, I conclude that social problems are time-limited depending upon the same factors that play a role in their emergence - dramatic events and cultural contexts. As long as the definition of a social problem is still in debate and it has elements of drama or dramatic events, it will remain within the social problems arena. However, if an issue is not resolved or does not sustain a certain level of drama, it will fade from public discourse, possibly to re-emerge again, depending upon dramatic events and the cultural contexts often associated with these events.

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Chapter 1

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PROBLEM STATEMENT

In the early 1980s premenstrual syndrome (PMS) emerged as a household word. Articles in the popular press instructed women on how to "beat the blues," overcome the "premenstrual uglies," and negotiate interpersonal relations during "that time of the month." Clinicians and researchers met at international conferences to discuss the definition, etiology and possible treatment for this syndrome that some researchers estimate affect up to 80% of all women.

Although premenstrual tension (PMT), as PMS was first labelled, has been in the medical discourse since Frank first wrote an article on the association between premenstrual tension and hormone imbalances (Frank, 1931), the label PMS did not capture the attention of the public discourse until the early 1980's. Why? What made PMS an issue for the 1980's? This dissertation traces the social history and the emergence of PMS as social problem, using Hilgartner and Bosk's (1988) definition of a social problem. They define a social problem as a "putative condition or situation that (at least some) actors label as a 'problem' in the arenas of public discourse and action, defining it as harmful and framing its definition in particular ways" (1988:70). Although I will discuss the

medical constructions of PMS, my primary focus is on the social constructions.

In order to trace the emergence of PMS, I conducted a content analysis of three arenas of literature: Medical, popular, and feminist. These arenas represent three distinct yet interacting paradigms of premenstrual symptoms and syndromes. From this analysis I create a model for the emergence of PMS as a social problem. Using this model I answer the following research questions: Why did PMS emerge in the 1980s? Who are the key actors and what are the key dimensions in this emergence process? I also discuss the contexts in which this discussion occurs and how these contexts relate to differing, yet interdependent, social constructions of women's bodies. Finally, I outline the implications of these constructions and processes.

In this introduction, I begin with a discussion of what PMS is and the controversies regarding its definition, management and treatment. Also I outline in narrative form the history of the emergence of PMS from 1931 through 1987. After this overview I briefly discuss women's divergent opinions regarding PMS, using some literature from my content analysis of the feminist and popular discourse but also sources not included in this review. From these sources it is clear that there is no single view that encompasses the meaning of PMS, an indication of the analytic problems one faces in doing research on such a topic.

It was important to include sources in addition to

those reviewed in the content analysis, since these views do not necessarily represent a picture of what many women might see in PMS. For example, the feminist literature examined in the content analysis was limited to articles that were critical or at least cautious of the generalized use of the label PMS to define women's premenstrual experiences. This strict selection criteria might not fit what others see as a feminist viewpoint, but was utilized in order to fit key facets of feminism and feminist theory as outlined in Chapter 3.

What is PMS?

Recent social attention to PMS suggests that it is a relatively new phenomenon. However, the existence of premenstrual emotional and physiological changes have been discussed for centuries. During the last century, women's reproductive organs were blamed for a variety of maladies, including the much discussed condition called hysteria (Smith-Rosenberg, 1972). Most of these discussions generalized women's problems to their uteri or menstrual cycles. I argue that the emergence of PMS represents a further fragmentation of women's menstrual cycles into discrete parts as opposed to an examination of the menstrual cycle as a process or whole.

In order to understand what I mean by the fragmentation of women's cycles, one needs some background about the biology of menstruation. In the following section I review this process using the medical model of a 28 day

cycle.

The Menstrual Cycle

The menstrual cycle is divided into four phases: follicular, luteal, premenstrual, and menstrual. In the follicular (preovulatory) phase, the pituitary gland secretes follicule-stimulating hormone (FSH), which stimulates several ovarian follicles to increase in size. These ovarian follicles contain the ova or eggs. Next the pituitary begins to produce luteinizing hormone (LH) and the follicles begin to secrete estrogen, which inhibits FSH. Ovulation occurs at the end of the follicular phase. The luteal (postovulatory) phase begins when the collapsed follicle or corpus luteum begins to produce progesterone. If the ovum is not fertilized, the corpus luteum begins to degenerate within 8-10 days. This signals the beginning of the premenstrual phase. Menstruation occurs as progesterone and estrogen levels drop to a very low level (The Boston Women's Health Collective, 1984.)

In brief, the cycle can be summarized as a follicular phase of 10-14 days, ovulation, a 8-10 day luteal phase, a 4-6 day premenstrual phase, and a 3-7 day menstrual phase which may overlap with the follicular. This, of course, is a simplified model and, in individual women, these phases differ somewhat in length.

In this simplified "ideal" model the premenstrual phase is relatively short. How can such a short part of a woman's cycle capture so much attention? In order to begin

to answer this question, I next review briefly the varying constructions of PMS as they emerged out of my content analysis.

Emergent Themes

Without discussing in detail the findings of this study, let me indicate some of the major themes which emerged from the content analysis as well as some general issues which emerged while conducting this research. (See Chapters 3, 4, and 5 for a detailed discussion of this analysis.) These themes indicate the diverse constructions of PMS. I start with a review of the medical construct and then discuss in a narrative, event - focused manner the history of the emergence of PMS. I conclude this section with a review of women's diverse constructions of PMS.

The Medical Literature

The content analysis demonstrates that there is no agreed upon definition of PMS. Definitions tend to be descriptive and vague. Although no concrete definitions are offered, researchers debate a variety of possible etiologies, symptoms, and treatments.

Researchers generally focus their efforts to find the cause of PMS on two areas: the hypothalamic-pituitary-ovarian-axis and the adrenal cortex. Although a variety of possible etiologies have been proposed, at this writing, the "cause" of PMS is unknown. Researchers are beginning to realize that there may be more than one syndrome as well as diverse symptom patterns.

The literature mentions some 150 possible symptoms which indicate that a woman may be suffering from PMS. I coded only the most commonly reported symptoms which included breast tenderness, bloating, cravings, depression and irritability. (See Appendix A for a complete list.) These symptom lists are inclusive rather than exclusive. Most women during some point in their cycles experience one or more of these symptoms, such as headache, irritability or fatigue. Most men also experience changes in mood and behavior during a month's time. Therefore, making a diagnosis of PMS is not easy or simple. In order for a physician to make a possible diagnosis, a woman should chart her cycles for at least two to three months. There should be a regular pattern of symptoms occurring at approximately the same time each cycle (any time from ovulation to 3-5 days before the onset of menstruation) with some similarity in the pattern of symptoms, but not necessarily in symptom severity. Ideally, there should be at least a 30% change between post-menses symptoms and premenstrual symptoms. These symptoms clear up or improve significantly with the onset of menses. Since there is not a test for PMS and the symptoms of PMS are extremely variable, a clinical diagnosis of PMS is based on a subjective assessment of a woman's reported symptoms.

Since there is no agreed upon cause of PMS and the symptoms women present are so varied, researchers and clinicians have proposed and tested a variety of possible

treatments with varied results. As new treatments emerge, articles generally appear that refute the alleged benefits of these treatments. As with possible etiologies and a concrete diagnosis of PMS, there is still no agreed upon effective treatment for premenstrual symptoms.

Major Events and Actors in the History of PMS:

In Chapter 5, I fully develop a framework and a history of the emergence of PMS as a social problem. The history of PMS as reflected in specific articles is reviewed. Events or actors that emerge as important historical markers in the literature that I reviewed are discussed.

The twentieth century history of PMS began in 1931 when Frank published an article on premenstrual tension (PMT) that continues to be cited today. (Frank, 1931). In this article, he outlined two case studies of women who had other medical conditions, yet these conditions appeared to worsen in the premenstrual phase. He stated that these cases illustrated the connection between ovarian function and systemic manifestations. The symptoms he discussed in relation to premenstrual tension were irritability, unrest, anxiety and "a desire to find relief by foolish and ill considered actions" (1931:1054). He conducted tests to determine if there was an abnormality in the secretion of hormones and concluded that women who suffered from PMT had an excess of female sex hormones. He recommended a variety of therapies from a reduction of caffeine to x-ray

treatments targeted at the ovaries.

At the same time, Karen Horney wrote a paper on premenstrual tension (Original publication date 1931; Reprinted in a collection of her work edited by Kelman in 1967). Her description of premenstrual tension is similar to what one could find today

> ...they consist of varying degrees of tension, ranging from a feeling that everything is too much, a sense of listlessness or of being slowed down, and intensities of feelings of self-deprecation to the point of pronounced feelings of oppression and of being severely depressed (1967:100).

She stated that most of these fluctuations were normal as opposed to pathologic. However, she claimed that PMT was caused by the physiological processes of preparation for pregnancy.

> I have by now become so certain of this connection that in the presence of the disturbance, I anticipate finding conflicts involving the wish for a child at the core of the illness and personality (1967:106).

Horney, a Freudian psychiatrist, concluded that PMT was caused by a woman's inner conflicts over becoming a mother.

During the next four decades, articles discussing premenstrual tension syndrome (PMTS), PMT, or PMS appeared with some regularity within the medical discourse. These articles generally reflected a similar type of analysis as found within Frank's work.

Articles on premenstrual symptoms did not emerge in the popular discourse until 1953. In 1953, PMT became a category in Readers' Guide to Periodical Literature. That

same year Greene and Dalton labelled premenstrual symptoms as PMS in an article published in the British Medical Journal (1953). Prior to this publication, the commonly used term for premenstrual symptoms was premenstrual tension. Greene and Dalton did not feel that PMT fully described the many components of the syndrome, since tension is only one symptom experienced during the premenstrual phase. This article was also one of the first to discuss the use of progesterone as a treatment for PMS.

PMT did not emerge as a separate category in Index Medicus until 1960. PMS did not become a category in either Index Medicus or Readers' Guide until 1985 (See Appendices D and E for a review of references in Readers' Guide and Index Medicus.)

From 1931 to 1980 one sees little difference between medical constructions and popular constructions of PMS. Most articles in the popular literature were medically focused and often medically constructed, consisting primarily in the format of doctor's advice columns.

In 1980 and 1981 two events occurred which dramatically changed the history of PMS. These events were two criminal trials in Britain in 1980 and 1981 in which PMS was used as a defense of diminshed capacity for murder charges. These trials represent the starting point of the contemporary history of PMS for it is after these trials that PMS emerged as a social problem. Articles in the popular literature increased and we see for the first time

a feminist discourse on PMS. The most dramatic increase occurred in the medical literature. This increase gradually built until, in 1985, there was a three-fold increase in the number of articles that appearred in Index Medicus. Each of these points is addressed in detail in Chapter 5.

Why do the trials represent a pivotal point in the history of PMS? In 1980 and 1981 the British courts reduced the sentences of two women charged with murder to manslaughter on the grounds that severe PMS reduced their capacity to control their behavior. They were released contigent upon their seeking progesterone treatment from the medical expert used at the trials. This expert was Katharina Dalton who not only co-authored the 1953 article in which PMS was first labelled but also has written several books about women's menstrual difficulties, specifically premenstrual problems. Dalton believes that PMS is a biologically grounded hormonal disorder due to a deficiency of progesterone during the premenstrual phase. This deficiency creates a chemical imbalance which affects both the mind and the body (Abplanalp, 1983).

These trials represent the first major public discourse on PMS. After the trials, many questions emerged about the etiology, treatment and effects of premenstrual symptoms on women. These questions in turn brought up larger questions about women's abilities to function while premenstrual as well as to control premenstrual difficulties. These questions and their implications will be addressed in Chapters 5 and 6.

As Sommer notes, the PMS defense "surfaced in England at a time when PMS seemed to have gained acceptance as an identifiable medical problem with a clear medical cure" (1984:36). This identification occurred earlier in the foreign medical discourse than in the U.S. As PMS moved into the U.S. medical arena, it became less clear and more controversial. PMS is not an acceptable defense in the United States although in 1982 a woman accused of child abuse did claim that it caused her to behave irrationally. This claim was dropped (Chait, 1986).

In 1986 another public controversy emerged. This controversy concerned whether or not a version of PMS, premenstrual dysphoric disorder, should appear as a new category in the Diagnostic and Statistical Manual of Mental Disorders. This manual is used not only as a basic reference book for mental health providers but also as a means to achieve reimbursement for services based on diagnosis. Since my review of the literature ended with the year 1987, I did not see much discussion of this event. However, it was a hotly debated issue within the psychological community as many psychologists and psychiatrists feared that it would reinforce the illness model of PMS and allow attorneys to exploit the new classification in criminal cases (Howard, 1986).

As noted, each of these events bring up central issues in the analysis of PMS as a social problem. Specifically, as I will trace in my analysis, the contending definitions

of PMS as they emerge out of each arena have potentially important implications for constructing views of the role a woman's biology plays in her ability to perform within the public sphere. Discussions regarding the impact that PMS has over women's lives thereby invoke long-debated issues regarding the influence that a woman's biology has over her destiny. Do women's reproductive cycles make them less stable or less reliable than men? Questions regarding the impact of a woman's biology on the rest of her life form the discurvive contexts in which discussions of PMS are framed.

Since discussions about PMS invoke arguments about women's abilities, the manner in which women construct these symptoms is important to consider. As one might expect, women are not unified in how best to handle the emergence of PMS as a women's health issue. Next I briefly outline the variety of opinions I encountered while conducting my research. These include authors who are part of my content analysis as well as others who were excluded from the formal analysis because they did not fit the the criteria I outline in Chapter 3. These comments begin to illustrate the variety of opinions and research complexities one encounters when researching the labelling of premenstrual symptoms under the heading of PMS.

Women's Views of PMS:

At one extreme women's constructions of PMS assert that PMS as a medical condition does not exist. These women

claim that PMS is another patriarchal attempt to oppress women and women's experiences and, by doing so, to divide and control them (Laws, 1983). On the other end of the continuum are those women who see the recognition of premenstrual symptoms by the medical profession as long overdue. These women are relieved that premenstrual symptoms are no longer considered a psychological disorder but are now recognized as a physical reality. (See Eagan's discussion of Virginia Cassara, 1983.) Between these extremes are women who recognize that PMS is a problem for some women but not for all. These women are critical of the general use of the term PMS to designate all premenstrual symptoms (Abplanalp, 1983).

In the following section, I briefly discuss each of these perspectives. First, I present data from secondary sources, such as magazine articles and scholarly articles. I conclude with a brief dicussion of women interviewed for a PMS study in which I assisted in order to get a feeling for women's lived experiences and first hand views.

The Public:

In terms of published discussions about PMS, I begin with those women who herald the recognition of PMS as a legitimate medical problem. The most vocal advocate of this stance is Virginia Cassara. Cassara, considered by some to be one of the primary actors in the emergence of PMS in the U.S., went to Dalton, a well known British physician and PMS researcher, in 1979 to be treated with progesterone for her PMS. Her treatment was successful and she returned to

the U.S. determined to help other women who have PMS. In order to do this, she started a national organization called PMS Action (Eagan, 1983).

Cassara views PMS as an ignored women's health issue and argues that when doctors do offer assistance, they push women into diet and exercise regimes that are hard to maintain and ineffective. She sees progesterone as the only valid treatment. However, it is not approved by the FDA for use as a remedy for PMS. Cassara states "'that it's paternalistic of the FDA to make those choices for us, to tell us what we can and cannot put in our bodies. Women with PMS are competent beings, capable of making their own choices'" (Eagan, 1983:31). Cassara sees PMS as a very serious health issue warranting treatment with progesterone. When asked of the possible risks of cancer from taking progesterone, she states that PMS is worse than cancer.

Moving to what might be called a middle ground, we find articles which discuss the emergence of PMS as not only a physiological condition but one in which socio-cultural variables may play a role. These articles recognize that premenstrual symptoms may be a problem for some women but are more critical of the general use of the label PMS to describe all women's symptoms.

In an article in Mademoiselle, Cantarow (1983) reported results from her interviews with women at a PMS Clinic. She found that many women are relieved to have a

label for their symptoms. However, Cantarow cautioned her readers to be careful of this label. Although no longer discussed as though PMS is "all in your head," another extreme, "all in your hormones," has materialized. Cantarow notes that there is evidence that socio-cultural variables may play a role in symptomatology. and cites a leading PMS researcher, Abplanalp, regarding her work with patients who had a high level of stress, brought on by factors such as a divorce, death, financial worries or school exams. In Abplanalp's study, women were more likely to suffer severe premenstrual symptoms than women who were not under stress (Cantarow, 1983:217).

Finally, we move to the other end of the continuum with women stating that PMS (or PMT as some authors refer to PMS) is not simply a physiological illness but a political construct with potentially far reaching implications for women:

> My argument is that Pre-Menstrual Tension is at its root a political construct - part of patriarchal ideology. Many feminists have supported the idea of PMT, and have promoted its acceptance by the medical profession, but have feared that it might be used 'against women'. I now think that we have been mistaken - PMT, as constructed as a medical problem is an idea through which women may be divided and controlled (Laws, 1983:20).

Laws does not deny the reality of women's suffering. However, she wants women to define and express their own experiences of their cycles and not have others define these experiences for them. She notes that the Western medical approach to PMT separates the mind from the body

which fragments a woman's experience of her cycle as part of her experience as a woman (Laws, 1983:20).

The Personal:

To contrast the public perspective with other perspectives of PMS, I want to present some themes from women interviewed for a PMS study (Lewis, 1989).

As a research assistant, I screened over 500 women for eligibility to participate in a PMS study. Although this study was not about these women's constructions of PMS, the screening interviews provided data on these women's experiences of premenstrual symptoms and what it means to and for their lives.

Their accounts fell along a continuum from having only a few symptoms to suffering symptoms that forced them drastically to alter their lives for up to two weeks each cycle. I spoke with women who either did not schedule appointments premenstrually or took time off from work in order to cope with their premenstrual symptoms. These women were desperate for answers and relief from their suffering. One woman broke down into tears and told me that if she did not get help, not only did she feel that her marriage would end but that she might not be able to go on living.

The most interesting group of women were those who reported to me that their husbands told them that they have PMS. When I asked them what they thought, some turned to their husbands for an answer. Several men telephoned for their wives. Some of these men had not told their wives

about the study before they spoke to me.

I also observed that there were a few women who self-reported severe premenstrual distress, yet when they started charting their cycles, their symptom pattern was not severe or did not particularly occur during the premenstrual phase.

Although this limited sample showed that PMS is very real for some women, many of these women were confused and unsure as to what exactly their symptoms meant to them or for their lives. They expressed confusion regarding the mixed messages that they received from their providers and the media. Others were angry that their doctors did not pay much attention to their symptoms or, on the other hand, that they assumed premenstrual distress was the cause of their troubles.

Although a few women were able clearly to articulate their experiences, some others found that their partners, friends and the media, defined their experiences for them.

What I have tried to show is that discourse, both public and private on PMS, is not easily captured by one article or one author. The emergence of PMS as a social problem has created not a clarification of women's premenstrual experience, but a muddling of understanding. It appears that the issue is no clearer now than it was 50 years ago when PMS first emerged as a label.

Summary:

In this introduction I have reviewed the necessary

background for the following discussion of the emergence of PMS as a social problem. I showed the divergent constructions of PMS within not only the literature I reviewed but also women's experiences of premenstrual symptoms and their reactions to public discourse.

Through out the following pages, many of these issues will be discussed in more detail. In the end, we will have a picture of how a women's health issue is constructed and defined through a process involving several arenas and cultural contexts.

In the next chapter, I discuss the theoretical framework necessary to begin this analysis.

Chapter 2

Theoretical Framework

Introduction:

> ...if social theory is to be viable and relevant, it must not only adhere to purely formal criteria of truth, however conceived, but it must also - as Foucault (1980) and Habermas (1971) have taught us - shift its focus as the pertinent questions and human predicaments of the lived world change their shape and form (Scott, 1988:4).

In this chapter I outline the theoretical and conceptual frameworks that I use to analyze the emergence and labelling of PMS. I choose as my primary framework social constructionism. I also discuss two conceptual categories within sociological discourse - the emergence of social problems and medicalization. These categories fit well within the social construction paradigm.

The term social construction is used by a variety of theorists. In this analysis, social construction refers to the work of Berger and Luckman (1966). Phenomenology forms the base for this framework. Others since Berger and Luckman have used the social constructionist label or been labelled as social constructionist. These writers include Marxists and post-structuralists, such as Foucault. However, these authors are not considered in this discussion since they do not ground their analysis in phenomenology or the work of Berger and Luckman.

The Social Constructionists:

In their book The Social Construction of Reality, Berger and Luckman take the concerns of phenomenological sociology and try to bring in a structural and institutional focus. Their approach attempts to integrate macro- and micro-phenomena: "Society is a human product. Society is an objective phenomena. Man is a social product" (Berger and Luckman, 1966: 79). Women and men are the products of the world in which they create. This process of the production of everyday knowledge is a key element of their argument.

Central to my interests, and closely associated with the work of Schutz, is Berger and Luckman's discussion of the "everyday world." They concern themselves with the commonsense knowledge that forms the basis for everyday life. This knowledge is shared with others and provides a sense of ordered reality in one's life. It is also "taken for granted as reality. It does not require additional verification over and beyond its simple presence. It is simply there..." (1966:37).

The reality of everyday life is created with others through the process of face-to-face interaction. This is the prototypical model of social interaction. This interaction involves the exchange of meanings between individuals in a personalized manner. However, as one moves to less intimate relations, the process of interaction is based more on typification. "The social reality of everyday life is thus apprehended as a continuum

of typifications, which are progressively anonymous as they are removed from the "here and now of the face-to-face situation" (1966:48). From this increasingly anonymous process develops what Berger and Luckman label as a social structure. The social structure is "the sum total of these typifications and of the recurrent patterns of interaction established by means of them...[and] is an essential element of the reality of everyday life" (1966:48).

The parts of society that we consider to be objective and real (what we label as structures) are humanly produced and constructed Berger and Luckman (1966:78). These institutionalized patterns of interaction are the result of habitualized actions that appear to exist beyond the actors. Social institutions do control human interaction in the sense that they provide predefined patterns of conduct which individuals must somehow negotiate.

Although Berger and Luckman attempt to bring together the macro and micro elements of one's everyday experience, except to state that the objective is subjective, they do not deal with the influence that structural elements have on the everyday world very well. They do not clearly answer their own statement that "society is a human product. Society is an objective reality. Man is a social product" (1966: 79).

Social construction has been used as the backbone for

a variety of types of analysis. Olesen (1986) analyzes toxic shock syndrome (TSS) as emergent issue in women's health. Her framework combines social construction with an analysis of an emerging issue. After a review of the history of the management of menstrual flow, she discusses the emergence of what became labelled as TSS. This review looks at the communities that took an interest in the issue. In the early phase of research and public awareness, there was a great deal of ambiguity and controversy over what TSS was and what should and could be done about it. In this sense,

> the toxic-shock phenomenon poses critical questions in the definition and construction of the issue qua issue and the nature of the parties generating contending definitions. This suggests that even medical or epidemiological knowledge of the problem is socially constructed (Olesen, 1986:57).

TSS is not simply a biological issue; it is a cultural or "sociogenic" issue. "Its origins lie in the sociocultural situation in which women find themselves" (1986:58).

The varying definitions of TSS represent different constructions of parties vying for control over the dominant or accepted definition. This type of analysis must include a consideration of the structural issues that shape and affect the definitions of the contending parties. These structural factors, in Olesen's analysis, include material interests that are tied to profit motives.

As one can see, Olesen ties her analysis of an emerging issue into the social constructionist perspective

in order to address the obvious as well as the latent interests and contending definitions of TSS.

The social constructionist framework is not without critics. Bury (1986) wrote an extensive critique of social construction as used in the field of medical sociology. I will briefly discuss those points that apply to my analysis.

Bury (1986) uses the social construction label in a general sense and brings in a variety of theorists whom he feels fit under this heading. By doing this, he brings up the point that social construction is ambiguous because so many use the label from so many intellectual and ideological perspectives. Bury is correct on this point when one brings in so many under the label. However, he does not really discuss the roots of the perspective and the fact that when a Marxist uses the term social construction, it is to further the Marxist framework, focusing particularly on the social construction of production and class society. He also brings in the work of Foucault, who discusses knowledge and power in a problematized fashion. Foucault usually is classified as a post-structuralist and not a social constructionist.

As the opening quote in this chapter states, in order for social theory to remain relevant, it must be adapted to changes in the world in which it is representing. The label "social construction" is used by a variety of theorists in order to address issues that are relevant to the time.

However, social construction, in its original form, comes out of phenomenology. One must be clear about the purpose and perspective when using the label.

Another criticism Bury makes is that social constructionists often fail to acknowledge the extent to which "external physical reality imposes itself upon human knowledge" (Nicolson & McLaughlin, 1987). In the case of PMS, this would mean not dealing with or addressing the physical reality of some women's suffering. In this dissertation, I intend to address the interplay between the physiological and the social aspects of PMS.

Although the major criticisms discussed above do not represent all of Bury's comments, they bring up some important points that I must address in my use of social construction. Bury also criticizes what he sees as an exaggeration of the phenomenon of medicalization. I will discuss this point further when I address medicalization.

PMS and the Social Construction Framework:

I choose social constructionism as conceived by Berger and Luckman because it enables me to draw out the social conditions, as traced through the actors involved, that help explain the explosion of interest in PMS during the 1980's. PMS is not just a medical phenomenon that has existed over the last 50 years and suddenly became a popular, feminist and medical concern. It became a concern for a variety of interacting factors. It is my goal to outline and trace these factors in order to explain the

emergence of a women's health issue in the 1980's and beyond.

PMS is a "sociogenic" issue that is played out within the public discourse through three arenas of literature - medical, popular and feminist. Through my content analysis of this literature, I will seek out the intended and unintended consequences of the emergence of PMS. I will also consider the contending, yet interacting interests of the actors involved in this emergence - clinicians, researchers, popular writers and individual women.

Although Berger and Luckman may not have succeeded in connecting and bringing in macro-level factors, Olesen shows that it is possible to use social constructionism to understand the influences of larger macro-level forces in the shaping of an emergent issue.

Conceptual Categories

In this section, I tie together literature on the emergence of social problems and medicalization with social constructionism. This is not a new approach.

> ...social problems are the definitional activities of people around conditions and conduct they find troublesome, including others' definitional activities. In short, social problems are socially constructed, both in terms of the particular acts and interactions problem participants pursue, and in terms of the process of such activities through time (Schneider, 1985:209).

Medicalization also ties into this discussion because this framework considers how medical issues are affected by social and cultural forces and how these forces are shaped

by the actors involved in the debate over the definition and management of a given issue.

These two conceptual categories are outlined below separately. Since scholars from a variety of theoretical paradigms have used each of these categories, I limit myself to only those that are appropriate to my analysis of PMS within a social constructionist framework.

The Medicalization/Demedicalization Literature

Within the field of medical sociology, theorists from a variety of perspectives discuss the concept of medicalization. What is medicalization? Riessman states that "It is widely recognized that illness has become a cultural metaphor for a vast array of human problems". She feels that the medical model has come to be used "from birth to death in the social construction of reality" (Riessman, 1983:3). This perspective alleges that the medical community plays an increasingly larger role in the defining and treatment of problems that are not historically medical in nature, such as drug abuse, obesity and childbirth. Some critics of this trend see the encroachment of a medical model as a way to regulate and control individual behavior that may be labelled as deviant or dangerous to society (Conrad and Schneider, 1980). Others, such as Strong (1979), feel that medicine is actually being constrained and limited rather than expanded.

There is no consensus on the cause of medicalization.

Illich (1976) believes it is derived from medical imperialism. Zola (1986) feels it is the result of a reliance on scientific experts who can explain an increasely complex society through the use of a rational scientific approach. Others see it as an attempt to control and create markets (Larson, 1977). Finally, Waitzkin (1981) views it from a Marxist perspective as an attempt to perpetuate and maintain existing class interests and dominance.

Although many authors speak about medicalization as though it exists as a real entity, it is in itself a social construction and a label for helping one analyze what occurs in the provision and management of health care. This point should be remembered through out this review of the medicalization literature. In my summary of this section, I present a critique of the concept.

In 1972 Irving Zola wrote what is considered to be a ground-breaking article on medicalization and social control. The article used in this summary was reprinted in 1986 in a collection of essays on the sociology of health and illness (Conrad and Kern, 1986). In "Medicine as an Institution of Social Control" (Zola, 1986), Zola writes that medicine is becoming a major institution for social control.

> It is becoming the new repository for truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts (Zola, 1986:379).

He sees this process occurring through the increasing

medicalization of daily living.

Zola believes that medicalization is not occurring through the efforts of professional imperialism but through "our increasingly complex technological and bureaucratic system - a system which has led us down the path of the reluctant reliance on the expert" (Zola, 1986:380). Zola grounds his argument within a sociohistorical framework in which he traces the rise of medicine and psychiatry.

How has society become medicalized? In Zola's view there are four ways in which the medical profession claims jurisdiction over traditionally non-medical areas. The first is "the expansion of what in life is deemed relevant to the good practice of medicine" (Zola, 1986:382). This includes the physician playing an increasing role in monitoring not only the patient's bodily symptoms but also personal lifestyle habits and worries, such as diet and exercise, personal relationships, and work problems. Closely tied with the latter is the physician's retention of absolute access to certain "taboo" areas. Medical practitioners have almost exclusive access to the "most personal of individual possessions - the inner workings of our bodies and our minds" (Zola, 1986:384). If anything can be shown to affect the body, then, it can be labelled as an illness or medical matter, for example, aging, pregnancy and drug addiction. The fact that it is accepted that physicians treat the body and mind means that people are seeking increasingly the assistance of physicians for personal and social problems.

Historically, doctors have put themselves in the position of personal confidantes, especially in treating women's illness, such as hysteria which has been connected with lifestyle and personal relations (Smith-Rosenberg, 1972). What needs to be addressed within this analysis is doctor's continuing retention of this access in light of decreased respect for medicine as shown by increased litigation and alternative types of health care. As Zola notes, we must increasingly rely on technical experts in order to have access to high-tech care. Doctors represent gatekeepers to the technology which many regard as necessary to live longer and remain healthier. In this case individuals seek out doctors for their role as technocrats in giving advice on what has increasingly historically included personal and social problems.

Doctors are not only technocrats who merely operate machines but, in Zola's analysis, also regulators of moral and social issues which are unassociated with medical necessity. Two areas of particular concern for Zola are surgery, including abortion and plastic surgery, and drug prescribing. Abortion and in many cases plastic surgery are associated with women's identities, choices, and roles. Doctors, having control over these practices, therefore, play an important role in defining what women can and should do with their bodies and their lives.

Lastly, Zola is concerned with the use of medical rhetoric and evidence used to advance any social cause.

His most interesting example is the charge that a school dress code was necessary for "health" reasons without the school officials stating why (Zola, 1986).

What are the consequences of medical control? Zola feels that medical control will expand as long as

> everyone has or believes he has something organically wrong with him, or to put it more positively, how much can be done to make one feel, look or function better (Zola, 1986:385).

One's self concept can change if one can find a way to appear or feel differently. Thus, it is possible for the medical profession to come to define social values (good vs. bad living) and control or influence what should or should not be done to attain the goal of good health.

Conrad and Schneider draw upon the work of Zola in their book Deviance and Medicalization: From Badness to Sickness (1980). These authors label themselves as interactionists who add an historical lens to their analysis. Classic interactionist discussions of deviance

> usually [focus] on the social processes of defining and labelling deviants in contemporary society. Rarely have interactionists ventured into history and attempted to use similar assumptions to understand the historical development of definitions of deviance (Conrad and Schneider, 1980:2).

Intergral to an interactionist analysis of medicalization is that concepts such as deviance, which have come to be medicalized, are socially constructed and "relative to actors, context and historical time" (Conrad and Schneider, 1980:2). These definitions, although they may encompass medical components, have a strong social

component. They have become labelled as a medical problem due to non-medical factors, cloaked within medical jargon. These factors include possible material, political and social motives.

Like Zola, Conrad and Schneider tie their discussion of medicalization and deviance to social control. They see the expansion of medicine pushing doctors into the role of agents of social control.

> Medicine has not always been the powerful, prestigious, lucrative, and dominant profession we know today. The status of the medical profession is a product of medical politicking as well as therapeutic expertise (1980:9).

By tracing the development of the medical profession over time, they show how the profession has consciously attempted to expand its authority and autonomy. This has expansion resulted in physicians winning an "almost exclusive right to reign over the kingdom of health and sickness, no matter where it may extend" (1980:16).

Conrad and Schneider outline six areas which have become medicalized: mental illness, alcoholism, opiate addiction, child abuse, homosexuality and crime. They show how categories, such as homosexuality, have become demedicalized over time due to the efforts of the gay rights movement and some reformist psychiatrists and psychologists. However, they point out that a majority of people would still label homosexuality as an illness requiring a cure. Thus, in actuality it may not be

demedicalized in the general population illustrating the strength of the medical definition.

Conrad and Schneider sum up their book with a discussion of the consequences for society of the dominance of medicine as an institution of social control. They see benefits to increasing medicalization. For example, alcoholism is "no longer considered a sin or even a moral weakness; it is now a disease," and the medical management of alcoholics can be viewed as a more humanitarian means of social control (1980:246). For some issues, a medical definition may increase compassion and tolerance for human problems and soften the potential to blame the victim. If persons are ill, they have a sickness. They are not to blame for their illnesses. Also, a possible treatment can be offered for this illness which, in turn, offers hope to the sufferer.

However, Conrad and Schneider feel that there is a darker, latent side to medicalization that has potentially serious negative consequences. When an issue is defined as medical, it falls into the realm of moral neutrality that presumably surrounds medical science. However, this moral neutrality merely cloaks the issues. The moral issues remain but are not addressed.

> Medical definitions have a high likelihood of dominance and hegemony: they are often taken as the last scientific word. The language of medical experts increases mystification and decreases the accessibility of public debate (1980:249).

Moreover, medicalization individualizes social

problems. Instead of addressing possible social causes for illnesses, the illness is treated on an individual, case-by-case basis, limiting the potential for social levels of analysis and consequent structural changes. Structural factors can cause or contribute to illnesss. For example, stress can play a role in increasing premenstrual symptoms (Meister, 1986). Therefore, it may be possible that such factors as increased roles and responsibilities or lack of day care may contribute to stress in women's lives which may lead to increased premenstrual symptoms. However, when a woman goes to her doctor for treatment, her symptoms become individualized and disassociated from her everyday experience as a working woman in a world constructed to fit men's, not women's, experiences.

Finally, Conrad and Schneider (1980) argue that when one suffers from what has been labelled as a medical illness, the individual can be treated in a manner that can take the form of social control. When homosexuality was identified as an illness/sickness, this label enabled the medical profession to treat what many considered perverted, abnormal behavior, and, thereby control the behavior of individuals to fit societal norms.

Conrad and Schneider's analysis was more elaborated than this summary. However, many of the points omitted here are addressed by Riessman's (1983) feminist social constructionist analysis of medicalization. In her "Women and Medicalization: A New Perspective," Riessman addresses medicalization in general and specifically looks at five

medicalized conditions which affect women's lives. Why is her perspective feminist? Riessman takes as the central focus of her argument women and women's experience as the targets of medicalization. She states that the medical profession is defining a greater and greater portion of women's lives and physiological functions as needing medical intervention. As evidence of this trend, she discusses the manner in which childbirth has become a condition "that necessitates routine medical scrutiny" (1983:6). She ties the medicalization of childbirth into a complex "sociopolitical process in which both physicians and women participated" (1983:6). This process includes the decline of midwifery as tied to the rise of physicians and the desire of some women for painless childbirth.

"As a larger number of critical events and human problems have come under the 'clinical gaze' ...our experience of them has been transformed" (Riessman, 1983:3). This gaze, as conceived by Foucault (1973), focuses frequently on women. Riessman, like Conrad and Schneider, stresses the negative and positive consequences of the process of medicalization. Women have "simultaneously gained and lost with the medicalization of their life problems" (1983:3). For some women, having a condition such as PMS (recognized as a somatic illness, and not as a mental state) is a relief. Perhaps they can be cured! However, this recognition may result in women taking possibly dangerous treatments or facing negative portrayals

of premenstrual women.

Riessman stresses that women actively participate in the construction of new medical definitions. Women are not "simply passive victims of medical ascendancy" (1983:3). She sees the casting of women into purely passive roles as a perpetuation of the very assumptions that "feminists have been trying to challenge." For example, the use of drugs to anesthetize women during childbirth ("twilight sleep") (Leavitt, 1980) was instituted not just for the convenience of the physicians but also because some women did not want to feel the pain associated with childbirth.

Riessman ties medicalization to the medical profession's ideological and material motives which relate to profession development and the market conditions during a given historical period. The interests of physicians have coincided with the interests of certain classes of women who desire to have their experiences, such as childbirth, understood in new terms.

As a variety of groups with different interests join together, a consensus develops that helps define a human condition in clinical terms. This consensus for women is "fraught with contradictions" because women stand to gain as well as lose from a redefinition of a social phenomen as a problem as medical. Women may get symptom relief, but the social causes of their problems are ignored. Also, the potential for political action becomes limited when women are treated on an individual basis and come to accept uncritically their condition as an "illness" and discuss it

as such with other women. Unless women come together to discuss what ails them, it becomes harder and harder to see the social, political or material factors that play a role in the process of disease definition.

Riessman, like the social constructionists, grounds her feminist argument within a social framework. She sees medicine as much more than merely a scientific enterprise.

> A biological basis is neither necessary or sufficient for an experience to be defined in terms of illness. Rather, illness is constructed through human action-that is illness is not inherent in any behavior or condition, but conferred by others (1983:4-5).

She goes further in her analysis to add that science as well as illness is socially constructed. The production of scientific knowledge is a historically determined social activity. It is not value-free and neutral.

> Certain problems are selected for study, others are not. Certain phenomena are embraced by scientific theory, others are not. Social agenda are embedded in these choices (1983:5).

Finally, the medicalization framework stresses that the power of physicians to define and monopolize the illness process is the outcome of a political process. Physicians' power is related to the structure of power in any given historical period.

> The political dimension inherent in medicalization is underscored when we note that structurally dependent populations - like children, old people, racial minorities, and women - are subject disproportionally to medical labelling (1983:5).

Riessman concludes with a discussion of

demedicalization. Unlike Fox (1977) who sees demedicalization occurring due to deprofessionalization, Riessman does not feel that demedicalization will occur until there is an alteration in "the ownership, production, and use of scientific knowledge" (1986:16). Although Riessman does not spell out the latter, one can assume from her arguments that she would advocate the separation of medical practice from material and political interests. This process may also entail a questioning of the objective nature of science and thus address the fact that science is not inherently objective and amoral.

The challenge for feminists, as articulated by Riessman, is to address women's health problems within the larger contexts of their lives. How would women's medical problems be addressed if women were more empowered and allowed to express a full range of emotions?

I conclude this section with a critique of the concept medicalization as a sociological phenomenon. I use the concept of medicalization critically. It is not my intent to reify the process of medicalization, although at times I discuss it in this manner in the previous review. In my literature review for this section, I located only a few articles which critique medicalization. In addition to Fox's (1977) commentary on medicalization and demedicalization within U.S. culture, there is Bury's (1986) commentary on social construction and medical sociology and a review of Conrad and Schneider's book by

Horwitz (1981).

Horwitz (1981) reviewed Conrad and Schneider along with another book on deviance. He generally focused his discussion on medicalization as it applies to deviance, yet he offers some general comments on the concept. He did do not question medicalization as a phenomenon but suggested that researchers should offer better explanations for its growth, specifically addressing the role of the welfare state. He also noted that researchers need to sharpen the meaning of the concept and "to explore its diverse and often metaphorical usages" (1981: 751).

In a critique of the social constructionist approach as applied to medical sociology, Bury (1986) stated that there is a "tendency to exaggerate the hold which medicine has over contemporary experience" (Bury, 1986:157). Although some of the authors reviewed in this section claim that life is becoming increasing medicalized, Bury notes that "there is increasing evidence to show that modern populations do not totally rely on technical or medical explanations in accounting for the causes of disease" (1986:158). Fox (1977) states that although cultural demedicalization is not occurring, there is still a process of demedicalization within society. Specifically, she says there are attempts to "destratify" doctor-patient relationships, develop patients' rights, and focus on ways in which people can remain healthy and not rely on the medical profession. This process of demedicalization is generally not addressed by the authors who claim that

medicalization is taking on a greater role in life. Therefore, a socially constructed category of medicalization should be considered as only one possible means to explain the many processes and factors that effect the health care system today. I see its use as a sensitizing concept in my analysis of the predominance of the medical definition of PMS (Blumer, 1954).

How does the concept of medicalization apply to my analysis of PMS? Whether or not PMS is a medicalized phenomenon is part of the analysis of the emergence of PMS as a social problem. Of the three eras of PMS history outlined in the introductory chapter, the issue of the possible medicalization of PMS fits into the second era. It is during this period that PMS emerged as a social problem with varying and contending definitions. As I will show, parts of this debate have elements of medicalization as traced within this discussion. While a health problem, in this case also a social problem, is still in a period in which its definition and management are problematic, aspects of this social problem may appear or be medicalized. As a social problem becomes more clearly defined, medicalized aspects of the problem shift in clarity as well. These points will be elaborated in Chapter 5.

Literature on the Emergence of Social Problems

Here I review the classic social problem literature, specifically the work of Fuller and Myers (1941). I will

also discuss a recent work on social problems that forms the backbone of my analysis of the emergence of PMS as a social problem.

This literature is critical for my analysis of PMS. I see PMS emerging as a social problem after the trials in Britain in 1980 and 1981. This discussion, therefore, focuses on the definition and emergence of a social problem. In "The Natural History of a Social Problem," Fuller and Myers define what a social problem is and offer four stages through which social problems go. These stages are considered a natural history.

A social problem is a "condition which is defined by a considerable number of persons as a deviation from some social norm which they cherish" (Fuller and Myers, 1941: 320). It consists of both objective and subjective elements. The objective elements are things in society that are measurable or can be experienced. Subjective elements are the feelings and attitudes that people hold about a given condition. The definition of a social problem is relative. People experience objective conditions differently. A problem for one person is not necessarily a problem for another. "Social problems arise and are sustained because people do not share the same common values and objectives" (1941:321).

The natural history of social problems is "a conceptual tool for the examination of data which constitute social problems" (1941: 321). Social problems

are in a dynamic state of "becoming " and pass through three stages: awareness, policy determination and reform (1941: 321). In later literature on social problems (Henslin, et al, 1983) there are four stages: awareness, official action, people reacting to official actions, and people devising alternative strategies to deal with problem.

Stage One - Awareness:

Before a social problem can be labelled, there must be an awareness on the part of the actors that a given issue or situation ought to have something done about it. "These people have not yet crystallized their definition sufficiently to suggest or debate exact measures for amelioration or eradication of the undesireable condition" (1941: 322). However, they feel a need to do something.

Stage Two - Policy Determination:

After the awareness stage, the debate over alternative solutions starts. "Ends and means are discussed and conflict of social interests becomes intense" (1941:324). In this stage the focus is on what ought to be done with proposals coming from all interests.

Stage Three - Reform:

The final stage, according to Fuller and Myers, is reform. In this stage general interests and possible policies have been debated. Now it is up to "administrative experts specially trained in their jobs to administer reform" (1941: 326).

In their conclusion, Fuller and Myers stress that one

> seeks to explain social problems as emergents of the cultural organization of the community, as complements of the approved values of the society, not as pathological and abnormal departures from what is assumed to be proper and normal (1941: 328).

Although Fuller and Myers comment on the importance of placing social problems within the cultural context of the community, they do not address larger structural matters, such as economic concerns, class interests, or political, social and cultural factors which may play a role in the definition process and natural history. Social problems tend consequentially to be defined by those who have access to the policy process which may be influenced by economic, social and political power. Therefore, what is considered a social problem will be skewed to the opinions of those who have definitional ability and access to the channels which create the policy. If those actors and groups with power do not feel a need to change the status quo, those persons fighting for change will have an uphill battle.

Social problems are also shaped by the cultural context of the time. In 1988 Higartner and Bosk, wrote a paper entitled "The Rise and Fall of Social Problems: A Public Arenas Model." This paper offers an excellent update of the social problems literature as well as some potentially important ways to analyze the emergence of PMS. (Their framework is discussed in greater detail in Chapter 5.)

The authors note that since public attention is a scarce resource, competition and selection in the media and

other arenas of discourse is important to consider in the process of definition of a social problem. Linkages among public arenas produce feedback that in turn drives the development of social problems. This growth, however, is limited due to the finite carrying capacities of the public arena. The tension between the constraints and forces for growth produce successive waves of problem definitions. When a social problem emerges and when it disappears is linked to a variety of social and cultural factors.

Hilgartner and Bosk provide a variety of important concepts to consider in the emergence of PMS. The emergence of PMS now as opposed to 10 years ago or 10 years from now, is linked with a variety of factors, including drama, culture and politics. These factors are tied to diverse actors, such as clinicians and researchers in medicine, the popular media and women as well as the women's health movement. As I will discuss in Chapter 5, PMS emerges as an issue in the 1980's due to many interacting factors: 1) changes in women's roles in the home and the labor force; 2) views of women in the medical arena, by the general public, and media; 3) the restructuring and redefining of the women's movement and "feminism" in the 1980's and; 4) interactions among women, physicians and the media. These interactions form the foundation of my analysis. How long PMS stays in the public eye is also related to drama, culture and politics. These factors will also be addressed in Chapter 6.

Summary:

In this chapter, I have outlined my primary theoretical framework and reviewed two conceptual categories that I will apply to this framework. By using a social constructionist framework, I am able to draw out the social conditions and actors involved in the emergence of PMS as a social problem. As part of this analysis, it is essential to address Riessman's (1983) argument that PMS is a medicalized phenomenon. The story of the emergence of PMS as a medical problem, possibly a medicalized phenomenon, and as a social problem will be told in Chapter 5. In the next chapter, I outline the methodological approach needed in order to tell this story as it emerges out of the medical, popular and feminist literature.

Chapter 3

Methodology and Data

In this chapter, I outline the selection process and nature of my data. I also review my methodological approach, content analysis, in processing the data collected. I elaborate on these results in Chapter 4.

Data Sources:

I went through several phases before settling upon my choice of data sources. I attempted to provide a representative sample of the medical, popular, and feminist literature pertaining to my topic, the emergence and social construction of premenstrual syndrome (PMS).

Medical Literaure:

First, I reviewed Index Medicus from 1931, when Frank published the first contemporary article on premenstrual tension, to 1987. (See Appendix E for a summary of the Index Medicus citation on premenstrual symptoms.)

I went through Index Medicus to see what journals had published articles on PMS over time. I also wanted journals that were generally accessible as well as considered to be legitimate in a given field of research. I limited myself to United States journals. The journals I chose for my final review are The American Journal of Obstetrics and Gynecology (OB/GYN), The American Journal of Psychiatry (AJP), Psychosomatic Medicine (PS), and Research in Nursing and Health (RHN). After speaking with various people in

these fields, they agreed that these journals generally represent the forefront of research in each field. I wanted to include a research nursing journal and chose Research in Nursing and Health after consulting several nurses with doctoral preparation. Both the American Journal of OB/GYN and the American Journal of Psychiatry have been in existence since (and before) 1931. Psychosomatic Medicine started in 1939 and Research in Nursing and Health started in 1952.

As a limitation of this approach, I reviewed only a limited number of journals and articles. Each journal has an inherent bias toward one type of discourse. While of necessity I had to limit the total numbers of articles reviewed, I still had to choose journals representative of a given field of research.

In terms of actual numbers of articles in each journal that discuss PMS from 1931 through 1987, there were 21 articles in the American Journal of OB/GYN, 13 articles in the American Journal of Psychiatry, 13 articles in Psychosomatic Medicine, and 4 in Research in Nursing and Health for a total of 51 articles reviewed. (See Appendix C for Summary of Articles reviewed.)

In reviewing Index Medicus I only chose articles that had PMS, PMT, PMTS, or premenstrual changes in the title. Therefore, I may not have found all articles dealing with premenstrual changes, especially if they fell into a general discussion of menstruation.

Popular Literature:

The process for choosing the journals that I reviewed in this category of literature is somewhat more arbitrary. Again, I sought U.S. journals that are fairly accessible to the general reader. I reviewed The Readers' Guide to Periodical Literature from 1931 through 1987. I wanted to find at least two journals that had published articles on PMS over at least 4 decades. I chose Ladies Home Journal and Reader's Digest since both included articles on PMS over several periods of time. I also decided to review a variety of journals that covered several possible types of readers. These journals were Essence, Mademoiselle, Newsweek, and Psychology Today. (See Appendix C for a summary of each of these articles.) I reviewed a total of 25 articles from these six journals. As with the medical literature, I only reviewed those articles having premenstrual changes, PMS(T) or some other label that is synonymous with PMS in the title. Articles that included premenstrual changes under a broader heading of menstruation may have been excluded.

Feminist Literature:

The process for defining and choosing what represented the feminist literature on PMS was more complicated than the process of choosing the medical and the popular literature. One cannot simply pick up a certain set of journals and locate the feminist literature on PMS. Rather this highly specialized literature is scattered and simply

needed to be tracked down using usual library research methods. I began by reviewing what literature I had that claimed itself to be feminist. I also reviewed a variety of articles and books that seemed to be feminist. It became clear after this initial process that I needed to set out clear guidelines for what I would and would not deem "feminist literature." This was not easy for I excluded some articles that others might consider feminist. I also realized that feminist literature on PMS falls along a continuum from a radical perspective that defines PMS as a patriarchal macro construct to articles that border on being fairly medical and micro in their focus, yet maintain a critical eye toward the labelling and construction of PMS.

Therefore, in thinking about my criteria for inclusion and exclusion, I considered several key facets of feminism and feminist theory. Feminist authors not only create studies that are broadly based, but they also consider the implications of a given research topic for women's lives. In the case of PMS, feminist authors need not necessarily deny a biomedical reality that has come to be constructed as PMS but must at least examine the implications of this construct for women. Finally, constructions of PMS must be considered on a variety of levels, since PMS is a phenomenon that effects individual women as well as societal images of women. Feminism traditionally has united "the micro and the macro, the personal and the political, the public and the private, theory and action, and male and

female" (Berg, 1987).

The term feminist most often

> refers to a point of view that (1) sees women as exploited, devalued, and often oppressed, (2) is committed to changing the condition of women, and (3) adopts a critical perspective toward dominant intellectual traditions that have ignored and/or justified women's oppression (Acker, 1983:423)

Feminist theory is more than just a commentary or critique of woman's position in society. It also focuses on social action and change. On the cover of Feminist Studies it states that feminists not only have the potential "fundamentally to reshape the way we view the world [but also]...to change women's condition" (Feminist Studies, 1988).

Koeske outlines specifically how a feminist perspective handles scientific and medical investigations of women's menstrual cycles:

> ...it challenges the view that science is disinterested and looks for linkages between beliefs about women and the social and political forces affecting women's lives. It strives to understand the hidden justification for power differences contained in scientific medicine's assumptions about what is normal or proper for women, for the cycle, and for the conduct of research (Koeske, 1983).

Therefore, I have three criteria that classify an author's work as feminist:

1) The author must question the dominant attitudes toward PMS research. This does not mean that an author must refute totally a medical construct but that she must consider a broader perspective. This broader view takes

into consideration that the etiology of PMS and its treatment must unite personal, social and cultural factors as well as medical/physiological factors that may cause premenstrual symptoms;

2) The writer must question the implications of commonly cited views and constructions of premenstrual changes for the individual woman and women as a whole;

3) and the author must unite various constructs of PMS with women's experiences.

These criteria clearly limit the number of authors that fit. There are several fine scholars whose research does not fit these criteria because they have an uncritical acceptance of the basic medical model of the etiology and treatment of PMS. Many of these authors are changing the face of traditional menstrual cycle research through a critical review of previous studies and methodologies. (In particular, see Woods, et al reviewed in Research in Nursing and Health under medical literature and the two volume set entitled The Menstrual Cycle, Vol. 1 & 2, 1980.)

I reviewed 15 articles in this category. Generally, I did not review more than one article by a given author unless it offered a different analysis or approach to the topic. This was simply a matter of convenience. Finally, I may not have included all feminist writers since there is no guide to feminist literature on this topic. Therefore, my sample includes only what was accessible.

Methodology:

In tracing the emergence of PMS as a social construct over time, it was important to step into the literature to see if my assumptions, as well as others, regarding the emergence of PMS as a socially constructed phenonemon had any foundation. I needed to ground my assumptions in a solid base from which an analysis could emerge. Therefore I chose content analysis as my primary methodology.

Content Analysis: Its Strengths and Weaknesses

Content analysis is considered to be an objective and systematic means to quantify and analyze both manifest and latent content in a text of any sort. Manifest content refers to what is actually present or absent in a text. Latent content refers to meaning and requires interpretation on the part of the researcher.

The process of a content analysis starts with a researcher developing a set of coding categories which will enable, ideally, the researcher to answer a theoretical question. Next, the researcher codes data (articles, speeches, and advertisements) in order to quantify the coded interests. As Holsti (1969:67) states content analysis starts with

> careful formulation of the question in theoretical terms prior to coding and analysis so that the interpretive process is not reduced to finding some explanation which fits the data.

However, recently, content analysis has taken a different approach. Researchers now often start with some

type of data in mind as well as a theoretical framework and question. They also allow some room for ideas to emerge from the data.

One of the major strengths of content analysis is that it can be extremely reliable if the coding categories and the rules for coding each category are clear. Ideally, different coders should be able to code the same materials in a reliable way. With a reliable coding scheme, data can be deemed objectively derived.

One other advantage in terms of my research interests is that content analysis allows one to study a phenomenon over time. I am able to review literature covering a 50 year period.

Although content analysis has its advantages, it is not without weaknesses and critics. Content analysis used exlusively as a means to count occurrences of given words or phrases says little without some analysis to compare and contrast categories. For my research interests in particular, the number of times, that the term PMS appears over time is interesting, yet needs to be considered within a broader framework and analysis.

Also, content analysis can be problematic when one considers that the data to be analyzed were generated for another purpose and may be limited in terms of another researcher's questions. This was a problem in several medical and popular articles where the topic did not fit into the coding category or where very specific topics did

not generate many categories. In terms of these articles, I coded for what I could and include them as part of my larger analysis.

Finally, due to the limited number of articles and journals reviewed, there is no easy way to determine if the data analyzed is a valid indicator of what is "actually" happening in the construction of PMS. Other journals could be reviewed as part of another data set to replicate this study but my results are generalizable to the specific journals and domains of discourse that I reviewed.

Content Analysis: The Process

Before setting up one's coding categories, a decision needs to be made regarding the unit of analysis (the recording unit). A recording unit can be a single word (or less), a sentence, phrase or theme (Holsti, 1969). I chose as my recoding unit a phrase because it can be as simple as a word or as complex as a sentence. As one can see from my coding categories (Appendix A), generally I coded for single items but there were times it was necessary to code a larger piece of data. My context unit, or case, is always the article from which I am coding.

In beginning the process of creating the coding categories, Berelson's advise seemed critical: "Content analysis stands or falls by its categories" (1952:147). In recent discussions of content analysis, it has become acceptable to let one's categories emerge from the data. "Categories constructed without prior inspection of

documents would no doubt exclude many important categories and include many that are superfulous or unneccesary" (Bailey, 1987:303).

My coding categories emerged primarily from the data, but were influenced by my theoretical interests. This will be discussed more fully in Chapters 4 and 5. Initially, I thought about what interested me and what I wanted to derive from the data. Specifically, I wanted to describe how each arena constructed and defined premenstrual symptoms. As my coding categories show, I wanted to see how each arena defined PMS, how the etiology of PMS is viewed, possible symptoms and treatments. I was also interested in what I term sociological variables. These variables include the way in which an author refers to PMS in other than medical terms (i.e., refer to PMS as a "curse" or "handicap").

Next, I reviewed a selection of each type of literature in order to fill in codes under each heading. I left blank categories under each heading so that I could add to each section as codes emerged from the data. In order to make sure that I reviewed each article using a full listing of coding categories, I reviewed all the articles once chronologically from the earliest to the latest. After cleaning up my categories, I went through all of the articles again in reverse from the latest to the earliest back in time to make certain that I had coded all categories for each article. I placed a coding sheet on the cover of each article so that I had separate data for each

article.

After completing my coding, I sought two outside judges, one nursing professional and one researcher in another discipline, to review four articles to check over my coding scheme. One of the judges questioned the inclusion of one article which was on the edge of what could be considered feminist based upon my criteria. We discussed how we each coded the article and clarified my criteria in order to come to an agreement. Other than this dispute, the judges and I agreed on my coding.

After I finished coding, I began to transfer totals for each type of literature onto summary coding sheets. For the medical literature, I have a summary coding sheet for each journal reviewed with the data totalled by decade and journal. I then transferred these data to a summary sheet for all medical literature by decade and by journal. For the popular literature, I have a summary sheet by decade. A summary sheet for journal totals was not created since there were so few articles per journal. For the feminist literature, which was predominately from the 1980's, I did a summary sheet for each article and transferred this data to a summary sheet for all feminist literature. It is from these summary sheets that I derived the tables for the feminist literature in Appendix B. I did encounter some problems in data coding which will be discussed in Chapter 4.

After I finished coding and summarizing the data, I

went back and eliminated some coding categories that did not emerge from the data, such as political or economic causes of PMS within the etiology section. I had put these categories in this section in order to see if any authors stated that PMS was exclusively a political or economic construct. They had not. I also re-organized the etiology and treatment categories into a more logical order. Specifically, I collapsed my categories for premenstrual symptoms and changes into one category.

Summary:

In this chapter, I reviewed the process that I undertook to analyze the emergence of PMS. This process, a content analysis of three arenas of literature, resulted in the data presented in Appendix B.

I found content analysis to be an excellent means to ground one's theories and hypotheses in a concrete base from which one can begin an analysis. In the next chapter, I report on the results of the content analysis.

Chapter 4

Results of the Content Analysis

In Chapter 3, I discussed the manner in which I conducted my analysis. In this chapter and Chapter 5, I review the results of this analysis. Here I not only review the data collected but also the logic behind my coding scheme and the questions I asked. I highlight the data in Appendix B as well as review coded data that were coded but do not appear in table form. The coding categories for the data not presented in table form are found in Appendix A.

What do the Tables in this Chapter and Appendix B Represent?

These tables represent the total figures from my content analysis of the journals and articles I discussed in Chapter 3. They are broken down by journal and decade for the medical literature and by decade only for the popular and feminist literature. Since there are a limited number of articles per journal it was unnecessary to create a separate table for journals in the popular arena. The feminist literature comes from such a diverse set of sources that one could not create a table by journal.

In the following sections, I summarize the results of some of the data which represent important variables in my analysis of the social history of PMS that will be discussed in Chapter 5.

How does Each Arena Refer to Premenstrual Symptoms?

This category is important in my analysis because the dissertation problem requires that I trace the evolution of the labelling of premenstrual symptoms over time. Due to the importance that I place on this term in my analysis, and due to the gradual shift in the subtle meaning of the terms such as PMT and PMS, I need to show that the label PMS is the most commonly cited term. PMT, although frequently grounded within a physiological base, generally refers to emotional symptoms. PMS, on the other hand, refers to emotional as well as physiological symptoms. PMS is a more generalized, encompassing term and, therefore, more easily applied to a variety of symptom patterns. However, as I will show, it is increasingly becoming clear that a single construct of premenstrual symptomatology is not generalizable to all women.

The Medical Construct: Most authors within this discourse refer to premenstrual symptoms as PMS, especially in the 1980's (see Tables M-1; M-2). The only journal in which this is not the case is Research in Nursing and Health (RNH). RNH only published 4 articles on PMS in the 1980's. These articles are predominately by the same set of researchers who refer to the premenstrual and menstrual phase as a single construct - the perimenstrual phase. They do not necessarily view PMS as a separate construct (see Woods, et al, 1982.) Premenstrual tension (PMT) and premenstrual tension syndrome (PMTS) also appear but not as

Table M-1
How Medical Literature Referred to Premenstrual Symptoms

Decade	1950	1960	1970	1980
PMS*	1	1	2	22
PMT	4	5	4	5
PMTS	2	3	0	2
Perimenstrual Symptoms	0	0	0	4
Premenstrual Symptoms/Changes	0	3	1	9
Recognize as more than 1 syndrome	0	0	0	5
Other	0	0	0	6

Table M-2
How Specific Journals Referred to Premenstrual Symptoms

Journal**	OB/GYN	RNH	AJP	PS
PMS	8	0	9	9
PMT	8	0	3	7
PMTS	3	0	3	1
Perimenstrual Symptoms	0	3	0	1
Premenstrual Symptoms/Changes	4	2	3	4
Recognize as more than 1 syndrome	0	0	4	1
Other	1	0	5	0

*PMS= Premenstrual Syndrome
PMT= Premenstrual Tension
PMTS= Premenstrual Tension Syndrome

**OB/GYN = American Journal of Obstetrics & Gynecology
RNH = Research in Nursing & Health
AJP = American Journal of Psychiatry
PS = Psychosomatic Medicine

frequently in the 1980's as PMS.

Although medical discourse usually discusses PMS as a single illness entity, this construction is gradually changing. In the mid-1980's, more authors acknowledge that premenstrual symptoms and premenstrual syndrome may form a continuum from mild symptoms that are not necessarily a problem for the majority of women to moderate to severe changes which can be a problem. (See discussion in Chapter 5.) They are also coming to recognize that PMS as a single construct may actually be several constructs depending upon a woman's symptom pattern (Brooks-Gunn, 1986; Reid, 1986).

The Popular Construct: This discourse generally uses the label PMS. Since the majority of articles I reviewed in this arena were written in the 1980's, there is little comparison over the decades. PMT was used more frequently prior to 1980. (See Table P-1.)

In general the popular literature takes PMS as a given. It is seen as a real disease and in only two cases do authors note that there is any controversy over its use. (See Cantarow, 1983; Hopson & Rosenfield, 1984.) Most authors do not define PMS. This differs from the medical literature as previously discussed. The popular discourse has yet to catch up with contemporary trends in the medical literature.

The Feminist Construct: In this discourse, authors use the accepted language of the medical arena. However, most feminist writers are critical of this language.

Table P-1
How Popular Literature Referred to Premenstrual Symptoms

Decade	1950	1960	1970	1980
PMS	0	1	0	13
PMT	2	4	0	6
PMTS	0	1	0	0
Perimenstrual Symptoms (Sxs)	0	0	0	0
Premenstrual Symptoms/Changes	0	0	1	5
Recognize many Sxs/Symptoms	0	0	0	0
Other	0	0	0	3

Except for one article written in 1973 (Parlee, 1973), the feminist discourse emerges in the 1980's. Most authors use the label PMS. (In constrast, British writers use PMT.)

> Although feminist authors refer to premenstrual changes as PMS, they discuss the vagueness and controversy over the definition and use of the label - Despite the impressive volume of research surrounding premenstrual phenomena, there exists no common, generally agreed-upon definition of 'the premenstrual syndrome.' Some writers have questioned the scientific legitimacy of the label on grounds that methodology of most relevant studies is weak, and inadequate to supposed conclusions (Abplanalp, et al., 1980).

As I will show in Chapter 5, feminist writers discussed the problems with the definition of PMS before medical authors.

Etiology, Symptoms and Treatment

I discuss these as a group because of their relationship to one another. That is, discussions of etiology frequently tied into discussions of treatment and symptoms within the literatures reviewed. These variables are important to my analysis because I need to show the manner in which writers describe premenstrual etiologies, symptoms and treatments. I also need to show that over time there has not been a clarification of premenstrual symptoms but rather an increasing complexity with no concrete answers regarding etiology or treatment.

Finally, as a point of clarification, the tables reviewing symptoms only refer to the twenty-one most frequently cited symptoms. This list is not encompassing. If an article mentioned over 15-20 symptoms, I only

recorded those symptoms that appeared most frequently within all of the literature reviewed, since there are some 150 possible symptoms of PMS. This was merely for simplicity in coding.

Medical Literature: Generally, authors within this arena discussed PMS as a medical problem to be medically managed and treated. Its etiology was biologically grounded and internal to individual women. In the literature, there were two primary areas which are generally regarded as the source of premenstrual distress: the hypothalamic - pituitary -ovarian axis and the adrenal cortex. Systemic functions tied to the hypothalamic -pituitary - ovarian axis are cited most frequently within 31 references over the four decades reviewed as opposed to 12 references to the adrenal cortex. These included references to estrogen/ progesterone imbalances (10 references) and prolactin imbalances (5 references). There has been an increase in the variety of proposed etiologies. However, over the forty year period reviewed, the category of estrogen/progesterone imbalance has remained popular. Other categories which emerged frequently were stress, vitamin B6 deficiencies, fluid retention and hypoglycemia. (See Tables M-6 & M-7.)

Of the 51 articles found in the medical literature, the most commonly cited symptoms of PMS were irritability (19 references), depression (18 references), anxiety (11 references), bloating (18 references), breast tenderness (12 references), and headache (16 references). In the

1980's there are increased references to fatigue/insomnia (14 references) and food cravings (11 references). (See Tables M-4 & M-5.)

The medical literature refers to a wide variety of possible options for the treatment of PMS. In the 1960's mood altering medications and diuretics were the only prescription remedies cited. However, most articles prior to the 1980's did not discuss treatments. In the 1980's progesterone and vitamin B6 are cited by three authors each which is greater than all other treatment options.

Popular Literature: Most popular articles were fairly vague regarding the possible etiology of premenstrual symptoms. When mentioned, causes internal to women were stressed. Out of 25 articles reviewed, the following represent the most frequently reported causes: hormone imbalances (14 times); prolactin imbalances (3 times); hypoglycemia (4 times); and vitamin B6 deficienies (3 times). (See Table P-3.)

Although the literature generally did not discuss causes, the symptoms of PMS were frequently noted. Bloating (14 times), headache (10 times), breast tenderness (8 times), irritability (8 times), depression (9 times), and anxiety (5 times) were the most frequently cited. For example, an article in Mademoiselle opened with

> Fatigue, depression, tension, bloating - the symptoms of premenstrual syndrome are real...and treatable. Here's the latest news on what causes this monthly misery, and how it can be cured" (Cohen, 1981:57).

Table M-4
Symptoms Cited in Medical Literature by Decade

Symptoms				
Physical	1950	1960	1970	1980
Breast Tenderness	3	0	2	7
Bloating	4	1	3	10
Headache	4	1	2	9
Cravings	2	0	1	8
Fatigue/ insomnia	3	1	1	9
Nausea	3	0	1	1
Altered Sex Drive	2	1	0	2
Cramps	0	1	0	1
Acne	0	0	0	1
Constipation	0	0	0	1
Backache	3	1	0	3
Emotional Symptoms				
Irritable	2	2	3	12
Depression	2	2	2	12
Anxiety	3	1	1	6
Crying	0	0	0	2
Loneliness	0	0	0	1
Loss of control	0	0	0	2
Mood swings	0	1	0	3
Tension	0	1	0	4
Argumentative	1	0	1	2
> energy	0	0	0	1

Table M-5
Symptoms Cited in Medical Literature by Journal

Physical	OB/GYN	RNH	AJP	PS
Breast Tenderness	7	1	2	2
Bloating	9	1	6	2
Headache	8	2	5	2
Cravings	6	1	2	2
Fatigue/ Insomnia	5	1	5	3
Nausea	2	1	2	0
Altered sex Drive	3	0	1	1
Cramps	1	0	0	1
Acne	1	0	0	0
Constipation	1	0	0	0
Backache	1	2	3	1
Emotional				
Irritable	8	2	4	5
Depression	6	2	6	4
Anxiety	6	1	1	3
Crying	1	0	1	0
Loneliness	1	0	0	0
Loss of control	1	0	1	0
Mood swings	0	0	1	4
Tension	0	1	1	3
Argumentative	0	0	3	1
> energy	0	0	1	0

Table M-6
Etiology Reported in the Medical Literature By Journal

Etiology	OB/GYN	RNH	AJP	PS
Hypothalamic Pituitary Ovarian Axis	1	0	2	1
Hormone Imbalance	0	0	1	0
Estrogen/Progesterone Imbalance	5	1	4	0
Estrogen	1	0	0	0
Progesterone	2	0	0	0
Vasopressin	2	1	1	0
Prolactin	2	1	2	0
Catecholomines	2	0	1	1
αMSh	1	0	0	0
Endorphins	1	0	0	0
Dysfunction of Neuro-intermediate lobe	1	0	0	0
Adrenal Cortex				
Fluid retention	4	1	1	0
Renin-Angiotensin Aldosterone	1	0	1	1
Angiotensin II	1	0	0	0
> Production of Aldosterone	1	0	1	0
Factors which can cause physiological reactions and contribute to Increased premenstrual symptoms				
Psychosomatic	1	0	0	0
Stress	4	1	0	0
Psychological	2	0	0	1
Psychosocial	0	0	0	1
Sociocultural	0	0	0	0

Etiology (continued)				
Learned Behavior	1	0	0	0
Other possible Causes				
Vit. B deficiency	1	1	2	0
Vit. A deficiency	1	0	1	0
Hypoglycemia	2	1	1	1
Endogenous hormone				
Allergy	2	0	0	0
Cause Unknown	2	0	1	2
Other	1	1	0	0

Table M-7
Etiology Reported in the Medical Literature by Decade

Etiology	1950	1960	1970	1980
Hypothalamic Pituitary Ovarian Axis	1	0	0	3
Hormone Imbalance	1	0	0	0
Est/Prog. Imbalance	3	1	1	5
Estrogen	0	0	0	1
Progesterone	0	0	0	2
Vasopressin	1	0	0	4
Prolactin	0	0	0	5
Catecholomines	0	0	1	3
αMSh	0	0	0	1
Endorphins	0	0	0	1
Dysfunction of Neuro-intermediate lobe	0	0	0	1
Adrenal Cortex				
Fluid retention	2	0	2	2
Renin-Angiotensin Aldosterone	0	0	1	2
Angiotensin II	0	0	0	1
> Production of Aldosterone	0	1	0	1
Factors which can cause physiological reactions and contribute to Increased premenstrual symptoms				
Psychosomatic	0	0	0	1
Stress	0	2	0	3
Psychological	0	2	0	1
Psychosocial	0	0	0	1
Sociocultural	0	0	0	0
Learned Behavior	0	1	0	0

Other possible Causes

Vit. B deficiency	1	0	0	3
Vit. A deficiency	1	0	0	1
Hypoglycemia	2	1	0	2
Endogenous hormone				
Allergy	0	1	0	1
Cause Unknown	0	0	1	4
Other	0	0	0	2

Table P-2
Symptoms Cited in Popular Literature

Symptoms				
Physical	1950	1960	1970	1980
Breast Tenderness	0	1	0	7
Bloating	0	2	0	12
Headache	0	2	0	8
Cravings	0	0	0	7
Fatigue/ Insomnia	0	1	0	6
Nausea	0	0	0	2
Altered Sex Drive	0	0	0	1
Cramps	0	0	0	2
Acne	0	0	0	2
Constipation	0	1	0	2
Backache	0	1	0	2
Emotional Sypmtoms				
Irritable	0	1	0	7
Depression	0	1	0	8
Anxiety	0	0	0	5
Crying	0	0	0	0
Loneliness	0	0	0	0
Loss of control	0	0	0	0
Mood swings	0	1	0	2
Tension	0	1	0	3
Argumentative	0	0	0	0
> energy	0	1	0	1

Table P-3
Etiology Reported in Popular Literature

Etiology	1950	1960	1970	1980
Hypothalamic Pituitary Ovarian Axis	0	0	0	1
Hormone Imbalance	1	1	0	5
Estrogen/Progesterone Imbalance	0	0	0	5
Estrogen	0	0	0	0
Progesterone	0	0	0	1
Vasopressin	0	0	0	0
Prolactin	0	0	0	3
Catecholomines	0	0	0	0
αMSh	0	0	0	0
Endorphins	0	0	0	0
Dysfunction of Neuro-intermediate lobe	0	0	0	0
Adrenal Cortex				
Fluid retention	1	0	0	1
Renin-Angiotensin Aldosterone	0	0	0	0
Angiotensin II	0	0	0	0
Increased Production of Aldosterone	0	0	0	0
Factors which can cause physiological reactions and contribute to Increased premenstrual symptoms				
Psychosomatic	0	0	0	0
Stress	0	0	0	1
Psychological	0	0	0	0
Psychosocial	0	1	0	1
Sociocultural	0	1	0	0

Learned Behavior	0	0	0	0
Other possible Causes				
Vit. B deficiency	0	0	0	3
Vit. A deficiency	0	0	0	1
Hypoglycemia	0	0	0	4
Endogenous hormone Allergy	0	0	0	0
Cause Unknown	0	0	0	2
Other	0	0	0	2

Women are presented with a variety of treatment options. When coding the popular literature for treatment options, mood altering medications fell into the category of "other." While I did not have a general code for mood medications or tranquilizers, they were mentioned twice in the 1960's. Other than mood medications, hormones, diuretics, and primrose oil appeared as possible treatments prior to 1980. In the 1980's the majority of treatments (63%) were self-help remedies, such as diet changes, exercise, and vitamin B6. Articles instructed women on how to "eat to beat PMS" (Mademoiselle, May 1987) or how "Good nutrition beats menstrual blues" (Essence, Feb., 1981). Progesterone was cited only 4 times in the 1980's. Diuretics were discussed in 6 articles, more frequently than in the medical literature.

Feminist Literature: Feminist authors in general discussed the etiology, symptoms and treatment of PMS within the context of a critical discussion of PMS. These authors included researchers, such as Abplanalp (1983) who does not discount the label PMS as viable in certain cases. Although some authors did discuss internal etiologies, what really distinguished feminist discourse from the popular and the medical was their consideration of non-physiological factors. Work roles and stress as a result of these roles was seen as contributing to the increased incidence of negative premenstrual experiences in the feminist arena (Martin, 1987). (See Tables F-6-7.)

Table F-6
Why is PMS an issue in the Feminist Literature?

All 1980's

Women's increased labor force participation	2
Concern for women's health	3
Political reasons	5
Economic reasons	4

Table F-7
What are the Consequences of PMS in the Feminist Literature

Decade	1970	1980
Marital Discord	0	0
Baby Battering	0	1
Criminal Behavior	1	1
Suicides	1	2
Accidents	1	2
Psychiatric Adm.	1	1
Avoid Success	0	0
Alcohol use	0	0
Devasting Impact on Family/Career	0	0

Feminists also discussed symptoms and did not deny that some women occasionally experience moderate to severe premenstrual changes. However, they also discuss the lack of discourse on positive dimensions of premenstrual experience (Koeske, 1983).

Finally, although feminists discussed treatments, they are considerably more reserved than those in the medical and popular discourse. For example, although progesterone is cited numerous times, it is discussed as something about which to be cautious.

> The use of progesterone is alarming to all feminist health workers with whom I have spoken. They fear that the progesterone treatments will prove to be another case of hormones being given to women in an untested and scientifically frivolous way. They point out that there are only a few studies investigating the safety of this drug, and these indicate problems such as breast tumors, cervical cancer and arteriosclerosis (Rome, Boston Women's Health Collective, p. 6).

Except in review articles, such as Aplanalp's (1983), specific treatments were not proposed.

Sociological Variables: Emergence of PMS

Tables M-12 through 15, P 6-7, and F 6-7 represent the sociological variables for which I coded. I wanted an idea of how many authors with each arena questioned <u>why</u> PMS has emerged as an important women's health issue. Here I do not ask about the emergence of PMS as a medical construct but rather what it was that made PMS suddenly become an important medical research interest, a popular topic in

women's magazines and an issue for concern among some feminist writers.

The variables that emerged in my analysis were an increased concern for women's health and women's increased labor force participation. I also coded for the consequences of unchecked PMS. These consequences included actions such as increased suicides, crimes, or accidents.

Both of these categories are important because of the possible implications of their use. As I will show, when writers in the popular or medical discourse discussed why they are concerned about women's PMS, they discussed work roles. Significantly, these discussions did not stress concern for women themselves as workers but instead for the financial consequences if women take time off or sick leave as a result of premenstrual problems.

Medical Literature: Although most authors within this discourse did not question why PMS became an issue, women's increased labor force participation was cited twice with the American Journal of Obstetrics and Gynecology (Paulson, 1961; Reid & Yen, 1981).

> Women for uncounted generations have suffered the distressing mental and physical symptoms of pre-menstrual tension. The increased importance of women in industry, the recognition of the role of premenstrual tension as a factor in crimes of passion and violence, and the significant advances in current endocrinologic research, have all contributed to an increased interest by the medical profession in this particular syndrome (Paulson, 1961:733).

Articles in Psychosomatic Medicine (Logue & Moos,

1986) and American Journal of Psychiatry (Berlin, et al, 1982) noted that PMS emerged due to an increased concern for women's health. However, for the majority of writers within this arena, PMS exists as a problem that needs to be addressed and why or when it became a problem was of little concern.

The consequences of unchecked premenstrual symptoms were also discussed These include behaviors and actions such as increased suicides, criminal behavior and accidents. Criminal behavior was a concern through out the period reviewed. In creating his widely used Menstrual Distress Questionnaire (MDQ), Moos stated

> The importance of menstrual symptomatology currently is appearing in a new light with the accumulation of evidence that a large portion of women who commit suicide or engage in criminal acts of violence, and who as pilots have serious and fatal airplane accidents, do so during the menstrual or premenstrual phases of the cycle (Moos, 1968:865).

He quoted Dalton's work (see Chapter 1) in references to an increased incidence of reported sick days for women who are premenstrual or menstruating (1968:865).

Popular Literature: Like the medical discourse, the popular literature rarely asked why PMS emerged. The only reason stated in the 1980's was an increased concern for women's health. Prior to the 1980's, in the 50's and 60's, women's increased labor force participation and economic factors as tied to this participation were noted. Again, these articles did not stress a concern for women as

workers but for employers in terms of sick leave and potential losses in overall productivity due to women's premenstrual distress. For example, in a doctor's advice article in Ladies Home Journal (1954), the doctor states

> `...I am glad you have been sensible enough to seek relief. This is a relatively serious problem. A great economic loss occurs every month, particularly in these days when so many women are employed outside their homes. Women struggling under such a handicap as yours find it impossible to concentrate properly on their duties. The result must be the loss of a tremendous number of work hours'(Safford, 1954;107).

Although one sees a shift in tone during the 1980's, we still see a concern for women's job performance. In a 1981 Ladies Home Journal article, women are told that

> ...menstruation need not adversely affect on-the-job performance...With increasing numbers of women proving themselves to be admirably capable in top career positions, men can no longer point to `menstrual rages' or `irrational behavior' as reasons to relegate females to less responsible posts. Indeed a man has his own mood swings- and unlike a woman's, they're not predictable. A woman executive can actually plan to avoid scheduling a high-level meeting when she's premenstrual, but her male counterpart has no way of knowing when he's going to be unaccountably cranky (Brody, 1981:40).

This quote reflects a shift in thought that occurred in the 1980's: Women no longer need to be burdened by PMS. They now need to learn how to manage their symptoms in order to continue and promote their careers.

The popular arena also reflected the medical arena in reporting the outcomes of unchecked PMS. Suicide and criminal behavior, specifically in the 1980's, topped the

lists of concerns.

Feminist Literature: Feminist writers often asked why PMS emerged. Political and economic factors top the list. The explanations often merge together within their discussions. For example, when Laws (1983) discussed PMS as a patriarchal phenomenon, she also discussed its possible implicit use as an explanation to limit women's role within the public sphere.

Feminist writers did recognize that PMS emerged in part due to an increased concern for women's health. However, some writers cautioned that this recognition or legitimation of women's premenstrual distress presented mixed results. The legitimation may be beneficial to some women who for years thought they were crazy or were labelled as such by family and doctors. Yet, the legitimation brings up potentially negative portrayals of premenstrual women as being hormonally out of control (Riessman, 1983).

Finally, feminist authors responded to medical and popular constructions of the consequences of unchecked premenstrual symptoms, rather than creating another list. For example, Rome commented on what she saw as Dalton's role in promoting stereotypes about premenstrual women -

> it becomes painfully clear that Dalton's goal is to help women function more smoothly in their traditional stereotypical role, subordinate to men...In a typical book, Once a Month (Dalton, 1978) she tries to give women's 'abnormal, unreliable' behavior a scientific basis... [by arguing] that females can be interpreted exclusively in terms of the hormonal cycle (Rome, Boston Women's Health Collective, p.4).

Rome cited Dalton's portrayal of premenstrual women not only as weepy and aggressive but also as provoking male violence. Rome was not alone in countering these portraits. But what is equally important is that feminist writers gradually appear to be creating their own constructions of premenstrual symptoms and PMS, rather than refuting those of the medical or popular discourse. As I will show in Chapter 5, Johnson (1987) and Martin (1987) represent this shift.

Other Variables

As discussed in the opening of this chapter, I coded for a variety of variables which are not easily presented in table format. Some of the categories are small or they only emerged within a limited number of articles within a given arena. These coding categories appear on the third page of Appendix A. They include checking for references to Katharina Dalton's work, specifically her studies on progesterone or her role as an expert witness in the British trials as discussed in Chapter 1, and Robert Frank's 1931 paper on PMS. I also coded for references to PMS as a psychologic construct and what I term the imagery of PMS and premenstrual women. Finally, I looked at references to PMS as a legal matter, such as discussions of the trials in Britain or the use of PMS as a defense of diminished capacity.

Role of Frank and Dalton:

As noted in the narrative history of PMS in Chapter 1,

the work of Frank and Dalton played a role in the emergence of PMS. I coded for Frank's name because I wanted to affirm that his paper was considered by others to be an important historical marker in the history of PMS research. I coded for Dalton because during my research, her name would frequently appear. Prior to my formal content analysis, I noticed frequent negative references to her work within feminist literature, whereas, in popular discourse, her work was frequently cited unproblematically. When I set out my formal coding categories, I decided to see if her work or name was discussed across all three arenas in order to assess her impact not only as a popular figure but also as a recognized researcher within medical discourse.

In the medical literature, Frank was cited throughout the four decades reviewed, especially in the 1980's. He was not discussed in Research in Nursing and Health. Dalton was only mentioned by four medical authors. She did write a letter in response to a double blind study of progesterone (Maddocks, et al, 1986). She was also cited by Moos, who developed the commonly used premenstrual assessment tool, the Menstrual Distress Questionnaire (MDQ) (Moos, 1968; Logue and Moos, 1986).

A radically different picture is seen in the popular and feminist literature. Frank was only mentioned once in the 1960's in the popular literature. Dalton, on the other hand, was cited and discussed in 7 articles. Often these references to her work include a list of behavioral changes

associated with premenstrual women. For example, in a 1969 article entitled "Advice to Women Who are 'Once-a-Month Witches'" (Lake, 1969), Dalton was cited as listing "many of the ailments that flare up in some women before the menses" (Lake, 1969:118). She was also cited in several articles in Mademoiselle published in the 1980's.

Several of these articles mention Dalton's role in the U.K. trials as well as her studies of progesterone as a treatment for PMS. Only one article within the popular discourse was critical of her work (Cantarow, 1986). (Please see Appendix C for a summary of the articles reviewed, organized by discipline and year of publication.)

In the feminist literature, as I already stated, many authors discuss the role that Dalton played in promoting the use of progesterone therapy as well as her role in the trials in Britain. Dalton was cited by 9 feminist authors. Frank was mentioned by 8 of feminist writers.

PMS as a Psychological Construct:

How PMS is discussed within the medical or popular discourse affects the manner in which women who "suffer" from PMS are viewed. Therefore, I reviewed each article to see the manner in which PMS was studied, where researchers recruited their sample and whether references to PMS were in pathological or psychological illness frameworks. I also coded for discussions of the DMS III classification controversy discussed in Chapter 1.

Appendix C summarizes the focus of each article

reviewed as well as the sample size and subject characteristics. The majority of articles published in the American Journal of Obstetrics and Gynecology dealt with physiologic factors in the etiology, diagnosis and treatment of premenstrual symptoms. Except in one 1950 study, the research subjects were not diagnosed or suspected of having mental illness.

In the American Journal of Psychiatry most of the studies deal with psychological variables. Also, more of the research subjects were clinically diagnosed within categories of mental disorders.

Psychosomatic Medicine publishes a variety of studies with approximately half dealing with psychological variables. In two of these studies, the subjects were suffering from a diagnosed mental disorder.

PMS was frequently considered both within psychological as well as physiological frameworks. In 1986, as discussed in Chapter 1, there was a debate over whether or not to include a form of PMS in the diagnostic manual for psychologists/psychiatrists (DMSIII R). Although this debate captured the attention of a variety of audiences it did not appear very often in any of the literature that I reviewed. However, I stopped my review at the end of 1987. Most of my articles were probably in press at the time of the DMS III discussions. It should be noted that there were numerous responses to the potential DMS III category from sources that I did not review, such as the Society for Menstrual Cycle Research and the Association for Women in

Psychology.

Imagery of PMS:

On page three of my coding categories I included a section on how a given author referred to premenstrual symptoms as well as premenstrual women. Included in this were negative terms, such as calling the menstrual cycle a "curse" or premenstrual women "emotionally unstable." I also coded for critical discussions of the phenomenon of PMS, such as a recognition that it's labelling can be both a benefit for women as well as problematic in terms of negative responses to its labelling. Basically, I wanted a section in which to tease out what I call the "imagery/ideology of PMS" or how PMS is constructed outside of purely medical or psychological terminology.

In general the medical literature avoided stereotypic portrayals of both women and of the premenstrual phase. Two articles, one in the American Journal of Psychiatry (AJP) (Lamb, et al, 1953) and one in Psychosomatic Medicine (PS) (Moos, 1968) referred to PMS as a disability or handicap . An article in American Journal of Obstetrics and Gynecology in the 1980's referred to PMS as both a monthly burden as well as a feminist issue. This article by Reid (1986) is reviewed in Chapter 5. The only negative labels for premenstrual women appeared in the 1950's. One article described premenstrual women as both emotionally unstable as well as pathetic (Morton, 1950).

The popular discourse presents a slightly different

picture, especially when one considers that the number of articles reviewed (N=25) was comparatively small and that many of these articles were brief advice pieces on exercise or diet changes. Most of the negative stereotypes about premenstrual symptoms and women occurred prior to the 1970's. In the 1950's one article referred to premenstrual changes as a disability or handicap. In the 1960's authors in Ladies Home Journal (Spicer, 1963; Chevalier, 1965) and Reader's Digest (Lake, 1969) referred to menstrual difficulties as a curse, the monthly blues and needing to be controlled. Premenstrual changes were referred to as a curse twice in the 1980's (Bray, 1980; Brody, 1981). One article in Newsweek (1982) discussing PMS as a legal defense stated that premenstrual changes and the constructions of these changes are important to consider as a feminist issue.

The popular literature generally did not label women as pathetic or emotionally unstable. One article, however, called premenstrual women "once-a-month-witches" and "irascible shrews" who must "admit to female weakness..." (Lake, 1969:119). These portraits appeared more frequently prior to 1980. Most articles published after 1980, did not label premenstrual women negatively.

As already discussed throughout this review, feminist writers did not present stereotypes about premenstrual women or the premenstrual phase. Many of the categories within this section were created specifically to code the feminist

literature. As I reviewed these articles, I realized that the categories I had created for the medical and popular literature did not capture the feminist discourse. The feminist writers frequently moved their discussions away from symptom lists, etiologies or treatments and discussed the variables that led to the rising interest in PMS, the medicalization of PMS or the possible negative consequences of its labelling. Therefore, I created categories which included the recognition that there are both positive as well as negative consequences of the emergence of PMS, that aspects of PMS may be medicalized and that in most literature women's moods and emotions were presented as problematic. These points are discussed in Chapter 5.

Legal Aspects of PMS:

I created this coding category because I had a specific question about the role of the trials in the emergence of PMS as a social problem. Specifically, I saw the trials as a pivotal point in the history of PMS. This will be discussed in Chapter 5 in detail. However, I will summarize briefly what emerged from my content analysis of the legal aspects of PMS.

This category includes whether an article discussed the trials, discussed the role of PMS as a defense, or just mentioned PMS as a legal issue. Few articles within the medical discourse discussed the legal aspects of PMS and one mentioned the trials. However, two authors in the edical literature discussed the legal aspects of PMS in

the 1980's (Reid and Yen, 1981; Reid, 1986). The popular literature discussed the trials as well as general legal issues during the 1980's. The feminist literature frequently discussed the legal aspects of PMS. Eight of the 15 articles in the feminist literature discussed the British cases.

Summary:

In summary, we see the emergence of three distinct yet interacting constructions of premenstrual symptoms which will be discussed in detail in Chapter 5. The medical literature discussed PMS within a medical framework without really questioning why PMS has emerged as a medical condition.

The popular literature is largely derivative of the medical literature and put forth a simplified and generalized version of the medical construct. It avoided for the most part any controversies or confusion over the construction of the syndrome. The popular literature painted the most negative portraits of premenstrual symptoms and premenstrual women, especially prior to the 1980's.

The feminist literature emerged as a response to the popular and medical stories. Feminist writers attempted to discuss PMS within a broader framework which began to question the implications of the emergence of PMS for women and their lives.

Each of these constructions will be reviewed and

Chapter 5

The Emergence of PMS

PMS has been a research concern for over fifty years. Yet, as I noted in Chapter 4, its etiology and treatment is still poorly defined and understood and it has only recently emerged a social problem.

In Chapter 4, I summarized the results of the content analysis and laid the groundwork for this chapter. What emerged from the content analysis were three constructions of PMS that interact and interplay with one another.

The popular literature frequently portrayed the premenstrual phase as a "curse" or "monthly burden" which women need to learn to cope and manage. The popular discourse generally accepted uncritically that PMS was a medical problem and should be managed as such. The medical literature in general treated premenstrual symptoms as a medical problem but did not usually label premenstrual women. The feminist literature responded to each of these portrayals and is gradually constructing a feminist vision of PMS.

This chapter teases apart the complexity of PMS as a social issue by interpreting the data presented in Chapter 4. This analysis will focus on the emergence of a social problem framed within the context of old and new constructions of women's bodies. It is also the story of how these constructions are played out in public discourse within and among three arenas - medical, popular and

feminist.

My analysis revealed three eras in the history of the emergence of PMS as a social problem. During the first era, 1931 - 1980, the medical and popular arenas did not differ in their constructions of PMS. As I will show, this discourse framed women's bodies within an old construction or mythic theme which portrayed women as deeply at the mercy of their reproductive cycles.

In the second era, 1980 to approximately 1985, PMS emerged as a social problem commanding the attention of three distinct yet interacting arenas - medical, popular and feminist. The dramatic events or tip-point through which PMS came into prominence were the criminal trials of two women in Britain in 1980 and 1981. The discourse during this era was framed within both an old view of women at the mercy of their reproductive cycles and a neo-feminist perspective, which draws upon the work of mid-nineteenth and early twentieth century feminist reconceptualizations of women's bodies and women's health. (See Clarke, 1989, for a review of this literature.) This neo-feminist perspective reflects the work of the 1960's and 1970's women's health movement and its redefinition of women's bodies and women's experiences of monthly changes. In this view reproductive functions do not limit abilities. (See Friedan, 1965; Ruzek, 1978.) These opposing constructions formed the context of the debate on the definition and management of premenstrual changes. Within this debate, a discussion emerged about whether or not PMS is a medical

condition requiring medical management or whether it is being constructed as a medical matter, that is, is it medicalized?

The third era marks the beginning of a new phase of discourse. This era emerged between 1985 and 1987. There is an increase in medical articles on PMS as well as the labelling of PMS within Index Medicus. While the medical arena was active prior to this time, it became a major factor during this period. We see a clarification of premenstrual symptoms and PMS. This is not necessarily a resolution of the cultural context or mythic themes about women's reproductive capacities, but a gradual change in the manner in which PMS is discussed.

Setting the Stage - Theoretical and Conceptual Definitions:

Before tracing the history of the emergence of PMS, one needs some background regarding the terminology and definitions used in this chapter. The primary theoretical framework used is social constructionism. The additional conceptual frameworks of the emergence of social problems and medicalization are also incorporated. This chapter integrates these three approaches with the data gathered from the content analysis.

The model created here was stimulated by Hilgartner and Bosk's (1988) paper "The Rise and Fall of Social Problems: A Public Arenas Model". They trace the processes that cause social problems to emerge as well as disappear. I draw upon their model and extend it to create a framework

that explains the emergence of a women's health issue.

Hilgartner and Bosk define a social problem as a "putative condition or situation that (at least some) actors label as a 'problem' in the arenas of public discourse and action, defining it as harmful and framing its definition in particular ways" (1988:70). Public discourse generally refers to arenas, such as the media, popular press or other writers, organizations or government associations in which access to information is fairly easily obtained.

As Hilgartner and Bosk state, these arenas only have a limited carrying capacity for the number of social problems that can take up time, space and money. In their framework, social problems emerge due to competition among arenas, drama, cultural and political factors and institutional rhythms and linkages.

Specific events influenced the emergence of PMS as a social problem warranting space in the popular and feminist public discourses. These events were the trials in Britain in 1980 and 1981 in which two women pled not guilty because of PMS. As I will show, the trials stimulated public debate within these arenas and initated a new phase in the history of PMS and constructions of women's bodies.

Public discussion regarding an emergent problem occurs within a context. Hilgartner and Bosk describe part of this context as pre-existing "deep mythic themes" (1988:71). In the case of PMS these mythic themes exist prior to the

dramatic events and play a role in the debate over the emerging constructions. This larger context can be represented as two alternative social constructions of women's reproductive functions. The older construction or mythic theme, represents long-held beliefs about the role that a woman's biology plays in her ability to control cyclic changes in mood and behavior. Almost a century ago, this mythic theme played a similar part in the public discourse on hysteria (Smith-Rosenberg, 1972) and menstruation (Clarke, 1989). The new construction represents a reinterpretation or reconstruction of these myths as articulate by women active in the women's movement and the women's health movement in the 1960's and 1970's. These women drew upon the feminist discourse in the 19th century and updated this discourse about women's bodies. This neo-feminist construct revolves around the perspective that women are not limited by their reproductive ability. (For examples of this discourse, see Friedan, 1965 and Ruzek, 1978.) These two constructions create a dialectic reflected in the current debate regarding the influence of PMS on women's lives.

The debate on the definition and management of PMS is tied to both beliefs about women's cycles and the issue of whether or not PMS is a medicalized phenomenon. Labelling a phenomenon as medicalized implies there is more to that phenomenon than a biological or physiological problem. It implies that there are social and cultural factors that play a significant role in its definition and management.

Some have labelled PMS as medicalized and therefore, as I trace the history of PMS, this issue will be addressed.

Each of these areas will be discussed in greater detail within the following history.

PMS Prior to 1980:

Prior to the increased interest in PMS in 1980, premenstrual symptoms, labelled as premenstrual tension (PMT), premenstrual tension syndrome (PMTS) or PMS appeared fairly constantly in the medical and popular literature between 1931, when Frank first discussed it, and 1980. Authors in these arenas generally constructed PMS as a medical phenomenon requiring management and treatment by a physician or a psychiatrist/psychologist. (See Appendix C for a summary of the medical and popular literature.) However, PMS was not seen as a major problem for the majority of women. For those women who viewed it as a problem, various treatments were offered. In the medical arena treatment options included mood medications and some OTC (over the counter) remedies such as vitamin B6. Hormonal drugs did not appear in the medical literature reviewed until the 1980's, which is surprising since hormonal remedies for menstrual difficulties were recommended through out the period reviewed in other literature, such as Frank (1931). The popular literature generally discussed PMS within doctor's advice columns and recommended hormonal treatments, diuretics and psychoactive medication, such as tranquilizers. OTC remedies were

rarely discussed.

The contexts in which these discussions occurred generally reflected an historically established construction of women's bodies. This construction portrays women's cycles as problematic and in need of control. During this period, women who suffered from moderate to severe premenstrual changes were labelled as "once-a-Month-witches" in the popular discourse suffering from the "needless misery" of "monthly blues." The medical discourse infrequently labelled premenstrual women but did label their cycles as disabling or handicapping (Lamb, et al, 1953; Moos, 1968. Also, see Chapter 4, sections on Sociological Variables and Imagery of PMS). For the majority of women, however, premenstrual symptoms were handled as a private matter. Some women might enter into a relationship with a physician and by doing so, their symptoms came to be defined within medical terms.

The Dramatic Events - The Emergence of PMS as a Social Problem:

The second era in the history of the emergence of PMS as a social problem began in 1980. The catalysts for change in the popular and feminist discourse were the trials in Britain in 1980 and 1981. As discourse about PMS moved into the public arena, using Hilgartner and Bosk's definition of social problems (1988), PMS emerged as a social problem and a debate within the feminist discourse began regarding whether or not PMS was a medical problem or

a medicalized problem. In the popular and feminist discourse, the influence that the trials had upon the growth of interest in PMS is vivid. This influence is less clear in the medical arena.

In the popular discourse, although criminal behavior was mentioned through out the four decades reviewed, there was an increase in the frequency of discussions of the legal aspects of PMS in the early 1980's. Five articles mentioned the trials. Two discussed criminal responsibility and two mentioned the role of PMS with regard to a defense of diminished capacity. The feminist discourse on PMS, which emerged for the first time during this era, also discussed the legal aspects of PMS. Eight of the 15 articles reviewed discussed the trials in Britain.

Within the medical discourse, there was some mention of potential legal uses of PMS but not as frequently as in the popular or feminist literature. The expansion of the medical discourse began somewhat later than that of the popular or feminist discourses. However, references to criminal behavior as a result of PMS appeared occasionally throughout the four decades reviewed. Generally, the medical discourse did not discuss the trials or the legal aspects of PMS as a defense. When coding for whether or not medical actors discussed the legal aspects of PMS, I found one author who mentioned it in the 1950's and two in the 1980's. Both articles in the 1980's were review articles which discussed the issue of criminal responsibility and the use of PMS as a defense of diminished capacity (Reid

and Yen, 1981; Reid, 1986).

As PMS emerged as a social problem within these arenas of discourse, authors within each arena offered constructions of the syndrome. These constructions represent attempts to come to terms with the two major conflicting views of the influence a woman's biological cycles have on her life and choices. I have termed these conflicting views the old and new constructions. I will now outline the popular, medical and feminist constructions of PMS as they relate to questions regarding the nature of PMS. Is PMS a medical construct, a cultural construct or a combination of the two?

Constructions in the Popular Literature:

The majority of discussions related to the definition and management of PMS appeared in support of or in opposition to, a medical construction. However, a medical paradigm frames most discussions of the phenomenon. The popular discourse on PMS reflected ambiguities regarding the etiology and treatment of PMS as it emerged out of the medical discourse. Writers in this arena uncritically accepted for the most part, that PMS exists as a medical condition and is a problem for the majority of women. They draw upon the medical arena and construct a popular and easily understood version of a complicated and poorly understood phenomenon.

The popular construction of PMS generally avoided stereotypes about premenstrual women. As seen in Chapter 4,

this was not the case prior to the 1980's. During the 1950's, menstrual difficulties were generally considered to be a curse that needed to be controlled . In the 1980's, the popular discourse reflects changing constructions of women's bodies. In this view PMS is something to be managed, yet it is not something that should get in the way of one's career or family. Most articles provided explanations for the possible causes of PMS and offered women advice on how best to handle their symptoms. (See Appendix C for a summary of the popular articles reviewed.) Premenstrual changes were problematized, while the women who suffer from the changes were not. This is a crucial distinction, and a dramatic change from the pre-1980 era.

The popular literature, like the medical, did not really address the research question regarding why PMS should be an issue. Only a few articles in the 1980's mentioned PMS as an issue because of a concern for women's health.

The Feminist Response:

The feminist discourse on PMS initially emerged in response to what appeared to be the medicalization of yet another aspect of women's cycles (Riessman, 1983). However, as discussed in Chapter 4, feminist authors' constructions of premenstrual changes form a continuum from a basic denial that PMS exists as a medical syndrome to articles that want physicians to recognize the legitimacy of women's

complaints and to address these complaints within the context of women's lives, not just their bodies. For example, Laws felts that PMT (as she refers to it) is a political construct - a part of patriarchal ideology. (Laws, 1983:20). She did not deny that some women may suffer from premenstrual symptoms, yet she stated that we

> must distinguish the medical men's construction of what I shall call PMT as they do, from a premenstrual state which is part of a woman's continuous experience of cyclic change, and which is not inherently a medical problem (Laws, 1983:20).

Abplanalp (1983), on the other hand, commented on the problems with research on PMS, specifically regarding the lack of a concrete definition as well as poorly studied treatments. However, she believed that it is very important for women's complaints to be taken seriously by practitioners (Abplanalp, 1983:120).

Significantly, only the feminist discourse attempts to address external factors that play a role in the increased incidence and concern regarding PMS. As the feminist discourse matures, as we will see in the contemporary era, authors move away from reacting to articles in the popular and medical literature to creating their own version of the PMS story.

Basically, feminist authors want to increase our understanding of the complexity of the issue. They do not simplify PMS or reduce it exclusively to a organic problem. This discourse put forth the strongest depictions

of attempts to grapple with old and updated constructions of woman's bodies.

The Medical Construction:

Early in the 1980's, the medical arena constructed PMS as a medical problem to be medically managed. This is consistent with the history of PMS in the medical literature reviewed prior to the 1980's. As the 1980's progressed, the medical investigators increased their research on PMS. The reasons for this increase are not clear from the data that I reviewed. One can speculate that there are a variety of interacting forces which bring about this increase but one would need to do an analysis exclusively of the medical literature, conference notes and other relevent data to answer this question.

For the purpose of this discussion I asked two PMS researchers what they viewed as reason why the medical discourse took an interest in PMS. Like Riessman (1983), one of the researchers felt that initally women played a role in fueling interest. Specifically, after Virginia Cassara, who was discussed in Chapter 1, came back from her progesterone treatments with Dalton and started PMS Action, more women sought remedies from their physicians. However, my source viewed Reid and Yen's 1981 article in the American Journal of Obstetrics and Gynecology as a pivotal article making PMS a legitimate research concern. Reid and Yen are considered by many to be respected researchers. When they took an interest in this issue, it

legitimated it for others in the field. Another legitimation for PMS as a research concern occurred in 1983 when the National Institute of Mental Health (NIMH) sponsored a workshop on PMS in order to clarify its definition to make research comparisons easier. This workshop started the debate over the classification of PMS within the DMS-III. As my source stated, each of these events served to increasingly legitimatize what physicians were seeing in their practices. (See Lewis, 1987.)

My second source also felt that each of the latter events were important, but she stated that advances in neuroendocrine research played an important role. In the 1960's and 1970's practitioners could only offer women progesterone or tranquilizers because there really was not much else with which to treat symptoms such as depression. With advent of cheaper assays to measure prolactin and brain prostaglandins in the 1980's, for example, researchers moved cutting-edge technology on neuroendocrine disorders into the mainstream and allowed researchers to look for a broader range of possible etiologies of premenstrual symptoms. Gannon (1985) also mentions the importance of improved hormonal assays as well as the influence of the trials and women's demands for better treatments for their symptoms as possible causes for the rise of interest in PMS.

The latter is merely speculation at this point, since very few medical authors in the literature I reviewed mention any reasons why they are studying PMS. Two sources

do mention that PMS became an issue due to a concern for women's health.

Although the medical actors construct PMS as a problem in need of management, they generally avoid gross stereotypes about premenstrual women. However, although gross representations do not appear, due to the nature of the medical paradigm, the focus of research on etiology as well as treatment is on the individual woman. (See Appendix C for a summary of the medical literature reviewed.)

The medical sources also are grappling with both the old and new constructions of the impact of a woman's cycle on career and family functions. As discussed in Chapter 4, articles in the American Journal of Obstertrics and Gynecology (Reid, 1986) mentioned that women's increased labor force participation is one reason why PMS has emerged as an important women's health issue. One of the noted results of PMS is a potentially negative impact on a woman's career and family.

The medical experts still do not know what causes PMS or how best to treat it. As research on PMS increases, we see a broading and refining of what constitutes PMS as distinct from premenstrual symptoms. This point is addressed in the most contemporary era.

Is PMS Medicalized?

> Premenstrual syndrome (PMS) has found a place among the medical maladies of our culture. Although PMS lacks a firm definition and a base of rigorous scientific research, specific premenstrual signs and symptoms have

> come under medical scrutiny... As evidence of medicalization, both medical and lay health journals are dealing with the topic with greater frequency, and a self-help guide written by a physician has appeared (Riessman, 1983:10).

Riessman offers a convincing argument about the medicalization of premenstrual symptoms as they have come to be labelled as PMS. She is not alone in claiming that PMS is medicalized. Laws (1983) also claimed that PMS has been constructed deliberately by the medical profession. However, the label of medicalization must be discussed within the context of this content analysis and the constructs that emerge from it. In this section, I discuss ways in which one could claim that PMS is medicalized. From this analysis, it becomes clear that the generalized labelling of all premenstrual symptoms as premenstrual syndrome does exhibit aspects of medicalization. As the label PMS becomes more specific and limited, as will be discussed in the next section, these aspects of medicalization also become more limited.

As discussed in Chapter 2, the conceptual framework of medicalization implies that the medical arena plays an expanding role in the definition and treatment of problems that historically are not necessarily medical in nature. These problems include drug use, obesity and childbirth. Medicalization is frequently discussed within a social constructionist framework since the implications of this framework tie into social and cultural forces as opposed to clinically defined ones.

The medicalization literature discusses a phenomenon in terms of absolutes: it is either medicalized or not; Alternatively, it once was medicalized and no longer is. However, I find that medicalization falls along a continuum. A phenomenon is not simply medicalized or not. Rather it depends upon the arenas, actors and their locations when constructing the definition, as well as the historical period in which one is considering the phenomenon. These constructions can and do interact, especially when an issue is emerging and its definition and management are not yet successsfully claimed by one set of actors under a specific paradigm. These constructions also change with time. Finally, as in the case of PMS, some authors within a given arena may medicalize part of a phenomenon while others do not. There is no consensus within arenas muchless across them.

In terms of the discourse on PMS during this era, PMS and premenstrual symptoms, are not entirely differentiated within the popular or medical literature. If a woman suffers from one or two symptoms, she is labelled as suffering from a syndrome, which is generally viewed as adversely affecting her ability to function. The label PMS becomes synonymous with any premenstrual symptomology and both are constructed as a medical matter. A physician's assistance in diagnosis and treatment is frequently required, although there is not concrete way in which to diagnosis or treat it. In this sense, premenstrual symptoms are medicalized when they come under the heading

of PMS. All women who suffer from one to 150 possible symptoms are grouped into a single illness category to be treated with a specific set of remedies which are generalized to treat all possible symptoms. However, the category of PMS representing the extreme end of premenstrual symptomology, in which only 5-10% of all women suffer, is not itself medicalized. These women may in fact be suffering from a hormone imbalance, a psychological illness or else some other physiological or biological imbalance. They may in fact fit a clinical category possibly warranting the label PMS.

During this era in the emergence of PMS as a social problem, when its definition, management and treatment are under contention, some aspects of medicalization are seen in the labelling of all premenstrual symptoms as PMS. However, as PMS becomes more clearly defined and as women begin to realize that they are not suffering from a syndrome but from normal monthly changes that may be exaggerated by external forces, such as stress, the label medicalization applies less and less. In the following section, the issue of the medicalization of premenstrual symptoms remains within the popular discourse, yet the medical discourse is beginning to differeniate premenstrual symptoms from PMS.

1985 and Beyond - Contemporary Constructions of PMS:

We now move into the contemporary era in the history of PMS. This phase emerged between 1985 and 1987 with

increasing attempts to clarify premenstrual symptoms and PMS.

This process is most obvious in the medical discourse. The popular discourse still treast PMS as problematic and non-specific with rare criticism. In the medical discourse, two articles in particular stand out as representative of these shifts. One is by Brooks-Gunn in Psychosoamtic Medicine (1986). The other is by Reid in the American Journal of Obstetrics and Gynecology (1986).

Brooks-Gunn, in an editorial, tied the fascination with premenstrual changes not only to the regularity of women's monthly cycles but also to the cultural beliefs associated with it. She stated that although researchers know a great deal about hormonal variation, cultural beliefs and menstrual knowledge acquisition during adolescence, "we do not know to what extent these and other factors influence each woman's overall menstrual experience" (1986:385). Researchers tend merely to pay lip-service to multideterministic, multi-disciplinary models. This in turn leads to a generalization about premenstrual changes when there are two different phenomenon occurring - "One is the existence of premenstrual symptoms; the other is the more specific designation of a premenstrual syndrome [or possibly syndromes...]," (1986: 385). Most studies do not differentiate these two distinct entities as reflected in the incidence rates of up to 100% of all women.

The second article, by Reid (1986) who as been active in

research on PMS through out the 1980's, is titled "Premenstrual Syndrome: A Time for Introspection." Although Reid is still working within a medical paradigm, his article represents a shift that is occurring among some PMS researchers. He appears to side with women who are concerned with premenstrual changes and faults the medical profession for not being able to address the concerns of "untold numbers of menstruating women," (1986:921). He still problematizes women's menstrually related changes, yet admits that for the majority of women these changes are not a problem.

> The very fact that premenstrual syndrome may represent the severe end of the spectrum of normal premenstrual changes and that there is presently no clear demarcation of the point on the spectrum where premenstrual syndrome begins creates the unfortunate situation where many healthy women have found themselves pejoratively categorized as suffering from a condition that may have significant implications regarding their health and functioning in society (Reid, 1986:922).

He notes that there needs to be a distinction made between premenstrual symptoms and PMS. He faults practitioners for not taking or having the time to listen to women's concerns in order to assess accurately their condition.

Finally, Reid also addresses the issue of the impact of these generalizations about women's premenstrual symptoms upon their careers and families as well as stereotypes about women. However, instead of taking a step away from a medical model of PMS, he concludes with this comment: "One need only consider how many more women might

enjoy a happy family life or excel in a career if effective interventions could be found for premenstrual syndrome" (1986:925). He bases male-female inequality in part on conditions such as dysmenorrhea and PMS. If PMS were treatable, this inequality would not be as big a problem. In Reid's model men are considered the norm. Women need to be fixed. Although Reid attempts to clarify the fog surrounding the definition and management of PMS, he does not step away from an individual, medical paradigm. This paradigm focuses attention on individual women as opposed to external forces. He does offer a refinement of the distinction between premenstrual changes and PMS, and he steps away from generalizations about all women.

Reid's comments are clearly an effort to respond to arguments that PMS is not a major problem for most women. But, for those women for whom it is a problem, doctors need to be sensitive to women's concerns. Reid even refers to PMS as a feminist issue. As Ruzek (1980) noted, this could be seen as an effort to coopt women's concerns in order to maintain the medical construction of PMS as dominant. This sort of cooptation was seen after women opened women's clinics in the 1960's and 1970's to provide women-centered care. When doctors realized that they could not repress these clinics, they coopted these programs to "reassert control over the activity" (Ruzek, 1980:336).

These articles show that the medical discourse on PMS is gradually changing. However, the controversy about the

opposing constructions of women's bodies is neither resolved, or nearing a resolution. The direction one sees in the medical discourse is toward a refinement of the previously existing picture of the impact and influence that PMS has upon women's lives. The popular discourse has yet to refine its discourse on PMS and premenstrual changes.

In this era, we still see a feminist discourse on PMS. As I noted in the last section, feminists during this era are less reactive to constructions of others and are working on creating their own constructions. For example, anthropologists, such as Martin (1987) and Johnson (1987) analyze PMS within the cultural context of the time. Johnson (1987:338) refers to PMS as a "western culture-specific disorder":

> a constellation of symptoms categorized by a given culture as a disease; the eiology of which symbolizes core meanings and reflects pre-occupations of the culture; the diagnosis and treatment of which are dependent upon culture specific technology and ideology. Further, the definition holds that while such symtpoms may be recognized elsewhere, they will not be categorized as the same disease, and treatment which is successful in one cultural context will not be seen as successsful in another.

Johnson asserts that PMS, as a culture-bound syndrome, can serve

> as a symbolic barometer of status and role changes of women in modern society ...[the] ultimate fate of PMS in our culture should mirror quite accurately -the resolution of conflicting role demands on women (1987:351).

Martin includes a chapter on PMS in her book <u>The</u>

Woman in the Body: A Cultural Analysis of Reproduction (1987). Using primary data from interviews and secondary data, she observed that discussions of PMS ultimately related to differing constructions of time and human capacities between men and women.

> Are women, as in the terms of our cultural ideology, relegated by the functions of their bodies to home and family, except when, as second best, they struggle into wartime vacancies? Or are women, drawing on the different concepts of time and human capacities they experience, not only able to function in the world of work but able to mount a challenge that will transform it? (1987:138).

As these two authors show, feminist discourse on PMS is also changing with time. Feminist authors are creating their own constructions of PMS and not merely reacting to those created by the medical or popular discourse.

Summary:

In this chapter, the emergence of PMS as a social problem during three eras was discussed. In the first era, PMS was seen primarily as a medical matter that affected a limited number of women. During this period, particularly within the popular discourse, both women as well as premenstrual symptoms were problematized. The context for discussions of premenstrual symptoms reflected an old construction or mythic theme regarding the role that women's biology plays in their ability to control monthly fluctuations in mood and behavior. This construction portrays women's cycles as limiting their abilities.

In the second era, PMS emerged as a social problem

within feminist and popular discourse as a result of the trials in Britain. These trials were important not only because of the legal implications of the use of PMS but because of the implications regarding constructions of women's bodies. Questions emerged regarding women's abilities to control themselves while premenstrual, which reinforces the old version of the influence of women's cycles on their behavior. As a response to this reinforcement, a feminist discourse on PMS emerged. This discourse not only refuted this portrait but deconstructed it and began the process of creating a feminist version of premenstrual symptoms.

During this second era the popular literature, for the most part, refrained from negative depictions of premenstrual women and centered on helping women cope with problematic symptoms. The medical discourse further reinforced this medical, problematic version of premenstrual symptoms and gradually began to increase research on the etiology and treatment of premenstrual symptoms.

In the final era, we see a refinement of the distinction premenstrual symptoms and PMS within the medical discourse. While popular discourse remains as it was in the previous era, The feminist discourse is also changing. It is shifting from refuting and reacting to previous constructions as they emerged out of the popular and medical discourse and beginning to create its own

constructions. In this era, a gradual shift among some is seen that involves a new construction of women's bodies. The medical literature appears more careful in its discussions of the influence of premenstrual symptoms on women's lives. However, the popular literature does not. In the final chapter, I discuss the implications of this analysis.

Chapter 6

Summary and Conclusions

In Chapter 5, I discussed three eras in the emergence of premenstrual syndrome as a social problem that were evident from my content analysis. Within each of these eras, writers in the medical, popular and feminist literature construct their own views of premenstrual symptoms and syndrome.

Within the first era (1931-1980), authors in the medical and popular discourse discussed PMS as a medical "problem." In the popular literature both women's cycles as well as their premenstrual symptoms were problematized. In the medical literature, women cycles were not always problematized, yet their premenstrual symptoms were. The cultural context which frames these discussions reflects an old construction or mythic theme (Hilgartner and Bosk, 1988) regarding the role that women's biology plays in their ability to control monthly fluctuations in mood and behavior. This cultural construction portrays women's cycles as not only problematic but also as affecting and limiting women's abilities.

In the second era, (1980-1985) PMS emerged as a social problem within public discourse. The trials in Britain represented the dramatic event or tip-point which heralded in this era. These trials were important not only because of the legal implications of the use of PMS as a defense but also because of the cultural context and themes in

which they were framed and reflect. First, they involved the human drama of a crime of passion committed by women, which is still a fairly rare occurrence. Secondly, and linked to the first point, they bring brought questions regarding the influence of women's cycles on behavior and women's abilities to control their behavior. This point ties into the cultural construction which formed the context in the first era. As a response to the popular discourse about the trials and implications of these trials for constructions of women's bodies, a feminist discourse on PMS emerged. This discourse, as the original feminist discourse in the 19th century on menstruation did, not only challenged the old construction but also worked to create a feminist construction of premenstrual symptoms.

During this second era, most of the popular writers reframed their portraits of premenstrual women and focused their attention on helping women to cope with what they put forth as a significant medical problem. The medical literature still discussed premenstrual symptoms which were generally synonymous with the label PMS as problematic and warranting medical intervention in up to 80% of all women. During this era, medical articles on PMS appearred with greater frequency.

In the contemporary era, which began in approximately 1985, the medical discourse began to differentiate premenstrual symptoms from PMS. An increase in the numbers of articles published on PMS is still seen. The popular literature remained as it was in the previous era. The

feminist discourse shifted from merely refuting and reacting to the popular and medical constructions of PMS and began to create its own constructions. In this era, the cultural context gradually shifts more toward the new constructions of women's bodies. These new constructions portray women's cycles as normal and not inherently limiting, rather than problematic and limiting.

In this chapter, I discuss the implications and speculate on the future of PMS as a social problem. Two questions are salient: What are the theoretical implications of the model of the emergence of PMS as a social problem? And, what is the future of PMS as a social problem, or PMS into the 21st century?

Theoretical Implications:

In my analysis I used a social constructionist framework. Within this paradigm, I applied two conceptual models, the emergence of social problems and medicalization.

The Emergence of PMS as a Social Problem:

The social constructionist framework provided the basis for a discussion of PMS as an emergent phenomenon which comes to be labelled as a social problem through an interactive process of contending and competing, yet interconnected arenas of discourse (Olesen, 1986; Hilgartner and Bosk, 1988). These arenas of discourse shape the manner in which PMS emerges as a social problem. In

order to fully understand this process, the history of PMS was traced as it emerged out of each of these arenas. Social problems do not emerge from a social vacuum. There is always a cultural context in which there are changing and competing forces. Hilgartner and Bosk call certain of these forces "mythic themes" (1988). These themes shape the manner in which a given social problem is constructed within public discourse. What emerged from my analysis of PMS is that there are two constructions which make up this context. The older construction portrays women's cycles as not only problematic and necessitating some sort of management but also portrays women as being at the mercy of their cycles. Women are unable to control monthly fluctuations in mood and behavior. The neo-feminist construction, on the other hand, portrays women's cycles as not inherently problematic and limiting. These constructions are not mutually exclusive. This new version of women's bodies emerges out of and in reaction to the old. They exist at the same time and play a role in the manner in which each arena constructs PMS and responds to questions and concerns about its definition.

The mythic themes transcend more than the six decades reviewed in this work. These themes are woven into a long history, as reviewed within the anthropology literature, of the fear of women due to their reproductive capacities, the power of women due to these capacities and the view of women's bodies as the repositories of life. (See Ortner and Whitehead, 1981; Paige and Paige, 1981; and Reiter, 1975

for examples of this discourse.) Mythic themes or mythic properties have a range of characteristics. I have shown through my analysis one type of mythic property as it ties into ancient views of women and their ability to reproduce. Research questions that follow from this analysis are what is the nature of mythic themes/properties? And what are other types or characteristics of these properties?

However, this context is not the only important variable in the process of the emergence of social problems. Hilgartner and Bosk argue that there needs to be some sort of drama that helps bring a given issue into the public discourse (1988). That is, the drama needs to continue at some level in order for interest to be maintained. I expand upon Hilgartner and Bosk by proposing that in many, if not all cases, there is a specific dramatic event or events that push an emerging phenomenon into the public discourse. One sees this in the case of toxic shock syndrome (TSS) in which several women became ill and died while wearing tampons. Suddenly, everyone was concerned over TSS and it moved from an infrequent medical event to a social problem (Olesen, 1986).

Such dramatic events can be seen as the tip-points from which a phenomenon moves into the social problems arena. The characteristics of these events are important. For almost fifty years, premenstrual syndrome appeared with relative consistency in the medical and popular discourse without ever becoming an important public issue. The trials

in Britain were pivotal within the popular and feminist discourse because they were highly publicized and because they tapped into cultural themes and stereotypes.

The trials, which were picked up within the popular discourse and then critically discussed within the feminist discourse, represent the first public debate about the influence of premenstrual symptoms on women's behavior. Although these issues had been discussed within both the popular and to a lesser extent the medical discourse prior to 1980, they did not elicit the response that discussions of the trials did. The trials forced PMS into public discourse because they dealt with profound matters in human life, such as the taking of life. But it was much more than homicide that made these trials the tip-point in the history of PMS. First, women murderers are still rare. Second, these women claimed that their premenstrual symptoms contributed to their actions. This in turn tapped into cultural themes regarding the effect of women's cyclical changes on their behavior and actions.

As we discussed in Chapter 5, the increase in the medical discourse is not as easy to mark with one event. As I speculated the rise of interest in PMS in the medical discourse may be related to 1) increasing questions from women patients as a result of organizations such as Virginia Cassara's PMS Action; 2) increasing legitimation by well-respected researchers such as Reid and Yen (1981) and the work of Rubinow and Roy-Bryne following the NIMH workshop in 1983 on the definition of PMS (Rubinow and Roy-

Byrne, 1984); and 3) advances in neuroendocrine research. In order to answer why PMS emerged as a research concern in the medical discourse, one would need to do a review of all the medical literature published after 1980 as well as read conference announcements, abstracts and introductions to special journal issues, to name a few possible sources.

Therefore, although Hilgartner and Bosk discuss the role that drama and culture play in the emergence of social problems, I clarify this discussion by showing that specific events which often preceed and trigger the emergence of social problems must tap into cultural themes of some significance. I have, therefore, shown one property of drama, its relationship to profound cultural themes, which brings forth questions about what goes into drama in the emergence of social problems. Future research should address the nature and characteristics of drama within other social problems, such as toxic shock syndrome.

The Medicalization of PMS:

In this analysis, PMS as an illness category is constructed and defined as a medical matter. As discussed in Chapter 2, several authors such as Riessman (1983) tie this medical context to the sociological concept of medicalization. Riessman (1983) does not view PMS as principly a medical construct but as a social construct linked to economic conditions (i.e., gynecologists wanting to expand their areas of practice) and to social conditions (i.e., women demanding that physicians pay more

attention to their complaints).

Prior to 1980, the medical construction of PMS was not questioned. When PMS emerged as a social problem, feminist writers, such as Riessman (1983) questioned the medical construction of premenstrual symptoms and PMS and further claimed that the premenstrual phase was medicalized (i.e., that it was consciously being constructed as a medical "problem" when its roots are actually within the social order). Grounding this claim within my analysis, I conclude that during the second era in the history of PMS, some but not all aspects of PMS, such as premenstrual symptoms, are medicalized.

As discussed in Chapter 5, from 1980 until the contemporary era, there was very little attempt to separate discourse on PMS from premenstrual symptoms. Premenstrual symptoms were medicalized to some significant extent. The medicalization literature implies that medicalization is an "all or nothing," or a monolithic process, such as Conrad and Schneider's (1980) discussion of homosexuality or Reissman's (1983) discussion of PMS. Yet, medicalization does not have a "yes or no" construction. In terms of the medicalization of PMS, premenstrual symptoms as part of the phenomenon, appeared during the second era to be medicalized. During this era, discussions of premenstrual symptoms and PMS were synonymous in the medical and popular discourse. Writers did not differentiate between women who might have symptoms periodically or who might only have one

or two symptoms that it did not interfere greatly with their lives from those women who suffered incapacitating symptoms with almost every cycle. As researchers have begun to clarify PMS, it has become clearer that only 5-10% of all women experience incapacitating symptoms or PMS which may be helped by medical intervention. In the contemporary era, premenstrual symptoms and PMS are viewed as forming a continuum from mild to severe symptomology (Brooks-Gunn, 1986; Reid, 1986). Yet, in the popular discourse even today and in the medical discourse in the second era, premenstrual symptoms are viewed as a medical problem requiring medical management even for non-prescription and lifestyle change remedies.

Therefore, total medicalization or at least such claims may occur intitially during a period of uncertainty, while contending arenas are debating a phenomenon's definition. While subsequently a more refined and only partial medical jurisdiction may be asserted. The initial claims of a given phenomenon as "all" or fully within the medical domain can be sociologically analyzed as jurisdictional claims-making in competition with other arenas who have an interest in the phenomenon. The medical arena asserted its own construction of PMS. This construction initially was criticized by the feminists who are now creating a feminist construction. Gradually, the medical discourse is also shifting its views. Future research needs to ask: How would one specify whether a phenomenon had been fully or partially medicalized? What

sectors or dimensions of the phenomenon might lend themselves most or least readily to medicalization? What are the characteristics of the parts of a phenomenon that have become medicalized? And, is there some reason to question the very definition of medicalization?

In summary, several primary theoretical implications emerged from my analysis. The first represents a further clarification of Hilgartner and Bosk's (1988) framework for the emergence of social problems. I argue that in many cases there needs to be a specific dramatic event or events which are framed within cultural contexts or themes. These contexts tap into fundamental values or questions within a given culture.

Secondly, I propose that the process of medicalization is not necessarily monolithic and homogenous. Parts of a phenomenon, such as the premenstrual symptoms may be medicalized while others are not, especially while the phenomenon is in a period of definitional uncertainty.

The emergence of PMS represents an interesting issue to analyze within a social problem and medicalization framework. In the first era, the medical, and to a lesser extent the popular, discourse discussed PMS. In the second era, the popular and then the feminist discourse move PMS from a private issue to a public forum. Gradually, during this era, the medical discourse grows until the mid-1980's when it dramatically increases. As discussed within this chapter and Chapter 5, I can only speculate on the reasons

for the growth within the medical discourse. However, the analysis shows that there is a differential pace of emergent issues within different arenas. The popular era increased dramatically in the early 1980's due to the trials and remained fairly consistent during the 1980's. The feminist emerged in the early 1980's as a response to the popular discourse and has declined somewhat over time. While the medical remained fairly constant throughout the earliest era and gradually grew until the mid-1980's when it dramatically increased. Future researchers need to address the differential pace of emergent issues within different arenas as well as ask why that pace differs. From my analysis, I can answer why the popular and feminist arenas increased. Yet I am not able to answer why the medical arena increased. Within the emergence of social problems, each arena must be analyzed in order to show its own process and stages of emergence.

Finally, the latter brings up the issue of the use of content analysis as a means to analyze emergent phenomena. In general I found that it provided a great deal of useful information over time. From the analysis, I was able to answer many of my research concerns. However, as I summarized above, my research was limited to selected journals and papers. I was unable to answer why the medical discourse began to address PMS. However, this was due more to my selection criteria and my limiting myself to accessible journals to construct a feasible dissertation project than to the limits of content analysis per se.

PMS into the 21st Century:

Will PMS still be a social problem 5 or 10 years from now? As Hilgartner and Bosk (1988) state, society only has a carrying capacity for a limited number of social problems within public discourse. In their model, social problems decline and re-emerge depending upon dramatic, culturul or political variables. These variables can be specified following the framework I used in the emergence of PMS. Social problems decline and re-emerge on the basis of cultural contexts and specific events that occur and re-fuel a debate. Future research on social problems should address the specific characteristics that make a social problems time-limited.

PMS as Time-Limited Issue:

Several factors will affect the future of PMS. We are already seeing a clarification and shift in the definition of premenstrual symptoms and PMS. The interacting, contending communities still exist and PMS is still a social problem, though currently at a less intense level of publically debated discourse. Its future depends upon the outcomes of medical uncertainties regarding its definition, management, and treatment. PMS will remain a social problem played out in all three arenas as long as there is still a controversy surrounding its definition and management. The controversy may fade if no specific cause, treatment, or cure is found within a few years. It may fade simply because the public loses interest in it.

Since it is not the life-threatening illness that toxic shock is, there needs to be continued drama which taps into cultural views of women, such as the 1986 debate over the DMS-IIIR classification, to keep PMS from fading.

If it does fade out of the public discourse, it will probably continue to appear within the medical, popular and feminist discourses and possibly re-emerge if the context and specific event creates some sort of controversy.

Issues, therefore, go through a process of emergence as social problems. This process involves both a cultural context and a specific tip-point after which an issue emerges as a social problem. Early in the emergence process, debates over the nature of a given problem occur as contending yet interacting arenas of discourse debate the definition of the phenomenon. If after some period of time, an issue is subsumed under the jurisdiction of a specific arena or resolved in some way, the issue is no longer a social problem. Alternatively, a social problem will remain in the public domain as long as there is still debate over contending definitions or some sort of sustaining drama. However, if at some point in time, a phenomenon such as PMS is not resolved or does not continue to maintain a certain level of drama, it will fade gradually from public discourse. It may still exist as an issue until it is resolved, or another dramatic event occurs which once again pushes it into the public discourse. This does not mean that actors within each arena do not continue to write and debate about the

phenomenon. It simply means the phenomenon no longer has a central role in public discourse and therefore, is no longer a social problem.

End Note

PMS, as a social problem and a women's health issue, presents researchers within a variety of fields with a rich base to begin an analysis of the manner in which issues emerge within public discourse as "problems." The implications of such an emergence extend beyond the theoretical to the personal. Although the personal is not explicitly addressed in this work, the many hours of conversations with friends and strangers about PMS, guided and sensitized this researcher to the complexity of analyzing an issue that effects one segment of a population. What PMS is and the best way to analyze it cannot be answered by one paper or one type of researcher. It trully lends itself to a cross-discipline approach. This disseration presents one piece of that approach.

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Appendix A
Coding Categories

For each category, check all that apply

Type of Researcher:
1)MD
2)PhD
3)Clinician
4)Researcher
5)Nurse
6)Sociologist
7)Fellow
8)Occupational therp.
9)MA/MS
10)MSW
11)Other

Purpose of Study:
1)Descriptive
2)Hypothesis testing
3)Model testing
4)Secondary analysis
5)Review article
6)Case presentation/ consult
7)Editorial

Methodology of Study: N=
1)Type of sample
a.Random
b.Purposeful
c.Doesn't state
d.Volunteer
e.Stratified
2)Questionnaire used
a.MDQ
b.Likert
c.Washburn Inventory test
d.used other-Specify:
3)Interview
a.Telephone
b.In-person
4)Other - Specify:

Study Design:
1)Prevalence
2)Prospective
3)Retrospective
4)Other- Specify:

Clinical Trial:
1)Drug therapy
2)Fluid Dynamics
3)Double-blind
4)Control
5)Blood Samples
6)Weight
7)Other - Specify:

How refer to premenstrual changes:
1)PMS -Premenstrual Syndrome
2)PMT -Premenstrual Tension
3)Premenstrual tension syndrome (PMTS)
4)perimenstrual symptoms
5)premenstrual symptoms/changes
6)Recognize = many Symptoms/syndromes
7) Other-Specify:

Types of symptoms:
Physical
1)Breast Tend
2)Bloating
3)Headache
4)Cravings
5)Fatigue/insomnia
6)nausea
7)Alt.sex drv.
8)cramps
9)acne
10)constipation
11)backache

Emotional:
1)Irritable
2)depression
3)Anxiety
4)crying
5)loneliness
6)"loss of control"
7)mood swings
8)tension
9)argumentative
10)>energy

Etiology of premenstrual symptoms: (check as many as appropriate)

1)Hypothalamic Pituitary Ovarian Axis
- a)Hormone Imbalance
- b)Estrogen/Progesterone Imbalance
- c)Estrogen
- d)Progesterone
- e)Vasopressin
- f)Prolactin
- g)Catecholomines
- h)αMSH
- i)Endorphins
- j)Dysfunction of Neuro-intermediate lobe

2)Adrenal Cortex
- a)Fluid Retention
- b)Renin-Angiotensin aldersterone
- c)Angiotensin II
- d)>Production of Aldosterone

3)Other Factors which may interact w/1&2
- a)Psychosomatic
- b)Stress
- c)Psychological
- d)Psychosocial
- e)Sociocultural
- f)Learned Behavior

4)Other
- a)Vitamin B Deficiency
- b)Vitamin A Deficiency
- c)Hypoglycemia
- d)Endogenous Hormone Allergy
- e)Cause unknown
- f)Other-Specify:

Treatment Options:

Prescription Medications:
- 1) Hormones
  - a) Progesterone
  - b) Oral Contraceptives
  - c) Chorionic Gonadotropin
- 2) Mood Medications
  - a) Amphetamines
  - b) Amobarital
  - c) Lithium
- 3) Diuretics (can be OTC)
  - a) Chlorothiazide
- 4) Other
  - a) Bromocriptine

Over the Counter (OTC):
- 1) Vitamin B6
- 2) Prostagladin Inhibitors
- 3) Primrose Oil

Other:
- 1) Diet Changes
- 2) Lifestyle Changes
- 3) Talk Out
- 4) Other

Define PMS?
1)Attempt to define
2)State lack of clear def.
3)Confusion over def.
4)Do not state definition
5)State def. = controversial
6)Etiology unknown

Authors' Estimated incidence:_____

1)0-10%	4)30-40%	7)50-60%	10)80-90%
2)10-20%	5)40-50%	8)60-70%	11)90-100%
3)20-30%	6)50-60%	9)70-80%	

Impact of PMS on women's lives:(not physiological impacts)
1)Work Efficiency
2)Absenteeism
3)Disruption of interpersonal relationships

Why PMS is an issue?:
1)Women's increased labor force participation
2)Concern for women's health
3)Politics
4)Economics

Consequences of PMS:(not physiological)

1)Marital discord	4)Suicides	7)Avoid success
2)Baby battering	5)Accidents	8)Alcohol use
3)Criminal behavior	6)Psychiatric admissions	9)Devasting impact on career/family

Article Cites:
1)Frank 2)Dalton 3)Greene and Dalton

Article discusses following in reference to PMS:
1)DMSIII classification
2)Psychosis
3)Pathology

Imagery/Ideology of PMS:
1)Refers to PMS/menstruation as:
a.Disability/handicap
b.Curse
c.Monthly blues
d.Relating to hysterical women
e.Needing to be controlled
f.Needing to be prevented
g.Need to learn how to cope
h.Feminist issue
i.Monthly burden
j.Other:
2)PMS as double edged Benefit/burden
3)Power of med. prof. ment.
4)Medicalization- control & interests
5)Women's moods/emotions problematic

View of women who suffer from PMS:
1)Emotionally unstable
2)Pathetic picture
3)Suffer temper tantrums/act out act out
4) Other:

Legal aspects of PMS:
1)Discusses cases in U.K.
2)Discusses criminal responsibility
3)States should be permissible as cause
4)Diminished capacity
5)Discusses PMT(S) as legal issue

Article Reviews history of PMS:
1)Type of history Medical: Social:

Funding Source:
Date of Article:
Journal/cite:
Author(s):

Memo: Questions/thoughts for further discussion

Appendix B
Results of the Content Analysis

I. Medical Literature

Table M-1
How Medical Literature Referred to Premenstrual Symptoms

Decade	1950	1960	1970	1980	Total
PMS*	1	1	2	22	26
PMT	4	5	4	5	18
PMTS	2	3	0	2	7
Perimenstrual Symptoms	0	0	0	4	4
Premenstrual Symptoms/Changes	0	3	1	9	12
Recognize as more than 1 syndrome	0	0	0	5	5
Other	0	0	0	6	6

Table M-2
How Specific Journals Referred to Premenstrual Symptoms

Journal**	OB/GYN	RNH	AJP	PS
PMS	8	0	9	9
PMT	8	0	3	7
PMTS	3	0	3	1
Perimenstrual Symptoms	0	3	0	1
Premenstrual Symptoms/Changes	4	2	3	4
Recognize as more than 1 syndrome	0	0	4	1
Other	1	0	5	0

*PMS= Premenstrual Syndrome
PMT= Premenstrual Tension
PMTS= Premenstrual Tension Syndrome

**OB/GYN = American Journal of Obstetrics & Gynecology
RNH = Research in Nursing & Health
AJP = American Journal of Psychiatry
PS = Psychosomatic Medicine

Table M-3
References to Premenstrual Symptoms by Journal & Decade

Journal	OB/GYN				RNH	AJP				PS		
Decade	50	60	70	80	80	50	60	70	80	60	70	80
PMS			1	7		1			8	1	1	7
PMT	2	3	2	1		2			1	2	2	3
PMTS		3				2			1			1
Perimenstrual Symptoms					3							1
Premenstrual Sxs/Changes		2		2	2				3	1	1	2
Recognize as more than 1 syndrome									4			1
Other				1					5			

Table M-4
Symptoms Cited in Medical Literature by Decade

Symptoms					
Physical	**1950**	**1960**	**1970**	**1980**	**Total**
Breast Tenderness	3	0	2	7	12
Bloating	4	1	3	10	18
Headache	4	1	2	9	16
Cravings	2	0	1	8	11
Fatigue/ insomnia	3	1	1	9	14
Nausea	3	0	1	1	5
Altered Sex Drive	2	1	0	2	5
Cramps	0	1	0	1	2
Acne	0	0	0	1	1
Constipation	0	0	0	1	1
Backache	3	1	0	3	7
Emotional Symptoms					
Irritable	2	2	3	12	19
Depression	2	2	2	12	18
Anxiety	3	1	1	6	11
Crying	0	0	0	2	2
Loneliness	0	0	0	1	1
Loss of control	0	0	0	2	2
Mood swings	0	1	0	3	4
Tension	0	1	0	4	5
Argumentative	1	0	1	2	4
> energy	0	0	0	1	1

Table M-5
Symptoms Cited in Medical Literature by Journal

Physical	OB/GYN	RNH	AJP	PS
Breast Tenderness	7	1	2	2
Bloating	9	1	6	2
Headache	8	2	5	2
Cravings	6	1	2	2
Fatigue/ Insomnia	5	1	5	3
Nausea	2	1	2	0
Altered sex Drive	3	0	1	1
Cramps	1	0	0	1
Acne	1	0	0	0
Constipation	1	0	0	0
Backache	1	2	3	1
Emotional				
Irritable	8	2	4	5
Depression	6	2	6	4
Anxiety	6	1	1	3
Crying	1	0	1	0
Loneliness	1	0	0	0
Loss of control	1	0	1	0
Mood swings	0	0	1	4
Tension	0	1	1	3
Argumentative	0	0	3	1
> energy	0	0	1	0

Table M-6
Etiology Reported in the Medical Literature By Journal

Etiology	OB/GYN	RNH	AJP	PS	Total
Hypothalamic Pituitary Ovarian Axis	1	0	2	1	4
Hormone Imbalance	0	0	1	0	1
Estrogen/Progesterone Imbalance	5	1	4	0	10
Estrogen	1	0	0	0	1
Progesterone	2	0	0	0	2
Vasopressin	2	1	1	0	4
Prolactin	2	1	2	0	5
Catecholomines	2	0	1	1	4
∝MSh	1	0	0	0	1
Endorphins	1	0	0	0	1
Dysfunction of Neuro-intermediate lobe	1	0	0	0	1
Adrenal Cortex					
Fluid retention	4	1	1	0	6
Renin-Angiotensin Aldosterone	1	0	1	1	3
Angiotensin II	1	0	0	0	1
> Production of Aldosterone	1	0	1	0	2
Factors which can cause physiological reactions and contribute to Increased premenstrual symptoms					
Psychosomatic	1	0	0	0	1
Stress	4	1	0	0	5
Psychological	2	0	0	1	3
Psychosocial	0	0	0	1	1
Sociocultural	0	0	0	0	0

Etiology (continued)					
Learned Behavior	1	0	0	0	1
Other possible Causes					
Vit. B deficiency	1	1	2	0	4
Vit. A deficiency	1	0	1	0	2
Hypoglycemia	2	1	1	1	5
Endogenous hormone Allergy	2	0	0	0	2
Cause Unknown	2	0	1	2	5
Other	1	1	0	0	2

Table M-7
Etiology Reported in the Medical Literature by Decade

Etiology	1950	1960	1970	1980
Hypothalamic Pituitary Ovarian Axis	1	0	0	3
Hormone Imbalance	1	0	0	0
Est/Prog. Imbalance	3	1	1	5
Estrogen	0	0	0	1
Progesterone	0	0	0	2
Vasopressin	1	0	0	4
Prolactin	0	0	0	5
Catecholomines	0	0	1	3
αMSh	0	0	0	1
Endorphins	0	0	0	1
Dysfunction of Neuro-intermediate lobe	0	0	0	1
Adrenal Cortex				
Fluid retention	2	0	2	2
Renin-Angiotensin Aldosterone	0	0	1	2
Angiotensin II	0	0	0	1
> Production of Aldosterone	0	1	0	1
Factors which can cause physiological reactions and contribute to Increased premenstrual symptoms				
Psychosomatic	0	0	0	1
Stress	0	2	0	3
Psychological	0	2	0	1
Psychosocial	0	0	0	1
Sociocultural	0	0	0	0
Learned Behavior	0	1	0	0

Other possible Causes

Vit. B deficiency	1	0	0	3
Vit. A deficiency	1	0	0	1
Hypoglycemia	2	1	0	2
Endogenous hormone Allergy	0	1	0	1
Cause Unknown	0	0	1	4
Other	0	0	0	2

Table M-8
Treatment Options Cited in the Medical Literature by Decade

Treatment	1950	1960	1970	1980
Prescription Medication				
Hormones				
Progesterone	0	0	0	3
Oral Contraceptives	0	0	0	2
Chorionic Gonadotropin	0	0	0	1
Mood Medication				
Amphetamines	0	1	0	0
Amobarital	0	1	0	0
Lithium	0	0	0	1
Diuretics	0	1	0	1
Chlorothiazide	0	1	0	0
Other				
Bromocriptine	0	0	0	2
Over the Counter				
Vitamin B6	1	0	0	3
Prostaglandin Inhibitors	0	0	0	1
Primrose Oil	0	0	0	0
Other				
Diet Changes	1	1	0	0
Lifestyle	0	0	0	0
Talk out	0	1	0	1
Other	0	0	0	1

Table M-9
Treatment Options Cited in the Medical Literature by Journal

Treatment	OB/GYN	RNH	AJP	PS
Prescription Medication				
Hormones				
Progesterone	1	0	2	0
Oral Contraceptives	1	0	1	0
Chorionic Gonadotropin	1	0	0	0
Mood Medication				
Amphetamines	1	0	0	0
Amobarital	1	0	0	0
Lithium	0	0	1	0
Diuretics	1	0	1	0
Chlorothiazide	1	0	0	0
Other				
Bromocriptine	1	0	1	0
Over the Counter				
Vitamin B6	3	0	1	0
Prostaglandin Inhibitors	1	0	0	0
Primrose Oil	0	0	0	0
Other				
Diet Changes	2	0	0	0
Lifestyle	0	0	0	0
Talk out	2	0	0	0
Other	0	1	0	0

Table M-10
How Medical Literature defines Premenstrual Symptoms by Decade

Decade	1950	1960	1970	1980
Attempt to def.	2	1	2	5
State lack of clear def.	0	1	0	5
Confusion over definition	0	0	0	5
Do not state definition	1	0	1	0
Definition Controversial	0	0	0	2
Etiology Unknown	0	0	0	1

Table M-11
How Medical Literature defines Premenstrual Symptoms by Journal

Journal	OB/GYN	RNH	AJP	PS
Attempt to def.	7	1	2	1
State lack of clear def.	2	0	2	2
Confusion over definition	3	0	1	1
Do not state definition	0	0	1	1
Definition Controversial	2	0	0	0
Etiology Unknown	1	0	0	0

Table M-12
Why PMS is an issue in the Medical Literature by Decade

Decade	1950	1960	1970	1980
Women's increased labor force part.	0	1	0	2
Concern for women's health	0	0	0	2
Politics	0	0	0	0
Economics	0	0	0	0

M-13
What are the Consequences of PMS in Medical Literature by Decade

Decade	1950	1960	1970	1980
Marital Discord	0	0	0	2
Baby Battering	0	0	1	0
Criminal Behavior	2	2	1	4
Suicides	0	1	1	4
Accidents	0	0	0	3
Psychiatric Admissions	0	0	1	2
Avoid success	0	0	0	1
Alcohol use	0	0	0	0
Devasting impact on family/career	0	0	0	2

Table M-14
Why is PMS an Issue in Medical Literature by Journal

Decade	OB/GYN	RNH	AJP	PS
Women's increased labor force part.	3	0	0	0
Concern for women's health	0	0	1	1
Politics	0	0	0	0
Economics	0	0	0	0

Table M-15
What are the Consequences of PMS in Medical Literature by Journal

Journal	OB/GYN	RNH	AJP	PS
Marital Discord	1	0	0	1
Baby Battering	1	0	0	0
Criminal Behavior	4	0	1	4
Suicides	3	0	1	2
Accidents	1	0	1	1
Psychiatric Admissions	1	0	1	1
Avoid success	0	0	0	1
Alcohol use	0	0	0	0
Devasting impact on family/career	1	0	1	0

II. Popular Literature

Table P-1

How Popular Literature Referred to Premenstrual Symptoms

Decade	1950	1960	1970	1980
PMS	0	1	0	13
PMT	2	4	0	6
PMTS	0	1	0	0
Perimenstrual Symptoms (Sxs)	0	0	0	0
Premenstrual Symptoms/Changes	0	0	1	5
Recognize many Sxs/Symptoms	0	0	0	0
Other	0	0	0	3

Table P-2
Symptoms Cited in Popular Literature

Symptoms				
Physical	1950	1960	1970	1980
Breast Tenderness	0	1	0	7
Bloating	0	2	0	12
Headache	0	2	0	8
Cravings	0	0	0	7
Fatigue/ Insomnia	0	1	0	6
Nausea	0	0	0	2
Altered Sex Drive	0	0	0	1
Cramps	0	0	0	2
Acne	0	0	0	2
Constipation	0	1	0	2
Backache	0	1	0	2
Emotional Sypmtoms				
Irritable	0	1	0	7
Depression	0	1	0	8
Anxiety	0	0	0	5
Crying	0	0	0	0
Loneliness	0	0	0	0
Loss of control	0	0	0	0
Mood swings	0	1	0	2
Tension	0	1	0	3
Argumentative	0	0	0	0
> energy	0	1	0	1

Table P-3
Etiology Reported in Popular Literature

Etiology	1950	1960	1970	1980
Hypothalamic Pituitary Ovarian Axis	0	0	0	1
Hormone Imbalance	1	1	0	5
Estrogen/Progesterone Imbalance	0	0	0	5
Estrogen	0	0	0	0
Progesterone	0	0	0	1
Vasopressin	0	0	0	0
Prolactin	0	0	0	3
Catecholomines	0	0	0	0
αMSh	0	0	0	0
Endorphins	0	0	0	0
Dysfunction of Neuro-intermediate lobe	0	0	0	0
Adrenal Cortex				
Fluid retention	1	0	0	1
Renin-Angiotensin Aldosterone	0	0	0	0
Angiotensin II	0	0	0	0
Increased Production of Aldosterone	0	0	0	0
Factors which can cause physiological reactions and contribute to Increased premenstrual symptoms				
Psychosomatic	0	0	0	0
Stress	0	0	0	1
Psychological	0	0	0	0
Psychosocial	0	1	0	1
Sociocultural	0	1	0	0

Learned Behavior	0	0	0	0
Other possible Causes				
Vit. B deficiency	0	0	0	3
Vit. A deficiency	0	0	0	1
Hypoglycemia	0	0	0	4
Endogenous hormone Allergy	0	0	0	0
Cause Unknown	0	0	0	2
Other	0	0	0	2

Table P-4
Treatment Options Cited in the Popular Literature

Treatment	1950	1960	1970	1980
Prescription Medication				
Hormones				
Progesterone	1	1	0	4
Oral Contraceptives	0	1	0	2
Chorionic Gonadotropin	0	0	0	1
Mood Medication				
Amphetamines	0	0	0	0
Amobarital	0	0	0	0
Lithium	0	0	0	0
Diuretics	1	2	0	3
Chlorothiazide	0	0	0	0
Other				
Bromocriptine	0	0	0	2
Over the Counter				
Vitamin B6	0	0	0	6
Prostaglandin Inhibitors (eg-Ibuprofen)	0	0	0	1
Primrose Oil	0	2	0	1
Other				
Diet Changes	0	0	0	12
Lifestyle	0	0	0	1
Talk out	0	0	0	1
Other	0	2	0	4

Table P-5
How Popular Literature Defines PMS

Decade	1950	1960	1970	1980
Attempt to def.	1	2	0	6
State lack of clear def.	0	0	0	1
Confusion over definition	0	0	0	0
Do not state definition	1	0	0	7
State def. controversial	0	0	0	1
Etiology Unknown	0	0	0	0

Table P-6
Why is PMS an Issue in the Popular Literature

Decade	1950	1960	1970	1980
Women's increased labor force part.	2	1	0	0
Increased concern for women's health	0	0	0	2
Political reasons	0	0	0	0
Economic reasons	2	1	0	0

Table P-7
What are the Consequences of PMS in the Popular Literature?

Decade\Consequences	1950	1960	1970	1980
Marital Discord	0	1	0	1
Baby Battering	0	0	0	1
Criminal Behavior	1	3	0	2
Suicide	0	1	0	3
Increased Accidents	1	1	0	1
Increased Psychiatric Admissions	0	1	0	1
Avoiding success	0	0	0	0
Alcohol Use	0	0	0	0
Devasting Impact on Family/Career	1	2	0	0

III. Feminist Literature

Table F-1

How the Feminist Literature Refers to PMS

Decade	1970	1980
PMS	1	10
PMT	1	8
PMTS	0	2
Perimenstrual Symptoms (Sxs)	0	1
Premenstrual Sxs/ Changes	0	2
Recognize Many Sxs/ Syndromes	0	1
Other	0	1

Table F-2

How the Feminist Literature Defines PMS

Decade	1970	1980
Attempt to Define	0	3
State lack of clear Definition	1	4
Confusion over Definition	0	3
Do Not State Def.	0	3
Definition Controversial	0	4
Etiology Unknown	0	1

Table F-3
Symptoms Cited in the Feminist Literature
{All 1980's-List may not be comprehensive. When article lists more than 15 symptoms, did not include all}

Physical Sxs.		Emotional Sxs	
Breast Tenderness	4	Irritable	4
Bloating	6	Depression	4
Headache	3	Anxiety	3
Cravings	2	Crying	1
Fatigue/insomnia	0	Loneliness	0
Nausea	0	Loss of control	0
Alt. sex drive	1	Mood swings	1
Cramps	1	Tension	3
Acne	1	Argumentative	1
Constipation	1	> Energy	0
Backache	3		

Table F-4

Etiology Reported in the Feminist Literature

Etiology	1970	1980
Hypothalamic Pituitary Ovarian Axis	0	2
Hormone Imbalance	1	4
Est/Prog. Imbalance	1	3
Estrogen	0	1
Progesterone	0	1
Vasopressin	0	0
Prolactin	0	3
Catecholomines	0	0
αMSh	0	0
Endorphins	0	0
Dysfunction of Neuro-intermediate lobe	0	0
Adrenal Cortex		
Fluid retention	1	1
Renin-Angiotensin Aldosterone	0	1
Angiotensin II	0	0
> Production of Aldosterone	0	0
Factors which can cause physiological reactions and contribute to Increased premenstrual symptoms		
Psychosomatic	0	0
Stress	0	2
Psychological	0	0
Psychosocial	0	1
Sociocultural	0	1
Learned Behavior	0	0

Other possible Causes

Vit. B deficiency	0	1
Vit. A deficiency	0	1
Hypoglycemia	0	0
Endogenous hormone		
Allergy	0	0
Cause Unknown	0	2
Other	0	0

Table F-5
Treatment Options Cited in the Feminist Literature

All 1980's

Treatment	1980
Prescription Medication	
Hormones	
Progesterone	5
Oral Contraceptives	0
Chorionic Gonadotropin	0
Mood Medication	
Amphetamines	1
Amobarital	0
Lithium	1
Diuretics	1
Chlorothiazide	0
Other	
Bromocriptine	1
Over the Counter	
Vitamin B6	4
Prostaglandin Inhibitors (eg-Ibuprofen)	0
Primrose Oil	1
Other	
Diet Changes	2
Lifestyle	0
Talk out	1
Other	2

Table F-6
Why is PMS an issue in the Feminist Literature?

All 1980's	
Women's increased labor force participation	2
Concern for women's health	3
Political reasons	5
Economic reasons	4

Table F-7
What are the Consequences of PMS in the Feminist Literature

Decade	1970	1980
Marital Discord	0	0
Baby Battering	0	1
Criminal Behavior	1	1
Suicides	1	2
Accidents	1	2
Psychiatric Adm.	1	1
Avoid Success	0	0
Alcohol use	0	0
Devasting Impact on Family/Career	0	0

Estimated Incidence of PMS by Category of Literature

Medical Literature

Journal	Mild Discomfort	Severe	Don't Differentiate
OB/GYN	25-90%	20-40%	20-70%
PS	30-92%	2-10%	25-100%
AJP	-	-	40%
RNH	-	-	-

Popular Literature

	Mild Discomfort	Severe	Don't Differentiate
All Journals	40-90%	< 5-40%	10-15%

Feminist Literature
(Majority of Articles do not state a range/incidence figure)

	Mild Discomfort	Severe	Don't Differentiate
All Articles	20-100%	-	-

*Range represents the lowest and highest estimated incidence of premenstrual symptoms for all women as reported by all articles in each category of literature.

Mild Discomfort= Experiencing one or more symptoms that do not necessarily interfere with daily life

Severe Discomfort= Symptoms which are debilitating/prevent normal functioning

Appendix C
Summary of Articles/Topics

Medical Literature by Date
American Journal of Obstetrics & Gynecology

Author Research/Article Topic	Date	Sample Size/Population
Morton, J. Study seeking etiology + Treatment Retrospective, Self-Reported data	1950	29 Ambulatory, Mentally Ill patients
Bickers, W. Testing hypothesis re: relationship between PMT/Weight gain Compared women with rat study Wants to find treatment	1952	3 Hospitalized women for electrolyte Study -22 Patients w/PMT for clinical study of weight gain
Behrman, S.J. Case presentation to discuss patient management	1961	1 46 yr. old woman with retrospectively reported symptoms
Paulson, M. Studying belief that PMT is caused by psychological factors, esp. women's beliefs about menstrual function & environmental stresses	1961	255 women from a variety org./groups - Factory workers, students, etc.. Asked women to complete questionnaires at diff. points in cycle
Menduke, H. Study of teens, PMT, dysmenorrhea & social adjustment	1963	173 High School Students
Eichner, E. Drug study- treating women with MPA for various menstrual cycle disorders including PMT	1963	15 Patients (does not state how obtained sample)
Golub, L., et al Study of premenstrual weight gain	1965	86 College students
Reeves, B., et al Study of weight gain & possible treatments	1971	20 Volunteers from Doctors offices

Wong, W., et al Clinical study of fluid retention	1972	6 women complaining of bloating- 7 controls
Reid, R., et al Review Article	1981	-
Faratian, B., et al Study to find way to quantify syndrome- Specifically looking at abdominal swelling & Body Image	1984	52 patients from PMS Clinics
Brush, M.G., et al Measurement of fatty levels in plasma of women w/PMS	1984	42 patients from PMS Clinic
Pariser, S., et al Review Article	1985	-
Rosenthal, J., et al Study of proton T, relaxation at diff. stages of cycle	1985	41 Healthy/normal women
Maddocks, S., et al Double Blind Study of progesterone suppositories	1986	Women diagnosed with PMS 20 women completed study
Magos, A., et al Part 1 Assessment of menstrual cycle sxs. by Trend Analysis- Discussion Part 2 Use of latter	1986	- 150 women w/history of PMS
Casper, R., et al Assessment of PMS using linear analog scale	1986	73 possible PMS women 20 controls
Reid, R. Review Article	1986	-
Posthuma, B., et al Assessing changes in functional ability	1987	12 PMS women, 9 controls Recruited through news-papers/referrals
Oian, P., et al Study of fluid dynamics in women w/out PMS	1987	11 volunteers w/out PMS

American Journal of Psychiatry

Author Research/Topic	Date	Sample/Population
Lamb, W., et al Study of correlation between sxs/personality Also, hormone study Compared controls/PMS using endocrine activity, EEG- Found no evidence for psychogenic etiology	1953	127 Student Nurses 10 in depth
Perr, I. Review Article	1958	-
Berlin, F. Case Report of teen-ager with periodic psychosis before menses reated with medrox-rogesterone acetate	1982	1 Teenager
Abramowitz, E., et al Study of incidence of psychopathology before menses	1982	136 depressed & schizo-phrenic inpatients
Deleon-Jones, F., et al Case report, study increase in MHPG prior to menses. Treated w/ lithium	1982	1 women w/PMTS
Friedman, R., et al Looking at relationship between premenstrual affective syndrome and unresolved sexual conflicts	1982	28 psychiatric inpatients
Rubinow, D, et al Review Article	1984	-
Rubinow, D., et al Prospective study using 100mm visual analogue scale. Test of tool	1984	96% of 220 women from a sample who went to menstrually related mood disorder progam
DeJong, R., et al Use of prospective study to assess PMS & major psyhiatric disorders	1985	57 self-selected women who gave histories of premenstrual changes

Stout, A., et al Study of race differences	1986	321 black women/462 white women from larger health survey. Retrospective data
Roy-Byrne, P., et al Study of TSH/Prolactin responses to TRH	1987	14 women w/PMS/ 9 control
Parry, B., et al Study of women w/ seasonal PMS. Treated w/light and oral melatonin	1987	1 women w/seasonal PMS
Parry, B., et al Treating women w/ sleep deprivation	1987	10 women w/premenstrual depression

Psychosomatic Medicine

Author Research/topic	Date	Sample/Population
Moos, R. Development of MDQ	1968	839 wives of grad. students
Smith, S., et al Study to find an association among food cravings, depression & premenstrual problems (physiological)	1969	300 nurses (study based on experiences of senior researcher w/ depressed patients)
Janowsky, D., et al Study looking for underlying cause for psychopathology linked to the menstrual cycle. Specifically, potassium/ sodium ratio & weight	1973	11 college volunteers
Parlee, M. Critique/commentary on MDQ	1974	25 women/34 men students
Awaritefe, A.,et al Study of personality and PMT	1980	40 parious/40 nulliparious Nigerian women

Endicott, J., et al Relationship between specific subtype of premenstrual changes & specific subtypes of mental disorders	1981	15 women w/depressive disorder; 12 w/other affective disorder; 9 w/nonaffective disorders; 13 w/no mental disorders
Woods, N,. et al Study of cultural stereotypes & re-collection of menarche & affects on menstrual attitudes	1982	193 women from cluster, random study from census lists in 5 racially/ economically mixed areas
Sanders, D., et al. 3 part study. Part 1 Study of mood, physical state, hormone changes	1983	55 women; 1/3 from PMS Clinic;Rest volunteers w/w/out PMS
Backstrom, T, et al Part 2- Comparison of hormone levels in women w/high/low degrees of clinical mood changes		12 high change women from latter group
Bancroft, J., et al Part 3- Sexuality & role of androgens at differing times in cycle		Same as part 1
Brooks-Gunn, J. Editorial on differ-enciating premenstrual symptoms from syndromes	1986	
Logue, C., et al Overview of prevalence/ risk factors for peri-menstrual symptoms	1986	
Leon, G., et al Relationship between bulimia/menstrual cycle	1986	45 bulimic women

Research in Nursing & Health

Author Research/Topic	Date	Sample/Population
Woods, N., et al Comparison of retro-spective/prospective data	1982	73 women from census of 5 racially/economically neighborhoods

Woods, N., et al Description of pre- valence of distress associated w/menstruation Should premenses/menstruation be regarded as a single construct-Perimenstrual distress	1982	193 women from latter sample
Coyne, C. Study of muscle tension during premenstrual vs. follicular phase	1983	22 women recruited from an ad
Shaver, J,. et al Study of non-pre- menstrual women. 2 cycles reviewed	1985	63 women from same Woods studies above

Popular Literature- Summary of articles/date
Ladies Home Journal

Summary/Date/Author

July 1954, Safford
Doctors advise column on what a women should do about premenstrual depression/crying jags. Mentions progesterone and Diuretics as treatments.

March 1963, Spicer
Advise column on "monthly blues." Recommends hormones and diuretics as treatments.

August 1965, Chevalier
Advise column on how to end "monthly problems." Recommends that women take progesterone, o.c.'s, diuretics and tranquilizers.

June 1981, Brody
Column on "lifting 'the curse' at last." Recommends vitamin B6, dietary changes, calendering and pampering oneself. References to women's behavioral changes from Dalton's data.

Reader's Digest

Summary/Date/Author

May 1955, Greenblatt
Doctors advise column on the "needless misery" of PMT. Recommends changes in diet, vitamin intake, a relaxant (did not specify) and a diuretic.

August 1969, Lake
Advise column for women who are "once-a-month Witches." Recommends diuretics, sedatives, tranquilizers and mood-elevating drugs. References to behavioral changes from Dalton's data.

February 1983, Angier
Article on how to manage the "Dr. Jekyll & Ms. Hyde" syndrome. Mentions progesterone as treatment. Discusses Dalton's work and trials in U.K.

Essence

Date/Summary/Author

September, 1980, Bray
Article on "lifting the curse" of menstruation. General overview of PMT. Mentions diuretics and diet changes as well as relaxation and pampering.

February 1981, Christopher
Q & A column by a nutritionist who recommends diet changes for "menstrual blues."

December 1986, Kotin
Article on how to prevent PMS recommending changes in lifestyle (such as more sleep and charting off symptoms), diet changes and oil of evening primrose.

Mademoiselle

Date/Summary/Author

October 1981, Cohen
Overview article on PMS, specifically mentions Dalton's work in association with hormonal causes of PMS. Recommends progesterone, O.C.'s, diuretics, bromocriptine, prostagladin inhibitors, vitamins and diet changes.

December 1982, Lauersen
Article written by M.D. on how to "win the hormone" war. Discusses Dalton's work. Science will one day find a cure for PMS until then women should consider progesterone, O.C.'s, diuretics, bromocriptine, spironolactone, vitamin B6, diet changes and exercise. Article does mention cases in U.K.

August 1983, Morrison
Article on beating the premenstrual "beauty blues." Discusses diet and exercise changes.

April 1985, no author
Article on beauty solutions for "pre-period uglies." Recommends diet and exercise changes.

March 1986, Cantarow
Articles discusses history of hysterical women stereotypes. Examines/discusses social and medical explanations of PMS. Critical of women's preferences to go take a pill rather than re-examine external factors in one's life that might lead to PMS. Mentions Dalton in a critical light as well as the U.K. trials. Does discuss diet changes and stress reduction.

September 1986, Malkin
Article on how to "tame the shrew (inside you)." Dietary changes discussed.

October 1986, Malkin
PMS included in a group of 14 "female health hazards." Overview of posssible causes and treatments, such as B6, spironlacine and diet changes.

October 1986, Lark
Guide to stretch away physical symptoms of PMS.

May 1987, Burtis
Article by an R.D. on diet tips to help women deal with PMS.

Newsweek

Date/summary/Author

November 8, 1982, Press
Discussion of Santos criminal case using PMS as a defense in U.S.

June 23, 1986, Howard
Review of proposed DMSIII diagnostic category for PMS.

Psychology Today

Date/Summary/Author

May 1978, Gaylin
Review of a study on premenstrual expectations or the role that cultural factors play in women's expectations about PMS.

August 1984, Hopson and Rosenfeld
Overview of PMS. Discusses Dalton's role in popularizing progesterone as a treatment. Not advocating one treatment or another. Article questions whether PMS should be a syndrome and the ambiguities about cause.

August 1984, Sommer
Article discusses U.K. criminal cases and implications for women of PMS as a defense. Considers use of PMS as a defense premature.

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Riessman, Catherine. "Women and Medicalization: A New Perspective." Social Policy, 1983, Vol. 14:1. Pp.3-18.

Rome, Esther. "Premenstrual Syndrome (PMS) Examined through a Feminist Lens." Boston Women's Health Collective.

Appendix D
Summary of Readers' Guide
(Also see Appendix E)

Date	Number of References to PMS or Menstruation
1932-35	0 on PMS, 1 on menstruation
1935-37	0 on PMS, 1 on menstruation
1937-39	0 on PMS, 1 on menstruation
1939-41	0 on PMS, 1 on menstruation
1941-43	0 on PMS, 3 on menstruation
1943-45	0 on PMS, ? on menstruation
1945-47	0 on PMS, 6 on menstruation
1947-49	0 on PMS, 4 on menstraution
1949-51	0 on PMS, 6 on menstruation
1951-53	0 on PMS, 3 on menstruation
1953-55	New category, Premenstrual Tension Ladies Home Journal, J. 1954
1955-57	Under menstruation, McCall's, F.1957 Reader's Digest, May 1955 Time, Oct. 22, 1956 and March 19, 1956 (No PMT category)
1957-59	0 References
1959-61	"Dangerous Days," Time, Nov. 28, 1960 Science News Letter, N. 26, 1960 Cosmo, N., 1960
1961-63	Under PMT, Good Housekeeping Oct. 1961
1963-65	Under PMT, Ladies Home Journal, March 1963
1965-66	Under PMT, Ladies Home Journal, August 1965
1966-67	0 References
1967-68	Under PMT, Today's Health, S. 1967
1968-69	O References

1969-70	Under PMT, Redbook, April 1969 Reader's Digest, August 1969 Good Housekeeping, June 1969
1970-71	0 References
1971-72	Under PMT, Good Housekeeping, May 1971
1972-73	0 References
1973-74	Under PMT, McCall's, F. 1973
1974-75	0 References
1975-76	Harper's Bazaar, not listed under PMT, possible PMT article, Nov. 1975
1976-77	Under PMT, Time, Feb. 23, 1976 Good Housekeeping, Sept, 1976
1977-78	Under PMT, Ruble, D., Science, 1977 (Vol. 197?)
1978-79	Under PMT, Ruble, D., Psychology Today, May 1978 Marsh, Science Digest, S, 1978 (Also see menstruation)
1979-80	Article on premenstrual diet, could not find listing under diet
1980-81	Under PMT, Essence, S., 1980
1981-82	Under PMT, Mademoiselle, O., 1981 McCall's, J. 1981 Macleans(?), Je., 15, 1981 Essense, F., 1981 Ladies Home Journal, Je., 1981 (PMS mentioned under menstruation, see menstruation disorders)
1982-83	Ms., Parlee, S., 1982 People Weekly, April 5, 1982 Newsweek, Nov. 8, 1982 Science News, Dec. 11, 1982 Mademoiselle, Dec., 1982 Discussion, N., 29, 1982
1983-84	Mademoiselle, Aug. 1983 Reader's Digest, F., 1983 Sat. Evening Post, April 1983 Dance Magazine, Ja., 1983 Teen, D., 1983 Glamour, Jan., 1983 Health, Fall, 1983 Ms., Oct, 1983

1984-85	PMS now is a heading Glamour, Dec. 1984 Psychology Today, Aug. 1984 (Two articles) Science, May 1984 McCall's, Nov. 1984 Jet, Dec. 1984 FDA Consumer, May, 1984 Women's Sports, Jan., 1984
1985	Health, July Science News, Nov. 9; Jan. 12 Vogue, June Glamour, Nov. Parents, Jan. Working Women, Aug. Mademoiselle, April Health, April
1986	U.S. News & World Report, May 26 Redbook, May Women's Sports and Fitness, March Jet, Aug. Essence, Dec. Glamour, March Mademoiselle, March, September, October Prevention, June
1987	Seventeen, Jan., 1987 Mademoiselle, May, 1987 Women's Sports and Fitness, May, 1987 Working Women, April, 1987 Health, S., 1987
1987-88	Ms., Dec., 1987 Women's Sports and Fitness, N., 1987 Prevention, Dec., 1987 American Health, April, 1988 Utne Reader, Jan/Feb, 1988 McCall's, March, 1988 Consumer's Research, F., 1988

Appendix E
Index Medicus
General Review of References

1931	Frank's article appears under disorders of menstruation
1932	No references to PMS
1933	No references
1934	Discussions of premenstrual fevers but not PMS/PMT
1935	No references
1936	References to premenstrual symptoms, not using term PMT/PMS (similar to 1934 reference)
1937-1952	References through out, similar to previous notations
1953	Premenstrual Syndrome first labelled - Dalton & Greene article in BJM, May 9, 1953
1953-1959	Various References
1960	Menstrual Disorders category separated out from premenstrual tension (new category in Index Medicus)

Index Medicus unavailable 1957-1959
In the Current List of Medical Literature- PMT became separate category in 1957

1985	PMS became category in Index Medicus

Index Medicus
References to PMS/PMT 1960-1986
By Decade and Foreign vs. English Language Journals

Number of Articles	1960's	1970's	1980's
English Language	92	83	267
Foreign Language	139	42	36

Reader's Guide
References to PMS/PMT
1960-1986

	1960's	1970's	1980's
Number of Articles	10	9	48