

MEDICALISING MENSTRUATION: THE CASE OF PREMENSTRUAL DYSPHORIC DISORDER AND DSM 5

Shimu Khamlichi

**A thesis submitted in partial fulfilment of the
requirements of the University of East London for the
Doctoral Degree in Clinical Psychology**

May 2013

ABSTRACT

The phenomenon of 'premenstrual syndrome' has attracted considerable attention during the early half of the twentieth century. Over the years, medical researchers and physicians have concluded that premenstrual changes could cause women severe distress and impair their ability to function at work and at home. In 1994, the Diagnostic Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association 1994) used the term 'premenstrual dysphoric disorder' (PMDD) to refer to these premenstrual changes. At present, PMDD is being proposed for inclusion as a new category in DSM 5, due for release in May 2013. This inclusion means women who experience premenstrual changes could be classified with a mental disorder. This study aimed to explore how premenstrual changes evolved from a normal biological fact of life into a psychiatric disorder.

The study examined the way premenstrual changes have been constructed in psychiatric and psychological literature. The study was informed by a critical realist epistemology and adopted a Foucauldian discourse analysis methodology. The study took a genealogical approach to explore the discursive and non-discursive practices that have influenced the medicalisation of premenstrual changes in DSM.

The study found three interrelated 'truths' about women's premenstrual changes that have been produced and disseminated by psychiatrists and psychologists to reify PMDD as a psychiatric problem. Psychiatrist and psychologists have drawn on the discourses of science and medicine to render these constructions or 'truths' intelligible. The literature focused primarily on negative mood changes and failed to consider positive premenstrual experiences that many women report. The literature did not consider premenstrual experiences from a non-biomedical perspective and neglected the role that relational, social, economic, cultural and structural factors play in contributing to or exacerbating premenstrual experiences. This means that the published research has excluded aspects of premenstrual experiences that could stand in contrast to the dominant accounts reported throughout the literature. The study found that the construct of PMDD taps into powerful cultural ideas about what it means to be a woman and what is

considered feminine. The study shows that the concept of PMDD is grounded in a historical tradition of problematizing menstruation. This increased tendency to view menstruation or aspects of menstruation as problematic does not benefit women.

We must recognise that the way we construct menstruation or menstrual cycle experiences has an effect on the way we view women and the way we treat them. The inclusion of PMDD may devalue women and result in the discrimination, marginalization, and stigmatization of women. This study recommends that the category of PMDD be excluded from DSM 5. Recommendations for clinical practice and further research are suggested.

TABLE OF CONTENTS

| | |
|--|-----------|
| ABSTRACT | 1 |
| TABLE OF CONTENTS | 3 |
| DEDICATIONS | 5 |
| ACKNOWLEDGEMENTS | 6 |
| CHAPTER ONE – INTRODUCTION | 7 |
| 1.1 <i>Aims of the Research</i> | 7 |
| 1.2 <i>Analytic Approach</i> | 8 |
| 1.3 <i>Historical and Cultural background</i> | 8 |
| 1.4 <i>The Modern Period and Biomedical Understanding</i> | 10 |
| 1.4.1 Premenstrual changes, mood and wellbeing | 10 |
| 1.4.2 Etiology and treatment of premenstrual distress | 11 |
| 1.5 <i>The Evolution of the PMDD Category in the DSM</i> | 12 |
| 1.5.1 Diagnostic Criteria for PMDD | 13 |
| 1.5.2 Rationale for the inclusion of PMDD in DSM 5 | 14 |
| 1.6 <i>Specific methodological, theoretical and empirical critiques of the evidence-base</i> | 15 |
| 1.6.1 Methodological Issues | 15 |
| 1.6.2 DSM and the problems of Reliability and Validity | 16 |
| 1.6.3 DSM and Gender-Bias | 18 |
| 1.7 <i>PMDD is socially constructed</i> | 20 |
| 1.8 <i>Summary, Rationale, and Research Questions</i> | 22 |
| 1.8.1 Summary | 22 |
| 1.8.2 Rationale for Research | 23 |
| 1.8.3 Research Questions | 23 |
| CHAPTER TWO: METHODOLOGY | 25 |
| 2.1 <i>Epistemology</i> | 25 |
| 2.1.1 Social Constructionism | 25 |
| 2.1.2 Critical Realism | 27 |
| 2.1.3 A Material-Discursive Approach | 27 |
| 2.2 <i>Foucauldian Discourse Analysis</i> | 28 |
| 2.2.1 Discourse, Knowledge and Power | 29 |
| 2.2.2 Discourse and Subjectivity | 29 |
| 2.2.3 Power and Resistance | 30 |
| 2.3 <i>Foucauldian Genealogy</i> | 30 |
| 2.3.1 History is not linear | 31 |
| 2.3.2 There is no ‘truth’ | 32 |
| 2.4 <i>Methodological Rationale</i> | 32 |
| 2.5 <i>Procedure</i> | 33 |
| 2.5.1 Strategy for searching for and selecting material | 33 |
| 2.5.2 Inclusion and Exclusion Criteria | 34 |
| 2.5.4 Process of analysis | 35 |
| 2.5.5 Doing Foucauldian Discourse Analysis: | 35 |
| 2.5.6 Doing a Genealogy | 37 |
| CHAPTER THREE: ANALYSIS AND DISCUSSION | 38 |
| 3.1 <i>Current Context of PMDD</i> | 38 |
| 3.2 <i>The emergence of premenstrual tension in the twentieth century</i> | 39 |
| 3.2.1 Constructing premenstrual tension as a hormonal disorder | 39 |
| 3.3 <i>The emergence of premenstrual syndrome (DSM-I 1952 & DSM-II 1968)</i> | 44 |
| 3.3.1 Constructing PMS as a hormonal disorder | 46 |
| 3.3.2 Constructing women with PMS as violent, suicidal and incompetent | 48 |
| 3.4 <i>The medicalisation of premenstrual syndrome (DSM-III 1980)</i> | 52 |

| | |
|---|------------|
| 3.4.1. Constructing PMS as an incapacitating illness that needs treating | 53 |
| 3.4.2 The construction of DSM diagnostic criteria for Premenstrual Tension Disorder | 54 |
| 3.5 <i>The emergence of premenstrual dysphoric disorder (DSM-III-R 1987 & DSM-IV 1994)</i> | 56 |
| 3.5.1 PMDD as a distinct diagnostic category | 57 |
| 3.6 <i>The concept of premenstrual dysphoric disorder (DSM 5 2013)</i> | 59 |
| 3.6.1 PMDD is a distinct disorder that causes impairments of work and social functioning | 60 |
| 3.6.2. Benefits of including PMDD in DSM 5 | 62 |
| 3.7 <i>Research Questions</i> | 64 |
| 3.7.1 How do psychological and psychiatric literatures construct premenstrual changes? | 64 |
| 3.7.2 Under what circumstances are women's premenstrual changes rendered problematic and what professional discourses render these problems intelligible? | 70 |
| 3.7.3 What discursive and regulatory practices warrant the constructions of premenstrual changes as a psychiatric disorder? | 73 |
| 3.7.4 What subject positions are enabled and what are the implications for action of these subject positions? | 76 |
| 3.7.5 Summary of Research Findings | 78 |
| CHAPTER FOUR: SUMMARY, EVALUATION AND IMPLICATION | 83 |
| 4.1. <i>Research Questions</i> | 83 |
| 4.2 <i>Evaluation and Critical Review</i> | 85 |
| 4.2.1 Limitations of Methodological Approaches Used | 85 |
| 4.2.2 Research Process | 87 |
| 4.2.3 Reflexivity | 88 |
| 4.2.4 Contributing in Advancing Wider Knowledge | 89 |
| 4.3 <i>Recommendations for Clinical Practice</i> | 89 |
| 4.4 <i>Recommendations for Further Research</i> | 91 |
| REFERENCES | 93 |
| APPENDIX ONE – DATABASE SEARCH RESULTS | 110 |
| APPENDIX TWO – ARTICLES SELECTED FOR ANALYSIS | 112 |
| APPENDIX THREE – ANALYTIC STEPS | 115 |
| APPENDIX FOUR – EXAMPLE OF INITIAL ANALYSIS | 118 |

DEDICATIONS

I would like to dedicate this research to Professor Mark Rapley (1962 - 2012). I started this work with his support and intelligence. Although he is no longer with us, I thank him for shaping my critical thinking. I would also like to dedicate this work to my parents, Minara Begum and Kaddus Miah, and to my husband, Wasim Khamlichi, all for their enduring support and faith in my abilities to complete this project.

ACKNOWLEDGEMENTS

I would like to thank my supervisor Ken Gannon for his support and encouragement throughout this project. Ken has been generous with his time and has always been approachable. I would also like to thank Pippa Dell for her guidance and for sharing her knowledge of feminist studies. I would like to thank my husband for his support, encouragement, and patience. And finally, I would like to thank my family and dear friends for their support and understanding.

CHAPTER ONE – INTRODUCTION

The female reproductive system, and in particular, menstruation has received considerable attention throughout human history. For millennia, most of the theorizing about menstruation and its effects on women has been recorded by men and shaped by particular religious and social institutions that were (and continue to be) male dominated. At present, popular culture as well as medical, psychological and scientific literatures have led us to believe that the effects of periodic bleeding in women have an inescapable destructive influence on women's lives (Ussher 1989). Many women, therefore, view menstruation as a 'curse', inconvenient, embarrassing and at worse an illness (Ussher 1989). In the early twentieth century, there was a shift away from menstruation being the focus of scientific research to a particular aspect of menstruation, namely the premenstrual phase. Scientific study sought to find out what effects the premenstrual phase of the menstrual cycle had on women's psychological state or behaviour. A significant amount of research concluded that premenstrual symptoms could cause women severe distress, diminish their quality of life, and impair their ability to function at work and in relationships. At present, the term 'premenstrual dysphoric disorder' (PMDD) is being used to refer to the distress and incapacitating effects of premenstrual symptomatology (American Psychiatric Association, 1994, 2013). In articulating this thesis, I will trace the development of the concept of 'PMDD' and focus on how it has been constructed and what implications these constructions have for the psychology of the women.

1.1 Aims of the Research

The main aim of the research is to explore how premenstrual changes evolved from a normal biological fact of life into a psychiatric disorder. The study will focus on premenstrual changes rather than the broader topic of menstruation. Since the 1930s, premenstrual changes, rather than menstruation, have been the focus of scientific research. The extensive research on this topic has led to the medicalization of premenstrual changes. This study proposes to explore how this

medicalization took place. The study will focus on the construction of premenstrual changes within the psychiatric and psychological literature.

1.2 Analytic Approach

My analytic approach will be discussed in more detail in chapter two. This research is informed by a critical realist epistemology. Researchers taking a critical realist position support the social constructionist assumption that language constructs our 'social realities' and acknowledge that broader social, historical and cultural events impact upon human experience (Sims-Schouten, Riley & Willig 2007: 102). For my analytic method, I have employed a post-structuralist approach to Foucauldian Discourse Analysis (FDA) drawing on the work of Foucault (1982). In essence, I am analyzing the discourses and discursive resources that have been used in the production and regulation of 'PMDD'. A post-structuralist approach undermines science's claims to objectivity and denies the possibility of objectively knowing a reality outside of discourse. Post-structuralist theory emphasizes that our knowledges of 'the real' are always socio-historically contingent and inevitably intertwined with power. Post-structuralist theory asserts that language does not simply describe reality; it has the power to construct certain realities as the 'truth' (Wetherell & White 1992 in Malson 1998: 37). Additionally, I will be drawing on feminist approaches to critically question the concept of 'PMDD' and locate premenstrual changes within a socio-cultural discursive context.

1.3 Historical and Cultural background

Ussher (1991: 22) argues that the 'menstrual taboo' is one of the most pervasive taboos affecting women all around the world. Historically, menstruating women have been confined to menstruation huts away from their husband and children and were forbidden from touching or preparing food for fears of contamination (Frazer 1938 in Ussher 1991: 22). A man who engages in sexual intercourse with women during this period has been warned that he will risk the destruction of his brain, eyesight and manhood (Weidegar 1985 in Ussher 1991: 22). Noddings

(1989: 39) reported that menstruating women were thought to be 'infected with an evil spirit or to be paying the price for an essential evil spirit that is part of her nature'. Seen as polluted, evil and contaminated, menstruating women have been barred from worship (McLaughlin 1974 in Ussher 1991: 22). Ussher (1989) argues that the menstrual taboo is still prevalent today but presented in a more sophisticated guise of 'premenstrual syndrome'.

The scientific study of menstruation and the effects of menstruation on women's wellbeing, behaviour and abilities began during the latter part of the nineteenth century. The development coincided with the emergence of feminism and demands for access to higher education, professions and electoral voting for women. Questions were raised about how the changes in women's lives, if granted access to higher education and professions, would impact upon the family (Walker 1997). Amongst male writers and scientists, the female reproductive system became the centre of attention. Theories emerged that located the cause of women's wellbeing, madness and physical illness to their reproductive system. Prominent physicians and scientists portrayed menstruation negatively and drew conclusions that menstruation can cause unpredictable behaviour, insanity and ill health in women. In 1843, Dr. William DeWees of the University of Pennsylvania used the term 'melancholies of menstruation' to describe the uterus as an organ that 'creates, exalts, or defines diseases, in every portion of the body' (Taylor 2005: 228). The typical symptoms of a uterine disorder, according to William Byford, a physician writing in America in 1864, were weight loss, irritability, headaches, and 'hysterical fits of crying' (Wood 1973: 29). In late nineteenth century, there was a shift in medical thought – the uterus was no longer the dominant organ; instead the ovaries were thought to control women's emotions and behaviour (Walker 1997). Henry Maudsley wrote in 1873: 'The monthly activity of the ovaries...has a notable effect upon the mind and body...Most women at that time [during menstruation] are susceptible, irritable and capricious' (Maudsley 1873 in Walker 1997: 35). Alongside Maudsley, Edward Clarke, a professor of Harvard University, believed that intellectual activity during menstruation would damage the reproductive system and could potentially cause infertility. Clarke argued that it was brainwork, rather than physical work, which damages the reproductive system. He argued that girls

who worked in factories would suffer less than schoolgirls because they 'work the brain less...hence they have stronger bodies' (Clarke 1873 in Walker 1997: 40). Despite evidence showing that menstruation did not cause reproductive or psychological difficulties (e.g. Jacobi 1877 cited in Walker 1997: 43), it was the opinions of medical professionals (particularly men) that formed the negative views of menstruation, which continued into the twentieth century. However, with the 'discoveries' of the female sex hormones in the 1920s research studies were no longer concerned with menstruation per se; rather the focus of research interest grew towards the premenstrual phase of the menstrual cycle. This marked a significant shift towards the medicalisation of premenstrual distress rather than menstruation.

1.4 The Modern Period and Biomedical Understanding

1.4.1 Premenstrual changes, mood and wellbeing

The premenstrual phase, also known as the luteal phase of the menstrual cycle, has been associated with some commonly reported changes such as fluid retention, acne, pains in the muscles, fatigue, irritability, tension, sadness, and feeling out of control (e.g. Frank 1931; Greene & Dalton 1953). These changes continue to be reported in the present time (DSM 2013). Scientific and medical literatures have focused on the impact of these changes on women's general mood and wellbeing and her ability to function at work and at home. Many studies have reported that women who describe themselves as suffering from negative premenstrual changes experience high levels of physical and psychological problems (Rubinow et al., 1986). Some of these include sleep problems (Hong et al., 2012), reduced health related quality of life (Heinemann et al., 2010) and reduced desire to participate in hobbies, social activities and relationships (Heinemann et al., 2010). Other studies have found that women who present with severe premenstrual symptoms do not cope well with stress (Girdler et al., 1998) and are less likely to use social support (Mitchell & Mitchell 1998). A few studies have shown that women who experience severe premenstrual symptoms were more likely to use coping methods such as avoidance and self-medication in the

form of increased smoking and alcohol intake (Ehlers et al., 1996). A relatively small number of recent studies report that women who present with severe premenstrual symptoms experience reduce brain activity associated with attention and motor control (Bannbers et al., 2012), experience deficits in working memory (Yen et al., 2012) and are impaired cognitively (Reed et al., 2008). Some studies have also found that women who presented with premenstrual symptoms had increased absenteeism from work and impaired work productivity whilst at work (Heinemann et al., 2010).

Previous research have also reported that women who seek treatment for premenstrual distress report higher than average incidents of sexual abuse (Golding & Taylor 1996) and sexual problems (Greenblatt et al., 1942). Moreover, numerous past studies have found that women who experience severe premenstrual distress also experience higher levels of affective disorders especially depression and anxiety (e.g. Halbreich & Endicott 1985). A few studies have reported that women who are diagnosed with PMDD have a high risk of suicidality and exhibit aggressive and dangerous behaviour (e.g. Endicott & Halbreich 1998). A great deal of the research effort went into reporting that premenstrual distress is discrete and different from other psychiatric disorders (e.g. Epperson et al., 2012). Researchers have reported that the prevalence rate of PMDD is between 3-5% (APA 1994).

1.4.2 Etiology and treatment of premenstrual distress

In the last 30 years, there has been an increase in biomedical research focusing on the etiology and treatment of premenstrual distress. A large number of earlier studies searched for endocrine factors to explain the presentation of premenstrual distress. These studies have attributed the cause of premenstrual symptoms to increased estrogen hormone (e.g. Frank 1931) and lack of progesterone hormone (Greene & Dalton 1953). The variations in the level of estrogen and progesterone have been reported in many studies (Benedek & Rubenstein 1939; Backstrom & Mattson 1975; Calhoun & Burnette 1984). These earlier studies assumed that premenstrual distress was caused by one factor in

the body and could be treated by one factor i.e. by reducing estrogen production (Frank 1931) or increasing progesterone hormone (Dalton 1954).

More recently, the research studies have focused on the brain and its interaction with the ovarian system as a source of dysfunction. A few recent studies have reported brain abnormalities in women diagnosed with PMDD, including gray matter abnormalities (Berman et al., 2012), decreased glutamate levels (Batra et al., 2008), and decreased melatonin secretion (Parry et al., 1995). At present, the cause of premenstrual distress is connected with malfunctions of the serotonergic system, in particular low serotonin density (Pearlstein & Steiner 2008; Halbreich 1996). As a result of these formulations, women considered to have PMDD have been treated with psychiatric drug Serotonin Selective Re-uptake Inhibitors (SSRIs) to increase serotonin levels. Numerous studies have reported that women who complain of premenstrual distress show marked improvements in premenstrual symptomatology when treated with SSRIs (e.g. Pearlstein et al., 1997). Recent reviews on the treatment of PMDD also reported high efficacy of SSRI in reducing premenstrual symptomatology (e.g. Pearlstein & Steiner 2008; Yonkers et al., 2008; Cunningham et al., 2009).

1.5 The Evolution of the PMDD Category in the DSM

In 1931, Robert Frank became the first gynaecologist to define a set of symptoms related to the premenstrual phase. Frank (1931) used the term 'premenstrual tension' (PMT) to describe physical and mental tension that he believed women experienced in the premenstrual week. In 1953, 'premenstrual tension' was relabelled as 'premenstrual syndrome' (PMS) by a British General Practitioner, Katharina Dalton, and a British Endocrinologist, Dr. Raymond Greene (Greene & Dalton 1953). In the 1980s, the American Psychiatric Association (APA) included PMS under the name of 'late luteal phase dysphoric disorder' (LLPDD) in the appendix of the Diagnostic Statistical Manual of Mental Disorders third edition (DSM-III-R) (APA 1987). Subsequently, LLPDD was changed to 'premenstrual dysphoric disorder' (PMDD) and was included in the appendix of DSM-IV (APA 1994). At present, the DSM 5 Work Group has recommended that PMDD be

moved from the appendix to reside as a diagnosis in the Mood Disorders section of the manual (APA 2013). The fifth edition (DSM 5) is being prepared for publication in May 2013 after a lengthy process of consultation.

1.5.1 Diagnostic Criteria for PMDD

According to DSM 5 Mood Disorders Work Group (APA 2013), a woman may have PMDD if she experiences five or more emotional, behavioural or physiological, changes during the week before menstruating. Interestingly, physical symptoms have been included as part of a psychiatric diagnosis. The diagnostic criteria for PMDD in the DSM are below:

A. In the majority of menstrual cycles, the following symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week post-menses. At least one of the symptoms must be either (1.), (2.), (3.), or (4.) below and the individual must experience at least five total symptoms:

- (1.) marked affective lability (e.g., mood swings; feeling suddenly sad or tearful or increased sensitivity to rejection)
- (2.) marked irritability or anger or increased interpersonal conflicts
- (3.) marked depressed mood, feelings of hopelessness, or self-deprecating thoughts
- (4.) marked anxiety, tension, feelings of being "keyed up" or "on edge"
- (5.) decreased interest in usual activities (e.g., work, school, friends, hobbies)
- (6.) subjective sense of difficulty in concentration
- (7.) lethargy, easy fatigability, or marked lack of energy
- (8.) marked change in appetite, overeating, or specific food cravings
- (9.) hypersomnia or insomnia
- (10.) a sense of being overwhelmed or out of control
- (11.) physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," weight gain

- B. The symptoms are associated with clinically significant distress or interferences with work, school, usual social activities or relationships with others (e.g. avoidance of social activities, decreased productivity and efficiency at work, school or home)
- C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Dysthymic Disorder, or a Personality Disorder (although it may co-occur with any of these disorders).
- D. Criteria A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation).
- E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment) or another medical condition (e.g., hyperthyroidism).

1.5.2 Rationale for the inclusion of PMDD in DSM 5

PMDD was added in the appendix of DSM-IV (APA 1994). This means that PMDD was not given full status as a mental disorder but was located in the appendix for further studies to consider whether some women with premenstrual symptoms suffer so seriously that their symptoms should be considered a disease. Scientific evidence was to be provided in order to establish whether PMDD is a disease. At present the DSM 5 task force has proposed that PMDD should be categorized as a psychiatric disorder. They summarize the rationale for this proposed change stating that: "While the inclusion of criteria in the Appendix of DSM-III-R and DSM-IV facilitated research, the workgroup felt that information on the diagnosis, treatment and validators of the disorder had matured to the point that it would qualify as a category in DSM V" (DSM 5, APA, in press, www.dsm5.org). However, feminist scholars (e.g., Chrisler & Caplan 2002) have proposed that the DSM is not based on scientific research and argue against the inclusion of PMDD in DSM 5. I will now explore some of these criticisms and

summarize the methodological problems inherent in the research on premenstrual changes.

1.6 Specific methodological, theoretical and empirical critiques of the evidence-base

1.6.1 Methodological Issues

Some psychologists, feminist theorists and researchers have argued that the classification of premenstrual distress as PMS and PMDD has been supported with little scientific evidence (e.g. Caplan et al., 1992). There are concerns that the literature on PMS (which includes PMDD) is plagued with methodological problems (e.g. Gallant & Hamilton 1998; Parlee 1973)¹. Generally, previous research studies have provided inconsistent prevalence rates of PMS and PMDD. Earlier studies rarely presented with an agreed definition of the condition, nor did the authors agree on how many symptoms need to be present or how severe the symptoms must be in order for it to be considered a disorder (Chrisler & Caplan 2002). Additionally, the definition of the premenstrual phase has been unclear, with some authors defining it as 5-7 days prior to the start of menses, others defining it as the entire luteal phase of 2 weeks prior to start of menses and yet others defining it as the first few days prior to menses or the entire menstrual phase (Chrisler 2001).

Parlee (1973) noted various general methodological flaws inherent in the menstrual cycle research up until the 1970s. The main criticism reported by Parlee (1973) has been the inability of most researchers to establish which phase of the menstrual cycle their participants are actually in whilst participating in the research. Most researchers have used the calendar method, where the participants are asked to remember the dates of their last period and then count ahead until they reach the premenstrual time frame to arrange testing. This

¹ Some of the research findings presented from 10-40 years ago have been reported in the present time. The use of present tense emphasizes the continuing attitudes to menstruation and to the criticisms of menstrual research.

method is often the least reliable method for two reasons. First, the method relies on the participant's memory (which can be incorrect) of the dates of their last menstrual period, and secondly, inherent in the method is the assumption that all menstrual cycles are the same length (Parlee 1973). Researchers have established that the "28-day" menstrual cycle can often vary in length between women and from time to time in an individual woman (e.g. Treloar et al., 1967) and that life stress (including social and school or work-related anxiety) can alter menstrual cycle length and/or suppress ovulation (Nagata et al., 1986). Other flaws previously reported include the frequent use of retrospective measures of symptoms (which also rely on memory), the focus on negative changes, the frequent absence of control groups, the exclusion of males as controls, and failing to screen participants for other medical and psychiatric disorders that may influence their symptom profiles (Parlee 1974). Others have noted that the poor research on premenstrual changes reflect tacit assumptions about the negative influence of the menstrual cycle on female functioning (Gallant & Hamilton 1998). For example, in the academic literature, there are no mention of positive premenstrual changes that are often reported by women, including bursts of energy and activity, increased creativity, increased sex drive, and feelings of affection (Chrisler et al., 1994; Lee 2002). This absence of positive changes is likely to perpetuate the negative associations of menstruation (Chrisler & Caplan 2002).

In view of the above methodological problems inherent in the research literature on PMS, many researchers have questioned whether premenstrual distress, labelled as PMDD, should be included in the DSM. Indeed, when the inclusion was first proposed in the 1980s, there was an outpouring of protests from the feminist community in general and from many individual members of the APA, who objected to the diagnosis on either political or scientific grounds (Kutchins & Kirk 1997; Chrisler & Caplan 2002). I will now consider some of these arguments.

1.6.2 DSM and the problems of Reliability and Validity

Since the first edition of DSM in 1952, the manual had gone through four major revisions, each time adding to the number of mental disorders and eliminating

those no longer thought to be mental disorders. The removal of mental disorders is problematic because it indicates that the classification of mental disorders may not be evidenced based since if it were supported by evidence, there would be no need to remove them from the manual. However, this is not the only problem – the DSM has been continuously adding new categories that may not be supported by evidence. DSM-I (APA 1952) included 106 mental disorders. Nearly forty years later, DSM-IV (APA 1994) was published and had included 374 categories of mental disorders. At present, this number is expected to rise in the upcoming DSM 5 (APA in press). With each edition, mental disorders have been created, eliminated, or radically defined, and these changes have been presented as scientifically guided, reliable and valid (Kutchins & Kirk 1997).

The most essential scientific criticism of DSM concerns the validity and reliability of its diagnostic categories (Kutchins & Kirk 1997). This refers, roughly, to whether mental disorders are actually real conditions in people in the real world, and whether they can be consistently identified by its diagnostic criteria (Kutchins & Kirk 1997). Indeed, the primary purpose of DSM classification systems is to enhance diagnostic agreements and allow professionals the ability to distinguish mental disorders from other human problems. This standard of reliability, however, has not been reported in the DSM. In 1973, Rosenhan's classic study 'on being sane in insane places' raised serious concerns about the reliability issue by revealing that mental health professionals were not able to distinguish the sane from the insane. Twenty years later, Kutchins and Kirk (1997: 53) argue that there is still no 'credible evidence that any version of the manual has greatly increased its reliability beyond the previous versions'. Zimmerman (1988) points out that the revisions of the manual came so quickly that it actually impeded the use of scientific findings to improve the manual. This must imply that the changes cannot have been informed by relevant scientific research. Zimmerman (1988) argued that the changes in each revision were presented as matter-of-fact and almost completely absent were any attempts to justify the changes on the basis of scientific evidence. He argued that the final product, which incorporated hundreds of minor and major changes, was never directly tied through citations to research articles, making it difficult to verify or dispute the claims of science-at-

work. Zimmerman (1988) concluded that the scientific progress of the manual is an illusion.

Critics have also questioned the validity of mental disorders, asking whether mental disorders are real conditions or not. For instance, in the 1970s, gay activists challenged the inclusion of homosexuality in the manual on the grounds that there was a lack of scientific evidence to suggest that homosexuality was a mental disorder (Kutchins & Kirk 1997). Indeed, homosexuality was removed from the manual in DSM-III (APA 1980) but its removal had illustrated that political pressure, rather than scientific evidence, can change the contents of the manual. Around the same time, other dissenters were critiquing the manual for medicalising everyday problems. Kutchins and Kirk (1997) have commented that the inclusion criteria for many mental disorders listed in the manual include everyday behaviours, such as not being able to sleep, lacking sexual interest, worrying, feeling blue, frustrated, experiencing difficulty in concentrating, being restless and so on. Others have suggested that the DSM transforms normal expectable response to distressing events into illness e.g. the distress experienced by child who is abused can be labelled as 'reactive attachment disorder' (Rapley, Moncrieff & Dillon 2011). Rapley, Moncrieff and Dillon (2011) have argued that the pathologization of the individual results in the contexts that are responsible for causing distress to be neglected. Studies have continuously found that exposure to many forms of social, moral and political problems such as poverty, discrimination, racism, and trauma play a major role in creating emotional distress (Bentall 2003; Read et al., 2001). Many feminist writers have also criticized the DSM for neglecting the contexts that give rise to emotional distress in women. Some feminist writers have gone further to suggest that the DSM categories and those involved in creating the DSM manual are discriminatory towards women (e.g. Caplan 1995).

1.6.3 DSM and Gender-Bias

Many feminist theorists have stressed that the DSM-IV and its predecessors is biased towards women (e.g. Caplan 1991, 1995). Over the years, feminists have fought against the inclusion of various categories on the grounds that it would unreasonably label women as mad. In the 1980s, following from APA's proposal

to include three new psychiatric disorders, namely, paraphilic rapism, masochistic personality disorder and PMDD in DSM-III-R (APA 1987), feminist theorists confronted the APA on the grounds that these proposed categories were not scientifically objective and were discriminatory towards women (Kutchins & Kirk 1989). APA faced pressures from the organized oppositions, protests, petitions, and letters summarizing the insubstantial evidence-base for the categories (e.g. Caplan 1987). After much deliberation, the APA did not fully approve any of the categories but placed them in the appendix for further studies. This did not leave the feminist critics at ease knowing that someone can propose moving them into the main part of the manual (Caplan 1987). Such doubts amongst feminists were not unreasonable since PMDD is now being proposed for inclusion in DSM 5. Caplan's (1995) experiences as a consultant to two DSM-IV subcommittees has led her to argue that science does not necessarily play a part when it comes to the classification of mental disorders. She emphasized the lack of scientific objectivity in many of DSM's decision-making process and concluded that the discussions surrounding what is normal and what is abnormal had more to do with the subjective (male) opinions of committee members than scientific evidence.

Some feminists believe that science has been employed to construct masculinity and femininity in a way that is in the interests of white, middle-class men (Malson 1998). Fee (1981 in Malson 1998: 35) suggests that the scientific research often posits 'rational man' as producing objective knowledge of the natural world. This ideology requires the tacit assumption that the characteristics of a 'rational man' are actually characteristics of males (Fee 1981 in Malson 1998: 35). In this way, scientific community has, whether purposely or unintentionally, excluded the possibility that women could be the 'agents of knowledge' (Harding 1987 in Malson 1998: 35). Rather, science has produced 'evidence' that women are naturally suited to domesticity and mothering (Jordanova 1989 in Malson 1998: 36), are less intelligent than men (Sayers 1982 in Malson 1998: 36), and are more prone to sickness (Ehrenreich & English 1974) and mental instability (Ussher 1991). Science has positioned the woman as the 'Other' of man, and situated femininity with nature, superstition and emotion (Jordanova 1989 in Malson 1998: 36; Ussher 1991). This 'Othering' allow women to be marginalized

and inevitably pathologized. Indeed, the World Health Organization (WHO, 2012) reported that doctors were more likely to diagnose depression in women compared with men even when they have identical symptoms as measured by scores on standardized measures of depression. Similar findings have been reported for PMDD (Caplan et al., 1992).

Caplan et al., (1992) argue that the same emotional displays that are considered normal in men are seen as a mental disorder in women. Feminists have been particularly concerned with why DSM developers have not identified parallel diagnoses of PMDD for men when there is evidence to suggest that men also experience 'hormonally' based mood or behavior changes (Caplan et al., 1992; McFarlane & Williams 1994). Caplan et al., (1992) asks why women's changes in moods due to hormonal changes are considered psychiatric abnormalities. Goodman (1986) contends that women's premenstrual behaviour is not abnormal by comparison with men's behaviour. Martin (1987) and Taylor (1988) argue that there is a double standard – men's anger may be accepted and even expected as part of men's nature but women's anger maybe unacceptable and labelled as PMS/PMDD with no attempt made to determine its source. Chrisler and Caplan (2002) and others have pointed out that, although PMS is often treated as a joke in popular culture (frequently by female comedians), PMDD as an alleged mental illness will result in increased bias and discrimination against women (e.g. Caplan et al., 1992; Figert 1996; Nash & Chrisler 1997; Tavis 1992). Women with a diagnosis of PMDD in their medical records may be seen as unfit mothers in child custody cases or as unsupportable candidates for political office (Tavis 1992). As a result of the diagnosis, society as a whole may be more willing to see women's behaviour as pathological, rather than socially constructed.

1.7 PMDD is socially constructed

There are several lines of evidence to suggest that the concept of PMDD is socially constructed. After writing extensively about the multitude of problems plaguing the PMS research, Parlee (1973) has concluded that the construct of PMS is not supported by scientific evidence. However, the fact that the medical

establishment treats PMDD as a legitimate disease category despite no scientific evidence may suggest that a 'shared cultural knowledge, as opposed to scientific facts' may be informing the researcher's understandings PMDD (Rodin 1992: 52). This cultural knowledge regards the female reproductive system responsible for the negative changes in women's behaviour/feelings. This belief is particularly dominant in the Western parts of the world. In Eastern cultures such as Hong Kong and China, women report premenstrual water retention, pain, fatigue, increased sensitivity to cold, but rarely report negative premenstrual mood (Chang et al., 1995; Yu et al., 1996). In these cultures, the changes are also accepted as normal part of daily existence rather than a disorder of some sort (Epstein 1995). This has led some to conclude that PMS is a culture bound syndrome (Chrisler & Johnston-Robledo 2002). Chrisler and Caplan (2002) argue that women in any part of the world may experience similar premenstrual changes (e.g. tension, sadness, irritability, or water retention), but only in Western societies are women encouraged to think that their premenstrual emotional state is abnormal and in need of professional help.

Chrisler and Caplan (2002) suggest that in Western cultures there is a belief that the menstruating woman is irrational or overly emotional. Such beliefs are depicted in magazines, films, television shows, calendars, songs, self-help books, and advertising (Chrisler & Levy 1990). Chrisler and Levy (1990) found that popular articles in the media present a picture of a 'menstrual monster'. These ideas are easily absorbed into a kind of folk wisdom – things 'everyone knows' about women (Chrisler & Johnston-Robledo 2002). Implicit in these beliefs and stereotypes are the ideas about how women should feel and behave (Markens 1996). For instance, the social construction of femininity tells us that good women are always soft-spoken, patient, receptive, nurturing, kind, and if she is anything but that, she and her family are quick to think something is wrong (Caplan 1995). Caplan (1995) believes that the classification of PMDD as a psychiatric disorder covers up the real reasons of women's distress and anger that might be the result of her position in society, relationship difficulties or life stress. There is evidence to suggest that relational, social, economic, cultural and structural factors can contribute to both the experience and perception of premenstrual changes (e.g. Ussher & Perz 2008). Markens (1996) argue that the gendered divisions of labor

(i.e. the demands of work and home life) can contribute to the physiological manifestation of symptoms (e.g. stress, anger, and fatigue). Markens (1996) argues that women's lives are stressful and highly demanding and if she complains, the label of PMDD can function to allow her genuine grievance to be ignored.

Another line of evidence to suggest that PMDD is socially constructed comes from socio-political studies (Laws et al., 1985; Martin 1987). These studies show that the concept of PMS emerged at a time when women's status and role in the West were changing and women were beginning to contest the inequalities of power and privilege (Martin 1987). Chrisler and Caplan (2002) argue that the belief that women are erratic and unreliable premenstrually serves to restrict woman's access to equal opportunities and prevent them from being employed in positions of responsibility, such as pilots (Parlee 1973) physicians and presidents (Figert 2005).

1.8 Summary, Rationale, and Research Questions

1.8.1 Summary

I began highlighting that the scientific study of menstruation emerged during the latter part of nineteenth century when feminists were demanding for access to higher education, higher professions and vote for women. Medical professionals formed a negative view of menstruation during this time, which continued into the twentieth century. I then presented the scientific and academic literature on premenstrual changes that ultimately explained premenstrual distress in biomedical terms. Thereafter, I wrote about the evolution of PMDD within the DSM and provided the scientific rationale that the DSM 5 had used to include PMDD in the manual. I briefly mentioned that feminist scholars have argued against the inclusion of PMDD in DSM 5 on the basis of methodological, theoretical and empirical critiques of the evidence-base. In reference to PMDD, some feminists (e.g. Caplan et al., 1992) have argued that the same emotional displays that are seen as a mental disorder in women are considered normal in men. And finally, I considered the evidence that women's daily experiences of

work and responsibilities can influence the menstrual cycle and exacerbate the premenstrual distress felt. Much of the critique above has led me to believe that the concept of PMDD is socially constructed, flawed and grounded in a historical tradition of problematizing menstruation. This study was warranted by the lack of evidence and justification for medicalising premenstrual experiences in the DSM. I argue that the inclusion of PMDD in the DSM 5 will have serious negative consequences for women. The way we construct menstruation or aspects of the menstrual cycle has effect on the way we view women and the way we treat them. For these reasons, the medicalisation of premenstrual changes must be critically examined and if evidence indicates that the concept of PMDD is not valid, then I strongly recommend that PMDD be excluded entirely from DSM 5.

1.8.2 Rationale for Research

The primary aim of the project was to explore how psychiatric and psychological literature has constructed premenstrual changes and how the concept of PMDD developed. I took a genealogical approach to understand the construction of PMDD within the context of the DSM. I attempted to assess whether the inclusion of premenstrual distress as a psychiatric disorder within the DSM is scientifically valid and evidenced based. By examining the psychiatric and psychological literature of the twentieth century, I aim to find out how premenstrual changes have developed into a psychiatric disorder. In doing so, four research questions were articulated in this study.

1.8.3 Research Questions

Main Research questions:

- How do psychological and psychiatric literatures construct premenstrual changes?’
- Under what circumstances are women’s premenstrual changes rendered problematic and what professional discourses render these problems intelligible?

Secondary research questions:

- What discursive and regulatory practices warrant the constructions of premenstrual changes as a psychiatric disorder?
- What subject positions are enabled and what are the implications for action of these subject positions?

CHAPTER TWO: METHODOLOGY

This present study utilised two qualitative methodologies to examine the way psychological and psychiatric literature has influenced the categorization of premenstrual changes in the DSM. The study employed a Foucauldian Discourse Analysis methodology to analyse texts within the literature. The study also employed a Foucauldian Genealogy to explore the discursive and non-discursive practices that have influenced our present understanding of premenstrual changes within the DSM.

2.1 Epistemology

2.1.1 Social Constructionism

Epistemology is the study of the theory of knowledge, concerned with what knowledge is, where knowledge comes from, and whether we know any knowledge at all. Social constructionism assumes a relativist epistemology (Burr 2003) and is in direct opposition to the realist epistemology often associated with the scientific and experimental methodologies. Social constructionism draws attention to the fact that human knowledge, experience and perception is bound by time and culture, and is mediated historically, culturally and linguistically (Gergen 1985; Burr 2003). Social constructionism does not believe in an objective reality 'out there', instead it perceives language to be central to the way we view or construct the world, such that, 'reality' becomes constructed through language rather existing outside of it. Harper (2011) described social constructionism as:

“[epistemologically] relativist in a number of ways: its scepticism about a direct relationship between accounts and reality; and its assumption that we do not make direct contact with the world but, rather, our experience of it is mediated through culturally shared concepts – in other words language shapes our experience of reality” (Harper 2011: 91).

Consequently, social constructionist approaches challenge mainstream psychological approaches to 'health' and 'illness' on the grounds that the meaning of 'health' and 'illness' are constructed within and sustained by social practices (Burr 1995). Social constructionist perspectives are concerned with identifying the various ways phenomena (e.g. premenstrual changes) are constructed through discourses that are available in a culture and exploring the implications of those constructions on people who are affected by them (Harper 2011). The term 'discourse' refers to a set of shared cultural beliefs and practices, which are utilized in everyday life in order to construct meaning and interpretation about the world (Parker 1992).

However, adopting a relativist social constructionist perspective and focusing specifically on language and seeing nothing beyond texts is problematic. One of the main problems in arguing that 'things' exist entirely at a discursive or at a linguistic level is that we are implicitly denying the influence of biology and the material aspects of people's lives (Ussher 2002). Ussher (2002) comments that positioning the body as irrelevant in the aetiology and meaning of say, emotional distress, can deny the 'reality' of the distress and lead to the conceptualisation of the distress as being 'all in the mind'. Ussher (2002) argues that viewing distress as created by negative social constructions or discourses is not helpful to all persons who seek treatment for such distress and perceive it to have a significant influence on their lives. Feminist psychologists such as Ussher (2002) and Stoppard (2000) have argued that traditional psychology has tended to adopt a solely materialist standpoint, thus serving to negate discursive aspects of experience, whilst many discursive accounts have tended to negate the material aspects of life. As a result of this challenge, Ussher (2002) and Stoppard (2000) have developed models for understanding women's emotional distress that attempt to incorporate both the material and discursive aspects of distress without privileging one over the other. In the next section, I will outline two specific and compatible approaches that have influenced my research: critical realism and material-discursive approach.

2.1.2 Critical Realism

Researchers taking the critical realist position support the social constructionist assumption that 'language is understood as constructing our social realities' (Sims-Schouten, Riley & Willig 2007: 102). However this does not mean that the events that take place outside of language are denied. Researchers taking a critical realist position also acknowledge the existence of broader social, historical and cultural events and the effects these events may have on individuals. In essence, critical realism includes both dimensions of human existence, the 'real or non-discursive (i.e. material structures that exist independently of our understanding of them)' and the 'discursive (i.e. discursive resources and practices that are available to make sense of human experience)' (Sims-Schouten, Riley & Willig 2007: 103). Researchers taking a critical realist approach to their work will merge both the bio-medical and psycho-social aspects of experience, as well as acknowledge the cultural and historical context in which individuals are positioned, and in which meaning about experience is created (Ussher 2002).

2.1.3 A Material-Discursive Approach

A material-discursive approach, informed by feminist thinking, places a specific emphasis on gender at both a material and a discursive level. The material-discursive position raises the issue that if we see emotional distress as wholly constructed and only discursive, we greatly limit our ability to acknowledge and be responsive to the undeniable presence of suffering in the lives of those who experience emotional distress. Feminist theorists such as Ussher (2002) and Stoppard (2000) have argued for the importance of combining biological, psychological, social, and discursive factors in understanding women's emotional distress. They argue that all of these factors are intertwined and should not override or marginalise all other possible explanations for understanding distress. Moreover, they argue that the body should not be seen as solely physical and independent of social circumstances. A key feminist concern has been that mainstream psychological models tend to conceptualize the female body solely in biological terms and as a result medicalize women's bodies and women's

distress. Stoppard (2000) suggests that the body is both naturally and culturally produced rather than being a timeless, natural organism. The body is immersed in culture and it is through the body, amongst other ways, that women can engage in the practices of femininity. Stoppard (2000: 92) writes: 'A key idea in material-discursive approaches to understanding depression [or any other distress] in women is that under certain circumstances engaging in practices of femininity (i.e. doing activities that signify a 'good woman'), can exhaust a women's body, while undermining her morale and sense of wellbeing...one way of understanding depression is as the embodied experiences which occur in conjunction with a woman's efforts to achieve the socially constructed ideal of a good woman'.

2.2 Foucauldian Discourse Analysis

The study set out to examine the ways in which psychological and psychiatric literature has influenced the construction of premenstrual changes. The study employed a Foucauldian Discourse Analysis (FDA) methodology to analyse texts within the psychological and psychiatric literature. This approach to analysis is informed by a critical realist epistemology and offers a particular critical approach to researching premenstrual changes by considering wider societal contexts. FDA is a variant of Discourse Analysis and is influenced by the writings of Michel Foucault (1926-1984). FDA is concerned with the role language plays in the construction of discourses and the 'constitution of social and psychological life' (Willig 2008: 112). The function of language goes 'beyond the immediate contexts' (Willig 2008: 113) of the words spoken by people and makes 'new sectors of reality thinkable and practicable' (Rose 1990 in Parker et al., 1995: 59). Language enables people to get things done, perform certain functions or serve certain interests (Edwards & Potter 1992). For Foucault (1972 in Malson 1998: 25) language consists of a variety of different historically specific discourses. Each discourse or construction makes available certain ways-of-seeing the world and certain ways-of-being in the world (Willig 2008). From a Foucauldian point of view, discourses facilitate and limit, enable and constrain what can be said, by whom, where and when (Parker 1992). In this way 'discourses regulate our

knowledge of the world' and make certain 'realities' seem more reasonable than others (Burr 2003: 67).

2.2.1 Discourse, Knowledge and Power

Burr (2003) draws on Foucault's ideas on the relationship between discourse, knowledge and power to suggest that if 'discourses regulate our knowledge of the world', and if these shared knowledge and understandings inform our social practices then it becomes clear that 'there is an intimate relationship between discourse, knowledge and power' (Burr 2003: 67). Foucault was concerned with this relationship and emphasized that 'power and knowledge directly imply one another' (Foucault 1979: 27). For Foucault, all discourses are about power, and it is in discourse that power and knowledge are joined. Burr (2003: 67-68) notes that some constructions or discourses have a 'greater tendency to be seen as common sense or more truthful than others'. An example of this could be seen in contemporary society where the knowledge of our world provided by science and medicine have more credibility and are viewed as more likely versions of the truth than versions that are constructed outside of science and medicine such as religion. From a Foucauldian point of view, the particular view of the world prevailing in a culture at any one time is intimately bound up with power (Burr 2003).

2.2.2 Discourse and Subjectivity

From a Foucauldian perspective, discourses produce subject positions and identities, which, when taken up, have implications for subjectivity and experience (Foucault 1972 in Malson 1998: 26). In contemporary society the professions of psychology, psychotherapy and psychiatry play a central role in occupying certain types of knowledge that give them permission to regulate people who are deemed mentally unfit (Rose 1985). Discourses produced in institutional sites produce knowledge that positions people in a particular category and define how they should be treated. Thus, discourses as social practices have 'real effects', legitimizing particular practices, constituting particular 'truths' about 'reality' and

positioning and constituting people as, for example, sane or insane (Walkerdine 1986 in Malson 1998: 26).

2.2.3 Power and Resistance

Willig (2008) notes that some discourses are so entrenched and powerful and have become 'common sense' to such an extent that it is very difficult to see how we may challenge them. However, since FDA assumes that all forms of knowledge and reality are socially constructed through language, discourse and discursive practices, no version of the world remains dominant eternally because it is in the nature of language that alternative constructions or 'counter-discourse' can emerge (Willig 2008). An analysis using FDA can make visible the power effects of particular discourses, discover how they have changed over time, and allow for the exploration of the ways social, physical and economic changes have provided the breeding ground for their emergence². Foucault (1969 in Burr 2003: 78) points out that if we can understand the social conditions that have led to our current ways of understanding ourselves, we can begin to question their legitimacy and resist and dislodge them from their position as truth.

2.3 Foucauldian Genealogy

The current research employed a Foucauldian genealogy as a methodology to explore the discursive and non-discursive practices that have influenced our present knowledge of premenstrual changes in the literature surrounding the DSM. Foucault's use of genealogy as a methodology can be seen as a development of concepts used by Nietzsche in '*On the Genealogy of Morals*' (1887). Foucault described genealogy using one of Nietzsche's well-known metaphors that describes a past that is neither black (i.e. totally unknown) nor white (i.e. transparent), but something in between (gray), that is, *ambiguous* and *uncertain* (Foucault 1977). The ideas that captured his attention were Nietzsche's rejection of the notion of the absolute truth. A genealogical approach assumes

² Foucault's Archaeology of knowledge entailed this tracing back to uncover the conditions, which allowed certain discourses and knowledge to emerge.

that certain taken-for-granted truths, such as scientific truths and 'facts', are historical constructs that have emerged out of social and political agendas. I will now highlight some key principles of a genealogy.

2.3.1 History is not linear

Traditional history is linear in that it moves on a single direction concerned with beginning and ending. Traditional history looks for origins and usually reinforces the idea of progress. Foucauldian genealogy challenges this idea of origins in our past and does not view history as a linear progress³. In his 1977 essay '*Nietzsche, genealogy, history*', Foucault wrote that Nietzsche challenged the pursuit of origins because the idea of origins assumes the 'existence of immobile forms that precede the external world of accident and succession' (Foucault 1977: 142). Foucault writes that a genealogy is used 'to identify the accidents, the minute deviation – or conversely, the complete reversals – the errors, the false appraisals, the faulty calculations that gave birth to those things that continue to exist and have value for us; it is to discover that truth or being does not lie at the root of what we know and what we are, but the exteriority of accidents' (Foucault 1977: 81). Tamboukou (1999: 203) writes that, 'instead of seeing history as a continuous development of an ideal schema, genealogy is oriented to discontinuities ... disruptions, uneven and haphazard processes of dispersions, that call into question the supposed linear evolution of history'. Foucault's genealogy seeks to find out the processes that lead to social phenomena, not the cause. It is not interested in explaining where things came from but how they were discursively constituted i.e. how their meaning came about.

³ This research adheres to Foucault's principle of the non-linearity of history though a chronological development has been used as a presentational device for the analysis. The non-linearity of emergence is emphasized throughout the analysis to reflect how different constructions of premenstrual distress have emerged since the publication of DSM in 1952 to the present time.

2.3.2 There is no 'truth'

Foucault (1977) is influenced by a key Nietzschean insight that truth cannot be separated from the procedures of its production. Foucauldian genealogy attempts to question taken for granted contemporary concepts and practices by looking at the conditions which gave rise to them (Foucault 1977). Foucauldian genealogy attempts to reveal that 'facts' are interpretations that are dependent on specific configurations of power, in other words, all 'truth' claims are influenced by power (Foucault 1977). For Foucault, the history as we know it has undergone constant editing and reediting by numerous and powerful individuals with a multitude of agendas, but for an end viewer, it appears like a solid fact. Merely looking at history does not expose the broad collaboration and the many fragmented historical steps that went into the creation of history. Foucault insists that 'A characteristic of history is to be without choice... nothing must escape it, and more importantly, nothing must be excluded' (Foucault 1977: 157). Foucault (1984: 76) writes that a genealogy 'must define even those instances when they are absent, the moment when they remain unrealised'. In the search for descent it turns out that 'truth or being does not lie at the root of what we know and what we are' (Foucault 1984: 81). Foucault comments 'since these things have been made, they can be unmade, as long as we know how it was that they were made' (Foucault in Kelly 1994: 27). The unraveling of the 'truths' allows us to resist them.

2.4 Methodological Rationale

In the present study, a genealogy and FDA methodologies were employed to study premenstrual changes. Foucault's concept of discourse provides a useful and theoretical space within to question critically the status of our current knowledges of premenstrual changes. This methodological approach will allow for the exploration of the ways social changes have provided the breeding ground for the emergence of PMS/PMDD. If we can understand the social conditions that have led to our current ways of understanding women's premenstrual changes, we can begin to question their legitimacy and resist them. Alternative

conceptualisation of premenstrual changes can then offer different ways to support women to manage their premenstrual distress.

2.5 Procedure

2.5.1 Strategy for searching for and selecting material

In order to answer the research questions, this study analysed the language (texts) used in psychological and psychiatric literature on premenstrual changes. In order to access materials related to premenstrual changes I conducted very broad searches, using the search term '*premenstrual*' – which found results for 'premenstrual dysphoric disorder', 'premenstrual syndrome' and 'premenstrual tension'. The databases psychINFO, PubMed, ScienceDirect were used. The search periods reflected the DSM editions. Appendix 1 includes the full Database search results. Below is a summary of the search results:

Table 1: Search Results for 'Premenstrual' in PsychINFO, ScienceDirect, and PubMed Databases.

| DSM | Date | PsychINFO | Science-Direct | PubMed | Total Results |
|-------------|-------------|-----------|----------------|--------|---------------|
| Pre DSM-5 | 2008 - 2013 | 302 | 2405 | 4873 | 7580 |
| Post DSM-IV | 1994 - 1999 | 400 | 1539 | 720 | 5593 |
| Pre DSM-IV | 1986 - 1993 | 652 | 1366 | 1021 | 3039 |
| Post DSMIII | 1980 - 1985 | 167 | 513 | 476 | 1156 |
| Pre DSM-III | 1974 - 1979 | 78 | 235 | 277 | 590 |
| Post DSM-II | 1968 – 1973 | 35 | 101 | 202 | 338 |
| Pre DSM-II | 1963 – 1968 | 21 | 120 | 177 | 318 |
| Post DSM-I | 1952 - 1957 | 9 | 61 | 129 | 199 |
| Pre DSM-I | 1947 - 1952 | 4 | 46 | 48 | 98 |
| Pre DSM | 1800 - 1946 | 11 | 176 | 8 | 195 |

Due to the vast amount of data on premenstrual changes, inclusion and exclusion criteria were applied to all studies retrieved by the searches. The decision to

include or exclude studies was made by reading the title and abstract of each article. Following this, the most cited / relevant articles (from database ratings/citations) were chosen but not exceeding a total of 10 articles for each period. Then, these chosen articles were entered into google-scholar and most cited articles (as identified in google-scholar) were selected for analysis. A total of 47 articles were entered for analysis (see Appendix 2). Below is a list of the inclusion and exclusion criteria that were used to identify these articles.

2.5.2 Inclusion and Exclusion Criteria

Inclusion Criteria

- Research studies based on psychological and psychiatric literature that focus on the diagnosis, symptoms and etiology of PMDD/PMS/PMT
- Research studies that were most cited or most relevant within the database as mentioned in the database. It is likely that the studies meeting this criteria have been influential in the construction of PMDD/PMS as a diagnostic category
- Peer reviewed journal articles only
- Research studies recognized in British and American Journals.
- Research studies that focus on Western constructions of premenstrual changes
- Research studies dated from the period of 1930-2012
- Research studies that indicate the medicalisation of premenstrual changes
- Literature reviews
- Gynaecological research studies that implicate the female reproductive system in the etiology of PMDD

Exclusion Criteria

- Research from feminism, religion, sociology and anthropology literature
- Treatment studies
- Dissertations, Books, and Electronic collections
- Studies focusing on premenstrual symptom screening tools
- Research studies that only focus on the menstrual cycle rather than

premenstrual phase

- Animal studies
- Research studies that mention premenstrual changes superficially
- Research studies that include other comorbid conditions e.g. anorexia, depression, anxiety
- Single case studies
- Research studies not peer reviewed or cited
- Research studies that are not in English language

2.5.4 Process of analysis

See appendix 3 for full analytic steps and appendix 4 for an example of the initial analysis of the data. Throughout the analyses, four research questions were used to examine the data. These questions, outlined below, were consistently thought of when reading and analysing the data:

1. How do psychological and psychiatric literatures construct premenstrual changes?’
2. Under what circumstances are women’s premenstrual changes rendered problematic and what professional discourses render these problems intelligible?
3. What discursive and regulatory practices warrant the constructions of premenstrual changes as a psychiatric disorder?
4. What subject positions are enabled and what are the implications for action of these subject positions?

2.5.5 Doing Foucauldian Discourse Analysis:

Willig (2008: 115-117) wrote a chapter on how to conduct a FDA. The analysis applied the procedures described by Willig (2008). The procedure involved six steps outlined below.

1. The first stage of analysis involved the identification of the different ways in which the discursive object was constructed in the text. This part of the analysis was interested in how premenstrual changes were constructed.
2. The second stage of analysis aimed to locate the various discursive constructions within wider discourses. For instance, the text may have drawn upon several different discourses when writing about premenstrual changes.
3. The third stage of analysis involved asking several questions that were concerned with the action orientation of the text e.g. what is gained from constructing the object in this particular way? What is its function and how does it relate to other constructions produced in the text? What are various constructions of the discursive object capable of achieving within the text?
4. The fourth stage was concerned with what subject positions the discursive object offer. In other words, discourse construct subjects as well as objects and, and as a result, make available positions within network of meaning that the author can take up (as well as place others within).
5. The fifth stage was concerned with the relationship between discourse and practice. The analysis of discourse maps the possibilities for action contained within the discursive constructions identified in the text. It explores what can be said and done by constructing particular versions of the world and by positioning subjects within them in particular ways.
6. The final stage in the analysis explored the relationship between discourse and subjectivity. Discourses make available certain ways-of-seeing the world and certain ways-of-being in the world. They construct social as well as psychological realities. This stage in the analysis traced the consequences of taking up various subject positions for the participants' subjective experience (i.e. what can be felt, thought and experienced from within various subject positions).

2.5.6 Doing a Genealogy

In none of his writing, lectures or interviews did Foucault set out a procedure of specific techniques for carrying out genealogical analysis. Foucault insisted on not following any specific methodology to do a genealogy. All those who have been inspired by Foucault's genealogy have made some attempts to make the genealogical method usable, whilst acknowledging that there is no one correct way of conducting a genealogical analysis. A genealogical analysis in the present study was conducted according to procedures described by Williams (2005) and Tamboukou (1999). This involved a number of steps that are outlined below.

1. The first step in doing a genealogy was to identify an area of study designated the 'problem', then, define the problem as the *dispositif*. A *dispositif* refers to 'discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions'.
2. The second step was to put together the different elements of 'discursive and non discursive' concerned with the area of study. Here is the beginning of a major interrogation of what has been accepted as the 'truth'.
3. The third step was to trace the historical developments and emergences of the 'problem', tracing their repetition, recurrence or even disappearance in relation to the time period.
4. The last stage was the opening up of future possibilities as a direct result of the analysis of the 'problem', both for society and for the subject.

CHAPTER THREE: ANALYSIS AND DISCUSSION

This chapter is organised within a structure that broadly sets out a chronological developmental of the concept of PMS and PMDD. The analysis will predominantly focus on mainstream psychiatric and psychological literature from the 1930s to the present. Some attention will be given to the nineteenth century literature on menstruation. The analysis will focus on the medicalisation of premenstrual changes that had resulted in the categorisation of PMDD in the DSM. I have structured my analysis according to each edition of the DSM, reporting on the most influential studies of that period. The first part of the analysis aims to provide an overview of the general discourse on PMS/PMDD. Extracts from the data will be used to demonstrate how constructions are made possible and what effects the constructions have on practice and subject positions. Subsequently, I will answer the research questions. Additionally, some of the multiple contingencies in the history such as the political circumstances, which often go unmentioned in mainstream accounts, will be highlighted. I conclude with a discussion of the significance of my findings.

3.1 Current Context of PMDD

PMDD was added in the appendix of DSM-III-R and DSM-IV (APA 1987, 1994). This means that PMDD was not given full status as a mental disorder but was located in the appendix for further studies. Since the 1980s psychiatry led most of the biomedical research on premenstrual distress and concluded that there is strong evidence to suggest that PMDD is a distinct disease. At present the DSM 5 task force has proposed that PMDD should be included in the DSM 5 as distinct psychiatric disorder. I will now analyse some of the leading studies that may have influenced the task force's proposal to include PMDD in DSM 5 as a mental disorder. The analysis was primarily focused on the development of the modern diagnostic formulation of PMDD.

3.2 The emergence of premenstrual tension in the twentieth century

3.2.1 Constructing premenstrual tension as a hormonal disorder

The earlier parts of the twentieth century marked a significant shift towards the medicalisation of premenstrual distress. The 'discovery' of the female sex hormones in the 1920s and the emergence of 'premenstrual tension' in the 1930s influenced the medicalisation of premenstrual distress for many decades to follow. The 'discovery' is the predecessor of the DSM, intended to provide evidence for a firm 'scientific' development of premenstrual distress. To the present day, the breakthrough of this period is used to support the specific psychiatric formulation and diagnosis of PMDD. Though the DSM is the main item of interest in the present study, the emergence of 'premenstrual tension' is important to investigate for it is the foundation of the medicalisation of premenstrual distress.

The analysis of the literature published during the 1930s showed a transition between nineteenth century and twentieth century medical concerns about menstruation. In particular, there was a shift away from the uterine and ovarian discourses to a hormonal discourse. Throughout the 1920s there were speculations within the medical literature about the existence of one or more ovarian hormones. Estrogen was identified in the early 20s and progesterone was discovered in 1929 (Walker 1997). The 'discoveries' of these sex hormones had changed the way women's wellbeing and illnesses were understood among physicians and researchers. In the twentieth century, the cause of women's madness and illness was now being described as a female hormonal problem, rather than an ovarian problem. These 'discoveries' greatly influenced medical theories. It was no longer dysfunctional menstruation or dysfunctional ovulation which causes women to become mad, but dysfunctional hormones. Though there was no direct evidence to suggest that dysfunctional hormones caused women to become mad, the 'discovery' of the sex hormones was used to support the existing belief that abnormalities within the body causes women to become mad. In particular, the dysfunction of estrogen and progesterone were thought to cause madness in women, rather than difficult life experiences and circumstances. This

illustrates the way in which scientific discoveries and progress are recruited to support existing beliefs and prejudices about women's wellbeing and madness.

With the emergence of the hormonal discourse, the analysis found that the focus of research interest grew towards the premenstrual phase of the menstrual cycle. In 1931, American gynaecologist Robert Frank was the first medical clinician to define a set of symptoms related to the premenstrual phase of the menstrual cycle. Frank (1931) was influenced by the understanding of ovarian hormones and thought that the abnormalities of these hormones were responsible for the premenstrual symptoms that he witnessed in many women. He held the view that premenstrual symptoms were caused by increased estrogen production. He wrote: 'blood concentration of estrogen is increased throughout the cycle... the urinary excretion is greatly diminished... this signifies a retention of estrogens in the blood stream, with resulting autonomic symptoms' (Frank 1940: 95). Frank (1931) used the term 'premenstrual tension' (PMT) to describe this collection of symptoms occurring in the premenstrual week of the menstrual cycle. Frank's (1931) description of the experiences of fifteen women is presented in the extract below:

Extract 1: These patients complain of unrest, irritability, like jumping out of their skin and a desire to find relief by foolish and ill considered actions. Their personal suffering is intense and manifests itself in many reckless and sometimes reprehensible actions. Not only do they realise their own suffering, but they feel conscience-stricken toward their husbands and families, knowing well that they are unbearable in their attitude and reactions. Within an hour or two after the onset of the menstrual flow complete relief from both physical and mental tension occurs" (Frank 1931: 1054)

In this extract, premenstrual changes have been constructed as a negative experience. Frank believed that premenstrual changes were a negative experience for all women. He assumed that all women experienced 'varying degrees of discomfort, fatigability, irritability and lack concentration' (Frank 1931: 1053). But for some women, Frank portrayed the premenstrual phase as a period

of both 'physical and mental tension', a time when women engage in 'foolish and ill considered actions' and have 'attitudes and reactions' that are 'unbearable' to their husbands and families. Franks categorization of women as sufferers/non-sufferers enables the construction of PMT as an identifiable thing that is distinct from normal suffering that all women experience premenstrually. Frank (1931) attributed the symptomatology of PMT to the accumulations of the estrogen and as a result, he advocated treatment to attenuate estrogen production for PMT sufferers.

The discourse on PMT presents a model of woman who can become out of control, irrational, reckless and irresponsible as a result of her hormonal changes. In Frank's descriptions, there are numerous connotations of how women should and should not behave. To Frank, 'reckless', 'foolish' and 'ill considered actions' are behaviours that he believed are atypical for a woman, something that is only exhibited when her menstrual cycle hormones are imbalanced. This version of PMT women is far from the idealised female portrayed within the discourses of femininity. The ideal woman or the 'good' woman is someone who is pleasant to be with, in control, calm, kind, placid and undemanding of others. The 'bad' or the premenstrual-hormonally-imbalanced woman is one who is angry, demanding, and improperly behaved, such as the women depicted in Frank's description. Moreover, PMT appears to have a moral purpose in Frank's description. Frank has implicitly made several judgments about what is 'acceptable' and 'unacceptable' behaviour for women e.g. 'foolish and ill-considered' 'reprehensible' are unacceptable behaviours for women. Furthermore, Frank's descriptions suggest that the main concern of PMT is with the impact it has on the husband and family rather than the woman herself ('unbearable' to her husband). As a result, Frank may be evaluating women and her premenstrual character solely in terms of her presumed role and function in society – to serve their husbands and be kind and acceptable to everyone around them. This construction ignores the impact of premenstrual distress on women themselves.

Frank's constructions may have negative consequences for women and for what is expected of her character and behaviour. For instance, these constructions of how women should behave may warrant people to gaze at the premenstrual

women and render her emotions as irrational and her behaviours as inappropriate. People may also ignore her expression of anger or irritability that might have genuinely resulted from the difficulties of her life. Through internalizing these gazes and self-regulating (Ussher 2008) her own behaviour, she may come to accept these attitudes as true and perceive herself as the 'bad' woman. She may judge her premenstrual self as improperly behaved and irrational and may seek advice from medical professions to help her regress back to the feminine 'good' woman that she is.

Within this period, the study did not find any mention of positive premenstrual changes or positive meanings of premenstrual experience. Most of the studies during this time have constructed premenstrual experiences negatively and attributed the cause of PMT to the menstrual cycle physiology. Cline (1946: 137) discussed the possibility of a 'disturbance of estrogen metabolism resulting in an excess of this [estrogen] hormone' to explain premenstrual tension, whilst Benedek and Rubinstein (1939) discussed estrogen activity and psychodynamic processes for the etiology of PMT. Benedek and Rubinstein (1939: 245) wrote: 'The oestrogenous phase of the cycle corresponds to an emotional condition characterized by active heterosexual libido. This appears normally as a wish for heterosexual gratification but it may turn into aggression towards the man or into a fearful defensive attitude'. Others have portrayed the negative effects of PMT on the female body. Reimann (1946) pointed out that otherwise normal women show a premenstrual fever, whilst Johnson (1932) observed the effects of 'periodic disturbances' on women's performance on walking a tight-wire. Albeit unclear about what phase of the menstrual cycle was studied, Johnson found that 'girls experienced some difficulty in making fine neuro-muscular adjustments of the large muscles groups during period disturbances' and 'a rapid rise in the achievements seems to follow, reaching the peak at about eleven days after the period' (Johnson 1932: 141). On the whole, the hormonal theories of PMT and the effects of PMT on the body drew on a biomedical discourse. The use of the biomedical discourse may function to legitimize PMT as a medical problem resulting from hormonal imbalance as well as legitimizing medical interventions to treat women complaining of PMT. Frank (1931) has, therefore, positioned PMT as a 'pathology that needs to be eradicated' (Ussher 2003: 136). The attention to

physiology gives 'hormones primary status as an explanation of premenstrual distress' (Markens 1996: 47). The analyses found no discussion of social, cultural and material factors in explaining the experience of premenstrual symptoms. The literature did not consider the possibility that factors outside of the body could cause or exacerbate premenstrual tension.

In addition to the shifts in research focus, from menstruation to premenstrual phase and from ovaries to hormones, there was another change that was observed during this period. In the late 1930s and Second World War, when more women were needed in the workforce as men went to war, occupational researchers shifted their attention away from the incompetence of women during menstruation on the whole, to the possibility that particular types of work may not be suitable for women with PMT. Walker (1997) suggests that the demand for female labour during wartime and economic depression in Britain stimulated research, which generally concluded that 'healthy' menstruation did not impact on women's ability to work (e.g. Seward 1944). For example, Holtz (1941) concluded that women with 'healthy' menstrual cycles are perfectly safe to fly aeroplanes while they are menstruating. Interestingly, this finding emerged during the Second World War when women pilots were flying military aircrafts and ferrying planes from factories to operational airfields (Cole 1992). The female pilots served to free male pilots for combat roles and duties. In other areas of work, researches were reporting similar findings. Lough (1937: 360) established that: 'menstruation has, as a rule, no noticeable effect on working capacity among normal, healthy women'. These studies provide evidence that when women's work is beneficial to the economy, menstruation is a sign of health, whereas when the labour of women were seen unnecessary as in the post-war 1950s, menstruation became an illness again (as it was in the late nineteenth century). However, this redefining of women's roles and capabilities was not the rule in other parts of the world during the war. For example in Nazi Germany there was extreme resistance, particularly from Hitler, to involving women in the war effort. The wider discourses about the 'proper' place and role of women i.e. the homes and childbearing, prevailed in Germany. Nazi Germany held the belief that the function of women was to be a good mother and bring up children (particularly to groom boys into soldiers and girls into young mothers) while their husbands

worked. These beliefs were widely held in the nineteenth century amongst the general public and prominent theorists and physicians. For example, Eliza Linton, a female theorist who wrote a number of anti-feminist articles on women's rights, advocated the importance of maintaining a distinct separation between the spheres of work, with the home for women and the world outside for men. In 1891 Linton wrote: 'The continuance of the race in healthy reproduction, together with the fit nourishment and care of the young after birth, is the ultimate end of woman as such' (Linton 1891 in Walker 1997: 32).

3.3 The emergence of premenstrual syndrome (DSM-I 1952 & DSM-II 1968)

In the 1950s, there was a change in the terminology that described premenstrual distress in women. In 1953, 'premenstrual tension' was relabelled as 'premenstrual syndrome' (PMS) by a British General Practitioner, Katharina Dalton, and a British Endocrinologist, Dr. Raymond Greene. Both authors criticized Frank's concept of PMT for being too simplistic, writing: 'tension is only one of the many components of the syndrome' (Greene & Dalton 1953: 1007). However, Greene and Dalton (1953) and others (e.g. Rees 1953) also argued that the term 'PMS' was not satisfactory. Rees (1953: 1014) commented that in 'some patients they [symptoms] occasionally continued throughout the menses', that is, symptoms do not always stop after the premenstrual phase. Despite the issues with the onset and offset of the syndrome, the term 'PMS' and the focus on premenstrual phase was retained. This change in terminology appears to be an important shift in the medicalisation of premenstrual distress. The term 'tension' does not really fit a medical diagnosis while 'syndrome', which means 'a group of signs and symptoms that occur together and characterize a particular abnormality' (Merriam-Webster's online Dictionary n.d.) fits with recognised systems of nomenclature.

During the 1950s, most of the research focused on the premenstrual experiences that make up the syndrome. In the 1960s and 1970s, research into the negative consequences of PMS on work and social functioning grew. A large number of studies searched for endocrine factors in PMS and explored the associations of

PMS and depression. Some effort was also spent on designing standardised questionnaires to assess menstrual and premenstrual experiences. In the mid-1960s, psychologist Rudolph Moos published the Moos Menstrual Distress Questionnaire, consisting of 47 items, with all but five items focusing on negative symptoms of menstruation (Moos 1969). According to Walker (1997), the increased acknowledgement of women's premenstrual experiences led to an increase in the number of women identifying themselves as PMS sufferers and seeking medical advice. This increase in women seeking medical advice for premenstrual distress could illustrate what Parsons (1951) referred to as the sick role. According to Parsons, the 'sick role' and the things that one does when they are determined as 'ill' are learned through socialization and through societal norms. Though the illness takes away an individual's responsibilities from society, the sick person is expected to try and find a way to solve their illness. It appears that the availability of a diagnosis may have conferred a type of 'respectability' on the disorder, legitimated it and triggered an influx of help seekers to seek medical assistance for distress that was once considered a normal aspect of being a woman. Indeed for the influx of women needing help, clinics were being opened in London by Dalton to treat them with progesterone hormone injections and suppositories (Oransky 2004). Despite the dissemination of PMS research and advances in the clinics, there was no mention of PMS or any other menstrual related disorders in the first and second editions of the DSM (APA 1952, 1968). Nevertheless, the leading articles published around this time constructed premenstrual syndrome as a hormonal disorder that needed treating. With this in mind, one could speculate whether conceptualising premenstrual syndrome as a hormonal disorder was a protection against thinking of it as a psychiatric problem. After all, lots of physical (particularly hormonal) disorders have psychological and behavioural manifestations and they are not considered to be psychiatric problems. Nevertheless, the focus on psychological and emotional problems (as opposed to physical symptoms) of premenstrual distress does increase as we move through the decades, making it easier and more 'sensible' to construct PMS as a psychiatric disorder.

3.3.1 Constructing PMS as a hormonal disorder

During this time, premenstrual changes were being described as a 'minor endocrine disorder' (Greene & Dalton 1953: 1007) consisting of numerous physical and emotional symptoms that require 'medical attention' (Simmons 1956: 99). Rees (1953) wrote:

Extract 2: The syndrome is composed of marked tension and irritability, together with one or more of the following symptoms: anxiety, depression, bloated abdominal feelings, swelling or subcutaneous tissues, nausea, fatigue, painful swelling of the breasts, headaches, dizziness, and palpitations. Less frequently there may be increased sex desire, excessive thirst, increased appetite, and hypersomnia. (Rees 1953: 1014)

In the above extract, PMS was constructed as a 'syndrome' accompanied by emotional symptoms (which were in the minority) and physical symptoms including irritability, depression, headaches, nausea and so on. This construction of PMS is similar to Frank's (1931) understanding of premenstrual changes. Similar to Frank (1931), Rees (1953) and Greene and Dalton (1953) believed that excessive oestrogen was responsible for some of the symptoms (i.e. sodium and water retention, painful breasts, weight gain, and dizziness), but they alleged that the lack of progesterone allowed for the 'unopposed action of oestrogens' to dominate and cause PMS symptomatology (Rees 1953: 1014). This illustrates that the construction of PMS had not changed from the 1930s, in the sense that both periods assumed premenstrual distress was caused by one factor in the body and could be treated by one factor. The deficiency of progesterone model was supported by studies that revealed positive effects of progesterone treatment (Greene & Dalton 1953, 1954; Rees 1953), either by oral administration, intramuscular injection, or implantation of progesterone (Dalton 1954). However, not all studies of this time supported progesterone etiology or progesterone treatment. Simmons (1956) found that in over half of his patients, the 'premenstrual symptoms were aggravated by the progesterone' (Simmons 1956: 100). Despite this, Dalton relentlessly pursued the progesterone theory and the

use of progesterone as a treatment. She argued that PMS was a debilitating disorder with various social consequences, and it needed diagnosing and treating. For instance, Greene and Dalton (1954) wrote that premenstrual changes can cause women to become unproductive at work, become mentally duller, more accident-prone and cause marital unhappiness. Due to these portrayed consequences, Dalton (1954) urged women who experience these symptoms to assist with the diagnosis. She suggested that the 'recognition of this syndrome must depend on the intelligence of the patient, or her doctor' (Greene & Dalton 1954: 339). Greene and Dalton (1953) wrote:

Extract 3: In this country very little has been done to alleviate their distress. This is partly due to the attitude of the patients...women generally accept the unpleasant symptoms of 'the change of life' as a necessary part of the business of being a woman, so still they pass through one week of discomfort in every month, usually without complaining to their doctors but not necessarily without disturbing the tranquillity of their homes. (Greene & Dalton 1953: 1007)

In the above extract, premenstrual changes have been constructed as something that is distressing for the 'sufferer' and disturbs the 'tranquility of their homes'. This description echoes Frank's (1931) understanding of the premenstrual distress, where the concern of PMT is considered by the impact it causes on her marriage and family life rather than the woman herself. Greene and Dalton is also evaluating women in terms of her presumed role and function in society – to serve their husbands, to be a good loving wife and promote the tranquility of her home. This construction ignores the impact of premenstrual distress on women themselves and neglects the possibility that the man (the husband) could have provoked a genuine grievance upon her and caused 'marital unhappiness'. She is deemed to cause the problems and as a result, her bad feelings or behaviours become dismissed by both men and women. According to the extract, in addition to being the sole person who is responsible for the tranquility of her home, women are also responsible for seeking help. In the extract, Greene and Dalton partly blamed women for the slow diagnosis and treatment of the 'disorder' and suggested that PMS is not a 'necessary part of being a woman'. This illustrates

that any positive accounts used by women can be overshadowed by the details of problems PMS can cause. It also demonstrates that women's subjective meanings of premenstrual experiences were disregarded, neglected or simply not addressed in the PMS research of that time. Walker (1997) suggests that women's reports of premenstrual experiences vary within a culture and cross-culturally and the premenstrual states are not always described or experienced as an illness or disease. For example, Rupani and Lema (1993) in their study of nurses in Kenya comment that although premenstrual symptoms are reported, they do not limit work activities and very few women seek medical or other treatment for them. It would seem unacceptable to assume that these women's views of their premenstrual symptoms and how they deal with it, is incorrect and unintelligent. According to Dalton, however, these women are likely to disrupt the tranquility of their homes whereas women who accept the medical approach to PMS are thought to be intelligent (Greene & Dalton 1953). By implication, the doctor's opinion is positioned as the 'truth' and any other constructions, positive or meaningful are deemed incorrect. The construction of PMS using the medical discourse warrants the diagnosis and treatment of women experiencing premenstrual changes regardless of how women view their premenstrual changes. Indeed, the diagnosis and treatment has been justified because the premenstrual changes, if left untreated, has been reported to cause women to become violent, suicidal and incompetent at work.

3.3.2 Constructing women with PMS as violent, suicidal and incompetent

In 1954, Greene and Dalton wrote:

Extract 4: During the final week of the cycle many women experience great or small degrees of irritability which they may fail to control; depression which may lead to suicide; lethargy which may make it almost impossible for them to continue their work. Women air pilots may lose their skill and unaccountably crash (Whitehead 1934). French figures show that 84% of crimes of violence by women are committed during or immediately before the menses (Cooke 1945)

(Greene & Dalton 1954: 337).

In the above extract, Greene and Dalton (1954) reported that during the premenstrual week many women experience 'irritability', 'depression' and 'lethargy' that can cause her to lose control, commit suicide, become more accident prone and inefficient at work. As mentioned earlier, the increased focus on psychological issues has started to take shape here. Additionally, Greene and Dalton (1954, 1953) frequently mentioned the incapacitating effects of PMS on women's ability to function at work. They also associated PMS with suicide and violence. Greene and Dalton (1954) supported these claims by citing three studies (Whitehead 1934; Cooke 1945; Morten et al., 1953) that have not been replicated to this date. Nevertheless, the analysis found that during the 1960s, Dalton carried out a number of studies and concluded that menstruation and PMS caused women to have high number of acute psychiatric admissions (Dalton 1959), more accidents (Dalton 1960), decline in cognitive ability (Dalton 1960b), and higher crime rates (Dalton 1961). However, the high crime rates reported by Dalton (1961) must be seen in the context of very low base rates for crimes by women (particularly crimes of violence) in comparison to men (e.g. Heimer & De Coster 1999). Without evidence, Dalton speculates that the problematic behaviours such as crime and suicide are caused by the symptoms of PMS including irritability, lethargy, and depression:

Extract 5: Premenstrual tension is also accompanied by irritability, lethargy, depression, and water retention, and these symptoms alone may be responsible for certain crimes- for example, irritability and loss of temper may lead to violence and assault, lethargy may lead to child neglect, and depression may lead to suicide. (Dalton 1961: 1753)

In this extract, Dalton has constructed premenstrual distress in several different ways. Premenstrual symptoms such as irritability, lethargy and depression have been constructed as something that can cause women to become mentally unstable, aggressive, violent, and abusive. These symptoms have been constructed as dangerous because the symptoms can lead to a child neglect or

suicide. Dalton's claims are speculations, not evidence based.

In summary, the PMS literature between the 1950s to the 1980s constructed premenstrual distress as a minor endocrine disorder, consisting of numerous physical and emotional symptoms. Lack of progesterone hormone was thought to cause PMS and progesterone treatment was thought to treat it. The social consequences of PMS were used to advocate for a PMS diagnosis. These constructions drew on biomedical, psychiatric, criminal, and productivity discourses. The use of the psychiatric discourse contains the subject positions of the mentally ill and irrational. The use of the criminal discourse contains the subject positions of the aggressive, violent, unpredictable and dangerous. The use of the productivity discourse contains the subject positions of unintelligent, clumsy, and inefficient. The use of these discourses renders the premenstrual phase as a problematic 'thing' and positions women with PMS as mad, aggressive, unintelligent and incompetent. The use of these discourses also warrants certain things to happen to women. For example, the psychiatric discourse may warrant the treatment of those who are deemed mad, whilst the criminal discourse may warrant the punishment for those who commit crimes, though it is likely to be more complex than that. If criminality is at least partly explicable on the basis of hormonal changes then presumably the woman is less responsible and culpable. This has been illustrated, as we shall see, in the 1980s when two murder trials effectively used PMS as a defence. The use of PMS as a defence in criminal courts is a double-edged sword because it has the capacity to reduce the woman's agency for good or ill.

Moreover, these constructions, like Frank (1931), are implicitly and explicitly defining how women should feel and behave (Markens 1996). Positioning women with PMS as abnormal, dangerous, neglecting and assaulting may have wider consequences for them. She may, for example, be positioned as a bad wife, an unfit mother and lose custody over her child; she may be positioned as an inefficient worker and may not be offered jobs of responsibility and higher salary; and she may experience stigma and discrimination from family, friends, and her community. As a result of these positions and practices, the woman diagnosed

with PMS may feel that she has failed as a woman, deem herself as ill and seek medical treatment. However, it is likely that these wider implications could broadly apply to all women presumably because premenstrual changes happen in the majority of women and they are all potentially open to developing such problems. Unless it is possible to single out specific women on the basis of PMS diagnosis, then all women could be discriminated on the basis of any premenstrual distress/changes. Evidence indicates that it not possible to distinguish PMS sufferers from non-sufferers (e.g. Van den Akker 1985). Thus, if all women have the potential to be stigmatised and discriminated simply because they menstruate, this may represent misogyny rather than science/evidence of a dysfunction.

During this period of twenty years, Dalton wrote many books and articles on the destructive effect of PMS on the domestic and industrial world. According to Dalton, women with PMS are a cost to industry because of their inefficient work or absenteeism, and ruin their marriages through bad housekeeping and temperamental behaviour (Dalton 1969 in Walker 1997: 175). Though Dalton's claims and studies had a powerful influence on researchers and women's understanding of premenstrual distress, this period also saw the emergence of critique from feminists against Dalton's work. Parlee (1973) criticized Dalton's research methods and questioned her goal of helping women to function more smoothly in their traditional stereotypical roles as subordinate to men. Similarly, Ussher (1991) suggests that Dalton's claims function to 'isolate women by denying or restricting them access to jobs or positions of responsibility, through the perpetuation of the belief that menstruating women are unstable' (Ussher 1991: 44). Indeed, after the Second World War and in the 1960s, as more and more women went to work, research on the relationship between the menstrual cycle and cognitive impairments resurfaced (Sommer 1973). In the 1930s and 1940s when women were needed in the workforce, studies were reporting that women were not impaired at work during menstruation. However, in the 1950s and 1960s, the perception of menstrual handicap returned. Martin (1987) argued that the 'menstruation as a liability' perception resurfaced after the war because women were encouraged (and forced) to give up their jobs for returning (male) soldiers. Taylor (2005) emphasized that the handicap of menstruation only applied to women of higher status and those who were in a position of

responsibility within the workforce. Walker (1997: 170) suggests that 'the existence of the label PMS can be used to both dismiss any form of 'unfeminine' behaviour and to deny women access to situations in which responsible actions are necessary'. Similarly, Laws et al., (1985) argued that the label serves to deny women access to the higher ranks of power and responsibility. The belief that a woman may suffer from PMS at any point and become unable to carry out tasks enables this form of discrimination to take place. Moreover, disabling women from accessing responsible and powerful jobs also means she is preserved for the household duties whilst men maintain their position of power and authority in the workplace and society. Accordingly, Laws et al., (1985) argued that the label of PMS benefits patriarchy (and men), rather than women.

3.4 The medicalisation of premenstrual syndrome (DSM-III 1980)

In 1980, the third edition of the DSM-III was published (APA 1980). Though PMS was not included in the manual, this period saw a growth in menstrual cycle research followed by APA's proposal to medicalize PMS. In the 1980s, the APA proposed to include PMS, under the name of late luteal phase dysphoric disorder' (LLPDD) in DSM-III-R (APA 1987) along with paraphilic rapism and masochistic personality disorder. Feminists objected to the inclusion of these proposed categories on the grounds that these categories were not scientifically objective and were discriminatory towards women (Kutchins & Kirk 1989; Chrisler & Caplan 2002). The APA faced pressure from organized oppositions, protests, media, petitions, and letters summarizing the insubstantial scientific bases for the categories. However, this did not lead to the categories being dropped or being fully approved in the DSM, rather the APA placed the categories in the appendix of the manual for further studies. It is likely that the increase in research and the proposal for PMS to be included in the manual was due to the increased publicity surrounding the two murder trials that had permitted the use of PMS as a defence (Chrisler & Levy 1990). In the first, Sandie Smith stabbed a fellow employee to death. During the trial, Dr. Dalton was brought in as an expert witness for the defence. The judge sentenced her to 3 years probation provided that her behaviour improves whilst on heavy doses progesterone (Dalton's recommendation). A year later, Christine English murdered her partner and once

again Dr. Dalton's testimony was critical in getting the defendant off the hook completely. This illustrates the point made earlier about the double-edged sword – not only are women protected by the PMS defence, at the same time they are defined as mentally disordered. Since the murder trials, PMS concerned the medical researchers with greater reason and led to the development of questionnaires and techniques to measure premenstrual symptoms. And in spite of the controversial protests led by feminists against the inclusion of PMS, research continued to report on the debilitating effects of the 'syndrome' and offered support for the categorisation of PMS.

3.4.1. Constructing PMS as an incapacitating illness that needs treating

Throughout the 1980s PMS continued to be written about as an incapacitating illness. Dalton's description of the PMS woman who is capable of producing a 'battered baby or bruised husband' (Dalton 1971 in Steiner & Carroll 1977: 323) continued to be quoted approvingly by other researchers. Steiner and Carroll (1977) used Dalton's results to associate premenstrual changes with an exacerbation of psychiatric illness, hospitalization, accidents and suicidality. Steiner, Haskett and Carroll (1980: 177) commented that all women experience 'premenstrual tension syndrome' yet in some it is an 'incapacitating ailment, serious enough to disrupt their lives and warrant treatment'. Again, like Frank and Dalton, there is an attempt in the literature to distinguish between 'normal' women and 'abnormal' women though all women are to some extent pathologized in that at least once a month they are unusually 'tense'. Carroll and Steiner (1978) reviewed numerous studies on PMS and concluded that the evidence indicated that prolactin and ovarian hormones play a major role in the cause of PMS. This illustrates that another hormone in addition to the ovarian hormones is thought to be 'responsible' for PMS. The authors also reported that the drug bromocriptine was effective in treating both physical and behavioural premenstrual symptoms. They wrote:

Extract 6: The recent trials of bromocriptine are much more promising. This drug is believed to act by suppressing prolactin secretion and appears to be effective against both physical and behavioral premenstrual symptoms. (Steiner & Carroll 1977: 333)

This extract suggests that women's hormones cause PMS and drug treatment can help to alleviate both physical and behavioural symptoms. This construction of PMS is similar to earlier constructions made by Frank and Dalton. As mentioned before, the attention to physiology gives hormones primary status as an explanation without much discussion of social factors that may be involved in the experience of premenstrual symptoms (Markens 1996). Having said that, it is only meaningful to seek hormonal (or other) 'explanations' such as social factors only once a particular disorder/disease has been identified. In the case of premenstrual distress/changes, a disorder per se has not been identified.

3.4.2 The construction of DSM diagnostic criteria for Premenstrual Tension Disorder

The articles published during this period pressed for the inclusion of PMS in the DSM (Haskett & Abplanalp 1983; Steiner, Haskett & Carroll 1980). Steiner, Haskett and Carroll (1980) whilst acknowledging that PMS was not recognised as a distinct entity in DSM-III, developed the research diagnostic criteria for PMS, albeit they changed the name to 'premenstrual tension disorder'. The authors of the article did not mention why the terminology had changed from 'PMS' to 'premenstrual tension disorder'. It might be that the change in terminology was a deliberate attempt to avoid potentially negative connotations that is associated with the term PMS. There are many PMS-related humorous connotations present in Western cultures and naming a psychiatric disorder as 'PMS' may not sound scientifically credible.

The study collected data using 7 rating scales from 42 women thought to be suffering from severe premenstrual tension disorder. The diagnostic criteria are below:

Extract 7:

PRIMARY RECURRENT PREMENSTRUAL TENSION DISORDER

A. At least 5 of the following are required for definite and 4 for probable as part of a current episode.

1. Irritable, hostile, angry, short-fused.
2. Tense, restless, jittery, upset, high-strung, unable to relax.
3. Decreased efficiency, fatigue.
4. Dysphoric, marked spontaneous emotional lability, crying.
5. Lowered motor coordination, clumsy, prone to accidents (cut finger, break dish, etc.).
6. Distractible, confused, forgetful, difficulty in concentration, lowered judgment.
7. Change in eating habits (cravings, overeating, etc.).
8. Marked change in libido.

B. Overall disturbance is so severe that at least one of the following is present:

1. Serious impairment socially, with family, at home, at school or work.
2. Sought or was referred for help from someone or took medication (especially tranquillizers and/or diuretics) at least once during a premenstrual period.

C. Premenstrual dysphoric symptoms for at least the six preceding menstrual cycles.

D. Symptoms only during the premenstrual period with relief soon after onset of menses. (Steiner, Haskett & Carroll 1980: 185)

In the diagnostic criteria above, premenstrual distress has been constructed as a disorder that is manifested by emotional and behavioural symptoms. What strikes me as interesting is the way in which the psychological and behavioural aspects have, over time, come to be emphasised at the expense of the physical symptoms. This begs the question as to why this occurred and why people were so keen to recognise premenstrual distress as a psychiatric rather than medical or gynaecological problem. Gynaecologists and feminist writers have criticized the focus on affective experiences rather than somatic ones because the criteria/diagnosis excludes woman with purely physical premenstrual experiences

(O'Brian 1987), and it implies that all premenstrual experiences constitute a psychiatric disorder (Caplan et al., 1992). The authors of the study excluded physical symptoms from the diagnostic criteria by stating that some women manifest the emotional and behavioural symptoms without the physical ones. This reason offered by the authors could be interpreted as an attempt to construct premenstrual distress as a psychiatric disorder than a medical one. Moreover, although Haskett and Abplanalp (1983) provided evidence to suggest that this diagnostic criterion could distinguish a group of women with premenstrual tension disorder from a group of women without the condition, Van den Akker (1985) reported that women who report PMS symptoms were indistinguishable from a non-suffering control group. They suggest that the same cyclical symptoms can be found in women who complain of PMS and those who do not. Furthermore, the evidence for the presentation of symptoms constructed in the diagnostic criteria is weak. For example, studies have not been able to find any significant differences in cognitive test performance during the premenstrual week (e.g. Golub 1976). Most of the symptoms reported in the diagnostic category appear to be stereotypic beliefs regarding menstrual cycle symptoms. In particular, these symptoms appear to reiterate Dalton's conclusions about the effects of PMS on women's functioning.

3.5 The emergence of premenstrual dysphoric disorder (DSM-III-R 1987 & DSM-IV 1994)

During the mid-1980s, the need for the inclusion of PMS in DSM and the identification of the 'true' PMS sufferer from 'healthy' women became essential for psychiatrists. This period saw the most development towards the medicalisation of PMS. In 1987, PMS was included as 'Late Luteal Phase Dysphoric Disorder' (LLPDD) in the appendix of the DSM-III-R (APA 1987). Subsequently, and in spite of APA's subcommittee concluding that very little research supported the existence of LLPDD, the term was retained albeit changed to 'premenstrual dysphoric disorder' (PMDD) and was included in the DSM-IV research appendix (APA 1994). In 1992, PMS was listed in the International Classification of Diseases Manual (World Health Organization

1992). In 1999, the US Food and Drug Administration (FDA) approved the antidepressant Prozac for the treatment of PMDD (Taylor 2006). Majority of the biomedical research continued and more research was now focusing on the brain and its interaction with the ovarian system as a source of dysfunction. The neuroendocrine theories were thought to account for PMS either as a result of altered sensitivities of neurotransmitters to 'normal' or 'abnormal' levels of ovarian hormones (Walker 1997). However, how the proposed interaction between these two different systems takes place remains unidentified (Walker 1997). At the same time, there was also an increased emphasis on separating PMDD from clinical depression and constructing PMDD as a distinct diagnostic category.

3.5.1 PMDD as a distinct diagnostic category

During the 1990s, numerous studies argued that PMDD was distinct from PMS and depression (e.g. Steiner 1997; Endicott et al., 1999). Endicott et al., (1999) reviewed the literature up until the late 1990s and provided evidence in support of the concept that PMDD is a distinct entity. The paper summarises a meeting that took place in 1998 between reputable experts in the field. Endicott et al., (1999) summarised the points from the meeting:

- Extract 8:
- In terms of symptom profile, PMDD differs from other mood or anxiety disorder. In particular, internal tension, anger, and irritability as characteristic of PMDD
 - The key difference between PMDD and other disorders is the clear onset and clear offset of symptoms, both linked to the menstrual cycle. There is considerably stability in the course of PMDD from cycle to cycle and over time in the absence of treatment.
 - Biologic characteristics outside the normal range tend to be related to the serotonin system
 - Symptoms of PMDD can be treated effectively
 - PMDD differs in response to treatment in comparison with other disorders.

- Blocking the menstrual cycle will cure women with PMDD but not those with other mood disorders
- ... sufficient evidence is now available to support the use of SSRIs in this disorder. (Endicott et al., 1999: 676)

In the above extract, premenstrual distress has been constructed as a distinct clinical entity, differing from mood or anxiety disorders. The summary indicates that PMDD responds well to treatment with SSRI's and is possibly caused by dysfunctions in the serotonin system. The serotonin theory was widely held by other prominent researchers of this time (e.g. Steiner 1997). Steiner (1997) wrote: 'increasing evidence suggests that serotonin (5-HT) may be important in the pathogenesis of PMDD' (Steiner 1997: 450). Endicott et al., (1999) and Steiner (1997) both comment that the diagnostic criteria for PMDD appear more stringent than for any other condition because a key component of the criteria include the onset of symptoms during the luteal phase of the cycle and offset during the early follicular phase. Steiner (1997) suggests that the strict criteria means that not all women who have premenstrual symptoms necessarily have a mental illness, but those who experience extremely distressing emotional and behavioral symptoms premenstrually and meet the requirements of the diagnostic criteria will be validated by a diagnosis. This seems to imply that the diagnosis is for the women's own good, suggesting that the only way of legitimating their experiences is by medicalising them. However, the analysis found inconsistent reports about the DSM criteria, which require that two cycles of mood and behavioural symptoms must be observed in women with PMDD. Whilst, Bloch et al., (1997) reported that women with PMDD have individual-specific symptom patterns that are stable and replicable across cycles, both Walker (1994) and Hardie (1997) found intercylic inconsistency. Walker (1994) found that in two consecutive menstrual cycles, physical experiences proved more consistent across cycles than did emotional ones. They both concluded that premenstrual experiences vary between menstrual cycles and suggest that the premenstrual changes cannot be adequately explained on the basis of simple biological determinism. Hardie (1997) argued that the widespread and largely inaccurate beliefs about premenstrual changes stems from early biomedical menstrual cycle research, the bulk of which was conceptually and methodology flawed but

nevertheless powerful in shaping the public perception of PMS. Despite the contradictory findings, it was widely held that PMDD is a distinct category that can be measured objectively and differentiated from any other conditions.

The analysis found that during the 1980s and 1990s, premenstrual distress has been constructed as a distinct psychiatric disorder caused by low serotonin levels in the brain. The studies also suggested that PMDD could be effectively treated with SSRI's. Thus etiology and treatment of premenstrual distress has shifted from the previous etiologies and treatment practiced by Frank and Dalton. This recent portrayal of premenstrual distress was made despite many members in Endicott et al., commenting that the evidence for the etiology of PMDD and the effectiveness of SSRI treatment is limited. Moreover, Dr. Severino in the meeting highlighted that most of the research on PMS/PMDD has been conducted in the US and expressed that 'If affective premenstrual distress cannot be identified consistently in non-United States or European populations, consideration must be given to the criticism that PMDD is a culturally bound syndrome or an unnecessary pathologising of cyclical changes in women' (Endicott et al., 1999: 666). Dr. Pearlstein also commented that 'there is limited self-report or observer-confirmed information on functional impairment associated with PMDD' (Endicott et al., 1999: 669) suggesting that women are more concerned with the effects on relationships (i.e. arguments with family and friends) than effects on work. Endicott et al., (1999) reported that recent reviews were unable to confirm luteal phase impairment in attention, memory, or learning (e.g. Morgan et al., 1996). Despite this, the medicalisation of premenstrual distress and the reporting of the debilitating effects of premenstrual distress continued. For the purpose of this study, it is important to comprehend why this has occurred.

3.6 The concept of premenstrual dysphoric disorder (DSM 5 2013)

From the mid-1980s to the present, we have seen a steady push towards the medicalization of premenstrual experiences (Taylor 2006). At present, the Mood Disorders Work Group for DSM 5 has recommended that PMDD be moved from the appendix to reside as a diagnosis in the Mood Disorders section of the

manual. The analysis found that numerous researchers have supported this proposal (e.g. Cunningham et al., 2009; Epperson et al., 2012; Hartlage et al., 2012; Protopopescue et al., 2008; Reed et al., 2008; Pearlstein & Steiner 2008). Most of these studies continued to portray premenstrual changes as a disorder that causes impairments in functioning.

3.6.1 PMDD is a distinct disorder that causes impairments of work and social functioning

The analysis found that research studies (e.g. Hartlage et al., 2012; Reed et al., 2008; Epperson et al., 2012) and literature reviews (e.g. Cunningham et al., 2009; Yonkers et al., 2008) have generally reported mood symptoms such as irritability, tension, and labile mood for PMDD and constructed PMDD as a debilitating condition. Pearlstein and Steiner (2008) wrote:

Extract 9: The burden of illness of PMDD results from the severity of symptoms, the chronicity of the disorder and the impairment in work, relationships and activities. It has been estimated that women with PMDD cumulatively endure 3.8 years of disability over their reproductive years. A study of 1194 women who prospectively rated their symptoms reported that women with PMDD were more likely to endorse hours missed from work, impaired productivity, role limitations and less effectiveness (Chalwa et al., 2002)...Borenstein et al., (2003) [found that] women with confirmed PMDD reported significantly lower quality of life, increased absenteeism from work, decreased work productivity, impaired relationships with others and increased visits to health providers, compared with control women. These authors also reported that, given a 14% absenteeism rate and a 15% reduction in productivity, PMDD was associated with US\$4333 indirect costs per patient per year." (Pearlstein & Steiner 2008: 292)

In this extract, PMDD has been constructed as a disabling illness that can diminish women's quality of life and impair their ability to function at work and in

relationships. PMDD has been rendered problematic because it can lead to decreased work productivity and absenteeism from work. The authors also portray women with premenstrual distress as a financial burden to employers. In the extract the authors estimate how much money it would cost per women per year if she were handicapped by her premenstrual changes. Others have also mentioned these costs (e.g. Cunningham et al., 2009) and provided evidence for the performance impairment (e.g. Reed et al., 2008). During this time, biomedical research continued and etiological studies investigated numerous possible causal mechanisms, with an increasing emphasis on the role of neuroendocrine factors in PMS. At the same time, more and more studies were providing evidence to show that PMDD can be differentiated from depression. In order for PMDD to be included in DSM 5, research evidence must show that PMDD is distinct from mood disorders. Pearlstein and Steiner (2008: 293) wrote, 'PMDD should generally not be diagnosed when an underlying depression or anxiety disorder is present.' Epperson et al., (2012) wrote:

Extract 10: Women experience a pattern of distressing symptoms beginning in the luteal phase of the menstrual cycle and terminating shortly after the onset of menses. This pattern of symptom expression is distinct from that of other disorders ...One of the most potent predictive validators of premenstrual dysphoric disorder as a disorder distinct from mood disorders is its preferential response to SSRIs. In no other psychiatric disorder do SRIs reduce symptoms with as short an onset of action as in premenstrual dysphoric disorder. (Epperson et al., 2012: 466-470)

This extract suggests that the evidence that PMDD is distinct from mood disorders has been supported, not by locating the etiological factors of each, but by reporting on the differential treatment response between these conditions. This extract has constructed PMDD as a condition that can be effectively treated with pharmaceutical medication that targets the serotonin system in the brain. The analysis shows that the serotonin system and its interaction with sex hormones were widely reported as the etiology of PMDD. Cunningham et al., (2009) wrote:

Extract 11: Aberrations in serotonergic transmission are found in women with PMS/PMDD. Symptomatic women have lower density of serotonin transporter receptors than do controls. Premenstrual symptoms are diminished both by serotonin reuptake inhibitors and by other treatments that increase serotonin (Cunningham et al., 2009: 126).

Additionally, Pearlstein and Steiner (2008) commented that FDA has approved the use of the SSRI's fluoxetine, sertraline and paroxetine for women with PMDD. Both Pearlstein and Steiner (2008) and Cunningham et al., (2009) have reported that SSRI's have high efficacy rates compared to other treatments such as hormonal interventions, oral contraceptives, progesterone or estrogen therapy, cognitive therapy, herbal remedy, and lifestyle modifications. All of these findings show that the cause of PMDD has been searched inside the body, without much discussion of social factors that may also cause or exacerbate the experience of premenstrual distress (Markens 1996). The use of the biomedical approach in the etiology and treatment of PMDD provides support for the inclusion of PMDD in the manual. Ironically, the possible advancement of the aetiology and treatment of PMDD is also used to highlight the benefit of including PMDD in DSM 5.

3.6.2. Benefits of including PMDD in DSM 5

The analysis found that various studies (e.g. Cunningham et al., 2009; Epperson et al., 2012) have reported on the benefits of including PMDD in the main text of the DSM 5. Epperson et al., (2012) wrote:

Extract 12: The Food and Drug Administration and similar authorities in other countries have approved several pharmacological agents for the treatment of PMDD, making it a de facto diagnosis regardless of its position within DSM...The inclusion of PMDD as a diagnostic category may further facilitate the development of medications that are useful for treatment and may encourage additional biological

research on the causes of the disorder... The overall health benefit for women of having an empirically based diagnosis would thus outweigh the potential for unfounded stigmatization or demeaning remarks that some groups fear. (Epperson et al., 2012: 470-471)

This extract suggests that PMDD is a 'real' category and FDA recognizes this and approves the treatment of it. There is a striking circularity here. The approval of medication is taken as evidence that a disorder is recognised and this is then adduced to support a claim that formal recognition will serve to encourage research into the causes. Paradoxically, the disorder 'exists' because we medicate something – this approval of medication is being used as an argument for research into the origins that has previously failed. This argument seems to perform like a completely closed system that does not appear to permit refutation. Nevertheless, Epperson et al., (2012) proposes that PMDD should be classified as diagnostic category since the benefits of inclusion outweigh any stigma. The benefits of including PMDD as a diagnostic category, as noted by Epperson et al., include the development of better treatments and understanding of the biological underpinnings of the condition. Epperson et al., (2012) have also developed diagnostic criteria for PMDD and recommended that DSM 5 task-group members consider the criteria and include it in the manual. Apart from minor differences, the criteria are identical to the ones proposed in DSM-5.org.

In summary, these studies have constructed premenstrual distress as a distinct psychiatric disorder and proposed for the inclusion of PMDD in DSM 5 manual as a category of its own. Studies of this time period have constructed premenstrual distress as an illness that is caused by low serotonin level in the brain that can be effectively treated with SSRI's. The extract suggests that FDA has approved the pharmaceutical treatment of PMDD and this means that the diagnosis is a fact ('de facto'). One of the implications of including FDA's approval might be that it makes PMDD appear like a 'real' condition. The studies have drawn on a psychiatric discourse that enables the authors to suggest there is a group of women who meet the criteria for PMDD and can be treated with psychiatric medication. This group of women is positioned as mentally ill, emotionally labile, irritable, and angry. As mentioned before, all of these discourses, practices and

subject positions have wider consequences for the person being classified i.e. unfit mother, bad wife, and inefficient employee. The studies also draw on a productivity discourse that renders the premenstrual phase as a problematic 'thing' and positions women as inefficient and costly to their employers. These constructions of PMDD not only reinforces the nineteenth century idea that women are a liability to employers whilst they are menstruating, it may also prevent women from being offered jobs of more responsibility, power and money. By implication, she may be encouraged to stay at home and carry out tasks that are 'naturally' assigned to the female gender. This move may be beneficial to the patriarchal society and pharmaceutical industries, but not necessarily to women who are diagnosed (Laws et al., 1985). Additionally, researchers too can build careers on the medicalisation of premenstrual changes i.e. by receiving funding from pharmaceutical companies to promote pharmaceutical treatments and look for the biological basis of PMDD.

3.7 Research Questions

In this section, the results will be pulled together and discussed in reference to the following research questions.

3.7.1 How do psychological and psychiatric literatures construct premenstrual changes?

On the whole, the analysis revealed that the construction of premenstrual changes since the 1930s have been negative. Premenstrual changes have been portrayed as pathological, debilitating, incapacitating for women sufferers and unbearable for those around her. Emotional problems such as irritability, depression, lethargy, and anger are predominantly noted as the most destructive premenstrual changes (e.g. Greene and Dalton 1954). The PMS/PMDD sufferer has been constructed as someone who is functionally impaired at work and in her social and family life. During the 1930s, premenstrual changes were constructed as 'PMT' consisting of both physical and mental tension caused by excessive estrogen hormone (Frank 1931). Between the periods of 1950s to 1980s, premenstrual changes were constructed as 'PMS' caused by progesterone

deficiency (Greene and Dalton 1953). PMS was portrayed as a debilitating syndrome that caused some women to become 'suicidal, violent, mentally dull, more accident prone, and abusive towards her husband and children' (Dalton 1961: 1753). Both 'PMT' and 'PMS' were constructed as an incapacitating illness that needs treating. In 1987, PMS was conceptualised as a psychiatric disorder in the name of LLPDD within the revised third edition of the DSM (APA 1987). Subsequently, LLPDD was renamed to PMDD and was listed in the appendix of DSM-IV (APA 1994). Researchers around the 1990s constructed PMDD as a distinct diagnostic category that can be measured objectively and differentiated from any other mood conditions (Endicott et al., 1999). At the same time, neuroendocrine theories of PMDD proposed that dysfunctions in the serotonin system are the most likely cause of PMDD. At present, PMDD continues to be constructed as a psychiatric disorder, which causes impairments of work and social functioning. The treatment choice for women diagnosed with PMDD is SSRIs. Since the 1930s to the present, a biomedical approach has been employed in explaining and treating premenstrual distress. The use of the biomedical approach has helped in the process of conceptualising and constructing premenstrual distress as a serious psychiatric disorder consisting of emotional, behavioural and physical symptoms. Within the literature, three different but connected knowledges or 'truths' produced and disseminated by psychiatrists and psychologists have helped to reify PMDD as a pathological problem. I will now consider these 'truths' individually.

The first of these 'truths' proposes that: "PMDD is an identifiable condition that can be objectively defined". This 'truth' proposes that women who suffer from PMDD (sufferers) can be identified and distinguished from other women who do not have PMDD (non-sufferers). This type of conceptualisation constructs PMDD as a distinct phenomenon separate from normal suffering. The search for premenstrual symptomatology and the deliberation over the precise diagnostic criteria for PMS/PMDD including the number of cycles the symptoms need to be present and the degree of impairment required for diagnosis, has helped to construct PMDD as a real identifiable disorder. Additionally, the reported distinctiveness of PMDD from other mood disorders and the introduction of standardised questionnaires (e.g. Moos 1968) has helped in the

conceptualisation of PMDD as a distinct disorder that can be objectively identified and differentiated from normal premenstrual distress. Similarly, Ussher (2003, 2008) also found that the knowledge circulated by psychiatry and psychology has helped to construct 'PMDD as a thing that can be objectively defined and measured' (Ussher 2003: 135). However, an argument could be made here against the classification of premenstrual distress as a psychiatric problem. It could be argued that the classification could be pathologizing something that is essentially and inextricably part of being a woman. For instance, during the late nineteenth century, though there was no evidence, physicians strongly held the belief that abnormalities within the body caused women to become mad. The ovaries were seen as the dominant organs controlling women's mind and body and menstruation was viewed as the cause of female maladies. However, at that time, a problem raised for the theorists was the realization that 'ovulation and menstruation do not happen at the same time', leaving theorists unsure on which part of the menstrual cycle to focus on and render it as the cause of female madness (Walker 1997: 34). This problem was solved in 1920s following the 'discovery' of the female sex hormones estrogen and progesterone. It was no longer dysfunctional menstruation or dysfunctional ovulation that causes women to become mad, but dysfunctional hormones found in the premenstrual phase. It was the emergence of the hormonal discourse and the 'discovery' of the sex hormones that shifted research focus from menstruation to the premenstrual changes. The 'discovery' of the hormones was also used to support previous belief that abnormalities within the body causes women to become mad. None of these beliefs have been based on evidence. Therefore there is no scientific reason for the pathologization of menstruation or any aspects of menstruation.

A further issue here is the way in which PMDD has been turned into a psychiatric condition largely by neglecting the presence and impact of physical changes (e.g. breast tenderness, dysmenorrhea, and headaches) that many women experience during the premenstrual week. Was this a strategic move from the creators of PMDD to dismiss critics who may question why premenstrual distress is considered a psychiatric problem rather than a physical (or gynaecological) one? Caplan et al., (1992) point out that a thyroid problem may lead to mood and behaviour changes, yet it is doubtful that anyone would consider the person with

the thyroid problem as mentally ill. However, this criticism should not be taken as a way of suggesting that, like thyroid problem, premenstrual changes should be considered a physical illness. Rather this problem points out that normal premenstrual experiences include both physical and emotional changes, but the psychiatric and psychological literature has carved out and focused on the emotional aspects in order to conceptualise premenstrual distress into a psychiatric problem.

The second of these 'truths' proposes that: "PMDD is an individual phenomena that can be treated using medical interventions". Since the 1930s, psychiatric literature has constructed premenstrual changes as a hormonal disorder that needs treating with medical interventions such as hormones and psychiatric drugs. The production of hormonal theories and the practice of medical interventions have helped to conceptualize PMDD as an individual phenomenon. The study found that the focus for treatment was within women's bodies (i.e. rest in bed, hormonal treatment, and SSRI's medication). However, placing the hormones as the dominant explanation of premenstrual distress and insisting on individual treatment programs may not be appropriate or helpful to women. There is evidence to suggest that relational, social, economic, cultural and structural factors can contribute to both the experience and perception of premenstrual changes (e.g. Ussher & Perz 2008). Markens (1996) argues that the medical construction of PMS tends to ignore the gendered divisions of labor within social institutions, which can contribute to the physiological manifestation of symptoms (e.g. stress, anger, and fatigue). Markens (1996) reasons that women's lives are stressful and highly demanding; not only do women try to successfully accomplish the demands of work and home life, they also do much of the emotional work in both of these arenas. Rather than prescribing antidepressants, social and institutional modifications in the form of changes in their day-to-day tasks and duties at home and at work may be more receptive to their needs and benefit women more generally and at times when premenstrual distress is severe. Martin (1989) argued that changes in the nature and or structure of work time could be more helpful to women than changes that focus on making modifications within her body. According to Laws et al., (1985) individual drug treatment of women benefit drug companies and generally patriarchal society –

both of whom attribute any 'inconvenient' female behaviour to her hormones, rather than having to deal with the realities that women's lives or experiences are difficult and need to be changed (which may involve change for men themselves). Moncrieff (2009 in Ussher 2010: 25) has provided numerous accounts of evidence to suggest that psychotropic medication, particularly when used alongside therapy, may be beneficial for alleviating some cases of 'extreme mental turmoil' but it is not necessary or appropriate for the distress that many of people experience in every day life (such as depressed feelings).

The lack of attention to these social, structural, and political factors within the psychiatric and psychological literature can also contribute to a medical construction of PMDD and privilege the biomedical approach in explaining and treating PMDD. Additionally, within this construction, there is an implicit assumption that negative experiences, such as the premenstrual experiences, should not be tolerated and should be removed. Within this perspective, it is assumed that our moods, behaviour and reactions should remain constant and not fluctuate; that any changes in our moods, behaviour and bodily experiences, is a pathology that needs eradicating (Ussher 2003). One could speculate that the lack of fluctuation in mood and behaviour in women benefit others (particularly men) rather than women themselves. If she is calm, gets on with work without complaining, nurtures others, and does not express any feelings of anger or irritability, then nothing needs to be addressed, no problems need to be fixed, and no one else needs to change. Paradoxically, even if she experiences fluctuations in her mood and behaviour and expresses some anger, according to the premenstrual research, she will be the one that needs to change and get better, not others.

The third 'truth' proposes that: "women with PMDD experience incapacitating symptoms". The negative effects of PMDD on women's lives have been written about since the 1930s. These include irritability, depression, lethargy, and anger. PMDD has been constructed as a disabling illness that can diminish women's quality of life and impair their ability to function at work and in relationships. However, the negative symptoms are implicitly and explicitly defining how women should feel and behave (Markens 1996). The 'good' woman, as far as the PMS

literature is concerned, is one who is sweet-tempered, calm, kind, placid and undemanding, whereas the 'bad' women or the premenstrual women is someone who is angry, demanding, and improperly behaved (e.g. Laws et al., 1985). These constructions of how women should behave impacts on how women are viewed by their family members and work colleagues. Being classified as a 'bad' or 'premenstrual' woman may have potential effects on employment and family relationships, particularly convincing them that she can function adequately at home and at work. Additionally, the label of PMDD can function to allow the 'bad' feelings and behaviour to be dismissed by both men and women since they become conceptualised as incapacitating symptoms of a disorder rather than genuine grievance caused by relational, social and structural factors. In describing the negative symptomatology of PMDD, the literature has contrasted a 'normal' woman to an 'abnormal' one. However, the boundaries of 'normal' and 'abnormal' women appear to be influenced by the discourses of femininity, rather than science.

In summary, since the 1930s the psychiatric and psychological literature has constructed premenstrual changes negatively. The analysis did not find any mention of positive aspects of premenstrual changes. The study found three interrelated 'truths' about PMDD that are present throughout the literature. These include: PMDD is an identifiable condition that can be objectively defined; PMDD is an individual phenomenon that can be treated using medical interventions; and women with PMDD experience incapacitating symptoms. These truths, constructed through the language used by researchers and clinicians, have helped in the conceptualisation of PMDD as a medical and psychiatric phenomenon. Additionally, these truths may have influenced men and women's perception of premenstrual changes as a disorder, as well as influencing some women's perception of their own premenstrual changes as a disorder (see research question three).

3.7.2 Under what circumstances are women's premenstrual changes rendered problematic and what professional discourses render these problems intelligible?

Foucault's (1977) 'genealogical' approach serves to show that knowledge and categories of any particular kind, such as 'mental illness' or 'PMDD', are not universal, atemporal and objective. According to Foucault, all concepts or knowledge comes from somewhere, all knowledge is linked into history and culture, and all knowledge is constructed and produced by discourses. Using Foucault's ideas of knowledge, we ask how the concept of PMDD came about, how it became accepted as common sense, and what discourses have been used to render the problem intelligible. The present study found that the discourses of science, medicine, and biomedicine have been heavily used in the psychiatric and psychological literature on PMS/PMDD. These discourses have been central in creating a version of truth that is deemed real and valid. The use of these discourses has helped to construct premenstrual distress as a real psychiatric disorder. The language used by researchers and clinicians in the literature has been crucial in constructing PMDD as a real, distinct, and incapacitating disorder, rather than a socially constructed category. Boyle (2002) highlights that in Western society those versions of physical, mental and bodily events offered by the discourses of science and medicine are given greater credence and thought of as real. The present analysis found that the literature was entrenched with references to medical, physical, mental and bodily events. The terms such as 'scientific', 'epidemiology', 'research', 'biology', 'psychiatric', 'physical', 'mental', 'hormones', 'neurotransmitters', etc., have been heavily used in the literature. Accounts of 'hormones', 'neurotransmitters', the 'endocrine system' and the 'reproductive system', have been mentioned in connection to the etiology of PMDD. The use of these words/theories not only fosters the impression that PMDD is a real bodily disease; it also signifies that the author of the study is an expert in the medical field, and therefore their articulations are the 'truth'. Thus, the use of medical and scientific words legitimizes the profession and makes their ideas appear as real, neutral and objective. The present study found that the use of neutral words in objective manner allowed PMDD to appear as real scientific fact rather than a cultural stereotype or gender bias. This way of

writing has been referred to the 'empiricist discourse/ repertoire' (Boyle 2002). Boyle (2002) suggests that the neutral and objective tone can be achieved when, for example, the researcher uses a passive voice (the research was designed) and phrases that imply that the research uncovers 'facts' (the research found that...). This style of writing helps to cover up the researcher's opinions and biases. There is also evidence that new discoveries, such as hormones, were recruited in support of the biomedical discourse.

Moreover, the present study found that the literature made use of the language often used in medicine. For instance, most of the literature had said something along the lines of: "Women *with* PMDD experience *physical* and *emotional* symptoms that are listed in the *diagnostic criteria* of the *DSM*, once *identified*, women with PMDD can be given a *diagnosis* and offered *treatment* in the form of *pharmaceutical medication* to eradicate the *symptomatology* of the *disorder*". The use of these terms creates the impression of similarity between medical disorders and psychiatric constructs (Boyle 2002). Interestingly, the PMDD literature rarely used the terms 'mental disorder' or 'mental illness' to refer to PMDD. This may have been deliberate because these terms tend to have numerous negative connotations and wider implications, such as stigma and discrimination. It is possible that the explicit use of the term 'mental disorder' in relation to PMDD will deter women from diagnosing themselves. Indeed Chrisler (2013) found that students use the term 'PMS' to refer to premenstrual changes without even realizing that the 'S' stands for 'syndrome' and means a medical disorder. Nash and Chrisler (1997) found that the knowledge of PMS as a psychiatric diagnosis increased participants' perception of premenstrual changes as a problem for women in general. These participants were more willing to attach a psychiatric diagnosis to women they know, but they were less willing to attach a psychiatric diagnosis to themselves. This suggests that medical and biomedical language can play an important role in the way we understand human distress, although our understanding may differ depending on whose distress is being described (i.e. our own vs. others). Similarly, Lafrance and McKenzie-Mohr (2013) argue that the biomedical frameworks have infiltrated our individual consciousness to the extent that in everyday conversations people use the biomedical framework to make sense of distress. Certainly, in modern Western culture, the most

dominant way of understanding distress is through a biomedical lens. Knowledge through these lenses is considered to be reasonable, intelligent, and truthful. Hence the 'truths' of premenstrual changes that have been constructed using medical and scientific languages (tied to the discourses of science and medicine) have helped to create the concept of PMDD.

However, to Foucault, all knowledge / truth is connected with the notion of power and power works in opposition to the truth. According to Foucault, powerful groups create ideologies, distort versions of ourselves, our history and reality, and 'suppress' the truth (Foucault in Bracken and Thomas 2010: 225). Figert (2005: 103) found that concepts or diseases achieve legitimacy when scientists or physicians, who have the 'cognitive authority to define, describe or explain' reality, call them real. If scientists or physicians define things as real, then the general public also believe it to be real. Figert (2005) argues that the concept of PMS has become a real medical condition because numerous professionals, including scientists, physicians, and doctors have defined it as such. The present study found that in psychiatric and psychological literature, researchers and clinicians have defined PMDD as a real phenomenon and an illness. Similar constructions have been found in magazines and newspapers (Markens 1996). A Foucauldian analysis would argue that psychiatry has created a distorted version of premenstrual experiences and society has accepted this version to be the truth. Lafrance (2007: 128) argues that the biomedical perspective is powerful because it uses medical concepts and draws on medical discourses, and medicine has the 'economic, political and institutional power to shape our view of the world'.

Lafrance and McKenzie-Mohr (2013) highlight that the biomedical formulation inherent in the DSM has been born out of a historical context, emerging in the 1960s and 1970s when psychiatry was heavily criticized for the lack of reliability and validity of mental disorders. Prior to this, the DSM had a psychoanalytic theoretical orientation. The biomedical approach offered the promise of a scientific understanding of mental disorders and effective treatment. This radical shift not only bolstered psychiatrists' professional status as a medical specialty, it also benefited pharmaceutical companies who were in a position to offer

psychiatric drugs to people deemed mentally ill. The beneficial relationship between psychiatry and the drug industry is troubling. Cosgrove and Wheeler (2013) found that of the DSM 5 task force members who oversaw the development of the manual, 69% reported having ties to pharmaceutical industry. The fact that many of the members had industry ties is problematic because it can result in implicit bias among researchers and clinicians. For instance in June 1999, when the patent for Eli Lilly's best-seller drug Prozac was scheduled to expire, Eli Lilly convened a roundtable discussion to which they invited many members of the DSM-IV PMDD subcommittee (Chrisler & Caplan 2002). Shortly afterwards, Endicott et al., (1999) published an article indicating that PMDD was a real phenomenon and that Prozac was an effective treatment. Eli Lilly was able to extend its patent by using the diagnosis of PMDD. A decade later, the DSM then used FDA's approval of Prozac to justify the inclusion of PMDD in DSM 5. This shows how scientific integrity can be sacrificed to corporate gain (Cosgrove & Wheeler 2013).

3.7.3 What discursive and regulatory practices warrant the constructions of premenstrual changes as a psychiatric disorder?

The current analysis found that women do complain of premenstrual distress as illustrated by the fact that women have participated in psychiatric, psychological and treatment studies. Certainly, Walker (1997) found that in the 1970s, the increased acknowledgement of women's experiences led to an increase in the number of women identifying themselves as PMS sufferers and seeking medical advice. How did women come to perceive premenstrual changes as a psychiatric disorder? And what warrants the construction of premenstrual changes as a psychiatric disorder?

This study found that the 'truths' presented by psychiatry and psychology has been powerful in shaping our understanding of premenstrual changes. These 'truths' may have also made some women believe that they suffer from PMDD. Rose (1998) suggests that the 'truths' about human wellbeing and diseases provided by the 'psy' professions (psychology and psychiatry) are not just academic; they have a particular kind of social authority that is linked to the

government of people. Rose (1998: 75) suggests that through a process of 'problematizations', 'psy' professions have rendered problems of the schoolroom, the court, the army, the factory, and the family, as their own. Rose (1998: 75) notes that in each of these sites, problems would emerge and 'psy' professionals would find its subjects, scrutinize and study them, elaborate theories to understand them, and seek to reform or cure them. In our modern world, Foucault suggests that the government of people can be exercised less through brutality and more through a subtle process of 'subjectification' (Foucault 1977). Subjectification is the process whereby judgments that are made about people are utilized by individual themselves in order to conduct his or her own conduct (Foucault 1977), in other words, the 'government of the self' (Rose 1998: 33). Rose (1998) argues that the 'psy' disciplines have played a key role in the formation of self-government and subjectification. They have done this by circulating their knowledge into the clinics, schools, hospitals, prisons, and the media. In fact, the 'psy' professions have made it 'impossible to conceive of personhood' or 'to govern oneself or others without psy' (Rose 1998: 34).

The present study illustrates that the knowledge and 'truths' circulated by the 'psy' professions has enabled the construction of PMDD as a real psychiatric problem. The 'psy' professions have co-opted knowledge from other disciplines (e.g. endocrinology, medicine, and biology) and made it their own. These knowledges have been reproduced in research journals, books, magazines, self-help books and disseminated in clinics, courts, and general culture. Markens (1996) found that in magazines and self-help books, accounts of women's premenstrual experiences and the use of doctors/expert knowledge has been a crucial rhetorical device in establishing PMS as a psychiatric phenomenon. When professional frameworks about PMDD are reproduced everywhere within our culture, it may become difficult for the public (particularly women who experience premenstrual distress) to take a critical stance towards the concept of PMDD. Rather, people (and women) may come to incorporate these professional frameworks as the truth. Ussher (2003, 2008) argues that it is through the process of subjectification that modern women come to label themselves with PMS/PMDD. This process of subjectification allows the 'truths' about premenstrual changes and distress to be reproduced and lived by women

(Ussher 2003). Indeed, Ussher (2003) found that throughout women's narratives, PMDD is constructed as a medical phenomenon.

According to Ussher (2008) self-surveillance, self-silencing, self-blame, and self-sacrifice are some of the apparatuses of subjectification that help women to accept the medical construction of premenstrual distress. Ussher associates these apparatuses with the dominant constructions of femininity. As mentioned earlier, the most dominant constructions of the idealised femininity include the positioning of the 'good' woman as emotional nurturers of others, responsible, and calm. Women, through a process of self-surveillance regulate and govern their behaviour according to the 'good' woman standard, whilst at the same time, they repress the 'bad' woman who is selfish, unruly, angry, and irresponsible (Ussher 2008). Ussher (2008) suggests that the symptoms most associated with the premenstrual phase could be conceptualized as an emergence of emotions that are repressed during the majority of the month. Premenstrually, a rupture in self-silencing occurs to allow the expression of both day to day frustrations and anger associated with more substantial issues as she attempts to live up to idealised representations of femininity (Ussher 2003). The rupture is, however, followed by increased self-surveillance, leading to guilt, shame, and blaming of the body (Ussher 2008). Ussher (2003) notes that women may deal with these difficult emotions by splitting off certain emotions and behaviour as 'not me' whilst maintaining the idealised construction of femininity. Ussher (2008) highlights that positioning PMDD as a 'thing' performs a regulatory function in women's lives; it allows women to pathologize and split off emotions and behaviours, such as feeling out of control or angry, that typically does not conform to the ideal woman standard (Ussher 2008). This splitting off allows women to position her 'true' self as calm, kind to others, rational, and in control of all her responsibilities, whilst positioning her 'PMS self' as angry, irritable and uncontrollable. The splitting off also functions to reinforce the belief that her body is blameworthy and not her 'personality'. The discursive construction of blaming the premenstrual body functions to exonerate women from responsibility for this fury and allows her to disassociate the fury from her sense of self. It is not her that is the monster, it is the 'PMS', the unruly body that must be constrained and contained (Ussher 2008). Indeed, research with women experiencing premenstrual distress has

illustrated how a medicalized understanding of women's experiences can serve to deflect individual blame and protect their identities (e.g. Ussher 2008; Lafrance 2007).

3.7.4 What subject positions are enabled and what are the implications for action of these subject positions?

In contemporary society the professions of psychology and psychiatry play a central role in occupying certain types of knowledge that give them permission to regulate people who are deemed mentally unfit (Rose 1985). The dominant discourses have the power to shape our knowledge about madness and our practices towards mad people. Though in the case of PMDD, I would argue that the knowledge of PMDD and our practices towards women diagnosed with PMDD is subtler than say the knowledge and confinement of a person diagnosed with 'schizophrenia'. This subtle knowledge and practices, however, does not mean the effect is less damaging, but rather it is more insidious. Discourses have 'real effects' in legitimizing particular 'truths' as 'reality' and legitimizing particular practices towards people set in that reality (Walkerdine 1986 in Malson 1998: 27). The inclusion of PMDD in the DSM, for example, provides legitimization of PMDD as a medical disorder and legitimizes the examination, diagnosis, and treatment of women who are deemed to suffer from PMDD. From a Foucauldian perspective, discourses produce 'subject positions' and identities, which, when taken up, have implications for 'subjectivity' and experience (Foucault 1972 in Malson 1998: 26). According to Foucault, psychiatric knowledge and practice are central to the process by which human beings are made subjects (Roberts 2005). The knowledge produced by psychiatry as well as the practice of diagnosing women with PMDD can position her as a 'psychiatric subject'. Once made into a subject, this can have a negative effect on how she perceives herself and how others perceive her. Once assigned to the category of being mentally ill, she is subjected to a variety of presuppositions that are associated with the concept of 'mental illness' (Robert 2005). These presuppositions can characterize the diagnosed woman as dependent, diminished in thought, unstable, irrational, and unpredictable (Robert 2005; Lafrance and McKenzie-Mohr 2013). These identities can also be used to 'legitimize explicit forms of psychiatric power and

control, such as compulsory admission' (Roberts 2005: 39) or pharmaceutical treatment of women deemed to be dangerous to themselves (i.e. suicidal) and to others (i.e. violent and aggressive). As a result of the categorisation, her behaviour and mood may be seen as irrational rather than a reasonable. There are profound implications for women who take up the position of the 'psychiatric subject'. Being diagnosed with PMDD may impact women in relation to the potential negative effects it may have on her relationships with her family, her chances of getting highly responsible employment or winning child custody in courts, and how she perceives herself. It may also impact how people perceive her and her complaints. Caplan et al., (1992) have argued that the existence of a formal psychiatric label makes it incomparably more difficult for women branded with that label to convince her family, friends, co-workers, employers and prospective employers that she is psychologically normal. Moreover her complaints are rendered irrelevant. The label of PMDD may invalidate the bad feelings and behaviour women may display by conceptualising it as incapacitating symptoms of a disorder rather than genuine complaint.

Once given the diagnosis, her negative premenstrual distress are thought of as a manifestation of her dysfunctional biology rather than influenced by relational, social, cultural and structural factors (e.g. Ussher & Perz 2008). Additionally, the drug (Sarafem) that she may be required to take as a 'psychiatric subject' has numerous side effects that may cause her more harm than good. The side effects of Sarafem have been constructed as 'tolerable' (e.g. Cunningham et al., 2009: 129) in the psychiatric literature. The side effects include digestive problems, sleep problems, sexual dysfunctions and in some cases, suicidal thoughts and violent deaths (e.g. Forsyth v. Eli Lilly 1984, in O'Meara 2001). Strangely, these side effects resemble some of the symptoms of PMDD itself. O'Meara (2001) reported that many women do not know that Sarafem is really Prozac, and if they knew, they might choose not to take the powerful, mind-altering drug. Rather, women are told that the pills would turn her back to the calm and contained person that she really is. Indeed, Eli Lilly's advertisement slogan for Safafem "Be more like the woman you are" (Chrisler & Caplan 2002: 295) depicts the gender ideology that is encompassed in the professional literature on PMDD. A 'good' woman according to the diagnostic criteria for PMDD is one who is calm, kind,

nurturing of others, always in control, and does not experience any fluctuations in mood and behaviour. Within the PMDD definition, if a woman deviates from these stereotypical feminine role by becoming angry, violent, or improperly behaved, she is deemed mad. Women who are described as angry and aggressive are labelled as mentally disordered for behaving in a way that is perfectly acceptable in a man (Jimenez 1997). Ussher (2003) argues that women are in a no-win situation. If she displays a range of feminized psychological changes premenstrually, primarily anxiety, tearfulness, and depression, she can be diagnosed with PMDD - as can woman who contravenes the idealized femininity through 'symptoms' of anger and irritability.

3.7.5 Summary of Research Findings

The analysis revealed that since the 1930s, the construction of premenstrual changes has been negative. The literature employed a biomedical approach in explaining and treating premenstrual distress. The use of the biomedical approach has helped in the process of conceptualising and constructing premenstrual distress as a serious psychiatric disorder. Three connected 'truths' produced and disseminated by psychiatrists and psychologists have helped to reify PMDD as a pathological problem. The first of these 'truths' proposes that: "PMDD is an identifiable condition that can be objectively defined". The search for premenstrual symptomatology, the deliberation over the precise diagnostic criteria, and the introduction of standardised questionnaires has helped in the conceptualization of PMDD as a distinct psychiatric disorder. Additionally, the focus on the emotional aspects rather than the physical changes of premenstrual experiences also helped to conceptualise premenstrual distress as a psychiatric problem. The second of these 'truths' proposes that: "PMDD is an individual phenomena that can be treated using medical interventions". The production of hormonal theories and the practice of medical interventions written in the psychiatric and psychological literature have helped to conceptualize PMDD as an individual phenomenon. Additionally, the lack of attention to social, structural, and political factors also contributed to a medical construction of PMDD (Markens 1996). The third 'truth' proposes that: "women with PMDD experience incapacitating symptoms". The symptoms include irritability, depression, lethargy,

and anger and exclude any positive changes. The literature has constructed PMDD as a disabling illness that can diminish women's quality of life and impair their ability to function at work and in relationships.

Using Foucault's ideas of knowledge, I sought to find out how these constructions and the concept of PMDD per se has been rendered intelligible. The present study found that the discourses of science, medicine, and biomedicine have been heavily used in the psychiatric and psychological literature on PMDD. The use of these discourses and the references to medical, physical, mental and bodily events has helped to construct premenstrual distress as a real psychiatric disorder. Additionally, medical and scientific language used to produce the three 'truths' has also helped to construct PMDD as a psychiatric disorder. According to Foucault, powerful groups create ideologies and distort truth. The present study found that scientific researchers, clinicians, doctors, physicians, psychiatrists and psychologists have all played a role in defining premenstrual distress as an illness. A Foucauldian analysis would argue that the professional construction of premenstrual distress as an illness is a distorted version of premenstrual experiences that society has accepted as truth. It has been accepted as the truth because the literature has drawn heavily on medical and scientific discourses, which in Western culture have the power to shape our view of human distress.

I then sought to find out the discursive and regulatory practices that warrant the constructions of premenstrual changes as a psychiatric disorder. I was interested in finding out how women come to perceive premenstrual changes as a psychiatric disorder. The study found that the 'truths' about premenstrual distress provided by the psychiatry and psychology professions are not just academic. The public renders the judgments made by psychology and psychiatry about people as truthful to the extent that individuals come to utilize these judgments to themselves. The present study illustrates that the knowledge and 'truths' circulated by the psychiatry and psychology has been a crucial rhetorical device in establishing PMDD as a psychiatric phenomenon. These 'truths' have, through the process subjectification, being incorporated by women who come to label themselves with PMDD. Ussher (2003) suggests that positioning PMDD as a 'thing' performs a regulatory function in women's lives; it allows women to

pathologize and split off emotions and behaviours that typically do not conform to the ideal woman standard and maintain her sense of femininity. However, accepting the diagnosis or being diagnosed does not always have a positive function. Rather, being diagnosed with PMDD, which is constructed as a mental disorder, can have wider consequences for women. The diagnosis of PMDD can legitimize the examination, diagnosis, and treatment of women who are deemed to suffer from PMDD. Once assigned to the category of being mentally ill, she may be seen as dependent, diminished in thought, irrational, unstable, unpredictable and dangerous. The identities can be used to 'legitimize explicit forms of psychiatric control' (Roberts 2005: 39), such as enforced admission to a mental health hospital or treatment with psychiatric drugs that have numerous side effects. Being diagnosed with PMDD may impact women and their lives in relation to the potential effects on relationships, employment, child custody, and on women's subjective experiences of herself (Caplan et al., 1992). It may also impact how people perceive her and her complaints. On one hand, her family, friends, colleagues, employers and prospective employers may deem her as psychologically abnormal (Caplan et al., 1992) and on the other hand, the PMDD label may invalidate her complaints, which are thought of a manifestation of her dysfunctional biology rather than influenced by relational, social, cultural and structural factors.

In considering all of the research questions, this study found that so far most 'psy' research effort has focused on negative changes and failed to consider premenstrual changes in a more multifaceted way. The research generally lacked in explanations of premenstrual experiences from a non-biomedical framework. The literature focused primarily on negative emotional mood symptoms (e.g. depression and irritability) and failed to consider physical experiences (e.g. breast tenderness, dysmenorrhea, and headaches) which women report around menstruation. Moreover, the literature only reported on negative premenstrual changes rather than positive ones. King and Ussher (2012) found that many women experience a variety of positive changes including feeling happy, energetic, increased attractiveness, release of tension, and better social and relational functioning. This stands in direct contrast to the accounts of premenstrual distress that was found in the analysis. Rather than viewing

premenstrual changes as fluid and not inherently negative or positive, the mainstream literature and standardized questionnaires have constructed a negative portrayal of premenstrual experiences. Chrisler et al., (1994) found that when women completed the Menstrual Joy Questionnaire (Delaney et al., 1987) more positive accounts of premenstrual change were reported than when they completed the Menstrual Distress Questionnaire (Moos 1968). This finding illustrates that a variety of premenstrual changes that could be experienced by women and what women report in studies may depend on the type of questions the researcher asks and the type of experiences the researcher seeks to measure.

In considering the research questions, I draw on to the statement that human knowledge, experience and perception are bound by time and culture, and are mediated historically, culturally and linguistically (Gergen 1985; Burr 2003). This statement applies to the knowledge, experience and perception of PMDD. Saying PMDD is socially constructed does not mean that women are imagining what they feel. Many feminists are aware that premenstrual symptomatology does exist, as testified by the high percentage of women who seek treatment, but argue that it does not have to be classified as a psychiatric syndrome or as a pathological disorder (Ussher 1989, 2003). Nash and Chrisler (1997) suggest that the association of premenstrual changes with an official psychiatric diagnosis increases people's tendency to view the premenstrual phase as problematic. This increased tendency to view premenstrual changes as problematic will not benefit women; rather it will bolster psychiatry's profession as a medical specialty and make serious money for pharmaceutical companies. For all of these reasons, it is recommended that the presence of PMDD in the DSM 5 should be reconsidered. We must recognise that the way we construct menstruation or menstrual cycle experiences has effect on the way we view women and the way we treat them. Indeed, as we have seen, PMDD taps into powerful cultural ideas about what it means to be a woman and what is considered feminine. There is an urgent need for change in our beliefs about menstruation and premenstrual experiences. In the case of premenstrual distress, a disorder per se has not been identified. The only thing we can be certain of is that some women do experience severe premenstrual distress. In that case, it is necessary that we understand those

experiences through a framework that incorporates broader social, economic and political contexts because evidence suggests that relational, social, economic, cultural and structural factors can contribute to, cause or exacerbate, the premenstrual physiological and emotional experiences such as stress, anger, and fatigue (e.g. Ussher & Perz 2008; Markens 1996). Additionally, women who experience distressing premenstrual changes are likely to benefit from support that does involve antidepressants, but rather modifications in social and institutional settings.

CHAPTER FOUR: SUMMARY, EVALUATION AND IMPLICATION

In this section, I will discuss my findings in relation to the initial aims of the research. I will also summarize the findings that emerged from answering the research questions. The research study will also be evaluated and recommendations for practice and future research will follow.

4.1. Research Questions

The primary aim of the project was to examine how psychiatric and psychological literature has constructed premenstrual changes and how the concept of PMDD developed. This study was warranted by the lack of evidence and justification for medicalising premenstrual experiences in the DSM. The rationale for the research was to find out how this particular aspect of the menstrual cycle became medicalized. To do this, I traced the development of the concept of PMDD throughout the psychiatric and psychological literature. In doing so, four research questions were articulated in this study:

- How do psychological and psychiatric literatures construct premenstrual changes?’
- Under what circumstances are women’s premenstrual changes rendered problematic and what professional discourses render these problems intelligible?
- What discursive and regulatory practices warrant the constructions of premenstrual changes as a psychiatric disorder?
- What subject positions are enabled and what are the implications for action of these subject positions?

The main research aim and question has been addressed through the presentation of three inter-related constructions/’truths’. Three ‘truths’ produced and disseminated by psychiatrists and psychologists have helped to reify PMDD as a psychiatric problem. The first of these ‘truths’ proposes that: “PMDD is an identifiable condition that can be objectively defined”. The second proposes that:

“PMDD is an individual phenomenon that can be treated using medical interventions”. The third proposes that: “women with PMDD experience incapacitating symptoms”. The literature has constructed PMDD as a disabling illness that can diminish women’s quality of life and impair their ability to function at work and in relationships. The second research question found that these constructions or ‘truths’ have been rendered intelligible because the discourses of science, medicine, and biomedicine have been used in the psychiatric and psychological literature. In Western cultures, medical and scientific discourses have the power to shape our understanding of human distress. The study found that scientists, doctors, physicians, psychiatrists and psychologists have played a role in defining premenstrual distress as an illness. These professionals have the ‘intellectual’ power to define human distress and their definitions have the power to become accepted as the ‘truth’, particularly if they use language derived from science and medicine. The study found that the ‘truths’ circulated by the psychiatry and psychology was a crucial rhetorical device in establishing PMDD as a psychiatric phenomenon. Women who come to label themselves with PMDD have also through the process subjectification, incorporated these ‘truths’. Ussher (2003) suggests that positioning PMDD as a ‘thing’ performs a regulatory function in women’s lives; it allows women to pathologize and split off emotions and behaviours that typically do not conform to the ideal woman standard and thus maintain her sense of femininity. However, being diagnosed with a mental disorder (i.e. PMDD) can have wider consequences for women. The diagnosis of PMDD can legitimize the examination, diagnosis, and treatment of women who are deemed to suffer from PMDD. Once assigned to the category of being mentally ill, she may be seen as dependent, diminished in thought, irrational, unstable, unpredictable and dangerous. Being diagnosed with PMDD may impact women and their lives in relation to the potential effects on employment, child custody, family relationships, and women’s subjective experiences of herself. It may also impact how people perceive her and her complaints.

The study found that so far most ‘psy’ research effort has focused on negative premenstrual changes. The research focused primarily on negative mood symptoms (e.g. depression and irritability) and failed to consider physical

experiences (e.g. breast tenderness, dysmenorrhea, and headaches) and positive premenstrual changes. The positive premenstrual experiences can stand in direct contrast to the dominant accounts of premenstrual distress reported throughout the psychiatric and psychological literature. This suggests that the history of premenstrual experiences reported in the mainstream literature is not linear, does not show progression since numerous aspects of premenstrual experiences have escaped and been 'excluded' from the main accounts. The literature on premenstrual experiences could have taken various roots if constructions other than the negative experiences were considered. For example, what is undocumented in the literature is that the scientific study of menstruation and the effects of menstruation on women's mood and behaviour emerged during the latter part of nineteenth century, at a time when women were demanding for access to higher education and professions. Menstruation then became a liability. This means the present concept of PMDD is bound to this historical time and culture; PMDD is not the 'truth' rather the concept is grounded in a historical tradition of problematizing menstruation. If this tradition continues, the inclusion of PMDD in DSM 5 may devalue women and result in individual shame, discrimination, marginalization, and stigmatization of women. This study recommends that the category of PMDD should be excluded from DSM 5.

4. 2 Evaluation and Critical Review

4.2.1 Limitations of Methodological Approaches Used

The epistemological position I adopted in this research was informed by critical realism and material discursive approaches. A Foucauldian Discourse Analysis (FDA) and a Foucauldian genealogical approach were undertaken. These types of methodologies have not been used to understand the constructions of premenstrual distress in the context of DSM. A genealogical approach and FDA was considered the most suitable method for exploring how premenstrual changes have been constructed, how the concept of PMDD emerged and how it impacts practices, subject positions and subjectivity. However, these methodologies are not without criticisms.

A general criticism of qualitative research is that this type of methodology does not provide the researcher with certainty or predictability (Willig 2008). It cannot, as opposed to studies taking a positivist epistemology, make prediction of cause and effect or declare the findings with certainty. The current research involved the negotiation of meanings and interpretations made by the researcher, and since the researcher's objectivity is an ideal rather than a reality, alternative interpretations of the data are always possible (Willig 2008). FDA has been criticized for being inconsistently applied and involving a certain amount of interpretation and understanding on the part of the researcher (Willig 2008). Similar criticisms could be made towards a genealogy methodology. I recognize that if another researcher was to read and analyze the same data I had read and analyzed, their analysis (or interpretation) could have been different to mine. I recognize that the analysis has been influenced by my own subject position (Willig 2008). My subject position has been influenced by feminists' approaches and by my own experiences of premenstrual changes.

A specific criticism of FDA, pointed out by Willig (2008), is that this methodology lacks a theory of how individuals can take up or resist particular subject position. There are some who argue that the mere availability of subject positions in discourse cannot account for the emotional investment individuals make in particular discursive positions and their attachment to those positions (Willig 2008). Moreover, discourse analysis does not clarify the way in which social and material reality in turn may impact upon the discourse (Willig 2008). If discourse does, indeed, construct reality, then to what extent can 'reality' be said to constrain discourse? (Willig 2008) And can we conceive reality as something separate from, or outside of, discourse? The relation between discourse and material reality is a complex one and discourse analysts cannot fully resolve this difficulty (Willig 2008).

In general, Foucauldian analysis (and indeed other social constructionist approaches) can be criticized because their focus on language can lead to relativism (if everything is text how can any judgments be made of one version against another?) and an inability to address the real and material consequences. Pilgrim (2013) has criticized constructionist approaches for taking a purely

relativist standpoint and for neglecting the contexts that can lead to emotional difficulties. Pilgrim (2013: 158) suggests that 'misery is not socially constructed by-products of psychiatric discursive practices', rather, the meanings people ascribe to their problem and the actual events in people's everyday lives such as losses, insults and future threats might be relevant to the expression and understanding of 'misery'. Similarly, Sims-Schouten, Riley and Willig (2007: 102) have also criticized discourse analysis for prioritizing discourse over materiality and for marginalizing any experiences that are 'out of the realm of language' i.e. embodied premenstrual experiences. According to Sims-Schouten, Riley and Willig (2007: 118) language does not solely and independently constitute our world; rather 'constructions and understandings of the world are formed and shaped by extra-discursive factors'. In line with this, I understand that the over emphasis on semantics can be seen as a problem with FDA (and other constructionist approaches). However, I have drawn on feminist/materialist approaches in an attempt to circumvent these limitations and redress this balance. The feminist/materialist approaches have allowed me to offer a social critique rather than simply examine the constitutive role of language. Taking a feminist/materialistic approach also made it possible for me to engage with the material impact premenstrual distress can have on women. In the analysis, I have attempted to identify how certain discourses have turned premenstrual changes into an object that can be classified, explained, and acted upon. I also attempted to highlight the communicative features inherent in the texts by bringing forth the subject positions of those who are diagnosed with PMS or categorize themselves as PMS sufferer. This interpersonal meaning is focused on the doing in language and not merely on the semantics or contents.

4.2.2 Research Process

All procedures for data selection and analysis were followed as stated in the methodology sections. The data was chosen rigorously and recommended guidelines for FDA (e.g. Willig 2008) were followed. See Appendix 3 for Analytic Steps.

4.2.3 Reflexivity

Willig (2008) highlighted the importance of researcher reflexivity in good qualitative research. This refers to an examination of how researcher's own assumptions and biases might influence the research procedures and interpretation of the findings. Harper (2003) proposes that to maintain a reflexive position, researchers should draw attention to and continuously review their role in their research process. Through supervision and keeping a reflective journal, I was able to give attention to how my personal, professional, historical and cultural context had influenced my analysis and understandings. There are various contexts that initially influenced my decision to focus on menstruation as a topic for research. I felt that being a woman experiencing variable and fluid premenstrual changes made it easier for me to be critical of the data and of the medicalization of premenstrual experiences. I did not have favourable attitudes towards psychiatric understandings of premenstrual experiences. My beliefs were influenced by my embodied experiences, by my professional background grounded in critical clinical psychology and feminist approaches, and by my upbringing. The menstrual taboo is deeply embedded within my culture and religion. In Islam, during menstruation, women are forbidden to practice in certain religious obligations such as worshipping in mosques, praying five times a day, fasting in the month of Ramadan and reading the Quran. I felt these practices to be silencing and isolating.

Upon reflection, I feel that the analysis of the data focused more on doing a Foucauldian discourse analysis rather than a genealogy. I struggled to bring together the genealogy and the discourse analysis aspects of the data analysis. This struggle may have emerged because my understanding of how to carry out a genealogical analysis was limited. As mentioned in the methodology section, Foucault did not set out a procedure of specific techniques for carrying out genealogical analysis, rather he insisted on not following any specific methodology to do a genealogy. Restricted by this, I read a few articles that attempted to make the genealogical method usable. However this did not raise my confidence about how I could go about doing a genealogy. From the reading, I understood that a genealogy is a methodology that examines the history of the

present. With this understanding, I started to look for social and political events that were occurring at the same time the papers on PMS were being published, with a particular focus on the events surrounding the DSM editions. In the analysis, I attempted to highlight that the concept of PMS/PMDD emerged out of certain social and political agendas rather than it being 'discovered' at some point in history as a real medical or psychiatric condition. I also explored some of the discursive and non-discursive practices that have influenced our present knowledge of premenstrual changes.

4.2.4 Contributing in Advancing Wider Knowledge

I argue that the constructions presented in relation to women's premenstrual experiences shed light on the way women's premenstrual experiences, which are hugely variable from one woman to another and not entirely fixed for an individual woman, have been pathologised as a result of institutional practices, namely psychology and psychiatry. The study contributes to wider knowledge by illustrating that the biomedical theory is limited in its approach because it cannot explain the full range of premenstrual changes that women experience. This study offers a critique of the inclusion of PMDD in the DSM on the grounds that the 'truths' circulated by the psychiatry and psychology was not based on scientific evidence, rather numerous rhetorical devices were used to establish PMDD as a psychiatric phenomenon. This adds to wider knowledge by illustrating that the medicalisation of premenstrual changes within the DSM is not warranted and therefore the category of PMDD should be eliminated.

4.3 Recommendations for Clinical Practice

1. The category of 'Premenstrual Dysphoric Disorder' should not be included in DSM 5 (APA, in press) due for publication in May 2013. The study did not find support for the inclusion.
2. Awareness of menstruation and the premenstrual phase as a biopsychosocial process should be increased among professionals who

work with women complaining of premenstrual distress. This approach enables one to understand that menstrual cycle is a normal process that both affects and is affected by mood and behaviour. This means every woman will experience menstruation differently.

3. Professionals working in service areas where women may present with premenstrual distress should be aware that these women may have other outstanding concerns such as relationship or work difficulties that may be exacerbating their premenstrual distress. Appropriate help should be given to these women whose premenstrual experience is affected by structural, material, social and cultural factors.
4. In working with women complaining of premenstrual distress, clinical psychologists should be aware of alternative frameworks (see Ussher 2003) that position premenstrual distress as a normal part of women's experience. Alternative frameworks such as Eastern approaches and Narrative therapy can acknowledge pain and distress in a non-pathological way and find creative solutions for positive change in their lives. Clinical psychology may also benefit from using interventions that are used by feminist approaches. These approaches can help women to resist labeling themselves as ill and exploring how cultural constructions of femininity can impact upon women's premenstrual experience.
5. Clinical psychologists need to develop full understanding of gender and power as well as the social, cultural, and economic circumstances of women lives and understand how these factors lead to emotional distress. Clinical psychologists will need to use this knowledge to provide appropriate support to women.
6. On a community level, the attitudes of menstruation needs shifting otherwise negative stereotypes will persist and women will continue to be medicalized. Clinical training and educational programs should focus on educating women and men about the menstrual cycle from a biopsychosocial context.

7. On a public level, feminist self-help texts, web based information, magazines, and books should be composed and disseminated into the mainstream popular culture. These texts will need to highlight that premenstrual distress is more than just a women's physical or mental health issue because it taps into powerful cultural ideas about what it means to be a woman.

4.4 Recommendations for Further Research

1. What are women's experiences of premenstrual distress/change? The voices of women who attend clinics or seek help for premenstrual distress remain largely undocumented in the psychiatric and psychological literature. Further research should explore how women view, make sense of and cope with premenstrual distress/changes.
2. Research on non-Western women and diverse ethnicities has been severely limited. Further research should attempt to address this imbalance through exploring how women from a variety of cultures understand and experience premenstrual changes. This might provide different findings.
3. Previous research studies have reported that negative premenstrual experiences can impair a women's ability to function at work and in her social life. Women's views on this have been neglected in the research. Research should attempt to address this gap in the literature through exploring the effects of premenstrual experiences on women's work, social and family life, how it impacts those areas and what women do to cope. This may reveal that changes in home and work environments i.e. working patterns and reducing demands of everyday tasks, may help women cope better with premenstrual changes or experience different premenstrual changes altogether.

4. Psychiatric and psychological research studies have predominantly focused on negative premenstrual change and failed to examine positive premenstrual experiences. Future research should address this imbalance by studying positive premenstrual changes as this may offer different findings.
5. Psychiatric and psychological research studies have predominantly focused on emotional changes and failed to consider physical experiences (e.g. breast tenderness, dysmenorrhea, and headaches) which women report around menstruation. Further research should explore how physical changes and emotional changes interact with one another.

REFERENCES

American Psychiatric Association. (1952). *Diagnostic manual of statistical mental disorders*. Washington, DC: Author.

American Psychiatric Association. (1968). *Diagnostic manual of statistical mental disorders* (2nd Ed.). Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic manual of statistical mental disorders* (3rd Ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic manual of statistical mental disorders* (3rd Ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic manual of statistical mental disorders* (4th Ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic manual of statistical mental disorders*. Retrieved from www.dsm5.org in September 2011.

Backstrom, T. & Mattson, B. (1975) Correlation of symptoms in premenstrual tension to oestrogen and progesterone concentration in blood plasma. *Neuropsychobiology*, 1, 80-86.

Bannbers, E., Gingnell, M., Engman, J., Morell, A., Comasco, E., Kask, K., Garavan, H., Wikstrom, J., & Sundstrom, I. P. (2012). The effect of premenstrual dysphoric disorder and menstrual cycle phase on brain activity during response inhibition. *Journal of Affective Disorder*, 142, 347-350.

Batra, N. A., Seres-Mailo, J., Hanstock, C., Seres, P., Khudabux, J., Bellavance, F., Baker, G., Allen, P., Tibbo, P., Hui, E., Le., & Melledo, J. M. (2008). Proton magnetic resonance spectroscopy measurement of brain glutamate levels in premenstrual dysphoric disorder. *Biological Psychiatry*, 63, 1178-1184.

Benedek, T., & Rubenstein, B. B. (1939). The correlation between ovarian activity and psycho-dynamic processes II. The menstrual phase. *Psychosomatic Medicine*, 1, 245-270.

Bentall, R. (2003). *Madness Explained*. London: Penguin.

Berman, S. M., London, E. D., Morgan, M., & Rapkin, A. J. (2012). Elevated gray matter volume of the emotional cerebellum in women with premenstrual dysphoric disorder. *Journal of Affective Disorder*, 146, 266-271.

Bloch, M., Schmidt, P. J., Su, T. T., Tobin, M. B., & Rubinow, D. R. (1998). Pituitary-adrenal hormones & testosterone across the menstrual cycle in women with premenstrual syndrome and controls. *Biological Psychiatry*, 43, 897–903.

Bloch, M., Schmidt, P. J., & Rubinow, D. R. (1997). Premenstrual syndrome: evidence for symptom stability across cycles. *The American Journal of Psychiatry*, 154, 1741-1746.

Borenstein, J. E., Dean, B. B., & Endicott, J. (2003). Health and economic impact of the premenstrual syndrome. *Journal of Reproductive Medicine*, 48, 515-24.

Boyle, M. (2002). *Schizophrenia: a scientific delusion*. (2nd Ed). London: Routledge.

Bracken, P., & Thomas, P. (2010). From Szasz to Foucault: On the role of Critical Psychiatry. *Philosophy, Psychiatry & Psychology*, 17, 210-228.

Burr, V. (1995). *An Introduction to Social Constructionism*. London: Routledge.

Burr, V. (2003). *Social Constructionism*. (2nd Ed). London: Routledge.

Calhoun, K. S., & Burnette, M. M. (1984). Etiology and treatment of menstrual disorders. *Behavioural Medicine Update*, 5, 21-6.

Caplan, P. (1987). *The myth of women's masochism*: Penguin Group Incorporated.

Caplan, P. (1991). How do they decide who is normal? The bizarre, but true, tale of the DSM process. *Canadian Psychology*, 32, 162-170.

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

Caplan, P., McCurdy-Myers, J., & Gans, M. (1992). Should "Premenstrual Syndrome" be called a psychiatric abnormality? *Feminism & Psychology*, 2, 27-44.

Cole, J. H. (1992). *Women Pilots of World War II*: University of Utah Press.

Chawla, A., Swindle, R., & Long, S. (2002). Premenstrual dysphoric disorder: Is there an economic burden of illness? *Medical Care*, 40, 1101-12.

Cline, W. A. (1946). Etiology of premenstrual tension and the rationale of its treatment. *Journal . Bowman Gray School of Medicine*, 4, 137-140.

Carroll, B.J., & Steiner, M. (1978). The psychobiology of premenstrual dysphoria: the role of prolactin. *Psychoneuroendocrinology*. 3, 171-180.

Chang, A. M., Holroyd, E. & Chau, J. P. (1995). Premenstrual syndrome in employed Chinese women in Hong Kong. *Health Care for Women International*, 16, 551-561.

Chrisler, J. C. (2001). How to regain your control and balance: The "pop" approach to PMS. *Paper presented at the meeting of the Mid-Atlantic Popular Culture Association*, Wilmington, DE, November.

Chrisler, J. C. (2013). Teaching Taboo Topics: Menstruation, Menopause, and the Psychology of Women. *Psychology of Women Quarterly*, 37, 128-132.

Chrisler, J. C., & Caplan, P. (2002). The strange case of Dr. Jekyll and Ms. Hyde: How PMS became a cultural phenomenon and a psychiatric disorder. *Annual Review of Sex Research*, 75, 272-306.

Chrisler, J. C., & Johnston-Robledo, I. K. (2002). Raging Hormones? Feminist perspectives on premenstrual syndrome and postpartum depression. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp.174-179). New York: Guildford.

Chrisler J. C, Johnston-Robledo. I. K, Champagne, N. M., & Preston. K. E. (1994). Menstrual joy: The construct and its consequences. *Psychology of Women Quarterly*, 18, 375–387.

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

Cook, W. R. (1945). The differential psychology of the American women. *American Journal of Obstetrics Gynecology*, 49, 457.

Cosgrove, L. & Wheeler, E. E. (2013). Industry's colonization of psychiatry: ethical and practical implications of financial conflict of interest in the DSM-5. *Feminism & Psychology*, 23, 93-106.

Cunningham, J., Yonkers, K., O'Brien, S., & Eriksson, E. (2009). Update on research and treatment of premenstrual dysphoric disorder. *Harvard Review of Psychiatry*, 17, 120-137.

Dalton, K. (1959). Menstruation and acute psychiatric illnesses. *British Medical Journal*, 1, 148-149.

Dalton, K. (1960). Menstruation and accidents. *British Medical Journal*, 2, 1425-1426.

Dalton, K. (1960b). Effects of menstruation on school girls weekly work. *British Medical Journal*, 1, 326-328.

Dalton, K. (1961). Menstruation and crime. *British Medical Journal*, 2, 1752-1753.

Dalton, K., & Greene, R. (1953). The premenstrual syndrome. *British Medical Journal*, 1, 1007-1014.

Delaney, J. Lupton, M., & Toth, E. (1987). *The curse: A cultural history of menstruation*. Urbana, I.L: University of Illinois Press.

Edwards, D., & Potter, J., (1992) *Discursive Psychology*. London: Sage

Ehlers, C. L., Phillips, E., & Parry, B. L. (1996). Electrophysiological findings during the menstrual cycle in women with and without late luteal phase dysphoric disorder: relationship to risk for alcoholism. *Biological Psychiatry*, 39, 720-732.

Ehrenreich, B., & English, D. (1974). *For Her Own Good: Two Centuries of the Experts' Advice to Women*. New York, NY: Random House.

Endicott, J., & Halbreich, U. (1998). Clinical significance of premenstrual dysphoric changes. *Journal of Clinical Psychiatry*, 49, 486-489.

Endicott, J., Amsterdam, J., Eriksson, E., Frank, E., Freeman, E., Hirschfeld, R., Ling, F., Parry, B., Pearlstein, T., Rosenbaum, J., Rubinow, D., Schmidt, P., Severino, S., Steiner, M., Stewart, D.E., & Thys-Jacobs, S. (1999). Is premenstrual dysphoric disorder a distinct clinical entity? *Journal of Women's Health Gender-Based Medicine*, 8, 663-679.

Epperson, C. N., Steiner, M., Hartlage, S. A., Eriksson, E., Schmidt, P. J., Jones, I., & Yonkers, K. A. (2012). Premenstrual dysphoric disorder: evidence for a new category for DSM-5. *American Journal of Psychiatry*, 169, 465-75.

Epstein, M. (1995). *Thoughts without a Thinker: Psychotherapy from a Buddhist Perspective*. New York: Basic Books Inc.

Figert, A. E. (1996). *Women and the Ownership of PMS*. New York: Walter de Gruyter, Inc.

Figert, A. E. (2005). Premenstrual Syndrome as Scientific and Cultural Artifact. *Integrative Physiological & Behavioural Science*, 40, 102-113.

Foucault, M. (1977). *Discipline and Punishment*. London: Tavistock.

Foucault, M. (1977). Nietzsche, Genealogy, History. In *Language, Counter-Memory, Practice: Selected Essays and Interviews*, edited by D. F. Bouchard. Ithaca: Cornell University Press, pp. 139-64.

Foucault, M. (1979). *The History of Sexuality Volume 1: An Introduction*. Robert Hurley (translator). London: Allen Lane.

Foucault, M. (1982). The subject and power. In Dreyfus H.L & Rabinow, P (Eds.) *Michel Foucault: Beyond Structuralism and Hermeneutics*: 202-226. New York: Harvester Wheatsheaf.

Foucault, M. (1984). Nietzsche, Genealogy, History' in Rabinow, P. (ed.) *The Foucault Reader*, Harmondsworth: Peregrine, pp.76-100.

Frank, R. (1931). The hormonal causes of premenstrual tension. *Archives Neurological Psychiatry*. 26, 1053- 1057.

Frank, R. (1940). Puberty, menstruation, pregnancy. *Bulletin of the New York Academy of Medicine*, 16, 83-97.

Gallant, S. J., & Hamilton, J. A. (1988). On a premenstrual psychiatric diagnosis: What's in a name? *Professional Psychology: Research and Practice*, 19, 271–278.

Gehlert, S., Song, I. H., Chang, C. H., & Hartlage, S. A. (2009). The prevalence of premenstrual dysphoric disorder in a randomly selected group of urban and rural women. *Psychological Medicine*, 39, 129-136.

Gergen, K. L. (1985). The Social Constructionist Movement in Modern Psychology. *American Psychologist*, 40, 266-275.

Girdler, S. S., Pedersen, C. A., Straneca, P. A., Leserman, J., Stanwyck, C. L., Benjamin, S., & Light, K. C. (1998). Dysregulation of cardiovascular and neuroendocrine responses to stress in PMDD. *Psychiatry Research*, 81, 163-178.

Golding, J. M., & Taylor, D. L. (1996). Sexual Assault History and Premenstrual Distress in Two General Population Samples. *Journal of Women's Health*, 5, 143-152.

Golub, S. (1976). The effect of premenstrual anxiety and depression on cognitive function. *Journal of Personality and Social Psychology*, 34, 99-104.

Golub, S. (1976). The magnitude of premenstrual anxiety and depression. *Psychosomatic Medicine*, 38, 4-12.

Goodman, E. (1986). Cursed and pre-cursed. *The Washington Post*, May 24: A43.

Greenblatt, R. B., Mortara, F., & Torpin. (1942). Sexual libido in the female. *American Journal of Obstetrics and Gynecology*, 44, 658-663.

Greene, R., & Dalton, K. (1953). The premenstrual syndrome. *British Medical Journal*, I, 1007-1014.

Greene, R., & Dalton, K. (1954). Discussion on the premenstrual syndrome. *Royal Society of Medicine*, 48, 337-347.

Halbreich, U. (1996). Premenstrual syndromes. In *Psychiatric Issues in Women (Clinical Psychiatry Series)*, ed. U. Halbreich, pp, 667-86. London: Bailliere's.

Halbreich, U., & Endicott, J. (1985). Relationship of dysphoric premenstrual changes to depressive disorders. *Acta Psychiatrica Scandinavica*, 71, 331- 333.

Hardie, E. A. (1997). Prevalence and predictors of cyclic and noncyclic affective change. *Psychology of Women Quarterly*, 21, 299-314.

Harper, D.J. (2003). Developing a critically reflexive position using discourse analysis. In Finlay, L., & Gough, B. (eds.). *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences* (pp. 78-91). Oxford: Blackwell Science.

Harper, D. J. (2011). Choosing a Qualitative Research Method. In Harper, D., & Thompson, A.R. (eds.). *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (pp. 83-97). Chichester: Wiley-Blackwell.

Hartlage, S.A., Freels, S., Gotman, N., & Yonkers, K. (2012). Criteria for premenstrual dysphoric disorder: secondary analyses of relevant data sets. *Archives of General Psychiatry*. 69, 300-305.

Haskett, R. F. & Abplanalp, J. M. (1983). Premenstrual tension syndrome: Diagnostic criteria and selection of research subjects. *Psychiatry Research*, 9, 125-138.

Heinemann, L. A. J., Minh, T. D., Filonenko, A., & Uhi-Hochgraber, K. (2010). Explorative Evaluation of the Impact of Severe Premenstrual Disorders on Work Absenteeism, and Productivity. *Women's Health Issues*, 20, 58-65.

Heimer, K., & DeCoster, S. (1999). The gendering of violent delinquency. *Criminology*, 37, 277-317.

Holtz, R. (1941). Should women fly during the menstrual period? *Journal of Aviation Medicine*, 12, 300-303.

Hong, J.P., Park, S., Wang, H-R., Chang, S. M., Sohn, J. H., Jeon, H. J., Lee, H. W., Cho, S. J., Kim, B. S., Bae, J. N., & Cho, M. J. (2012). Prevalence, correlates, comorbidities, and suicidal tendencies of premenstrual dysphoric disorder in a nationwide sample of Korean women. *Social Psychiatry and Psychiatric Epidemiology*, 47, 1937-1945.

Hurt, S. W., Schnurr, P. P., Sverino, S. K., Freeman, E. W., Gise, L. H., Rivera-Tovar, A., & Steege, J. F. (1992). Late Luteal Phase Dysphoric Disorder in 670 women evaluated for premenstrual complaints. *American Journal of Psychiatry*, 149, 525-530.

Janowsky, D. S., Berens, S. C., & Davis, J. M. (1973). Correlations between mood, weight & electrolytes during the menstrual cycle: a renin-angiotensin-aldosterone hypothesis of premenstrual tension. *Psychosomatic Medicine*, 25, 143-154.

Jimenez, M. A. (1997). Gender and psychiatry: Psychiatric conceptions of mental disorders in women. *Affilia*, 12, 154–175.

Johnson, G. B. (1932). The effects of periodicity on learning to walk a tight-wire. *Journal of Comparative Psychology*, 13, 133-141.

Kelly, M. (1994). *Critique and Power: Recasting the Foucault/Habermas debate*. London: MIT Press.

King, M. & Ussher, J. (2012). It's not all bad: women's construction and lived experience of positive premenstrual change. *Feminism & Psychology*, Published online March 22 2012. doi:10.1177/0959353512440351.

- Knaapen, L., & Weisz, G. (2008). The biomedical standardization of premenstrual syndrome. *Studies in History and Philosophy of Biological and Biomedical Sciences*, 39, 120-134.
- Kutchins, H., & Kirk, S. A. (1989). DSM-III-R: The conflict over New Psychiatric Diagnosis. *Health and Social Work*, 34, 91-103.
- Kutchins, H., & Kirk, S. A., (1997). *Making us crazy: DSM-the psychiatric bible and the creation of mental disorders*. London: Constable and Company.
- Lafrance, M. N. (2007). A bitter pill: A discursive analysis of women's medicalized accounts of depression. *Journal of Health Psychology*, 12, 127-140.
- Lafrance, M.N. & McKenzie-Mohr, S. (2013). The DSM and its lure of legitimacy. *Feminism and Psychology*, 23, 119 – 140.
- Laws, S., Hey, V., & Eagan, A. (1985). *Seeing red: The politics of premenstrual tension*. London: Hutchinson.
- Lee, S. (2002). Health and sickness: The meaning of menstruation and premenstrual syndrome in women's lives. *Sex Roles*, 46, 25–35.
- Lough, O. M. (1937). A psychological study of functional periodicity. *Journal of Comparative Psychology*, 24, 359-368.
- Morton J. H., Addison H., Addison R. G., Hunt I. & Sullivan J. J. (1953). A clinical study of premenstrual tension. *American Journal of Obstetrics. Gynecology*, 65, 1182-1191.
- Malson, H. (1998). *The Thin Woman: feminism, post-structuralism and the social psychology of anorexia nervosa*. New York: London: Routledge.
- Markens, S. (1996). The problematic of 'experience': A political and cultural critique of PMS. *Gender and Society*, 10, 42–58.

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

McFarlane, K. M. & Williams, T. M. (1994). Placing Premenstrual Syndrome in Perspective. *Psychology of Women Quarterly*, 18, 339-373.

Moos R. H. (1968). The development of a menstrual distress questionnaire. *Psychosomatic Medicine* 30, 853–867.

Morgan, M. Rapkin, A. J., d'Ella, L., Reading, A., & Goldman, J., (1996). Cognitive functioning in premenstrual syndrome. *Obstetrics and Gynecology*, 88, 961-966.

Mitchell, L. L., & Mitchell, C. W. (1998). Effects of premenstrual syndrome on coping style. *Psychology: A Journal of Human Behavior*, 34, 2-10.

Nagata, I., Kato, K., Seki, K., & Furuya, K. (1986). Ovulatory disturbances: Causative factors among Japanese student nurses in a dormitory. *Journal of Adolescent Health Care*, 7, 1-5.

Nash, H., & Chrisler, J. (1997). Is a little (psychiatric) knowledge a dangerous thing? *Psychology of Women Quarterly*, 21, 315-322.

Noddings, N. (1989). *Women and evil*. Berkeley: University of California Press.

Oransky, I. (2004). Katherina Dorothea Dalton Obituary. *The Lancet*, 364, 1576.

O'Brian, P. (1987). *Premenstrual Syndrome*. Oxford: Blackwell Scientific Publications.

O'Meara, K. P. (2001, April 30). Misleading medicine. *Insight on the News (Washington times Magazine)*, p.10.

Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual*. London: Routledge.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith. (1995). *Deconstructing Psychopathology*. Cambridge: Sage Publication.

Parlee, M. B. (1973). The premenstrual syndrome. *Psychological Bulletin*, 80, 454-465.

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

Parry B. L., Cover H., Mostofi N., LeVeau B., Sependa P. A., Resnick A. & Gillian J. C. (1995). Early versus late partial sleep deprivation in patients with premenstrual dysphoric disorder and normal comparison subjects. *American Journal of Psychiatry*, 152, 404-412.

Parsons, T. (1951). *The social system*. London: Routledge & Kegan Paul.

Pearlstein, T. & Steiner, M. (2008). Premenstrual dysphoric disorder: burden of illness. *Journal of Psychiatry & Neuroscience*, 33, 291-301.

Pearlstein, T. B., Stone, A. B., Lund, S. A., Scheft, H., Zlotnick, C. & Brown, W. A. (1997). Comparison of fluoxetine, bupropion, and placebo in the treatment of premenstrual dysphoric disorder. *Journal Clinical Psychopharmacology*, 17, 261-266.

Pilgrim, D. (2013). In defence of inclusive realism in psychology. *The Psychologist*, 26, 156-159.

Protopopescue, X., Butler, T., Pan, H., Root, J., Altemus, M., Polanecsky, M., McEwen, B., Silberweig, D., & Stern, E. (2008). Hippocampal structural changes across the menstrual cycle. *Hippocampus*, 18, 985-988.

Protopopescue, X., Tuescher, O., Pan, H., Epstein, J., Root, J., Chang, L., Altemus, M., Prolanecsky, M., & McEwen, B. (2008). Toward a functional neuroanatomy of premenstrual dysphoric disorder. *Journal of Affective Disorders*, 108, 87-93.

Rapley, M., Moncrieff, J., & Dillon, J. (2011). *De-Medicalising Misery: Psychiatry, psychology & the human condition*. Basingstoke; Palgrave MacMillan.

Read, J., Perry, B., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry: Interpersonal and Biological Processes*, 64, 319-345.

Reed, S. C., Levin, F. R., & Evans, S. M. (2008). Changes in mood, cognitive performance and appetite in the late luteal and follicular phase of the menstrual cycle in women with and without PMDD (Premenstrual Dysphoric Disorder). *Hormones and Behaviour*, 54, 185-193.

Rees, L. (1953) Premenstrual tension syndrome and its treatment. *British Medical Journal*, 1, 1014-1016.

Reimann, H. A. (1946). Habitual hyperthermia; premenstrual fever. *Journal of the American Medical Association*, 21, 132-144.

Richardson, T. E. (1995). The premenstrual syndrome: A brief history. *Social Science & Medicine*, 41, 761-767.

Roberts, M. (2005). The production of the psychiatric subject: power; knowledge and Michel Foucault. *Nursing Philosophy*, 6, 33-42.

Rodin, M. (1992). The social construction of premenstrual syndrome. *Social Science and Medicine*, 35, 49-56.

Rose, N. (1985). *The psychological complex: psychology, politics and society in England 1869–1939*. London: Routledge and Kegan Paul.

Rose, N. (1998). *Inventing ourselves. psychology, power, and personhood*. Cambridge MA: Cambridge University Press.

Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 179, 250-8.

Rubinow, D., Roy-Byrne, P., Hoban, C., Grover, G., Stambler, N., & Post, R. (1986). Premenstrual mood changes: characteristic patterns in women with and without PMS. *Journal of Affective Disorders*, 10, 85-90.

Rupani, N., & Lema, V. (1993). Premenstrual tension among nurses in Nairobi, Kenya. *East African Medical Journal*, 70, 310-313.

Seward, G. H. (1944) Psychological effects of the menstrual cycle on women workers. *Psychological Bulletin*, 41, 90-102.

Sims-Schouten, W., Riley, S., & Willig, C. (2007). Critical realism in discourse analysis: a presentation of systematic method of analysis using women's talk of motherhood, childcare and female employment as an example. *Theory & Practice*, 17, 127-150.

Simmons, R. J. (1956). Premenstrual tension; review of 288 cases. *Obstetrics Gynecology*, 8, 99-102.

Sommer, B. (1973). The effect of menstruation on cognitive and perceptual-motor behaviour: a review. *Psychosomatic Medicine*. 35, 515-534

Steiner, M. (1997). Premenstrual syndromes. *Annual Review of Medicine*, 48, 447-455.

Steiner, M., & Carroll, B.J. (1977). The psychobiology of premenstrual dysphoria: review of theories and treatments. *Psychoneuroendocrinology*, 2, 321-335.

Steiner, M., Hasket, R. F., & Carroll, B. J., (1980). Premenstrual tension syndrome: the development of research diagnostic criteria and new rating scales. *Acta Psychiatrica Scandinavica*, 62, 177-190.

Steiner, M., Streiner, D.L., Steinberg, S., Stewart, D., Carter, D., Berger, C., Reid, R., & Grover, D. (1999). The measurement of premenstrual mood symptoms. *Journal of Affective Disorders*. 53, 269-273.

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

Tamboukou, M. (1999). Writing Genealogies: an exploration of Foucault's strategies for doing research. *Discourse: studies in the cultural politics of education*, 20, 210-217.

Tavris, C. (1992). *The Mismeasure of Woman*. New York, NY: Touchstone.

Taylor, D. (1988). *Red Flow: Rethinking Menstruation*. Freedom, Calif: The Crossing Press.

Taylor, D. (2005) Perimenstrual Symptoms and Syndromes: Guidelines for Symptom Management and Self Care. *Obstetrics & Gynecology*, 5, 241.

Taylor, D. (2006) "It's all in your head" to "Taking back the month": contributions to understanding PMS from the Society for Menstrual Cycle Research. *Sex Roles*, 54, 377-391.

Treloar, A. E., Boynton, R. E., Borghild, G. B., & Brown, B. W. (1967). Variation of the human menstrual cycle through reproductive life. *International Journal of Fertility*, 12, 77-126.

Ussher, J. M. (1989). *The psychology of the female body*. London: Routledge.

Ussher, J. M. (1991). *Women's Madness: Misogyny or Mental Illness?* Amherst, MA: University of Massachusetts Press.

Ussher, J. M. (2002). Premenstrual syndrome: fact, fantasy, or fiction? In C.B. von Hofsten and L. Blackman, Editors, *Psychology at the Turn of the Millennium*, 2, p. 497 -527. New York: Psychology Press.

Ussher, J. M. (2003). The role of premenstrual dysphoric disorder in the subjectification of women. *Journal of Medical Humanities*, 24, 131-146.

Ussher, J. M. (2008). Managing the monstrous feminine: The role of premenstrual syndrome in the subjectification of women. In: Moss P and Teghtsoonian K (eds) *Contesting Illness: Process and Practices*. pp.181–200. Toronto: University of Toronto Press.

Ussher, J. M. (2010). Are we medicalizing women's misery? A critical review of women's higher rates of reported depression. *Feminism & Psychology*, 20, 9–35.

Ussher J. M. & Perz, J. (2008), Empathy, egalitarianism and emotion work in the relational negotiation of PMS: The experience of lesbian couples. *Feminism and Psychology*, 18, 87–111.

Van den Akker, O. B. A., Eves, F., & Lennon, B. (1985). Menstrual cycle symptom reporting in three British ethnic groups. *Social Science and Medicine*, 40, 1417-1423.

Walker, A. (1994). Mood and well-being in consecutive menstrual cycles. *Psychology of Women Quarterly*, 18, 271-290.

Walker, A. (1997). *The Menstrual Cycle*. London: Routledge.

Whitehead, R. E. (1934). Women pilots. *Journal of Aviation Medicine*, 5, 47-49.

Williams, A. (2005). Genealogy as methodology in the philosophy of Michel Foucault. Retrieved from http://www.uel.ac.uk/cnr/documents/GenealogyasMethodologyinthePhilosophyofMichelFoucault_001.doc in March 2013.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd Ed.). Maidenhead: Open University Press.

Wood, A. (1973). The fashionable diseases: women's complaints and their treatment in nineteenth-century America. *Journal of Interdisciplinary History*, 4, 25-52.

World Health Organization. (1992). *International Classification of Diseases*, Tenth Revision. Geneva, Switzerland: World Health Organization.

World Health Organization. (2012). Gender and women's mental health. Retrieved from http://www.who.int/mental_health/prevention/genderwomen/en/ in September 2012.

Yen J. Y., Chang, S.J., Long, C.Y., Tang, T.C., Chen, C.C., & Yen, C.F. (2012). Working memory deficit in premenstrual dysphoric disorder and its associations with difficulty in concentrating and irritability. *Comprehensive Psychiatry*, 53, 540-545.

Yonkers, K. A., O'Brien, P.M., & Eriksson, E. (2008). Premenstrual syndrome. *Lancet*, 37, 1200-1210.

Yu, M., Zhu, X., Li, J., Oakley, D., & Reame, N. E. (1996). Perimenstrual symptoms among Chinese women in urban areas of China. *Health Care for Women International*, 17, 161-172.

Zimmerman, M. (1988). Why are we rushing to publish DSM-IV? *Archives of General Psychiatry*, 45, 1135-1138.

APPENDIX ONE – DATABASE SEARCH RESULTS

Search Results for 'Premenstrual' in PubMed Database

| DSM | Date | Results | After Inclusion & exclusion criteria | Final Selection |
|--------------|-------------|----------------|---|------------------------|
| Pre DSM-5 | 2008 - 2013 | 4873 | 10 | 2 |
| Post DSM-IV | 1994 - 1999 | 720 | 10 | 2 |
| Pre DSM-IV | 1986 - 1993 | 1021 | 10 | 2 |
| Post DSM-III | 1980 - 1985 | 476 | 10 | 0 |
| Pre DSM-III | 1974 - 1979 | 277 | 10 | 2 |
| Post DSM-II | 1968 – 1973 | 202 | 10 | 0 |
| Pre DSM-II | 1963 – 1968 | 177 | 5 | 0 |
| Post DSM-I | 1952 - 1957 | 129 | 10 | 3 |
| Pre DSM-I | 1947 - 1952 | 48 | 6 | 0 |
| Pre DSM | 1800 - 1946 | 8 | 2 | 3 |

Search Results for 'Premenstrual' in PsychINFO Database

| DSM | Date | Results | After Inclusion & exclusion criteria | Final Selection |
|--------------|-------------|----------------|---|------------------------|
| Pre DSM-5 | 2008 - 2013 | 302 | 10 | 7 |
| Post DSM-IV | 1994 - 1999 | 400 | 10 | 3 |
| Pre DSM-IV | 1986 - 1993 | 652 | 10 | 2 |
| Post DSM-III | 1980 - 1985 | 167 | 10 | 1 |
| Pre DSM-III | 1974 - 1979 | 78 | 10 | 2 |
| Post DSM-II | 1968 – 1973 | 35 | 5 | 3 |
| Pre DSM-II | 1963 – 1968 | 21 | 0 | 4 |
| Post DSM-I | 1952 - 1957 | 9 | 2 | 1 |
| Pre DSM-I | 1947 - 1952 | 4 | 1 | 0 |
| Pre DSM | 1800 - 1946 | 11 | 1 | 1 |

Search Results for 'Premenstrual' in ScienceDirect Database

| DSM | Date | Results | After Inclusion & exclusion criteria | Final Selection |
|--------------|-------------|----------------|---|------------------------|
| Pre DSM-5 | 2008 - 2013 | 2406 | 10 | 1 |
| Post DSM-IV | 1994 - 1999 | 1539 | 10 | 1 |
| Pre DSM- V | 1986 - 1993 | 1366 | 10 | 1 |
| Post DSM-III | 1980 - 1985 | 513 | 10 | 1 |
| Pre DSM-III | 1974 - 1979 | 235 | 10 | 0 |
| Post DSM-II | 1968 – 1973 | 101 | 5 | 0 |
| Pre DSM-II | 1963 – 1968 | 120 | 9 | 0 |
| Post DSM-I | 1952 - 1957 | 61 | 0 | 1 |
| Pre DSM-I | 1947 - 1952 | 46 | 0 | 0 |
| Pre DSM | 1800 - 1946 | 176 | 0 | 6 |

Example of database search history [ScienceDirect]

ScienceDirect – Search History
08/05/2013 10:38

Control P (P) to Print
CLOSE

Printable History

| Search | Results |
|---|---------|
| pub-date > 1822 and pub-date < 1947 and Premenstrual AND LIMIT-TO(contenttype, "1,2","Journal") AND LIMIT-TO(topics, "menstrual cycle") [All Sources(- All Sciences -)] | 4 |
| pub-date > 1951 and pub-date < 1969 and (Premenstrual dysphoric disorder) [All Sources(- All Sciences -)] | 0 |
| pub-date > 1967 and pub-date < 1981 and (Premenstrual dysphoric disorder) [All Sources(- All Sciences -)] | 10 |
| pub-date > 1979 and pub-date < 1995 and (Premenstrual dysphoric disorder) [All Sources(- All Sciences -)] | 166 |
| pub-date > 1967 and pub-date < 1981 and (late luteal phase dysphoric disorder) [All Sources(- All Sciences -)] | 2 |
| pub-date > 1951 and pub-date < 1969 and (late luteal phase dysphoric disorder) [All Sources(- All Sciences -)] | 0 |
| pub-date > 1993 and Premenstrual [All Sources(- All Sciences -)] | 7,044 |
| pub-date > 1993 and (Premenstrual dysphoric disorder) [All Sources(- All Sciences -)] | 1,982 |
| pub-date > 2007 and Premenstrual [All Sources(- All Sciences -)] | 2,411 |
| pub-date > 1993 and pub-date < 2000 and Premenstrual [All Sources(- All Sciences -)] | 1,539 |
| pub-date > 1973 and pub-date < 1980 and Premenstrual [All Sources(- All Sciences -)] | 235 |
| pub-date > 1979 and pub-date < 1986 and Premenstrual [All Sources(- All Sciences -)] | 513 |
| pub-date > 1985 and pub-date < 1994 and Premenstrual [All Sources(- All Sciences -)] | 1,366 |
| pub-date > 1951 and pub-date < 1958 and Premenstrual [All Sources(- All Sciences -)] | 61 |
| pub-date > 1962 and pub-date < 1969 and Premenstrual [All Sources(- All Sciences -)] | 120 |
| pub-date > 1946 and pub-date < 1953 and Premenstrual [All Sources(- All Sciences -)] | 46 |
| pub-date > 1967 and pub-date < 1974 and Premenstrual [All Sources(- All Sciences -)] | 101 |
| pub-date > 1822 and pub-date < 1947 and Premenstrual [All Sources(- All Sciences -)] | 176 |
| pub-date > 1951 and Premenstrual [All Sources(- All Sciences -)] | 9,516 |
| pub-date > 1993 and pub-date < 2000 and Premenstrual AND LIMIT-TO(contenttype, "1,2","Journal") AND LIMIT-TO(topics, "menstrual cycle,premenstrual syndrome,premenstrual dysphoric") [All Sources(- All Sciences -)] | 129 |

CLOSE

Copyright © 2013 Elsevier B.V. All rights reserved. SciVerse® is a registered trademark of Elsevier Properties S.A., used under license. ScienceDirect® is a registered trademark of Elsevier B.V.

http://www.sciencedirect.com/science?_ob=MiamiSearchURL&_metho...rsion=1&_userid=12266602&md5=9ffc9986429a4e5d384a54d2ee19af41
Page 1 of 1

APPENDIX TWO – ARTICLES SELECTED FOR ANALYSIS

Articles (47 in total) included in the analysis (descending order).

- Epperson et al., (2012). Premenstrual dysphoric disorder: evidence for a new category for DSM-5.
- Hartlage et al., (2012). Criteria for premenstrual dysphoric disorder: secondary analyses of relevant data sets.
- Cunningham et al., (2009) Update on research and treatment of Premenstrual dysphoric disorder.
- Gehlert et al., (2009). The prevalence of premenstrual dysphoric disorder in a randomly selected group of urban and rural women.
- Knaapen & Weisz (2008). The biomedical standardization of premenstrual syndrome.
- Pearlstein & Steiner (2008). Premenstrual dysphoric disorder: burden of illness.
- Protopopescue et al., (2008). Toward a functional neuroanatomy of premenstrual dysphoric disorder.
- Protopopescue et al., (2008). Hippocampal structural changes across the menstrual cycle.
- Reed et al., (2008). Changes in mood, cognitive performance and appetite in the late luteal and follicular phase of the menstrual cycle in women with and without PMDD (Premenstrual Dysphoric Disorder).
- Yonkers et al., (2008). Premenstrual syndrome.
- Endicott et al., (1999). Is premenstrual dysphoric disorder a distinct clinical entity?
- Steiner et al., (1999). The measurement of premenstrual mood symptoms.
- Bloch et al., (1998). Pituitary-adrenal hormones & testosterone across the menstrual cycle in women with premenstrual syndrome and controls.
- Bloch et al., (1997). Premenstrual syndrome: evidence for symptom stability across cycles.
- Steiner (1997). Premenstrual syndromes.
- Richardson (1995). The premenstrual syndrome: A brief history.
- Hurt et al., (1992). LLPDD in 670 women evaluated for premenstrual complaints.
- Rodin (1992). The social construction of premenstrual syndrome.
- Schmidt et al., (1991). Lack of effect of induced menses on symptoms in women with premenstrual syndrome.

Haskett & Abplanalp (1983) Premenstrual tension syndrome: Diagnostic criteria and selection of research subjects.

Steiner et al., (1980). Premenstrual tension syndrome: the development of research diagnostic criteria and new rating scales.

Carroll & Steiner (1978) The psychobiology of premenstrual dysphoria: the role of prolactin.

Steiner & Carroll (1977). The psychobiology of premenstrual dysphoria: review of theories and treatments. 321-335.

Golub (1976). The magnitude of premenstrual anxiety and depression.

Golub (1976). The effect of premenstrual anxiety and depression on cognitive function.

Janowsky et al., (1973). Correlations between mood, weight & electrolytes during the menstrual cycle: a renin-angiotensin-aldosterone hypothesis of premenstrual tension

Parlee (1973). The premenstrual syndrome.

Sommer (1973). The effect of menstruation on cognitive and perceptual-motor behaviour: a review.

Dalton (1961). Menstruation and crime.

Dalton (1960). Menstruation and accidents.

Dalton (1960b). Effects of menstruation on school girls weekly work.

Dalton (1959). Menstruation and acute psychiatric illnesses.

Simmons (1956). Premenstrual tension; review of 288 cases.

Greene & Dalton (1954). Discussion on the premenstrual syndrome.

Greene & Dalton (1953). The premenstrual *syndrome*

Rees (1953) Premenstrual tension syndrome and its treatment.

Cline (1946) Etiology of premenstrual tension and the rationale of its treatment.

Reimann (1946) Habitual hyperthermia; premenstrual fever.

Seward (1944) Psychological effects of the menstrual cycle on women workers.

Holtz (1941) Should women fly during the menstrual period?

Frank (1940) Puberty, menstruation, pregnancy.

Benedek & Rubenstein (1939). The correlations between ovarian activity and psychodynamic processes. I. The ovulatory phase.

Lough (1937) A psychological study of functional periodicity.

Goldschmidt (1934) The menstrual taboo and woman's psychology.

Johnson (1932). The effects of periodicity on learning to walk a tight-wire.

Frank (1931). The hormonal causes of premenstrual *tension*.

APPENDIX THREE – ANALYTIC STEPS

Step 1

In the analysis, I read all the data twice and looked for interesting features and themes. I kept notes of how each source began its presentation, what symptoms were listed, what theories were given to explain premenstrual distress, what treatment or therapeutic methods were discussed and recommended. I then went through my notes of the themes and features and extracted (copying word for word) large excerpts from each article and placed them in a word document accordingly to categories below:

1. Symptoms, prevalence
2. Diagnostic criteria or category
3. Etiology or explanations of premenstrual distress
4. Treatment

Step 2

Once the data was transferred on to a word document, I changed the document format to make the margins on the right hand larger. In this space, I entered my own comments and ideas on constructions, practices, subject positions, discourses, who was quoted, how women with premenstrual distress were being constructed, what was missing/unsaid, what did not make sense, and any contradictories. I kept reading, comparing different extracts, reading in detail and making notes of my reading, thinking and initial stage of analyzing.

Step 3

At this point, I used the steps outlined by Willig (2008) on doing Foucauldian Discourse Analysis. In this part, I read my extensive notes and also the data again and looked for the different ways in which the premenstrual changes/distress were constructed in the text and what discourses these constructions may have drawn from. I paid close attention to the language and

terminologies that were being used to describe premenstrual changes, its causes, the effects, and treatment. Thereafter, I thought about the action orientation and the functions of the constructions. I then looked for what subject positions that they offered and what this meant in terms of what can be done to these subjects. In the final stage of this analysis, I reflected on the consequences of women taking up various subject positions and what this means for their subjectivity. For each of the stages, I selected extracts that best reflected the ways premenstrual changes were medicalized.

Step 4

In the fourth stage of my analysis, I examined the data to answer the research questions:

1. How do psychological and psychiatric literatures construct premenstrual changes?’
2. Under what circumstances are women’s premenstrual changes rendered problematic and what professional discourses render these problems intelligible?
3. What discursive and regulatory practices warrant the constructions of premenstrual changes as a psychiatric disorder?
4. What subject positions are enabled and what are the implications for action of these subject positions?

I evaluated how premenstrual changes were constructed (e.g. positive, negative, risks, incapacitating, dangerous), the way it was problematized and medicalized and what circumstances had rendered these constructions intelligible. And once again, I wrote about the impact the constructions have on women and their subjective experience.

Step 5

A list of key constructions was drawn up based on these analysis. During this process, it was possible to identify three distinct arrays of inter-connected constructions, examples from which would serve to address the research

questions. Specific extracts were considered in terms of how they might or might not exemplify this.

Step 6

In this stage of the analysis, I brought together all of the studies from each period and merged the analysis that were similar. The analysis showed that the constructions were similar throughout the literature. I chose extracts that supported one another to add to the construction of premenstrual changes. Extracts were used to demonstrate the key constructions of premenstrual changes. The constructions were organized by time period. Throughout the literature, three interrelated constructions about premenstrual changes was produced to reify premenstrual changes as a psychiatric problem. Extracts were carefully chosen to represent this.

Step 7

The final stage of the analysis involved the write up. Here I organized my analysis around the DSM editions. For each period, there was approximately 2-3 ways that premenstrual distress was constructed, all supported by extracts.

APPENDIX FOUR – EXAMPLE OF INITIAL ANALYSIS

2008-2013 Bartle's Project

1. PMDD Description, Symptom Expression and Prevalence

1. Cunningham et al (2009) Update on research & treatment of PMDD (same as Yonkers et al., 2008)

(p120) Many women in their reproductive years experience some mood, behavioral or physical symptoms in the week prior to menses. Variability exists in the level of symptom burden in that some women experience mild symptoms, whereas a small minority experience severe and debilitating symptoms. For an estimated 5-8% of premenopausal women, work or social functioning are affected by severe premenstrual syndrome. Many women in this group meet diagnostic criteria for premenstrual dysphoric disorder (PMDD). Among women who suffer from PMDD, mood and behavioral symptoms such as irritability, depressed mood, tension, and labile mood dominate. Somatic complaints, including breast tenderness and bloating, also can prove disruptive to women's overall functioning and quality of life. (p123) For symptomatic women, the six days prior to menses commonly are marked by an increase in symptom levels, with the two days prior to menses resulting in the highest symptom reports, particularly involving mood symptoms of anger and irritability. A diagnosis of PMDD requires that women experience no symptoms during the pre-ovulatory period. But she may experience tension at this time - is that not a symptom then? why is it a symptom during premenstrual phase? Premenstrual phase is constructed as a premenstrual phase, not the actual mood & behavioral changes!

(p123) Prevalence rates of premenstrual difficulties are derived primarily from retrospective reports. While recall bias may affect such reports, the ratings are consistent with those of epidemiological studies using prospective ratings, which indicate between 2% and 8% of women in the United States and Europe experience moderate to severe symptoms. Slightly lower estimates (1.2% for moderate to severe PMS to 5.3% for PMDD) are projected for part of Asia based upon retrospective self-reports. - Culture syndrome

(p128) Women with PMDD, in particular, are more likely to have a past history of mood disorders and other psychiatric disorders, with lifetime estimates ranging from 30% to 70%. Premenstrual exacerbation of PMDD symptoms generally refers to worsening of symptoms of MDD or bipolar disorder during the luteal phase but can refer to exacerbation of any existing condition, such as anxiety. → premenstrual phase is dangerous & can cause her to become mad / mentally ill. She, as a result, can have other psychiatric conditions.

2. Epperson et al., (2012). PMDD: evidence for a new category for DSM-5.

(p470). Data from clinical as well as epidemiological cohorts show that many women experience symptoms that begin during the luteal phase of the menstrual cycle and terminate around the onset of menses. Prevalence rates vary considerably depending on study methods, particularly with respect to prospective or retrospective symptom reporting, consideration of symptom interference, and population sampling.

(p467) Premenstrual dysphoric disorder is not a culture-bound syndrome and has been found in epidemiological cohorts in the United States, Canada, Europe, India and Japan.

4. Hartlage et al., (2012). Criteria for PMDD: Secondary Analyses of Relevant Data Sets

(p.300) There is substantial information from biological investigations that premenstrual dysphoric disorder (PMDD) is a clinically significant psychiatric disorder with unique biological underpinnings.

(p.305) We examined data from a community sample and a clinical cohort to generate empirical evidence that would inform the DSM-5 sub-Work Group regarding criteria for PMDD. Physical symptoms (e.g., bloating, breast tenderness) showed the greatest change in both samples regardless of the perimenstrual interval. Affective lability, irritability, and feeling anxious/tense/on edge were more frequent than depressed mood in both samples. The optimal number of symptoms associated with impairment in the community cohort was 2, while in the clinical cohort it was 7. After combining the 2 cohorts and weighting them equally, the optimal cutoff point was 4 symptoms. The implication of this analysis is that clinicians and researchers may consider the measurement of symptoms from 4 days before through the first 3 days of menses rather than the traditional method of measuring symptoms of PMDD during the premenstrual week only.

5. Pearlstein & Steiner (2008). PMDD: burden of illness & treatment update.

premenstrual experience is considered an illness, that must be treated because women are burdened by it

Constructions, practices, subject positions. My own ideas.

Menstruation is constructed as a bodily event consisting of symptoms. In medical language, symptoms are referred to as a disorder. All premenstrual changes are referred to as symptoms. She can't work or function properly because of it. Irritability or tension is considered a symptom - why? we all experience these mood & behavioral changes, why is it for her that it is a symptom? - is that not a symptom then? why is it a symptom during premenstrual phase? Premenstrual phase is constructed as a premenstrual phase, not the actual mood & behavioral changes!

Medical language = clinical epidemiological = prevalence of disease. - as if to say accurate / normal.

Really? only in developing countries perhaps? not constructed regularly in many Eastern parts of the world.

Scientific & medical language PMDD constructed as a psychiatric disorder & viewed as biologically caused (in her body) - it is a bodily phenomenon, mental with version of reality sensible.

Highly specialised scientific language - criteria exist & need to be discovered.

Contradiction of premenstrual phase

① Cunningham et al (2009) 6 phor -

④ Hartlage = 4 days prior - 3 days into menses.

① Difficult to say as all women or if some women premenstrual experience is