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Witches Every Month? The Social Construction of Premenstrual Syndrome

Suzanne Latham

WITCHES EVERY MONTH? THE SOCIAL CONSTRUCTION OF PREMENSTRUAL SYNDROME

by

Suzanne Latham

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Latham, Suzanne Marie, M.A.

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U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

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CHAPTER I

INTRODUCTION

Queen Victoria may have had it (Clark & Shapiro, 1981); so might have Sylvia Plath and Lizzie Borden (Norris, 1983). Authorities disagree about how many women are affected--some say 3% to 5% (Hopson & Rosenfeld, 1984), others say 100% (Norris, 1983). The symptoms include bloating, headaches, irritability, nausea, depression, food cravings, tension, anxiety and rage (Eagan, 1983; Hopson & Rosenfeld, 1984). It has been blamed for damaging lives by indirectly causing child abuse, alcoholism, and divorce, and at the very least disrupts the family unit on occasion (Norris, 1983). It has even been used as a mitigating circumstance when sentencing criminals for violent behavior such as murder (Chait, 1986).

What is this seemingly rampant condition that purports to turn normally competent women into inept, oversensitive, emotional wrecks? The answer is premenstrual syndrome, commonly known as PMS. PMS is now a reality in the mind of the American public. Coffee cups are emblazoned with messages such as "I have PMS; what's your excuse?" Pins state "Don't blame PMS--I'm always like this." Over the counter drugs like Midol-PMS can be bought to treat the symptoms. Even pregnancy is no escape. One prominent pregnancy guide warns PMS-like symptoms may be present the first, second, third, fourth, and fifth months of pregnancy (Eisenberg, Murkoff &

Hathaway, 1984). Popular books have been written for mass audiences. PMS has even been called the hypoglycemia of the 1980 due to its sudden popularity (Eagan, 1983).

Public exposure to PMS increased dramatically in the late 1980s. Midol has expanded its shelves and now offers Midol PMS; at one point people could call a special 800 number to "hear leading specialists give helpful information and suggestions" about PMS. Greeting cards wish a Happy Birthday in this manner: "The secret to birthday happiness is learning to accept the aging process as something as beautiful and natural as premenstrual tension." On television's "Designing Women," the character Suzanne, an immature and superficial woman, occasionally makes references to being affected by PMS. Men can purchase a special calendar that informs them about PMS each month; cartoons forewarn them not to overreact when a female associate becomes very difficult or weepy.

Women can also take solace in the possibility that many historic women may have had PMS. Ronald Norris, author of PMS: Premenstrual Syndrome (1983) and director of the first PMS clinic to open in the United States, briefly writes the biographies of several influential women in his book. He does not diagnose these women, but he does strongly suggest that their unpredictable behaviors were caused by PMS. Included in his PMS Hall Of Fame are Mary Tudor, Katherine of Aragon, Pauline Bonaparte, Mary Todd Lincoln, Queen Victoria, Alice James, Lizzie Borden, Sylvia Plath, Maria Callas, and Judy Garland. Markie Post, another television actress, exclaims "Once a month I'm a woman possessed" in a May 1986 issue of Redbook

(Mehren, 1986).

In this thesis I will attempt to show that the syndrome, PMS, as a label, is being used as a means of the social control of women by the male dominated medical profession. It is my contention that PMS is a political creation of the medical community, and that much of the disorder called premenstrual syndrome is actually a compilation of various stereotypes about women. In an effort to "put women in their place," PMS has effectively discredited women and trivialized their successes.

I examine PMS from a social constructionist perspective. According to this point of view, all knowledge has a cultural basis, including medical knowledge. The process whereby a set of symptoms came to be a syndrome known as PMS, and the consequences of this occurrence, can be understood better when placed in a model which considers cultural, as well as medical, factors.

The history of PMS will be provided, both within the medical and non-medical spheres. The groups currently debating its legitimacy will be reported. Finally, a critical analysis of the PMS phenomenon will be included, merging the theoretical basis of the paper with the social experience of premenstrual syndrome.

CHAPTER II

THEORETICAL PERSPECTIVE

In this chapter I discuss the theoretical framework of my paper. I begin with a brief presentation of the constructionist model, along with important studies that have utilized it. The concept of social control, as understood by Gamson (1968), introduces a central idea of my thesis. Spector and Kitsuse's (1977) concept of the definition of social problems presents a constructionist explanation of how behaviors become defined within society as problematic. Their concept of claimsmaking is particularly relevant.

Social control has existed as long as societies have. In simple terms, social control can be defined as the means by which society secures adherence to social norms, both formally and informally. The ability to define an activity as deviant is tantamount to power. Determining which behaviors will be denounced is a process that is heavily reflective of current modes of thought, and it changes as people change.

The medical community's role in preserving order, and, indirectly, social control, is presented through the writings of Wright and Treacher's The Problem of Medical Knowledge (1982) and Conrad and Schneider's Deviance and Medicalization (1980). These authors present medicine as a highly social and influential profession, whose boundaries are widening even as other agents of social control experience less power. The chapter concludes with a detailed presentation

of Conrad and Schneider's (1980) ideas as they apply to PMS.

Social Constructionism

Numerous sociological studies have used the constructionist framework with enlightening results. Each points out the interconnectedness of deviance designations and the prevailing power structures. These studies show how the temporal context of deviance matters more than the behavior itself. Not only must someone disapprove of the behavior; that someone must be in a position of authority to enforce his or her conviction.

At least four sociologists have studied the passage of the various drug regulations acts. Becker (1963) was the first, and he used the legislation as an example of moral entrepreneurship. At the time in question, according to Becker, marijuana use was not a concern of the public. A publicity campaign by the Bureau of Narcotics, and led by Commissioner Henry J. Ansliger, resulted in greater awareness by the public who urged Congress to make marijuana use illegal. It was Becker's contention that the Bureau had effectively created a new category of deviants, marijuana users and sellers. Donald Dickson (1968) pointed out that, at the time of the incident, the Bureau was facing cutbacks and needed to present itself as essential to public welfare. In Dickson's analysis, it was bureaucratic survival and growth as opposed to moral entrepreneurship that prompted the Bureau to single out marijuana. More recently, in 1977 Galliher and Walker reanalyzed these various drug regulatory acts.

They concluded that, since these acts came after most states were instituting their own anti-marijuana laws, and the passage of these acts did not result in a budget increase, the legislation was symbolically reassuring, but meant little else.

The Women's Christian Temperance Union's crusade against alcohol was studied by Gusfield (1963). Since its members were rural Protestants whose lives were largely not affected by alcohol, at first their involvement seems peculiar. Gusfield pointed out, however, that the Temperance movement was a response to a changing society. Immigrants were flooding the shores of 19th Century America, bringing with them radically different lifestyles, including the use of alcohol. In an effort to legislate its morality and reaffirm its influence, the WCTU lobbied long and hard for the passage of the 18th Amendment. The fact that the enforcement of this legislation was not a concern supports Gusfield's analysis.

Conrad (1976) saw the emergence of hyperkinesis as the result of a drug, Ritalin, in search of a disease. First described in 1937, but not named until 1957, hyperkinesis became popular in the 1970s and was widely publicized through articles and research. Two questions were raised by Conrad. First, when does a deviant behavior become a medical problem? Since the type of drug used to treat hyperkinesis was discovered 20 years before the label was invented, a distorted view of medicine is presented: does the label appear only when the social control mechanism is available? Second, why is this type of deviance a part of medical jurisdiction? Conrad suggests that, in the case of hyperactivity, pharmaceutical

companies were crucial. Ad campaigns presented as information articles, and heavy involvement with physicians resulted in hefty profits for those who produced Ritalin. By presenting both the disorder and the treatment, drug companies were able to carve a new market in the highly profitable pharmaceuticals business, and a new type of deviant behavior was successfully introduced.

It was Spector and Kitsuse's (1977) contention that the definition given to a behavior was intimately tied to the prevailing politics of the day:

> Definitions of social problems are expressed in terms that describe the condition, reflect attitudes toward the condition, and give numerous other hints as to how that condition is considered offensive or problematic. Groups often vied for control of the definition of a problem. When one group wins, its vocabulary may be adopted and institutionalized while the concepts of the opposing groups fall into obscurity. When terminologies change, when new terms are invented, or existing terms are given new meanings, these actions signal that something important has happened to the career or history of a social problem. (p. 8)

In short, the objective reality of a behavior matters less than the definition given to that behavior. Thus, for example, while homosexual activity has always occurred, the meaning of that activity might be defined as immoral, psychologically twisted, or normal depending upon who did the defining.

Of crucial importance to this model is the concept of "claims-making." According to Spector and Kitsuse (1977):

> We define social problems as the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions. The emergence of a social problem is contingent upon the organization of activities asserting the need for eradicating, ameliorating, or otherwise changing some condition. The central

> problem for a theory of social problems is to account for the emergence, nature, and maintenance of claims-making and responding activities. (p. 76)

The reasons behind any statements thus become as important as the statements themselves, and can be presented as such. Claims regarding a condition or situation take on a political cast as they not only present the "truth" as one side sees it but also support that groups' version of reality. Success depends upon whether one's claims about a behavior are accepted or not.

The process of social control by and for the larger society is not a new topic. Gamson (1968) saw social control as one of the ways power was utilized. In this understanding, the "public good" takes precedence over the individual's needs. As Gamson said: "How does leadership operate to achieve societal goals most efficiently while at the same time avoiding costly side effects?" (p. 11). However, this allocation process does not preclude conflict. Thus, the system is not only the power holder, but also the conflict regulator responsible for handling the different demands of the groups who compose it.

Social Construction of Medicine

In The Problem of Medical Knowledge, Wright and Treacher (1982) contend that medicine is a social construction. The usual practice of sociologists in the past was to treat medicine as asocial and purely empirical. This approach was challenged by sociologists who saw medicine as a player in a social arena, whose boundary is not clearly marked, much like any other profession. Social

anthropologists have pointed out parallels between modern medicine's world-view and non-Western or preliterate cultures' world-view. Wright and Treacher cite Foucault's notion that the language of medicine not only serves to name the diseases it treats but also to create its own objects of analysis points to the social, as opposed to clinical, aspects of medicine. The authors are careful not to imply that medicine is a flawed institution because of these revelations, saying "medicine is (not) unscientific because it is permeated by social forces: but, in contrast, that both medicine and science are essentially social enterprises" (p. 7).

In the past, the technical aspect of medicine posed a problem in that medicine, by claiming to have "special access to the real workings of Nature" (Wright & Treacher, 1982, p. 6), was seen as incontrovertible. Social constructionists challenged this viewpoint, and asked why the knowledge of medicine was so prestigious. Social constructionists also refuse to regard medicine and its technology as given entities, separate from other human activities. Such an approach removes the restriction technology places on medical knowledge, making it accessible to sociological study.

As social entities, medicine and the medical community have an obligation to insure their existence. Friedson (1970), borrowing Becker's moral entrepreneur, says medicine is a moral entrepreneur because it seeks to treat illness both to relieve the patient and to keep itself in business. In Friedson's (1970) words:

> (Medicine) is active in seeking out illness. The profession does treat the illnesses laymen take to it, but it also seeks to discover and describe a "new" disease or

> syndrome and to be immortalized by having his name used to identify the disease. Medicine, then, is oriented to seeking out and finding illness, which is to say that it seeks to create social meanings of illness where that meaning or interpretation was lacking before. And insofar as illness is defined as something bad--to be eradicated or contained--medicine plays the role of what Becker called the "moral entrepreneur." (p. 252)

Medicalization of Deviance

Conrad and Schneider (1980) took Specter and Kitsuse's idea and applied it to the medical community. In their analysis, the medical community is the most recent agent of social control, whose predecessors were organized religion and then the state. With the growing authority medicine secured in the late 19th and early 20th centuries, it became possible to assert control over areas previously reserved for other institutions. Yet, medicine was, and always has been a product of its times. Thus, for example, Wright and Treacher (1982) report physicians of the 19th century told middle class women education or a career would damage their reproductive systems, a sentiment echoed by journalists and politicians of the day.

The medical community succeeded in its efforts by claiming many deviant behaviors were actually illnesses, as opposed to sins, moral deficiencies, or willful criminal acts. However, according to Conrad, (1976 as cited by Wolinsky, 1988), in order for medicine to consider a behavior as being amenable to its treatments, five conditions must be met by the behavior:

1. The behavior in question must be defined as deviant and a problem for some portion of society.

2. Traditional forms of social control must no longer work in relation to the "problem."

3. A medical form of social control must be available.

4. There must be some organic data that can be used to document the true cause of the problem.

5. The medical profession must be willing to accept the deviant behavior as lying within its jurisdiction. (p. 344)

When attempts are made to change definitions of deviance, attention is given to people with authority. In short, a physician has more clout than a layperson not only when issues of medicine are considered, but also technical or esoteric issues. When medicine claimed certain deviant behavior was its "turf," it needed to legitimate its claim by establishing a medical vocabulary and reinterpreting the behavior using a medical definition. Because it was a trusted institution, it has the power to insure its version of reality would be accepted.

When changes are made in deviance designations, not only the social control agent changes. According to Conrad and Schneider (1980), other changes may occur. Five are especially salient to this discussion. The meaning of a behavior may change, as when children who were difficult to manage at school no longer were considered bad, but rather hyperactive. When people who drank too much were helped at AA meetings instead of spending time in a drunk tank, the mode of intervention changed. The attribution of responsibility may shift; drug addicts were no longer blamed for their anti-social behavior, rather they could claim their need for drugs manifested itself in poor

conduct. The authority in charge of dealing with the problem may change, as in the case of homosexuality. The church used to punish homosexuals as sinners, until the mental health community claimed homosexuality was a mental illness. The area of examination also may change; child abuse was a private matter until x-ray technicians showed they were able to detect evidence of abuse in their slides.[1] In the case of "illness," the medical community ousts the legal community as the social control agent. It then "seeks to limit, modify, regulate, isolate, or eliminate deviant behavior with medical means and in the name of health" (Conrad & Schneider, 1980, p. 5).

Summary

This chapter has presented the theoretical framework of this thesis. This perspective, which emphasizes the importance of a social world that is constantly being created by society, is the backdrop upon which the rest of these ideas play out. The work of Spector and Kitsuse (1977), Wright and Treacher (1982), and Conrad and Schneider (1980) forms the basic argument, which is that the medical community, as a social entity, enjoys significant power. It is able to use this power to determine which behaviors can be considered medical problems, and then is able to treat these new medical conditions accordingly. The final result is a change in the definition of acceptable and unacceptable behavior, in this case of women.

CHAPTER III

HISTORY

A short introduction to the subject of how menstruation was viewed in ancient times sets the stage for future interpretations of menstruation. Key players in the PMS debate are included, specifically Robert Frank and Katharina Dalton. Finally, PMS in the popular press and in medical literature is examined to show what messages about PMS reached the public and physicians.

Menstruation

The emergence of PMS has not been sudden, nor, in retrospect, is it surprising. The monthly cycle of women has long been an event that causes fear, wonder, revilement and confusion in man. Early societies, not understanding what was occurring, attempted to control it through taboos and sacrifices. They saw the "natural" connection between females and the earth, and hoped by controlling their women they would be appeasing or at least not angering mother earth, thus assuring their survival. However, women were potentially dangerous; often, contact with elements necessary for a tribe's survival was taboo, as in food or hunting gear. The Roman Pliny (cited in Delaney, Lupton & Toth, 1988) wrote of the dangers of menstrual blood:

> Contact with it turns new wine sour, crops touched by it become barren, grafts die, seed in gardens are dried up, the fruit of trees falls off, the edge of steel and the

> gleam of ivory are dulled, hives of bees die, even bronze and iron are at once seized by rust, and a horrible smell fills the air; to taste it drives dogs mad and infects their bites with an incurable poison. . . . Even that very tiny creature the ant is said to be sensitive to it and throws away grains of corn that taste of it and does not touch them again. (p. 9)

In both the old and new testaments of the Bible, references to the menstrual cycle and its paraphernalia, are negative. Leviticus 15:19-33 gives specific instructions for the behavior of menstruating women and warns if these actions are not followed she and that which she touches will be unclean. A ritual cleansing bath, or mikveh, concludes the cycle. Indeed, "the fact of menstruation kept women out of the temples and out of the political and economic lives of their times" (Delaney, Lupton & Toth, 1988, p. 15). When Christ spoke to the Samaritan woman and drank from her vessel, the action was surprising because, according to Jewish laws, Samaritan women were considered as unclean as menstruating women. An early question of Catholic leaders was whether menstruating women should be allowed to enter the church or receive communion.

The medical community has also viewed menstruation and women with a sexist ideology. Early physicians claimed the age of menarche was a reflection of a girl's moral standards--the lower the age of a girl's first menstruation, the lower her standards as well. In the late 1800s, it was commonly recognized that a woman's physical or mental disorders were caused by her sexual organs. A plethora of sexual surgeries followed, from burning off the outer clitoris with hot irons, to effectively castrating her with an oophorectomy (Scull & Favreau, 1986). It was at this time that the symptoms of PMS were first noted. According

to Norris (1983), Brierrede Boismont was the first person to write about the connection between mental state and menstruation. Specifically, he said "various low grade psychotic tendencies appeared at this time" (p. 22). In the years that followed, researchers wrote of the relationship between menstruation and a wide range of physical ailments, including genital herpes, gall bladder attacks, and metabolic changes. Between 1900 and 1931, over 20 papers appeared noting periodic occurrence, in conjunction with the premenstrual phase, of such disorders as epilepsy, arthritis, edema, skin disorders, headaches and psychosis (Norris, 1983).

Robert T. Frank

Robert T. Frank, an M.D., coined the term premenstrual tension in 1931. He described the disorder in the Archives of Neurology and Psychiatry, after first distinguishing the different types of problems that occur premenstrually. Some women experience "increased fatigability, irritability, lack of concentration and attacks of pain" (Frank, 1931, p. 42) of a minor nature. Others have these same symptoms, but they are in sufficient discomfort to require bed rest for a few days. However, a third group of sufferers existed; what clearly made their situation unique was the presence of extreme tension that was only relieved when their periods started. Frank used case studies to support his hypotheses that, first, a condition existed, and second, the cause was excessive female hormone in the blood. His treatment consisted of restricting the amount of hormone released either through drugs or radiation of the ovaries.[2]

"Biology is destiny" appears to be Frank's guiding ideology. Frank mentions in the first paragraph that "it is well known that women suffer varying degrees of discomfort preceding the onset of menstruation" (p. 1053). However, Frank presents no data to document this statement. Also, the effect of the cycle on those not menstruating is noted: "Employers of labor take cognizance of this fact and make provision for the temporary care of their employees" (p. 1053). Thus, within the very first paragraph, Frank's negative labels of women are stated; first, women are victims of their reproductive systems, and second, those who come into contact with women are victims of woman's reproductive systems.

Nothing illustrates Frank's (1931) presumption better than his introduction, to the reader, to premenstrual tension:

> The group of women to whom I refer especially complain of a feeling of indescribable tension from ten to seven days preceding menstruation which in most instances, continues until the time that the menstrual flow occurs. 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 realize their own suffering but they feel conscience-stricken toward their husbands and families, knowing well that they are unbearable in their attitude and reactions. (p. 1054).

In an effort to substantiate his claim, Frank presented a table listing patients he was treating for premenstrual tension, their complaints and treatments used. There were 15 cases cited. Complaints included "severest tension," "suicidal desire," "shrew," "husband to be pitied," "almost crazy," "incapacitated mentally," "sexual tension," and "impossible to live with." Frank's treatment

consisted of x-ray "toning" and elimination. He set great store in x-ray therapy, to the extent that "at present, in the severest cases of this nature temporary or permanent amenorrhea, brought about by roentgen treatment, appears to be the proper procedure" (p. 1056).

Frank was commended by his colleagues. In the discussion section following the article, two female physicians laud him for writing about PMS. Dr. Edith R. Spaulding mentioned specifically those women who have difficulty coping emotionally with their sex lives; many, she said, experience heightened symptoms when given ovarian extract, mainly those whose sexual emotions are expressed through hysteria. Dr. Frank's treatment of eliminating the production of sex hormones will thus be helpful in two ways. First, the women will be helped psychologically by finding more "adult outlets for their emotions." However, she does point out as well that "in many cases, especially in unmarried women with deep-seated emotionally difficulties, the lessening of the sexual drive offers a helpful therapeutic procedure" (p. 1057).

Frank's article found an interested audience. In the years that followed, a spate of research was published linking many recurrent conditions with the period before the period. A major paper was published in the Journal of the American Medical Association, the official journal of the American Medical Association, in 1938 by S. Leon Israel. The article, titled "The Premenstrual Tension," listed the then current symptoms of the disorder, and said progesterone was an effective therapy, after attributing the cause to an excess of estrogen. More research and articles followed.

Katharina Dalton

By 1953, researchers had a long list of problems and behaviors associated with the premenstrual time. In 1953, an issue entrepreneur was able to make people take notice of PMS. Dr. Katharina Dalton, a British podiatrist--later trained as a physician--had been treating herself with progesterone for purported premenstrual headaches. She switched her practice to treating others for the disorder, and published a great number of articles on the subject. One of the earliest was coauthored with Raymond Green. Written in 1953 and titled The Premenstrual Syndrome, Dalton and Green (1964) claimed tension was only part of the disorder, thus premenstrual tension was a misnomer. Calling it the premenstrual syndrome was a way of including other aspects of this disorder.

In 1964, Dalton and Green published The Premenstrual Syndrome, which became a landmark much as Frank's article did. The 18 chapters cover various topics including symptoms, diagnosis and treatment, as well as the effects of menopause, artificial menopause, behavior and social significance. The longest chapter is 13 pages, the shortest is 2 pages, and the average length is 5.4 pages.

Early in the book, Dalton relates key aspects of premenstrual syndrome. As the diagnosis is related to cyclical symptoms rather than a specific set of symptoms, almost any malady can be considered a symptom. Thus, tension, irritability, depression, lethargy, alcoholic excess, nymphomania, sleep disturbance (either insomnia or hypersomnia), headache, epilepsy, vertigo, syncope, paraesthesia,

asthma, engorgement of the nasal mucous membrane, hoarseness, nausea or vomiting, constipation, hemorrhoids, colicky pain, mittelschmerz (a mild cramping pain), abdominal bloatedness, increased appetite or anorexia, hypoglycemia, enuresis, urinary retention, joint and muscle pains, palpitations, varicose veins, spontaneous bruising, dermatological lesions, breast symptoms, conjunctivitis, sties, and glaucoma are all possible manifestations of premenstrual syndrome if they occur cyclically. In addition, certain signs may be present. Fluctuations in weight, edema, fluctuations of blood pressure, albuminuria , facial pallor, puffiness and darkening beneath the eyes, and problems present all the time may worsen during the premenstruum.

To determine if PMS is the cause of the symptoms, Dalton recommends a menstrual chart be kept for three months. The chart lists when symptoms occurred, and when menstruation occurred. By observing if the symptoms consistently precede menstruation, a proper diagnosis can be made. A woman's menstrual history may also be used; pain-free menstruation, the effects of pregnancy, childbirth, estrogens, and stress on symptoms, and continual weight fluctuation all reveal whether or not she is a good candidate for the disorder.

Dalton's treatment varies according to the number, type and severity of symptoms. Some women need only treat the symptoms that occur, such as taking aspirin for headaches. However, Dalton writes that treatment may require the use of drugs, therapy, and dietary restrictions. Of these, Dalton's clear preference is for drugs, specifically hormone therapy in the form of progesterone. Her

praise is high: "progesterone is the most universally successful form of treatment for premenstrual syndrome" (p. 50); "progesterone is the treatment of choice for patients with severe symptoms which have resisted other forms of treatment" (p. 51). Suggested dosage varies from 10 to 100 mg. daily, as the patients respond differently to the hormone. Dalton recommends the initial dose be high, as "it is important first to bring complete relief of symptoms" (p. 52), and gain the confidence of the patient. Subsequent doses may be reduced to the lowest level possible while still relieving symptoms. Dalton admits progesterone is a difficult drug to administer as it must be given in intramuscular injections to be fully effective. The only reference to oral use is made when she writes of synthetic progesterone, or progestogen. Apparently, taking progestogen orally is ineffective, only giving symptomatic relief instead of complete relief. The possibility of progesterone implants is discussed; however, its duration is uncertain, and the procedure can be both painful and unsuccessful.

The etiology of PMS, according to Dalton, has its roots in the adrenal cortex. Within this area of the brain there are many steroids, some of which act as antagonists to each other. The sex hormones, progesterone and estrogen, originate in this gland. Dalton hypothesized that there is an imbalance in the relationship between these two hormones, with an excess of estrogen. Her treatment is an attempt to restore the balance. Progesterone may also act as an antagonist to other hormones; a lack of progesterone may lead to other manifestations such as sodium retention.

The writing style used is colorful, if not descriptive. Women with PMS are called "sufferers" (p. 98); treatment brings "the joys of good health" (p. 51). Once information about PMS reaches the public, "the more sympathetically (they) can regard the inequalities thrust upon woman by her hormonal variations during the menstrual cycle" (p. 92). In her conclusion, Dalton writes of the "untold misery and suffering" of these women, saying treatment brought "dramatic relief to so many deserving women, their families, relatives, and associates." Her plea for progesterone therapy, which is costly, includes a quote from a meeting at the Royal Society of Medicine: "The cost of progesterone therapy is high, but when this charge is weighed against the price in terms of human misery, suffering and injustice, it is seen as a justifiable expense opening up a new vista of Medicine" (p. 100).

These words are not particularly negative towards women. Other statements are. Stereotypical cliches are used: "It's a woman's privilege to change her mind" (p. 2); "She's got one of her moods today" (p. 7); ". . .the unpredictable enigma of women" (p. 77). The supposed poor driving ability of women is attributed to PMS. Successful progesterone treatment could be seen in the woman who was "feeling feminine again, working well, placid" (p. 76). The women themselves report their "high level of guilt at all the trouble they have caused" (p. 7). Even more revealing is how PMS affects other people, especially husbands. She may become "a nagger" (p. 7), may "look for quarrels" (p. 1). The "fluctuations in the mother may result in feelings of insecurity in the child"

(p. 94). According to Dalton (1964), artificial menopause is no panacea:

> after the operation the unaccountable and unexpected attacks of irritability strain the domestic harmony. As one husband put it, "She used to have a reason for it, but now she's quite unpredictable," or another, "I hoped the operation would make her more even tempered." Indeed, one remarked, "Since the hysteria operation my wife's been more hysterical than ever." (p. 75).

"The high cost of women's monthly absenteeism is reported" (p. 94). The most startling statements deal with how little stock one can put in a woman's word. Her work as a teacher, judge, or other authoritative position may be subject to her "monthly fluctuations, rendering her ineffective, even unfair" (p. 77). Spousal abuse by the wife may be the result of the woman's inability to control herself by "(throwing) the proverbial rolling-pin at her husband" (p. 95), while her reports of abuse by the husband should be suspect. As Dalton puts it: "When a woman demonstrates bruises as signs of her husband's cruelty it is well to remember the possibility that these may be spontaneous bruises of the premenstruum and it is wise to enquire about the date of her last menstruation" (p. 94).

Dalton's book is still cited in articles today. Her pioneering effort is duly noted, even if its contents are not.

The Popular Press

PMS was first reported in the popular press in 1952, (Safford) in the Ladies Home Journal column "Tell Me Doctor." For the next 28 years, the Reader's Guide to Periodical Literature lists only two or three articles per year, primarily in women's magazines. A review

of the Readers's Guide to Periodicals shows a dramatic increase in articles about PMS after 1980, with a high of 12 articles in 1986.[3] As for the magazines they appeared in, Mademoiselle had the highest number, with 10 articles (since 1952). Glamour came in second with 6 articles, and Good Housekeeping, Health and McCalls all had published 4 articles.

The articles themselves present PMS as a medical fact, and serve to inform women of the disorder. The tone and style of these articles are similar to Dalton's: anecdotal, colorful and relying heavily on stereotypes. Women are presented as victims of their biology. Little has changed with time, except the more recent articles are more subtle, not so blatantly sexist. One of the earliest, a piece in Time (1956) entitled "Witches Every Month," reports a gynecologist who classifies women as grade-one, grade-two and grade-three witches. Readers Digest (Greenblatt & Frey) wrote in 1955, "It hits 50% of the women of childbearing age, doctors say, and as a result, 100% of the men of every age" (p. 37). Most articles wrote about symptoms to look for, advising women to consult calendars to account for their poor dispositions. PMS may cause marital breakup, child abuse and neglect, accidents and low test scores ("How the Menstrual Cycle," 1969).

The most sexist article was found in McCalls, written in 1973 by William A. Nolen, M.D. He starts by saying 90% of women between 15 and 50 suffer from premenstrual tension. He follows by stating: "When I see a patient with a severe case of premenstrual tension I always say to myself (silently, of course), 'Thank God I'm not a

woman'" (p. 12). After explaining the biological process, he describes the behavior of women with premenstrual tension:

> They don't want their kids making a lot of noise; they don't want unexpected guests for dinner; and they most certainly don't want to hear anyone say, "Oh, come on, cheer up--it's all in your head." In fact, they would like very much to hit with a baseball bat anyone--and particularly a husband--who utters that line. (p. 12)

As for treatment, he says there is no single cure, and symptomatic treatment may also not work. He does say, regarding tranquilizers, "I'm not a big advocate. . .but if there's ever a place for them - besides in the treatment of mental illness - its in the treatment of the tense, premenstrual woman" (p. 12). Nevertheless, the premenstrual woman owes it to herself and those around her to get help. In Nolen's words (1973):

> And if you'll concede, as I will, that the most miserable person in the world is the woman in the grip of a severe attack of premenstrual tension, then you'll also have to concede that the second-most miserable person is whoever is closest to her. It is almost impossible to behave properly toward a woman with premenstrual tension. It's impossible to live or work in peace with her. (Therefore) the woman who knows she is susceptible to premenstrual tension owes it to those who are close to her to help herself. If she doesn't, she isn't being fair to herself or them. (p. 15)

Ironically, Nolen admitted at the end of the article to having been rather ignorant about PMT until he did his research for the piece.

Only one article presents a differing point of view. A review of the book Menstruation and Menopause by feminist author Paula Weideger in ("Culture and the Curse," 1976) includes Weideger's position that menstrual taboos (including premenstrual tension) were the product

of society's fear of women and their desire to keep women second class citizens.

The New York Times first reported on PMS on July 26, 1970 (Lydon). The article did not specifically name PMS; rather, it reported statements made by Dr. Edgar Berman at a session of the Democratic party's Committee on National Priorities. Berman, a member of the committee and close friend of Hubert H. Humphrey, was responding to Patsy Mink's plea for the Democratic party to give women's rights a high priority. In an oddly prophetic statement, he said women were not qualified for positions of authority because "raging hormonal influences make them unstable" (p. 35). In a letter to Ms. Mink after the incident (and in response to her angry reaction), Berman wrote:

> There are physical and physiological inhibitors that limit a female's potential. . . . It would be safer to entrust a male pilot's reactions and judgments in a difficult in-flight or landing problem than to even a slightly pregnant female pilot. (p. 35)

Eight years later Lydon (1978) again addressed PMS indirectly in its "Personal Health" column (Brody, p. 10). Symptoms are listed, along with the assurance that they are real and not imagined, but the label premenstrual syndrome is not used.

Medical Literature

A review of the medical literature after Dalton's book was published reveals confusion regarding the etiology, incidence and treatment of PMS. The symptoms, however, were not questioned. Nor could the increasing interest in PMS be ignored. Between 1968 and

1979, Index Medicus lists at least six articles per year; the average per year was 13 articles. One major change did occur. From 1968 to 1973, the majority of articles were printed in foreign languages; after 1973, English was the language of choice for people studying PMS. During the 1980s, a large amount of interest was generated in the medical community. Between 1980 and 1987, the number of articles listed in Index Medicus increased almost 400%, from 22 articles to 90 articles published per year.

Even though the disorder has been written about and studied, diagnosed and treated with drugs, the medical community has been reluctant to grant PMS syndrome status. Premenstrual tension was used in Index Medicus with nearly the same frequency as premenstrual syndrome until 1982, at which time PMS became the name of choice of authors. Index Medicus itself did not officially change from PMT to PMS until 1986. Even premenstrual tension syndrome has been infrequently used.

In the early articles, PMS was associated with many different factors to see if a relationship existed. PMS was studied in conjunction with anxiety and libido changes (Shader, DiMascio & Harmatz, 1968), food cravings (Smith & Sauder, 1969), children's doctor visits (Dalton, 1966), oral contraceptives (Herzberg & Coppen, 1970), body composition (Herzberg, 1971), physical exercise (Timonen & Procope, 1971), "psychogenic" anemorrhoea (Russell, 1972), mood, weight and electrolytes (Janowsky, Berens & Davis, 1973), affective disorder (Wetzel, Reich, McClure & Wald, 1975), baby battering (Dalton, 1975), selective breeding through time (Rosseinsky & Hall, 1974), functional

infertility (Benedek-Jaszmann & Hearn-Sturtevant, 1976), depression in men and older women (Brush & Taylor, 1977), psychiatric admission (Zola, Meyerson, Reznikoff, Thornton & Concool, 1979), and central nervous system imbalances (Halbreich, 1979).

A number of interesting claims can be found within these articles. Many wrote of the debilitating nature of severe PMS. Russell notes that in extreme cases, mental instability, criminal acts or violent deaths may occur (1972). Symptoms include depression, irritability, fatigue, tension, headache, pain in stomach, anxiety, nausea, impatience, and argumentativeness (Herzberg, 1971; Herzberg & Coppen, 1970; Janowsky et al., 1973; Russell, 1972; Smith & Sauder, 1969; Wetzel et al., 1975). Mental disturbances may flare up premenstrually (Zola et al., 1979). Dalton specified child or spouse abuse as criminal behaviors often caused by PMS (1966). The need for physicians to treat PMS, as opposed to other health professionals, was addressed by Dalton as well. And it was suggested that husbands be enlisted in the treatment process as being calming influences.

The most interesting cause of PMS was suggested by Rosseinsky and Hall (1975) and Morriss and Keverne (1974). Morriss and Keverne thought PMS was caused by infertility in the male. The longer the female remains without child, the greater her hostility. This hostility leads to a breakdown of the relationship, enabling her to seek a more "productive" partner. Rosseinsky and Hall countered with their own interpretation, and said there was an evolutionary basis to PMS. PMS frustrates the male sexually, according to Rosseinsky and Hall. Intercourse is delayed until after menstruation,

thus raising the chances that the sexually frustrated male will copulate more, and increase the likelihood of fertilization.

In a constructionist perspective the history of an event provides crucial information. In the case of PMS, its history reveals a not so subtle undercurrent of sexist ideology. From its humble beginnings PMS was seen as the reason for a variety of stereotypical behaviors possibly exhibited by women. The "sexual surgery" of the 19th Century illustrates the fact that people did not question the notion that a woman's emotions were seated in her pelvis. Early proponents of PMS were no less blatant; Robert Frank and Katharina Dalton presented women as being victims of their biology, then used current sexist stereotypes to support their theories. Their treatments seem as barbaric as their predecessors. The image presented in the popular press, though it aimed to be helpful, did not challenge the negative aspects of menstruation. Rather, it embraced PMS, and gave women few options whether to accept it or not. The medical literature was also clearly negative. While it did not accept PMS completely, when it did study the menstrual cycle usually it looked at any negative reaction a woman might have. Thus, PMS had become the medically sanctioned "reason" for the myriad of odd behaviors a woman might exhibit before her period.

CHAPTER IV

ACTORS IN THE CONTROVERSY

Numerous groups have been involved in the current debate over PMS. They are significant in that their actions help shape the definition given to PMS. The legal community, for example, seems to have been the conduit for introducing PMS to the public, not just the select few who read women's magazines or medical journals. This chapter presents these actors, and aims to reveal their motives behind accepting or negating PMS. Included are the legal community, feminists, the mental health community, pharmeceutical companies and entrepreneurs.

The Legal System

PMS was first exposed to a large audience under unusual circumstances. In England, two women successfully used PMS as a mitigating factor when being sentenced for violent crimes. As reported in the New York Times (Brozan, 1982), Sandie Smith, a 29-year-old barmaid, was put on probation after attacking a policeman with a knife. Previously she had stabbed another barmaid to death. Her lawyer, saying each month she was turned "into a raging animal," said her premenstrual condition was the cause of her behavior. The next day, Christine English was conditionally discharged after pleading guilty to manslaughter; her lawyer claimed Ms. English had killed her lover while in a premenstrual frenzy.

Shortly after these cases gained attention, Shirley Santos, an unwed mother of six living in Brooklyn was accused of child abuse. Her court appointed lawyer, Stephanie Benson, said, "Miss Santos repeatedly said to me, to policemen, to ambulance attendants, that she had been depressed and fatigued because of her period. It became very clear that she was suffering from the same disorder as the women in Britain" (Brozan, 1982, p. C16). This case, the first in the United States to use PMS as a defense, had a different sequence of events than the ones in Britain.[4] It was revealed during questioning that Ms. Santos struck her child after her period had started. The case was resolved when she pleaded guilty to a lesser charge, harassment, and released with the stipulation that she stay in a counselling program for one year.

Lawyers on both sides of the case claimed victory. Elizabeth Holtzman, the Brooklyn District Attorney, said "the withdrawal of this defense is a signal that PMS is a defense without merit. . . . There is not scientific evidence that there is any such thing as a syndrome which causes women to become insane or violent in connection with the menstrual cycle" (Bird, 1982, p. B4). In addition, the penalty Ms. Santos received was normal for a case where the injuries were minor and the defendant had no previous record, according to Holtzman. Stephanie Benson, Ms. Santos' lawyer, said in a letter to the editor of the New York Times, that "I wholeheartedly believe that without the PMS arguments Ms. Santos would still be facing criminal charges. The fact that they were all dropped is, instead, a testament to its validity" (Benson, November 15, 1982, p. 18).

She also stated the nature of the PMS defense should not have been interpreted as an insanity case.

The association between crime and PMS has been studied with inconclusive results, due mainly to methodological problems. Katharina Dalton, the PMS issue entrepreneur, first gained notoriety by testifying at the trials of the Englishwomen. Dalton (1980) has been saying PMS can cause violent behavior for a long time:

> Aggression in women may be one of many presentations of the premenstrual syndrome, occurring suddenly without provocation in the premenstruum and with complete normality at other phases of the menstrual cycle. Women appear in court charged with assault, homicide, and arson; detention is not a deterrent and while in custody self-injury--slashing wrists, shaving hair, hanging, arson and suicide--are commonplace. (p. 255)

Yet in the aftermath of the trials, she was overwhelmed by requests from lawyers to aid their clients. "Lawyers are sending more and more cases to me. It's a great worry because I get plenty of rubbish. The courts will accept premenstrual tension if it's the genuine article, but doctors have to be more careful about the diagnosis" (Fields, 1982, p. 95).

Using a PMS defense is difficult to begin with. First, lawyers must prove it exists to the court. Second, they must prove their clients suffer from it, which could be very difficult if no medical records establishing it exist. Third, a connection must be made between the disease and the crime (Press, 1982).

Lawyers are skeptical about the PMS defense. "Nancy Morrison, a former judge in the British Columbia criminal and family courts, admits, 'During 18 years in court, I've never run into PMS, and in

some cases it may well be greeted with hilarity'" (Gray, 1981, p. 47). Others are more concerned with the end results; if a woman is released on the basis of PMS, she could be sent to a mental institution, making the cure worse than the disease.

The greatest worry is the long term effects of using PMS as a defense. Lawyer Silver Dranoff warned: "Elevating PMS to a behavior pattern sufficient to get a woman off a criminal charge is tantamount to saying that we can't control our behavior when we're premenstrual and that's ridiculous. I regret that PMS is being taken seriously in legal systems anywhere" (Gray, 1981, p. 48). Said Judith Levin, a lawyer who specializes in women's issues, "this could be misused to support a spurious theory that all women are prisoners of their biological processes and can't be held responsible" (Angier * Witzlebin, 1983, p. 120). And H. Richard Uviller, a professor of criminal law at the Columbia Law School, says that as a feminist he is outraged: "Do we now say that the full moon causes crime and that the actor is not criminally responsible?" (Chambers, 1982, p. 46). PMS may even be used as a means for abusing women; Elizabeth Holtzman, the D.A. involved in the Santos case, fears some may justify abuse by saying, "If a woman's out of control, you've got to control her" (Allen, 1982, p. 38). Ironically, in Buffalo, N.Y., PMS was turned against women when a dentist was acquitted of rape and sodomy in November, 1982 after claiming that his girlfriend had filed charges during a period of premenstrual irrationality (Herbert, 1982).

Some lawyers see clear benefits in using PMS as a defense, if it is handled correctly. In a paper published in the Women's Rights

Law Reporter (1986), Linda Chait offers a guideline as to how to present a PMS defense. She suggests lawyers educate the judge and jury about menstruation to dispel any myths or misconceptions that could be used against a client. PMS must be presented as an organic condition, like hypoglycemia and epilepsy, to avoid its becoming a "women's defense." Finally, when considering which type of defense to use, she prefers the diminished capacity plea, or as a mitigating factor in sentencing. She clearly counsels away from using an insanity defense. Another feminist lawyer says succinctly, "If it's grounded in fact, let's use it" (Gray, 1981, p. 47).

Other lawyers feel no qualms about using PMS, and they do not feel they are selling women short. Edmiston (1982) is a good example when she says:

> I'm a feminist, a very, very ardent feminist. . . . Hypoglycemia had been used successfully as a legal defense in cases of murder and assault, and spontaneous hypoglycemia is one of the symptoms of PMS. Hypoglycemia causes aggression, sudden outbursts, amnesia such as my client described, tiredness, fatigue. I'm looking at PMS as if it were such a defense. . . . The D.A. is saying there's no evidence of PMS. They're trying to discredit something that could really be happening to women. It's reckless; it's a knee-jerk feminist response. Nobody's going to say, "No more women need apply because of PMS"; it hasn't hurt women up to now. . . . But this fear of talking about it is bad. Nobody is saying, but everybody has it. Premenstrual syndrome has a real basis in fact. I hurt and other people hurt. (p. C2)

Ronald Norris (1983) dismisses fears that PMS will implicate all women, saying since it affects very few women, the entire group will not be under suspicion. "Despite the media attention given to PMS murder cases, examples of women out of control because of premenstrual syndrome are extremely rare. They're almost as rare as bubonic plague"

(Andrews, 1985, p. 55). Dalton points to the fact that in France, premenstrual syndrome is recognized as a cause of temporary insanity (1980).

Feminists

Feminists are divided on the subject of PMS. In what seems to be a no-win situation, feminists feel they can either deny PMS altogether, possibly hurting those women who are affected, or accept its legitimacy, possibly opening the door for future discrimination. As Linda Chait (1986) has written:

> PMS has been characterized as a double-edged sword. If denied or treated lightly, researchers will ignore it and women whose symptoms could be treated will continue to suffer. On the other hand, since the menstrual cycle is one of the few real biological differences between women and men, when we do acknowledge menstrual problems, they are alleged to be evidence of our biological inferiority. (p. 277)

Feminist attorneys (Chait, 1986) face the problem of serving their clients versus not serving the community of women:

> Fear has been expressed that all women could be labelled "deficient" and in a society that routinely discriminates against women, PMS could become just one more excuse for denying women access to jobs and positions of power. . . . Others are more concerned that the pressing needs of women sufferers may go ignored while the feminist community debates whether PMS is a "politically correct" disease. (p. 271)

In the feminist publication Our Bodies, Ourselves (The Boston Women's Health Collective, 1976), PMS was mentioned once in passing, and emphasizes the physical symptoms like nausea, water retention, headaches, back aches and tension. In the 1984 edition of Our Bodies, Ourselves, the authors (The Boston Women's Health

Collective) presented PMS as a natural part of the menstrual cycle. Katharina Dalton was cited as the person who identified and popularized PMS. The symptoms were listed, and treatment suggestions were made. Progesterone was listed as a popular treatment, though the authors did say "There have been few controlled studies to test whether progesterone actually works better than a placebo or another remedy. . . . Effects of long-term progesterone use is not known; the few animal studies done indicate problems" (p. 214). "Dietary changes are suggested, as are exercise" (p. 42), "acupuncture" (p. 65), and "birth control pills" (p. 244).

Andrea Eagan, who wrote the 1983 Ms. magazine article, and Jennifer Allen, author of the 1983 New York piece, are feminists who do not accept the legitimacy of PMS. Skeptical and highly critical of the entire process by which a woman is diagnosed and treated, these feminists see PMS as dangerous in that it could be used to discriminate against all women. Eagan (1983), wondering about the safety of the untested treatments, likened current practices to past experiences with estrogen replacement therapy, concluding, "I fear that, somewhere down the line, we will finally learn all about progesterone treatment, and it won't be what we wanted to know" (p. 31).

Others say people believe PMS exists because it fits the stereotypes that exist about women (Chait, 1986). Or, as Allen has recounted, various studies have shown that people behave the way they think they are supposed to behave. Women who have been led to believe they are in their premenstrual phase report more

premenstrual tension. Karen Paige (Chait, 1986) found women's premenstrual complaints varied with their religion, with Catholics reporting the most problems, followed by Jews and then Protestants. Another study showed that both men and women, if they believe a woman is in her premenstrual phase, will attribute her actions to her menstrual cycle.

In The Curse, Delaney et al. (1988) chronicle the cultural history of menstruation. Early in the book, they write that tribal African !Kung women were studied for signs of PMS both in interviews to determine their moods, as well as by examining blood samples for hormonal fluctuations. While the blood samples yielded the same results as the blood samples of women already diagnosed as having PMS, the !Kung women themselves did not display any of the difficulties the PMS-women did. Yet, the authors note this may have been due to the !Kung women's excellent physical conditioning. Another possible explanation was given; the !Kung women were normally pregnant or nursing.

Perhaps PMS becomes a problem in industrialized societies where women do not constantly bear and rear children. The effect of PMS on women's absenteeism is rejected, as Delaney et al. (1988), report the correlation between the two has not been proven. Also denied is the supposed negative affect PMS has on women athletes. After noting a study of female Olympians that showed these women were able to perform admirably while premenstrual, they state the likelihood of women who do suffer from PMS of reaching Olympic levels of competition as slim, thus these women would never have the chance of being studies. Yet,

fears of PMS affecting women while in athletic competition do exist. As Dick Butera, owner of the Philadelphia franchise of the World Team Tennis League, said after revealing he planned to hire more female athletes than he needed at one time: "What happens if Billie Jean wakes up the morning of a big match and she's got her period bad? What are you going to tell the fans?" (p. 61).

In the afterward to their chapter on PMS, Delaney et al. (1988) wrote about the changes that occurred since 1974, when the book was first published. They note the jokes and novelty items, the variety of cures offered, the multitude of books and articles, the legal question, and the overabundance of organizations (both for and not for profit) whose goal is to treat women with PMS. When one of the authors appeared on a nationally syndicated television talk show, "woman to woman," to discuss the PMS controversy with 14 other women, the results were recounted in this manner:

> The discussion was more than lively; it was occasionally bitter and accusatory. As the group debated the merits of therapies and the publicity generated by PMS as a legal defense, it illustrated the "PMS dilemma": how far can medicine go to recognize, treat, and "legalize" PMS as an exclusively female condition without endangering the extremely tenuous position of women in the economy and the political arena in the 1980s and beyond? Women are becoming publicly divided on this problem, with many of those who call themselves feminists generally seen as opposing the publicizing and dramatizing of PMS symptoms, not only because of the impact such ideas could have on women's progress in the world, but also because they see women being exploited in a new way. (p. 102)

Delaney et al. (1988) also quote Randi Daimon Koeske, a researcher who finds fault with those who try to relate "bad" emotions

to biological cycles as well as others who deny any relationship at all between the emotions and the cycle. Koeske asks "Why are the positive emotions associated with the premenstruum never studied as a clue to premenstrual behavior or to the real nature of women and their cycles?" (p. 125). Koeske, a psychologist, has presented a new way of approaching menstruation. It is her contention that society has created and reinforced stereotypes about women's irritability. In another article, she suggests that women "Learn to identify premenstrual physical changes as irrelevant to emotion" ("Culture and the Curse," p. 59).

The Mental Health Community

Within the medical community, the debate over who should treat women with PMS has raged for decades. Katharina Dalton specifically states in her book The Premenstrual Syndrome (1964) that, while psychotherapy may be helpful, it should by no means replace the treatment a physician can provide. Members of the mental health community feel that, since much of the disorder is clearly psychological in nature, they should definitely be included in treating patients.

During the 1980s physicians and mental health professionals made efforts to emphasize PMS with either biological or psychological symptoms. The mental health community was determined to claim PMS, though. While mental health professionals acknowledged the physical aspects of PMS, they also emphasized the social and psychological sides. In an editorial in Psychosomatic Medicine (1986),

Brooks-Gunn wrote:

> While we know a great deal about hormonal variation, cultural beliefs, and menstrual knowledge acquisition during adolescence, we do not know to what extent these and other factors influence each woman's overall menstrual experience. (p. 385)

There has been an effort to link PMS with affective disorders, especially depression. The fact that, in the past, before much was known about PMS women sought help with psychiatrists has not been lost on the mental health community. Thus, they account for the women who continue to seek treatment as perhaps psychiatrically ill women who are less able to cope with symptoms that healthy women find tolerable ("Premenstrual Uncertainties," October 22, 1983). Another possibility is that when the symptoms are exacerbated by "stresses, life problems or personality weaknesses" (Magos & Studd, 1983, p. 1301) women seek treatment. Howard Osofski, after noting that women with affective disorders are at risk for developing PMS, reasons: "It would appear likely that severe premenstrual changes are not due to any single factor and that biological, environmental, and psychosocial factors must be considered" (1985, p. 302).

One major drawback for the mental health community was the fact that PMS was not listed in its diagnostic manual, the Diagnostic and Statistical Manual of Mental Disorders 3rd ed., also known as DSM-III (1987). During the annual meeting of the American Psychiatric Association (APA) in 1986, members debated whether to include premenstrual dysphoric disorder, the name APA officials used instead of PMS, in the upcoming revised third edition of the DSM. Proponents of the addition claimed that, in addition to responding to real clinical

problems enabling psychiatrists to better treat patients, inclusion would also encourage insurance companies to reimburse physicians for treating the problem. Opponents said the diagnosis of PMS as a mental disorder had not been sufficiently proven, and that it could be misused to discriminate against women (Carey, 1986).

In a letter to the editor of The Lancet, Sally K. Sererino and Saverio G. Mortati (1986) addressed the fears expressed by opponents of the inclusion of PMS in DSM-III. They referred to PMS as perilu-teal phase dysphoric disorder, or PPDD, and did not feel the problems presented were serious enough to prevent inclusion. In response to fears of feminists that a psychiatric diagnosis would stigmatize women, they responded "the classification relates not to individuals but disorders" (p. 1386). Premature ejaculation is a condition known only to men, yet DSM-III lists it. Even though not much was known about the etiology of PMS, this should not be a reason to resist it. Sererino and Mortati reminded readers that this never stopped other disorders from being included; indeed, research would provide the answers that could redefine PPDD. Until more was known, however, there must be a starting point. They dismissed fears that the court system would be faced with women trying to "get away" with bizarre or violent crimes, since a psychiatric diagnosis would readily be at hand. Such "implications are not medical issues and should not be the basis for deciding whether to classify" (Sererino & Mortati, 1986, p. 1386). They conclude their letter by saying:

> Human behavior cannot be understood within any single frame of reference. While a hormonal frame of reference is accu-rate in itself, it is not sufficient to understand all that

> a woman is experiencing. To acknowledge that women with PPDD need the skills of psychiatrists means to accept all social, political, legal, and reimbursement ramifications of doing so. The current public debate could reach the point where it inhibits scientific exploration of the syndrome. Nothing can be studied and understood until it has been recognized and described. If the medical decision to describe PPDD gets stopped because of all the turmoil, clinicians and women will be deprived of a fuller understanding of this entity. More serious, women with PPDD may be deprived of potential treatments for the disorder. Let us pick up the challenge and make it possible for women with this disorder to come forward. Medicine, not politics, must maintain control of the diagnostic process. (p. 1386)

The authors' bid was partially successful as PMS was included in the 1987 revised edition of DSM-III; however, its inclusion was listed in Appendix A: Proposed Diagnostic Categories Needing Further Study. In the introduction to this section, the authors state, "This appendix presents three diagnoses that were proposed for inclusion in DSM-III-R. They are included here to facilitate further systematic clinical study and research" (American Psychiatric Association, 1987, p. 367).

In an interesting turnaround, three Australian researchers reported the inclusion was actually an example of social health injustice (Hart, Russell & Coleman, 1987). In their report, the central issue was whether mental illness is actually inappropriately labeling behavior as a means of social control. They saw PMS as a social response to unacceptable moods in women. When women report feeling very angry, tense, aggressive or hostile, they are told in effect such emotions are "incorrect." The women then feel guilty and anxious about having unacceptable emotions, leading them to seek counsel. The authors concluded that PMS should be seen as partly a

biological phenomenon and partly a social phenomenon but not a psychiatric illness.

Pharmaceutical Companies and Entrepreneurs

Since there is debate about the safety of progesterone, the FDA has not approved it for the treatment of PMS; physicians can prescribe it, in whatever dose he or she sees fit, and a pharmacy can fill the prescription. Herein lies another issue surrounding PMS. Because progesterone must be hand made by pharmacists (Allen, 1982; Eagan, 1983), many would or could not fill the order.

Yet progesterone is a very lucrative drug. It costs one dollar per each 20 mg dose, though it can run as high as $2.75 per dose (Allen, 1982). A one month supply can cost anywhere from $32.00 to $55.00, depending upon the type of treatment (Allen, 1982). Thus, a group of pharmacists has gone into business making progesterone. There is even a company, the Professional Compounding Center, that packages a progesterone kit called Apothakit for pharmacies short of know-how (Allen, 1982).

There is a fine line between what these pharmacies are doing and the Food and Drug Administration (FDA) restrictions. One company, Madison Pharmacy Associates, reports having between 800 to 1000 customers (Allen, 1982). Another company, H & K Pharmaceuticals, was shut down after authorities were told it was manufacturing and shipping progesterone to pharmacies, physicians, and patients without proper federal approval. Drug companies are waiting for the FDA to approve testing and subsequently the sale of progesterone. Though the drug

cannot be patented, there is optimism that "it will become just like toothpaste. Ten percent of that market is a hell of a lot of money" (Allen, 1982, p. 41).

Madison Pharmacy Associates or MPA (Ahlgrimm, 1986) provides literature to any who ask for it. Background information about the company is included. MPA was the direct result of co-founder David Myers' experiences, as his wife suffered from PMS. After contacting Katharina Dalton, Myers and his partner Marla Ahlgrimm, both registered pharmacists, worked together to create a treatment for Myers' wife. Word spread about their work, and in 1982 Madison Pharmacy Associates was started. According to Myers and Ahlgrimm, their success is due to satisfied customers; statements such as "You are providing an excellent and much needed service! My life has really turned around" and "I thought I was going crazy until Dave and Marla helped me" are included in the literature. Their desire to help clients led them to create PMS Access, a division of MPA aimed at PMS education and referral.

A significant portion of the brochure is devoted to information about PMS. The authors stress the importance of charting one's cycle, to see if there is a cyclical aspect to their problems thus indicating PMS. In their booklet Premenstrual Syndrome: The Odds Are Almost Even, (Ahlgrimm, 1986) other basic information such as drugless treatments and the most common symptoms and experiences a woman with PMS may have are included. At the end of the booklet, MPA is marketed. The hormonal products MPA makes are advertised, with a note saying hormonal treatments should be prescribed by a physician. Should the patient's physician be unable to meet the

woman's needs, however, she is advised to call MPA and speak to one of their pharmacists. MPA has an entire line of products for sale. Their "Self help plus PMS packet" has books, a PMS Access newsletter, physician referral list, and $10.00 value coupon, a $25.00 value for "only $9.95." Individual books are for sale, covering topics such as PMS, hypoglycemia, endometriosis and post-partum depression, by authors such as Katharina Dalton and Michelle Harrison. A cassette is available for $6.00; a slide show (suggested for PMS support groups) is $125.00.

The most surprising part of the brochure is the order form for vitamins and progesterone. A variety of vitamins are available, from B6 to magnesium, as well as MPA's own ProCycle Multivitamin-mineral Supplement, which sells for $6.95 for 90 tablets, $13.50 for 180 tablets. Progesterone is sold in capsules, suppositories, liquid suspension, powder, and oral tablets; dosages vary from 50mg to 400mg. The prices are quite high, from $.52 to $1.10 per dose. Customers can pay by check, credit card, or C.O.D. and may place an order 24 hours a day, using MPA's toll free number.

There is much to question about Madison Pharmacy Associates. Myers and Ahlgrimms' credentials for treating PMS are slim, only their own research and experiences with women with PMS, and "PMS Training and Accreditation from Dr. Katharina Dalton, M.D. London England" (Ahlgrimm, 1986, p. 1). Their slogan, "We're dedicated to providing knowledge, hope and help to women" (p. 1) emphasizes a rounded approach to treatment, but their brochure, naturally, is intended to sell their products. And though they purport to take

PMS seriously, (Ahlgrimm, 1986) their initial advice to women who think they have PMS is trite:

> The 3 most important things you can do to help yourself right now:
> 1. Go for a walk.
> 2. Eat a bran muffin.
> 3. Call (608)833-7046 for your free 90-tablet supply of ProCycle Multivitamin-mineral Supplement. (p. 1)

Lest the customer think this free vitamin pack is harmless, a warning is included that she should discontinue use if a tingling or numbness in extremities occurs.

Self help groups and businesses have sprung up. One support group in Dunham, North Carolina, had a novel way of raising money. "For a dollar a whack, PMS victims and their family members can take mallets to an old car with an enraged woman's face and the words 'MISS PMS' painted on it" (Allen, 1982, p. 38). The most well known group is called PMS Action. Started by Virginia Cassara, a social worker, PMS Action was the end result of Cassara's own experiences. After years of problems, including a failed marriage, Cassara read about PMS while waiting to see yet another doctor. She sought out Katharina Dalton in England, started progesterone treatments, had success with it and returned to the United States to spread the good news. As of 1983, the group had an annual budget of $650,000, 17 paid staff members and 40 volunteers. For a fee, women can be counselled in person or over the phone, and can get more information through the mail (Eagan, 1983).

Cassara herself spends time traveling and lecturing. Her speech is filled with the speech of the '70s social movements: Women

need to "come out of the closet, and physicians need to have their consciousness raised" (Allen, 1982, p. 37). She feels the real issue of PMS lies not with whether or not it exists but with whether it is treated properly. Her choice of treatment is progesterone, saying diet and exercise routines are difficult to maintain and do not always work. As for the FDA restricting progesterone, she states, "I think its paternalistic of the FDA to make those choices for us, to tell us what we can and cannot put into our bodies. Women with PMS are competent beings, capable of making their own choices" (Eagan, 1983, p. 36). While she says progesterone may not work for everyone, the choice should be the woman's to make.

Some have gone into business running clinics, and claimed to be able to diagnose and treat women with PMS. Often the procedure used was very simple. Women paid anywhere from $295.00 to $400.00 for two or three visits (Allen, 1982). At the first visit, a variety of psychological and physical tests were taken. PMS was then explained, along with directions on how to chart one's cycle. At the next visit, charts were analyzed to determine if the woman had PMS, and if she did a prescription for progesterone was given, along with tips on dietary changes that might help. Any lab work cost extra, injections were extra, even the sheet of paper used to chart one's cycle was extra. However, there was no way to tell from a series of tests whether or not a woman had PMS; charting was the most widely used, but the other tests these clinics ran did not necessarily reveal anything. Some suggested they were used only as a means of getting to know the patient.

Often the attitude of those running the clinics was that all women should at least have been tested, whether symptoms existed or not. "At another Manhattan center for the afflicted, a nurse asks an innocent visitor what her symptoms are. None that she can think of, says the woman. Well, says the nurse softly, 'maybe you should consider a blood test. You may have it and not know it'" (Allen, 1982, p. 38). A brochure advised women "if you have any of the cyclical symptoms, you should be referred for an evaluation" (Allen, 1982, p. 38).

The existence of questionable practices is acknowledged. "Other (clinics) I've heard are ripoffs. They charge high fees, try only one treatment and hold out too much false promise for too much money" said Dr. Jean Endicott, a professor of clinical psychiatry at the College of Physicians and Surgeons of Columbia University and director of the Premenstrual Evaluation Unit there ("Premenstrual Syndrome Keeps Doctors Guessing," p. 5).

One individual has consistently misrepresented himself to clients, and has been in trouble with the FDA as well. James Hovey claimed to have a B.A. from UCLA in public health, although a check on his records by the Village Voice revealed he had only completed a few extension courses, not to mention the fact that UCLA does not even have a B.A. program in public health (Eagan, 1983). That was the first in a series of misrepresentations and lies he told. In an article in Ms. magazine (Eagan, 1983), it was reported that Hovey met Katharina Dalton in England, learned of PMS and progesterone, and returned to the United States only to work at a new PMS clinic

with a Boston physician. He left the clinic a few months later and opened The National Center for Premenstrual Syndrome and Menstrual Distress in New York City, Boston, Memphis, and Los Angeles.

In 1982, Hovey's wife Donna, a nurse who was working at the New York clinic, told reporters that they were participating in an FDA approved study of progesterone. Eagan (1983) found out afterwards the only study the FDA had approved was not associated with the Hoveys. After a negative article about him was printed in the Village Voice, in which it was revealed his qualifications for running a PMS clinic consisted of having been a former Army medical corpsman, Hovey left the clinics and said he was going to devote his time to research. His research was not approved by the FDA because the doses of progesterone were considered too high.

Hovey turned up again in 1984 when the FDA Consumer reported his further troubles with the FDA. After receiving reports of a company that was selling progesterone, the FDA investigated only to find H & K Pharmaceuticals, Hovey's firm, was indeed selling progesterone illegally. He was warned not to continue his practice, and said shipments would be stopped. Only a few days later it was learned that H & K Pharmaceuticals had shipped several packages, one to a physician in Massachusetts; the packages contained progesterone. When contacted, Hovey said the packages had been sent by another family member without his knowledge. The FDA in turn sent Hovey a regulatory letter which is documentation of a company's improper actions, and which commits the FDA to take action (as in recall, seizure, injunction or revocation of a license) if the violation is

not corrected promptly. H & K Pharmaceuticals went out of business shortly afterwards (Hommel, 1984).

CHAPTER V

CURRENT TREATMENTS

Current treatment of premenstrual syndrome can be called unpleasant and difficult (Allen, 1982; Eagan, 1983). PMS has a remarkable placebo affect--it responds to most treatments initially (Hopson & Rosenfeld, 1984; True, Goodner & Burns, 1985; Vaitukantis, 1984). And it seems just about everything has beentried. Drugless treatments center around lifestyle changes; women are advised to cut back on salt (Claverie, 1987; "Premenstrual Syndrome," 1985; Witkin-Lanoil, 1985), exercise more (Fortino, 1987; "Premenstrual Syndrome," 1985), eat more grains and fresh fruit (Burtis, 1987; Malkin, 1986), eliminate caffeine (Claverie, 1987; "High Caffeine Intake Linked to PMS", 1986; Witkin-Lanoil, 1985), learn stress management (Cantarow, 1986), do stretching exercises (Claverie, 1987; "Stretch away PMS," 1988), drink no alcohol (Claverie, 1987), take vitamin E ("PMS Eased by Vitamin E," 1987), evening primrose oil (Breecher, 1983) and vitamin B6 (Claverie, 1987). The list of physicians' "favorite pet treatments" is also varied: "minor tranquilizers, oral contraceptives, regular breakfast, orgasm, bromocriptine, scientific information and emotional support, potassium, calcium, amphetamines, ibuprophen, and hiding in your room" (Gonzales, 1981, p. 1395).

Katharina Dalton has been using progesterone since the 1950s,

and although tests on the drug thus far are inconclusive, she relies on anecdotal success stories. Progesterone, the sex hormone produced in large quantities after ovulation, has not been approved by the Food and Drug Administration for treatment of PMS, though it has approval for other menstrual problems. There is evidence that it causes cancer in rats and beagles. There is no literature on its long term effects on women. Yet, an underground information system is being used by women who want progesterone treatments (Allen, 1982).

Those physicians who are willing to prescribe progesterone are overwhelmed by new patients, even though the treatment is rather unpleasant (Allen, 1982). The amount of progesterone used in treatment varies depending on the physician. While the Food and Drug Administration has approved progesterone in 5 and 10 mg doses for women with irregular periods and uterine bleeding, women with PMS have been known to take up to 2400 mg daily in suppository form (Eagan, 1983). Side effects include swelling in the vagina and rectum so severe that walking is difficult, chest pains, dizzy spells, no bleeding, constant bleeding, and vaginal infections.

The aesthetics of progesterone treatment are also unpleasant. According to Allen (1982) and Eagan (1983), used as suppositories it leaks, or in the rectum it is frequently expelled. It makes intercourse painful as it leaves a gritty residue. It tastes unpleasant when the powdered form is sprinkled under the tongue. When injected, the constant shots leave the buttock sore and bruised.

Even faced with these side effects, doctors still prescribe it

and women still use it. Michelle Harrison, a gynecologist, said, "I treat people with it because sometimes it works" (Allen, 1982, p. 40). The women are frightened, but as one said, "We're scared to death. We don't know what we're doing, but the medics aren't helping us" (Allen, 1982, p. 40). Even though there are serious questions about progesterone's safety, the sentiment expressed by women is that PMS is worse than anything progesterone could do to them, even give them cancer. Other physicians have seen no serious side effects and continue to praise progesterone. Said Dalton, "This drug is safe and effective, there's no question about that. I've used it personally for 35 years in thousands of patients, and the results have been quite satisfactory" (quoted in Vinocur, 1983, p. 36).

Dalton intended to report her experiences at FDA hearings in an effort to encourage the FDA's approval. Other physicians applied to the FDA for permission to study progesterone suppositories, but the FDA refused when it was revealed the dosages exceeded 200 mg per day, the limit set by the FDA's Fertility and Maternal Health Advisory Committee (Hommel, 1984). The FDA has also prevented large scale production and distribution of the drug. Doctors can, however, prescribe it in whatever dosage he or she sees fit and a pharmacy can fill the prescription.

The political nature of PMS becomes apparent when the various groups that deal with it are studied. Much more than a simple condition that may or may not make life difficult for some women, PMS is big business to the drug companies that seek to make money by

making progesterone. On a smaller scale, PMS also means money to entrepreneurs who open clinics. For lawyers, PMS is a possible legal maneuver to be used either for their clients or against their opponents. For the medical community, it acts as a way to expand its influence. It is perhaps for this reason that the mental health community seeks to establish PMS as lying within its' jurisdiction. For feminists, PMS poses a true dilemma. It can be viewed as a threat to feminist ideology, as it can only (by definition) apply to women, and it presents a rather negative picture of how women respond to their menstrual cycles. It can also be seen as a true, enlightened and liberating discovery, by acknowledging the unavoidable biology of women's lives. This view likens women with PMS to epileptics who have not taken their medication; they may act out in a way that is unacceptable to society, but they are not to blame entirely for their actions. Thus, PMS affects more that the woman who may have it, the the decisions made regarding PMS may have more to do with who has power than what is best for the women alone.

CHAPTER VI

DISCUSSION

Simply reviewing the past is not a good way to understand it. With this thought in mind, this thesis sought to apply several theoretical constructs within sociology to the subject of PMS. Three concepts were especially useful. This author sees PMS as a new method of social control, one that is enforced by the medical community, though with the sanction of the greater society. Closely related for this thesis is the concept of the medicalization of deviance. In the case of PMS, behaviors that were not noticed before, or merely accepted as part of the menstrual cycle, were grouped and labeled as premenstrual syndrome. The last sociological concept is "claimsmaking," the statements made by any group or individual which can reveal the claimsmaker's hidden agenda.

Social Control and Claimsmaking

Gamson (1968) presented social control as being one application of power, which was owned by the system, and that the system also worked to resolve conflict. The ultimate goal of leadership was to achieve societal goals without costly side effects. The creation of PMS could be a means to reaching these goals, if the goals include stability for the power structure. PMS can be effectively used to prevent women from gaining status, equality and power by discrediting their abilities, and by legitimizing stereotypes that exist.

Just as the dentist accused of rape was acquitted by saying his girlfriend was irrational at the time she filed the charges due to PMS, the words and actions of women can be filtered through a mental PMS screen and that which does not fit what society prefers may be questioned.

Though its existence was written of as far back as 1931, it was not until 50 years later that physicians and others paid any real attention to PMS. During these 50 years, the manner in which it was described is particularly interesting, and illuminates Spector and Kitsuse's (1977) contention that definitions of social problems reflects current modes of thought. When Frank (1931) first wrote about PMS, the typical patient was a woman who described her problem as being difficult to live with, and whose husband was to be pitied as she was a shrew. Katharina Dalton, writing in the early 60s (1964), was no less prejudiced in her account of PMS. While her early list of symptoms was exhaustive and physical in nature, her list of behaviors that could affect others was very negative of women. Again, husbands were to be pitied, as are children, co-workers, and even those people who are on the road when the woman was driving. Her words were always to be compared to her menstrual cycle; that is, when was a woman's next period compared to what she said. Through the years, little has changed when it comes to describing PMS. Though the words are phrased so as not to offend women, the premenstrual woman is still very difficult for other people to be around.

The fact that Index Medicus did not have a separate heading

for Premenstrual Syndrome until 1986 is also telling, as is the effort of the mental health community's efforts to change the name of PMS to Late Luteal Phase Dysphoric Disorder. According to Spector and Kitsuse (1977), changes such as these are institutional battles, with one group trying to take control of the condition away from the other. Index Medicus is not only an abstracting system, but a legitimizing one as well. When Index Medicus gave its stamp of approval, PMS became a legitimate disorder. The mental health community would like to be the group to treat PMS, and so gave PMS a new name, one that fits the guidelines set by its manual, DSM, which is published by the APA.

Various assertions have been made by the different groups trying both to claim PMS and convince others that it is real. When Katharina Dalton (1964) said PMS could not be helped by visits to a therapist, in effect she was staking a claim for the medical community. Years later, when Sererino and Mortati (1986) wrote to the editor of the Lancet, their entire letter was intended to convince both physicians and therapists that PMS did indeed belong in the mental health sphere. The legal community, in order to be able to use PMS in the courtroom, has used the claims of the medical community to present some women as incapable of controlling their actions.

The entrepreneurs have been especially adept at making claims about PMS. Since they made their living by treating PMS, it was necessary for clinics and drug companies to present PMS as affecting nearly all women, and as being treatable. Thus, one clinic's nurse advised all women to be tested for PMS, and said even without

symptoms a woman still may have PMS. Pharmacies advertised vitamins that would (in conjunction with a well balanced diet) help a woman manage irritability, anxiety, tension and loss of energy. The incidence rates these groups report is as high as 100% of all women. Fear that progesterone therapy may be harmful is dismissed by some entrepreneurs as being an overreaction: "The American public is hung up on side effects. People should realize you don't take anything without side effects. So what? You have to balance the risk with the benefit. We're not dealing with matters of life and death here" (Allen, 1982, p. 40).

Conrad's Formulation

The supposed deviant behaviors women display in the week prior to their menstrual cycle have been grouped under the heading premenstrual syndrome. Using Conrad's (1976) concept that medicine can only claim a deviant behavior if it meets five conditions, PMS is a perfect fit to be included in this designation. The first condition is that the behavior must present a problem for certain portions of society. While it is arguable that having weepy, irritable, uncomfortable women is indeed a problem, I feel the real problem is the vocal, powerful and demanding woman who has begun to assume behaviors previously assigned to men. At one point these women would have been called bitches; now it is assumed they are premenstrual.

Conrad's (1976) second condition is that traditional forms of social control must no longer work in keeping the behavior in question manageable. In the past, society exerted greater control

over its women. Simple stereotypes about proper behavior, as well as enforcement by the family, church, and informal means such as gossiping, all worked to provide the parameters of proper, acceptable behavior by women. Once women challenged these parameters, society was in disorder. Keeping women in line became impossible since any of the old methods relied on obvious stereotypes. A new form of social control that relied on the supremacy of the scientific model was to become the answer. Since PMS has its roots in the chemical complexity of the menstrual cycle, it is hard to doubt the "fact" that women are emotional, unpredictable, and so on.

In Conrad's (1976) formulation, the third condition is that a medical means of social control must be available. For PMS, a variety of treatments have been proposed, from Frank's archaic use of radiation, to Dalton's use of progesterone. Progesterone continues to be the drug of choice, although a number of other less hazardous treatments has been suggested. Grouped, they fall into three categories: dietary changes, physical exercise, and over the counter drugs. In any case, though no one treatment works for all women, there are many treatments to choose from.

The fourth condition is that there must be some organic data to document the existence of the problem. Most point to women's hormonal system, even though it has not been proven to be the cause of PMS. The cyclic nature of most women's symptoms is used as well to implicate the menstrual cycle. Oddly, in studies where women are asked to write down what their mood and behavior had been on a daily basis, no cycle of mood swings appears. As well, when women

are falsely led to believe they are premenstrual, they attribute their mood to their cycle.

The final condition is that the medical community must be willing to accept the deviant behavior as lying within its jurisdiction. The nature of PMS is seen as a medical condition by most people in that it involves a woman's monthly, biological cycle. The medical community would like to present itself as making a contribution to society by treating those who suffer from various disorders. And, not unlike early obstetricians, there is little one can do wrong in treating PMS; sometimes, just listening and being a shoulder to cry on is sufficient treatment. In addition, there is a great deal of money to be made in the diagnosis and treatment of PMS. All of these factors combine to make PMS a disorder that is very attractive to the medical community.

Conrad and Schneider (1980) also pointed out different aspects of a behavior may change when a behavior is considered a medical disorder. The meaning of the behavior changed when women were diagnosed as having PMS. No longer were they shrews, as Frank's (1931) patients called themselves. Now, women who display certain behavior are said to suffer from PMS. Whereas in the past spouse abuse or shunning may have kept a woman from challenging authority, the mode of intervention now is to discredit her words and actions by saying she is difficult because she has PMS. Women with PMS may not be held responsible for their actions, as the women who committed murder in England show. As society became unable to control its women using traditional means, the authority in charge of dealing with the

problem changed and the physician became the social control agent. Since PMS is now seen as a medical condition, the area of examination has been reduced from all of society to the physician alone.

Though theoretically PMS should always have existed, it was not described until 1931, and did not meet widespread attention until the early 1980s. Perhaps the ultimate question in an analysis such as this is: why did PMS emerge when it did? I believe there were a number of factors working to make premenstrual syndrome well received when it was. The peak and decline of the feminist movement may have served to weaken any claims the feminists made about the equality of women and men. With the failure of the Equal Rights Amendment to be ratified, the movement lost steam and perhaps got tired of fighting. The conservatism of the times made it easier to accept old notions about the proper roles of men and women, and it became fashionable for women to be "feminine" again. Part of this femininity was rejecting the positive aspects of menstruation, so that menstruation became dirty and bothersome. It was not possible to blindly go back to the uninformed past, where the stereotypes first formed, but medicine was able to justify these stereotypes by creating a new disorder. The fact that it took fifty years for medicine's claims to be noticed is a reflection of the importance of timing. Continued reliance on drugs to deal with life's problems, especially hormones, made the treatment for PMS readily accepted.

I feel there may be a deeper explanation for the emergence of PMS. PMS is, I believe, simply another means of controlling women. This differs from what I have said in preceding pages because the

timing is only important as a reflection of past methods that have failed. To elaborate: there have always been ways to control the subordinate group, in this case women. Power has long been kept from them, as was property. Women were even considered to be property themselves. The obvious reason for this inequality was the fact that women were women, with breasts, ovaries, and menstrual cycles. When little was known about the biology of women, many things were blamed on menstruation. It weakened the woman, sometimes her mate, made her weak in the head and body, and unsuitable for leadership positions. When more was understood, instead of liberating women from their physical bodies this new information only served to control them anew. The menopause debate of the late 1960s and early 1970s is a prime example of this. While it is important to recognize the institution that makes these conclusions about women (in the past, it may have been the church, presently it is the medical community), I feel the institution is largely symbolic. There will be another institution after medicine loses favor, just as there was medicine after the church lost importance. These thoughts apply to American women, and perhaps First World women in general. The struggle for equality will always be hampered by this basic difference between men and women.

PMS has served the medical community well in its role as agents of social control. Women with the disorder are quickly eliminated from being a threat to the existing power structure as their symptoms of irrationality and emotionality make them poor leaders. The historic timing of PMS is especially interesting; coming on the

heels of the menopause debate, PMS can now be seen as the newest form of discrimination against women. Once it was shown that menopause was not a deficiency disease, but rather a normal aspect of aging for women, it could no longer be used legitimately as a reason to keep women as second class citizens in society. PMS thus effectively kept the old stereotypes about women in society's collective psyche.

This is not to say that some women are pretending to be affected negatively by their menstrual cycles. Indeed, some have argued that an absence of symptoms would be abnormal, as opposed to being the norm. Feminists concede that menstruation can be a difficult time for some women. Rather, they fear the grouping of all women in terms of an assumption that all women have PMS to such a degree that they are witches every month.

The role of the medical community has been as issue entrepreneurs who have much to gain from society's acceptance of PMS. Not only monetarily, though the potential profit is great, but also as a means of confirming their authority, the medical community has much at stake in the PMS debate. With the current shrinking of its power, medical professionals are reasserting themselves in a way that is oddly similar to the way it first gained widespread power. The first specialist of medicine was the obstetrician, a man who assisted at births, in reality doing little but earning much respect in the process. Now, one hundred years later, though no specialty exists as yet, physicians are again using the female reproductive system to prove their own usefulness. Whether or not they are doing any good

or harm has yet to be seen.

Thus, the combination of the need for a new reason to keep women in their place, and the need for physicians to maintain their power has resulted in the recent popularity of PMS. The court cases of the early 1980s have shown that society is willing to accept this new proof for its old definition of women. And, while feminists argue amongst themselves about whether or not this is a good thing for women, while entrepreneurs make a lot of money selling treatment and support to women, and while the drug companies sell a potentially deadly product used only by women, premenstrual syndrome continues to be the latest in a long history of discrimination against women.

FOOTNOTES

[1]Conrad and Schneider claim three other changes may also occur: The legal status of the deviance, the range of behaviors within a deviance category, and the behavior to be studied all may change.

[2]Frank's justification of his treatment is located in the discussion section at the end of the article. He mentioned the two schools of thought regarding therapy for endocrine disturbances--either proof that treatment works is needed before physicians use it, or that proof may be gained after it is tested on the patient. He mentions the toxicity of some drugs and their obvious negative effects when given in large doses. He then indirectly proves the value of his treatment, by noting "On the other hand, such 'things' as desiccated ovary, desiccated testis, thymus and anterior pituitary extracts can by given by the pound or bushel, and the only effect I can note is a disturbance of a delicate stomach" (Frank, p. 1057).

[3]Prior to 1980, at most only three pieces appeared in the popular press. In 1981, five articles were written; in 1982, 9 articles; in 1983, 10 articles; in 1984, 8 articles; in 1985, 9 articles; in 1986, 12 articles; and in 1987, 8 articles appeared.

[4]Ms. Santos seriously undermined her own case by saying in a television interview "my nerves are not bad that I am going to beat up on my kid because my period comes down" (New York Times, p. B4, Nov. 4, 1982).

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