

Premenstrual Syndrome (PMS) Examined Through A Feminist Lens

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The medicalization of premenstrual syndrome, or PMS, is one more step in the continuing medicalization of women's lives; that is, the labeling of increasing numbers of normal life events as appropriate for medical "expertise" and treatment. Dr. Katharina Dalton, the world's foremost proponent of progesterone therapy for PMS, has run a PMS clinic in London for thirty years. She claims that about half of all women become "ill" with PMS. She calls it "the world's commonest disease. . ."¹ We need to recognize there *are* cycle changes which can be very uncomfortable and debilitating. Recognizing this as a fact of life for some women and not a defect in their characters is helpful and freeing. But this does not mean the cycle changes are an illness. The illness label reflects a strong anti-woman bias. Treating women with strong cycle changes as ill is similar to treating pregnant and menopausal women as ill. The analogy of PMS to menopause is particularly striking. First, both are called deficiency diseases, one of estrogen and the other of progesterone. They are treated with replacement hormones of mostly unproven value and unknown long-term risks.

Sophie Laws, in a pamphlet soon to be published in England, elaborates on PMS as a political theory used to separate out a particular group of women and to divide women from each other. Some feminists have not helped, either, by saying that most women are "normal" and only a few have problems. This only serves to separate those who "pass" in our male regulated society from those who can't or won't pass, rather than to examine

the broader issues of societal rules not classifying a wider range of human experience as acceptable. Laws suggests that the labeling of PMS as an illness is a way of ignoring and invalidating women's rebelliousness. Some women who report deliberately using the premenstrual time to vent some of their rage and frustration understand this on an intuitive level. Calling these times of rage symptoms of disease is a handy way of not looking at what women are upset about and why. It is a way of "keeping us in our place." But trivializing and discounting anger is dangerous for women.

Dr. Sharon Golub² has found that women learn to attribute negative events in their lives to particular times of their cycles whether or not they actually correspond to cyclical changes in any measurable way. Yet women today are actively questioning the notion of the premenstrual time as *necessarily* negative. For some, it is a highly creative time, although Dalton never acknowledges this as a possibility. Emily Culpepper, who has run menstrual workshops for years, reports that after a workshop women will send her drawings, poems and other creative work that they have felt particularly inspired to do premenstrually. A letter to *Ms.* magazine³ suggests we change the name to Pre-Menstrual Energy to help us think differently about it. We need to regard these times, even when we feel out of control, as teaching us something.

Now I wish to examine how social expectations and support that is or isn't available influence our perceptions to make the experience of PMS more negative than it needs to be. My phone conversations with women who are looking for a progesterone

dispensing clinic may be instructive. Though the numbers of women are small, I hear recurring patterns. First of all, they present their life situations as essentially positive. A typical example is, "I'm married, have a small child who was very much wanted, and a loving husband who has a good job." However, the woman has a premenstrual problem and is desperate. She may feel uncomfortable, depressed, edgy, or angry for days on end. The phrase I hear over and over again is "out of control," the last thing a woman is brought up to be. She cannot live up to the image of herself as a good woman that she maintains through the rest of her cycle: that is, cheerful, compliant, easing everyone else's social relations. She often is embarrassed by her mood swings, sometimes humiliated. She feels she *should* be able to manage this on her own. Generally, she does not discuss this problem with friends or other family members and tends not to get help for it. This isolation makes PMS even harder. As the conversation goes on, it turns out that her partner is quite fed up with the whole business of her moods. What woman doesn't have trouble coping when she has an unsupportive and critical partner?

Even particular symptoms take on a value influenced by society. Bloating, for instance, can be painful in and of itself, but it would not carry a social stigma if we all wore loose clothing like robes and believed fatness was beautiful.

Since the dispensing of progesterone and overall medicalization of PMS is being done on the strength of Dalton's work, it would be worthwhile to look at her view of women and the goals of her treatment.

I wish to concentrate on her attitudes toward women and how that has shaped her work. (Dalton's poor research methods have been examined already in the last ten years by M.B. Parlee⁴ and others⁵. Since Dalton's writings have remained remarkably consistent for the last 20 years, to the point of using the same anecdotes and studies to support her work, I believe the same methodological criticisms still stand, so I will not repeat them.)

It becomes painfully clear that Dalton's goal is to help women function more smoothly in their traditional stereotypical role, subordinate to men. She wants to help women do what they "ought": function as housewives and mothers in an uncomplaining, cheerful way. I will quote some passages from a typical book, *Once A Month*, published in 1978. She tries to give woman's "abnormal, unreliable" behavior a scientific basis.

"It (this book) has been written to help men to understand the capricious and temperamental changes of women, so that the image of woman as uncertain, fickle, changeable, moody and hard to please may go, to be replaced with the recognition that all these features can be understood in terms of the ever-changing ebb and flow of her menstrual hormones."⁶ Or "sudden mood changes, irrational behavior, and bursting into tears for no apparent reason are bewildering (to a husband), while sudden aggression and violence are deeply disturbing when, with little warning and no justification, his darling little love bird suddenly becomes an angry, argumentative, shouting, abusive bitch."⁷ She seems to prefer the non-cycling male as the norm since she says, "The ideal would seem to be to abolish menstruation altogether at those times when conception is not required."⁸ A woman is responsible if the family does not function smoothly. She causes and is responsible for male violence. "Her irritability and tiredness were hindering her husband."⁹ "How many wives batter their husbands during their paramenstruum is unknown, nor do we know how often the husband is provoked beyond endurance and batters her."¹⁰ "... the mother's tears caused the fraught husband to beat his daughter."¹¹ And "... the husband naturally has problems trying to calm a hypersensitive, edgy, irrational and agitated woman during these days of each cycle."¹² Her opinion of women who might resist treatment is clear. "I

think women have a duty if they know they are going to break something and going to be irritable to be treated and to look after themselves. They owe it to themselves and to women in general. Otherwise they will get what they deserve from men."¹³ She really wishes to pacify women. Her solution, as the medical solution so often is, is to help women individually, out of context of their social setting, one by one, and with drugs. In her defense, I will say that Dr. Dalton has acted within the context of her time and training. We must simply be aware of what it is and not necessarily continue to accept her treatment or her negative view of women.

I believe that the difficulties researchers have in agreeing on a definition of PMS have partly to do with their attitudes toward women. Some insist on a symptom-free time during the cycle; others include a premenstrual intensification of symptoms experienced to a lesser degree all through the cycle. Dalton is adamant in her definition of the syndrome as having at least a week symptom-free in the cycle, although this week does not have to include the time of menstruation. What is the significance of this symptom-free time? First, it means that a woman has a "normal" time when she is her "old self" even if it is the minority of the time when she is a good woman rather than a raging harpy or suicidally depressed. She still has a core which is self-confident as well as adjusted to male values, when she is loving and docile. This is her true self. The theory of a symptom-free time also provides a way to tell the hopeless (no cure yet) and the malingerers (just getting on the bandwagon) from the true PMS sufferers who deserve help. For Dalton, this serves an important function since no objective differences have been found so far in the hormone levels between PMS sufferers and others, although this difference is the rationale for her treatment. However, this definition invalidates the experiences of a whole set of women who report a worsening of symptoms premenstrually which otherwise come anytime during the cycle. Dalton classifies this as "premenstrual distress" and claims only the "real" PMS sufferers respond to progesterone. We don't know if this is true, since no one has confirmed this with careful studies.

Next I'd like to talk about my impressions of how the progesterone

treatment is being carried out. Clinics for dispensing progesterone are mushrooming in this country as if they were a new growth industry. Women find out about progesterone through the recent rash of newspaper and magazine articles, books, and TV programs on PMS. But many of the articles and shows do not make it clear how little we know about PMS, and often recommend progesterone as the treatment of choice. Progesterone advocates often talk or write in a way that suggests that the doctors are knights on white horses saving damsels in distress from the PMS dragon.

From what I can see in the reports of the women from the Lynnfield, Mass. clinic, the women who go there have a typical medical encounter. The woman sees only the medical staff on a one to one basis, although there is an initial group meeting before diagnosis and treatment begin. Women are not encouraged to get in touch with each other afterwards or during their treatment. Nor are their complaints about the treatment always taken seriously. Supporters of progesterone treatment continue to claim that the only side effect of taking the drug is euphoria and excess energy at the beginning of treatment. Yet many women complain of serious yeast infections while using the vaginal suppositories, severe diarrhea and cramping with the rectal suppositories and an excessive drop in blood pressure with the sublingual form of the drug. I have heard of cases of these complaints being brushed off or denied by the clinic. I have many questions: What happens to women who go to a clinic like the one in Lynnfield, which primarily dispenses progesterone, and fail to obtain the results they would like? What happens to their social and marital relationships? Do they become more isolated than before? We definitely need followup from the consumer's point of view.

The use of progesterone is alarming to all the feminist health workers that I have spoken to. We are afraid that the progesterone treatments will turn out to be another case of hormones being given to women in an untested and scientifically frivolous way. There are only a few studies investigating the safety of this drug, and they may indicate problems. Some of the women receiving treatment also are worried about being guinea pigs.

There *are* other treatments

besides progesterone. These include rest, exercise, dietary changes, especially eliminating refined sugar and flours and caffeine, frequent meals, vitamin B-6, oil of evening primrose, reorganizing schedules, meditation, relaxation exercises, biofeedback, and acupuncture. Dr. Michelle Harrison has details about many of these in her booklet *Self-Help for Pre-Menstrual Syndrome*.¹⁴ Harrison, who treats women with PMS as a large part of her practice, finds that women are about equally helped by any of the treatments. I believe it is acknowledged that any PMS treatment, including placebos, is about 50-70% effective in relieving symptoms. Because of this and given that we know so little about the long term effects of progesterone, a powerful hormone, I believe the only ethical approach is to try treatments first which pose no known harm.

Different women respond to different treatments, but each, after having found what seems to work for her, feels she has found her old self again. What then is happening with all these treatments? First, we should remember that the woman is finally being taken seriously and her cycle changes are being acknowledged; her reality is being validated. This in itself is enough help for some women. We see how hungry women are for confirmation of their experiences in the overwhelming response of women to articles or TV shows on the subject. The R.I. Feminist Health Center had hundreds of inquiries to one short letter in the *Providence Journal*.

Secondly, the woman may be increasing her self esteem just by taking action on a perceived problem. In finding the "right" treatment, has the woman been learning how to assert herself?

There is a very important role that women-organized-and-run self help groups can perform to enhance both the validation of a woman's experiences and her self esteem. The woman can gain an enormous amount of encouragement and support just from talking with other women who have the same life problem. Many of us know this from our personal experiences in conscious-raising groups. The support can function on many levels. On a practical level, the women could help lighten each other's load during the premenstrual time, like exchanging meals or finding baby-sitters. You don't need to see yourself as sick to benefit from doing this. (I found Dalton's

quotes of women describing their difficulties in getting meals one of the more compelling arguments for communal kitchens!) Women could share medical information, what they know about alternative treatments, and how well each has worked. This is one area in which an independent group is particularly useful—not one with a single point of view. Women could set up a buddy system to help each other over the phone when one gets feeling desperate. Women could discuss the conflicts, desperation, depression, or feeling out of control that surfaces during the premenstrual time. They could help each other figure out how they live with or avoid these feelings at other times of the cycle. They could identify what in their lives they *do* want to change. They could work together toward understanding PMS as something other than a disease.

This kind of discussion is equally valuable to women with less noticeable cycle changes and perhaps can help us see that our experiences with cycle change form a continuum. We cannot divide women into distinct and abrupt categories. We are all affected by how women with the most extreme experiences are classified.

7. *Ibid.*, pp. 79-80.
8. *Ibid.*, p. 191.
9. *Ibid.*, p. 84.
10. *Ibid.*, p. 84.
11. *Ibid.*, p. 86.
12. *Ibid.*, p. 29-30.
13. Sophie Laws quoting the *Coventry Evening Telram*, July 15, 1982.
14. Matrix Press, PO Box 740, Cambridge, MA 02238. \$4.50 each plus \$1.50 postage and handling; Massachusetts residents add 5% sales tax.

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Footnotes

1. Dalton, Katherina, M.D. *Once A Month*. Pomona, CA: Hunter House, 1979, p. 193. British Edition first published in 1978.
2. Golub, Sharon and Denise M. Harrington, "Premenstrual and Menstrual Mood Changes in Adolescent Women," *Journal of Personality and Social Psychology*. 41,5 (1981), pp. 961-965.
3. Letter to the Editor by M. Grace Melucci, Ms. Magazine, September 1982.
4. Parlee, Mary B., "The Premenstrual Syndrome," *Psychological Bulletin*. 83, 6, (1973), pp. 454-465.
5. I have a couple of unpublished manuscripts in my possession which are critiques of Dalton, as well as various articles which deal with PMS and critique her work as one part of them. One example is Elizabeth Rasche Gonzalez, "Premenstrual Syndrome: An Ancient Woe Deserving a Modern Scrutiny." *Journal of the American Medical Association*. 245, 14 (1981), pp. 1393-1396.
6. Dalton, *Once A Month*, p. xi.