Period, Interrupted:
An Intervention in PMS and Menstruation Discourse

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Women’s Studies Senior Thesis
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2005-6
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Introduction

“Complete relief. Midol helps you get rid of your symptoms so you can get on with your life. It’s strong on menstrual cramps, plus it relieves bloating, fatigue, and even breast tenderness” (midol.com).

This ad campaign fails to mention that Midol Pre-Menstrual Syndrome (PMS) formula does nothing to remedy the need for pink boxes to hold Tylenol-type, for-women-only tablets, especially when certain drug companies target women and their pathologized bodies. Midol’s campaign also conveniently leaves out the fact that PMS is about as American as apple pie, which, in other words, is not commonly found in any other country in the world. In fact, while Midol may alleviate cramps and bloating, it doesn't address the depression, confusion, and anxiety that hormonal changes associated with the onset of menstruation allegedly cause, and it certainly doesn't defend women from all the name-calling used by men and other women against those who experience these “symptoms” as part of an illness called PMS. Does this sound like complete relief?

In this thesis, I argue that women need the myths surrounding menstruation to be debunked and replaced by factual information about their bodies and selves. Menstruation is a woman-only biological process wherein the lining of the woman’s uterus passes through the cervix and out of the vagina; this process can often be uncomfortable. Dr. Katharina Dalton defines PMS as “any symptoms or complaints that regularly come just before or during early menstruation, but are absent at other times of the cycle. … Symptoms must occur premenstrually, and there must be a symptom-free phase each cycle” (17). Put simply, menstruation is a biological process that happens to
women all over the globe. PMS\textsuperscript{1} is a “syndrome,” not a biological process, that is defined as a mental, emotional, and physical disorder linked to menstruation. My thesis highlights the need to bridge the gap between two concepts seemingly at right-angles to one another: on the one hand, there is an extensive feminist critique of PMS discourse as damaging and PMS itself as socially constructed. On the other hand, there is a compelling reality of women’s subjective, embodied experience of menstruation including those women who suffer from PMS. Surrounding Midol, Pamprin, and the idea of ‘PMS’ “bitchiness” is a much bigger problem regarding gender inequality. ‘PMS’ was once considered a semi- or pseudo-clinical term applied to the experience of changes leading up to menstruation—a medically and scientifically correct term. Now, PMS has grown two legs: it is “medically” manifested in Premenstrual Dysphoric Disorder (PMDD), the mental/emotional leg of PMS, and on the other leg exists dysmennorhea, which accounts for the physical dysfunction connected with menstruation. The older, broader term ‘PMS’ is now only a cultural concept and phenomenon, which makes it exceedingly more difficult to understand the material impact of this acronym on American women. Where exactly did these ideas come from and how have they been reinforced? Furthermore, is there a way to interrupt this process of knowing what it means to be a PMS-suffering woman?

Many scientific studies have been conducted in attempts to pinpoint the exact maneuvers PMS as a construct makes in American society. Theorists such as Nancy

\textsuperscript{1} In this thesis, I utilize PMS and ‘PMS’ as separate notions. PMS represents the actual, on-the-ground bodily experience of menstruation that American women often attribute to PMS. ‘PMS’ means the gendered discourse American women embody vis-à-vis PMS. ‘PMS’ denotes cultural construction and ramifications, rather than individual experiences.
Krieger use embodiment, which will be discussed in a later chapter, to explain how concepts like PMS can be both socially constructed and part of a woman’s bodily experience. While the idea is provocative, it is still somewhat of a “black box,” that is, it does not specify how negative ideas about PMS might somehow affect or change the operations of a woman’s bodies, or her cognition and mood. For the purpose of this thesis, I will accept, rather than explore, the idea that PMS discourse can affect women’s cognition and bodily experience of menstruation. But my interest lies in the possibility of interrupting this process. That is, I don’t want to just deconstruct the concept. Instead, I hypothesized that the learning process that disseminates and perpetuates PMS must be disassembled and restructured with new information. To do this, I have suggested a PMS discourse consciousness-raising workshop followed by ongoing critical discussion, all of which intervene in the PMS-construct reuptake process. A more narrow purpose of this venture is to examine whether an interruption of this nature is useful in reinforcing a “new” perception about PMS. On a broader level, it is an attempt to begin proposing a new discourse on women’s bodies for women to take up and reinforce in their daily lives; a way of regarding PMS and women’s bodies to replace the current approach, or to at least acknowledge an alternative. In the end, the project fulfilled many of my goals.

The subsequent chapters include two histories of PMS followed by critical American and cross-cultural studies about mood, menstruation, and cognition. Essentially, the workshop I conducted contained much of the information found in these first three chapters. The methodology and materials of the project is discussed in chapter four. More information about methodological problems and the actual materials are located in appendices I and II. Chapter five contains project analysis and conclusions.
Western, medical discourse on menstruation conceives it as a “disease,” as one of the fundamental signs of “essential” ill health in women’s bodies. That is, menstruation as disease is a core of a medical view that frames women, ourselves, as fundamentally un-well, and the site of this un-wellness is within the body.

Unlike men, women experience a menstrual cycle, rather than a constant state of stability, thus they are regarded as unstable in relation to their male counterparts who are considered to be models of stability (they are consistent). In her book Beyond the Natural Body, Nelly Oudshoorn discusses endocrinology and the cycling of sex hormones. She writes, “In addition to the chemical model, sex endocrinology also provided a model in which sex differences came to be conceptualized in terms of the rhythm of hormone production” (146). A few lines later, Oudshoorn specifies the scientific practices that produce this concept:

Gynecologists used the hormonal blood test to specify the nature of hormone regulation in the female and male body. Based on this test, the female body became characterized by its cyclic hormonal regulation and the male body by its stable hormonal regulation. In this biological context, sex difference thus became conceptualized in terms of cyclicity versus stability (146).

Using hormones to articulate sex-difference, Oudshoorn provides a stunning path of logic to follow: Men’s bodies are reliable and consistent because they are hormonally “regular.” Comparatively, women’s bodies are inconsistent because of the documented
hormonal cycles and subsequent mood fluctuations. Thus, men, seemingly free of historically documented hormonal cycles, have been labeled as standardized bodies, or, that to which Other bodies compare. Any variation from this medical point of reference is socially labeled as deviance by society, thus women are deviant, un-well from the bottom up and top down.

In her book *Embodying Gender*, Alexandra Howson illustrates the aforementioned. “For instance, anatomy is used to differentiate between male and female bodies in ways that are meaningful and produce not only differences but also inequalities between men and women,” she writes (30). The perceived un-wellness of women’s bodies further exacerbates power disparity between the two genders, which Howson further extends: “The body, then, is symbolic in the way it’s used to communicate relative social positions” (31). Men’s bodies are perceived as the pinnacle of form, thus women’s bodies, naturally subordinate, taken an even lower “social position” due to menstruation.

In 1931, Dr. Robert T. Frank, an American endocrinologist, first described "premenstrual tension," which would two decades later take on the name "premenstrual disorder" as documented by Elizabeth Lee Vliet in *Screaming to Be Heard*:

'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 a time that the menstrual flow occurs … 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 attitudes and reactions' (138).
Dr. Frank formulated his description from observing and listening to women who were experiencing premenstrual discomfort. His psychosocial observations laid the groundwork for development of the concept “premenstrual syndrome” and the acronym PMS that would eventually become a household term.

Twenty years after Dr. Frank made his comments about the "tension" of women's lives, Dr. Katharina Dalton officially coined the term "premenstrual syndrome," and wrote, *The Premenstrual Syndrome*, which was first published in England in 1964. Dalton, “the foremost authority on PMS” as the cover of her book states, picked up Frank’s work on moods and menstruation and has been the most ardent proponent of PMS to write and disseminate information about the "disorder." Coming from one of the few doctors interested in the happenings of women's bodies and menstruation, Dalton's theory became increasingly influential as the 1960s and 1970s progressed. In *The Mismeasure of Woman*, Carol Tavris underscores the growing emphasis on PMS during the 1970s that “fits the pattern of recent history” with an observation by Emily Martin. “Women had made greater incursions into the paid work force for the first time without the aid of a major war,” she said (141). Tavris continues to quote Martin who notes that “when women’s participation in the labor force is seen as a threat instead of a necessity, menstruation becomes a liability” (141). Even in this time of blooming feminism, menstruation still set women’s and men’s bodies apart, and thus, underscored a “difference” in working abilities as well. ‘PMS’ then became a dual-usage tool. On the one hand, women could utilize PMS as an excuse, further showing the difference between men and women’s bodies, and therefore, each gender’s limits as well. On the other hand, PMS as an “excuse” became another way for men to feel superior to women.
As stated, this period in American history is perceived to signify an upheaval of archaic concepts of sex and gender, yet this was not the entire truth. In her introduction, Oudshoorn points out the complex realities of the women’s liberation movement:

The 1970s witnessed the publication of numerous gender studies that revealed social, cultural, and psychological conditions in which girls and women acquire a feminine role and identity. My argument is that the sex-gender distinction did not challenge the notion of a natural body (2).

Oudshoorn addresses the trust many women may have put in ‘PMS’ as a “good” scientific term, even though the appropriation of ‘PMS’ as an empowering strategy for women did not erase the underlying, historical sexism. The medicalization of PMS allowed doctors to label women’s physical discomfort associated with menstruation. By giving the “symptoms” a title, women were then allowed to express what they felt was wrong with them. In short, PMS became simultaneously a comfortable excuse and a gendered disparagement.

In her own book, Dalton presents PMS as a condition causing a great deal of confusion in medical professionals. Everyone who menstruates does not show symptoms of PMS, but Dalton ascertains that there is “much confusion about PMS” and that “medical professionals are confounded by it” (21). She also suggests that the “abysmal lack of knowledge and experience of PMS revealed in the writings of an increasing number of lay authors, together with the appalling ignorance and utter befuddlement of the media’s presentation on the subject” contributes to the mis- or under-diagnosis of PMS (Dalton, 21). Dalton brings up a good point here: this "disorder" is unclear, and it may be due, in part, to the expansive definition. She writes, “The definition of PMS is
‘the presence of any symptoms or complaints that regularly come just before or during early menstruation, but are absent at other times of the cycle’” (21). Because she is understood and accepted as the “authority” on PMS, her definition is the definition. In the second chapter of *Once a Month*, she discusses the trouble of diagnosing this illness. There are 150 “symptoms” of PMS, including tension, depression, irritability, backache, epilepsy, and weight-gain (Dalton, 17). If one takes a closer look at all of them, one will find that many of them are contradictory. While many “illnesses” have a number of “symptoms,” this large number of symptoms linked to menstruation makes one wonder how easy it might ever be to diagnose such a vastly defined “illness.” In other words, Dalton leaves little room to question nor dispute her medical prowess concerning this matter because she creates an inviting space where menstruation can only be named through the language of PMS pathology.

The PMS discussed in *Once a Month* is similar to, but not the same as, PMDD, the more exclusively mental form of PMS found in the *Diagnostic and Statistical Manual of Mental Disorders*. In 1987, PMS found its way into the *DSM* by yet another name: Late Luteal Phase Dysphoric Disorder, or LLPDD, which was said to apply to premenstrual syndromes that “seriously interfere with work or with usual social activities or relationships with others” (Tavris 142). LLPDD and its successor PMDD have become the more specific labels for the mental and emotional experience of menstruation. PMS had become a catch-all phrase for all premenstrual discomfort, whether it actually fulfilled the admittedly capacious definition (or lack thereof) set forth by Dalton. The inclusion of PMS under a different name in the *DSM* appears to be an effort to fully medicalize PMS, and subsequently further pathologize natural bodily events that
frequently accompany menstruation. In 1993, the American Psychiatric Association (APA) "decided to give [LLPDD] a fresh new name (PMDD) and move it into the official text of the DSM's new edition" (Tavris 142). As various analysts have pointed out, the distinction between PMS and PMDD is fuzzy. Due to the lack of definition of PMS, it is hard to discern whether PMS is actually the lay version of PMDD or if there are any distinctions that might concretely differentiate PMS from PMDD.

In a paper from *Psychoneuroendocrinology* called "Premenstrual syndrome and premenstrual dysphoric disorder: definitions and diagnosis," Ellen Freeman examines these two "disorders" and comes to an early conclusion that "there has been considerable difficulty in arriving at a definition of clinically significant premenstrual syndrome and in reaching a consensus on diagnostic criteria" (2). PMDD, she then notes, is a more severe form of PMS; one that is quantifiable by the *DSM* in the "Criteria Sets and Axes Provided for Further Study." Between PMS and PMDD, there are many intersections among "symptoms" present for diagnosis of either PMS or PMDD.

Freeman shows that PMS is characterized by physical symptoms, yet cannot be calibrated by a hormone or other laboratory test that proves PMS exists in a particular woman (28). Freeman finds that "functional impairment is a required criterion of the PMDD diagnosis and is relevant to any diagnosis of clinically significant PMS" (28). The only thing that may detect an organic cause for change in mood may be a thyroid function test (TSH, T3, T4) which is often used to rule out organic etiology in individuals classified as having mood disorders. For clinical diagnosis, Freeman recommends a few "essential components" for consideration: “the severity of the PMS symptoms, the degree of disruption of functioning, and the differentiation of the disorder from other physical or
psychiatric conditions” (32). At the end of her paper, Freeman states that there will never be a treatment for PMS until specific guidelines exist (32). Although Freeman comes to the conclusion that PMS is nebulously defined, she does not explain what form a treatment for PMS might take: is PMS in fact grounded solely in the body? If not, how do we account for the mental, emotional, and social components of this “disorder”?

In *DSM-IV-TR*, PMDD is essentially defined as a PMS-identical disorder characterized by more severe mood fluctuations. PMDD is officially defined as “markedly depressed mood, marked anxiety, marked affective lability, and decreased interest in activities. These symptoms have occurred during the last week of the luteal phase in most menstrual cycles during the past year” (771). Later in the description, the authors write, "these symptoms may be superimposed on another disorder but are not merely an exacerbation of the symptoms of another disorder, such as Major Depressive, Panic, or Dysthymic Disorder, or a Personality Disorder" (772). In other words, PMDD is closely related to a number of major disorders, except it is specific to women only. The manual goes on to note that Mood or Anxiety disorders may increase susceptibility to have PMDD. The *DSM* does not define PMDD in concrete and specific enough manner to make these distinctions clear to anyone. In addition, PMDD is said to cause severe "functional impairment" as Freeman's article suggests, yet the cause of this is uncertain. Beyond that, the treatment is unclear.

Over the years, PMS has grown, stretched, and been manifested in a number of ways. There aren’t any other widely renowned alternatives to this explanation for why women “act the way they do,” as in justifications for allegedly sex-specific behaviors. As
one of the only doctors interested in theorizing about mood and menstruation, Dalton
constructed a framework through which we almost exclusively understand menstruation,
and, furthermore, our bodies. PMS has become an integral part of the way American
women view the world.

This is where the history of PMS leaves off and the introduction of critical theory
comes in.
Chapter Two
A Feminist and Critical Analysis of the History of PMS

The first chapter delineated an uncritical history of PMS and its chameleon-like transformations over the years. This chapter will offer a more pointed assessment of the history of PMS. Within those three letters, there is much at stake for women. Excuse, resource, label, yardstick for normal behavior, safety valve for gender roles and power structures: these are all functions of PMS. At first glance, one might venture to dismiss PMS along with Midol and myths about cabbage soup diets, but PMS implies less sensationalism, and is much more complicated than meets the eye. PMS is PMS. No “check” on PMS exists, which means there is absolutely no language outside of PMS-language with which to discuss or critique it. An alternative context in which American women might read their menstrual cycle simply does not exist. In this chapter, the lens is focused on PMS and the all-consuming American myth Katharina Dalton set into motion.

In *Once a Month*, Katharina Dalton reports that the “cyclic changes” inflict “chaos” on women's bodies and minds to the point of "baby-battering, alcoholism, shoplifting and homicide and thus, by Dalton's reckoning, rank as one of the greatest public health issues of our times," notes Gail Vines, author of *Raging Hormones* (36). PMS more resembles a great public health crisis, rather than issue, of our time.

Dalton’s theory is dangerously popular. Due to Dalton's singularity as the leading authority on PMS, there are few prominent figures that challenge her theory by exploring whether other stressors may explain the PMS “symptoms,” for example. Women may not be "diseased" or plagued with an "illness" but may have external forces affecting them,
such as occupational stress or they may actually have an undiagnosed or untreated mood or anxiety disorder. PMS cannot actually be the *only* explanation for women’s behavior. Dalton’s theory suggests that women experience PMS, while their male counterparts, who may voice the same complaints, are simply “stressed out.” Her theory has put women in a precarious place in the scientific world. On the one hand, women who experience menstrual distress may be reassured by the label of PMS because they have a seemingly concrete explanation for their ailments (as opposed to simply being labeled “hysterical”). On the other hand, this same reassurance suppresses any need for women to challenge PMS with an alternate, less “reassuring” theory about menstruation.

The term "premenstrual syndrome" gave women, who *do* suffer poor physical health and/or emotional distress, an explanation and even an excuse for their ailing physical health and emotional "distress," yet forced them into a position where the decision about whether or not to voice their discomfort became a contentious point of sexism. While some women benefit from the accessibility of ‘PMS’ as a catch-all label, they are then victimized by the gendered discrimination, and emotional and psychological weakness the term begets. Dalton’s terminology created a supply and demand cycle of ‘PMS’ (which is assumed to be cyclic in itself) as a reason for women to voice their problems, and, in turn, a need for the term itself.

As women were beginning to feel comfortable with labeling their experience, this very label and its association with menstruation problematized women's ability to work in the same way as men during the 1950s and 60s. With women entering the work force, the idea of menstruation and pregnancy became issues to be dealt with by employers. Thus, women's bodies were (and are) scrutinized, while men’s bodies were not. The attention
brought to bear on women’s bodies felt more empowering, however, to feminists during
the women’s liberation movement. Dalton's ‘PMS’ appears in every book about women's health, including the seminal text of the 1970s women's health movement, *Our Bodies, Ourselves*. In *Myths of Gender*, Anne Fausto-Sterling critiques sex-biased medicine and picks up on PMS and menstruation as culturally perceived handicaps for women in the work place. She writes, “How often are women refused work, given lower salaries, taken less seriously because of beliefs about hormonally induced erratic behavior? In the game of PMS the stakes are high” (94). If women connected the “stakes” of PMS with cultural gender discrimination, would they still cling to PMS for dear life? For 1970s-era feminists, PMS was a point of agency for women, but, as Fausto-Sterling suggests, pro-PMS women should count their losses and find another source of empowerment.

Dalton devotes a chapter of *Once a Month* to “empowering” men in coping with their wives "symptoms." Through addressing men, Dalton sets up a very stark gender difference with her recommendations. She begins her "Advice for Men" chapter by offering, "It is often said that if men suffered from PMS they would soon find a cure. Well, men do suffer from the effects of PMS on the women with whom they come into contact" (101). Under the "How to Cope" heading, Dalton assures men, "Above all, keep control of yourself, and try not to become angry. Remember that PMS is an illness, a disease" (104; my italics). Dalton presents PMS as an affliction to be pardoned, a permissible judgment against women. In a book whose audience is inquisitive women, the section directed at men provides not so much therapeutic guidance for them, but is meant for women to read and realize that their husbands are suffering, too. In other words, Dalton encourages her primarily female readers to see that they are diseased, that
their husbands are not, and that they should be aware of how their “illness” affects others. Nowhere does she recommend for women to understand what is going on within their bodies, and, at the very least, to understand that menstruation is uncomfortable for many women. Women must keep close to their femininity or else their husband will suffer. Ultimately, the very existence of “Advice for Men” is an example of how ‘PMS’ works as a “safety valve on gender roles.” It is predicated on the idea that woman is the Other, the subordinate, the “deviant” body, and less than men, thus women must keep the gendered power structure in place by honoring their husbands through taking care of their PMS.

There is no disputing the existence of PMS with someone who has debilitating cramps prior to her period: she knows what she feels, and she calls that PMS. What she feels physically has been given the name Dalton produced, even though they are mere pains due to a chain of reactions within the body. And why should women dispute Dalton’s PMS? As discussed, it offers a certain kind of solace to have a label attached to one’s bodily problems, but this particular label and its usage invites a bevy of other problems for women. PMS cuts two ways in negotiating its existence: On the one hand, there is a need for someone, anyone, to take seriously women’s physical, mental, and emotional well-being. With the term PMS, a space for women has opened up in the field of medicine; their physical complaints are now validated by the assignment of an acronymic condition. This feels good for those who are desperate for answers about their own bodies. On the other hand, this global term, 'PMS,' carries a much bigger weight than simply giving a sophisticated name to cyclic bodily changes. As briefly noted, ‘PMS’ brings a whole new vernacular to the experience of American life, and this language is
used to create power structures where the woman, by virtue of the fact that she potentially menstruates, is on the bottom. Not all women menstruate\(^2\), yet all women are associated with ‘PMS’ and, subsequently, instability. PMS has transcended a form of “illness” because usually “ill-people” are in the minority of society; an “illness” is something that happens to people, but isn’t always something they’re born with and certainly isn’t something that one’s sex produces. But the fact that one is sexed produces ideas of difference, and dichotomies of “healthy” versus “ill.” Fausto-Sterling further explains “disease” and the locus of difference between men and women in its relation to ‘PMS’,

Despite the problem of method and definition, the conviction remains that PMS constitutes a widespread disorder, a conviction that fortifies and is fortified by the idea that women’s reproductive function, so different from that of “normal” men, places them in a naturally diseased state (98).

Fausto-Sterling highlights the supply-and-demand concept of PMS: it acts as a valid currency in fortifying sex difference by providing a capacious “syndrome” in which men and women can acknowledge difference, and subsequently tighten or loosen the “safety valve” on gender maintenance and power dynamics. This supplies PMS with a high cultural currency value and provides an explanation for sex difference.

Dalton cites depression as a "symptom" of PMS. She writes,

There is a loss of self-control and an inability to make decisions or to control one's tears, behavior, and appetite. There is a loss of insight and an inability to realize, in the case of premenstrual depression, that very shortly the symptoms will pass and there will be a return to normalcy (41).

\(^2\) Not all women menstruate because some women have had hysterectomies during their “child-bearing years,” for example.
The uptake of premenstrual "syndrome" as a gender-discriminatory concept began with Dalton but was and is reinforced by an entire system of medical and psychological authority, especially via *The Diagnostic and Statistical Manual of Mental Disorders*, the book that holds the diagnostic categories for all recognized mental disorders by the American Psychiatric Association.

Through the addition of PMDD to the *DSM*, it is once again evident that ‘PMS’ has become a safety valve. Women, never men, are diagnosed with PMDD, a real illness as deemed by the American Psychiatric Association. PMDD and Major Depressive Disorder share many similarities such as intensity and extremity of depression and length of “lows” (APA, 370, 771). PMDD is undeniably a gender-discriminatory disease, yet another concern surrounds its existence: treatment. It is possible that women who *just* have Major Depressive Disorder and periodic cramps are routinely diagnosed with PMDD by gynecologists, and thus prevented from receiving the proper treatment their condition necessitates. According to the American Academy of Family Physicians, treatment of PMDD can range from “lifestyle changes” such as exercise to pharmacological treatments such as SSRIs and Anxyolotics, such as Fluoxetine and Alprazolam respectively (Bhatia, 1245). The SSRIs must be taken all the time, while Alprazolam may be taken when needed. SSRIs and Anxyiolitics are commonly prescribed for mood and anxiety disorders. Psychotherapy is not necessarily mentioned as part of this regimen. The diagnosis of PMDD, saturated with sexism, may obfuscate a more correct diagnosis and proper treatment for women with real mental illness.

PMDD officially pathologized women’s bodies, but Dalton’s idea of PMS
promotes female un-wellness in further, more insidious ways. In describing PMS, Dalton juxtaposes "symptom" and "complaint" in her definition, leading to an underlying problem with PMS: the physiological events associated with menstruation that many women experience like breast tenderness and bloating have become misconstrued as irregular: Regular, routine events are then classified as part of an illness and require specific, illness-based treatment to assuage them. If menstruation follows a regular 28-day cycle like that of the moon, the "complaints" (if they even exist) may come every month.

Within Dalton’s assessment, there seems to be a diagnostic creep which means that the boundaries between certain experiences being pathological and normal lacks definition and is permeable; therefore giving the authority of the label ‘PMS’ to any experience that is unpleasant and temporarily coincides with the days preceding menstruation. Women are expected not to perform as themselves or the role of American woman. For some women, this may become a self-fulfilling prophecy where buying into the economic cyclicity of ‘PMS’ allows them to perceive certain experiences, such as cramps or emotional discomfort, as pathological, rather than natural. Because the only way to define PMS is by calling it a “disease” or “syndrome” (that’s inherent in its title), there is absolutely no space in which a woman can decide if anything she’s experiencing is actually “normal” for her own body. PMS is, inherently, pathologizing women’s bodies, therefore anyone who experiences a number of the well known symptoms of PMS will automatically assume that she, in fact, has PMS. The reality could be that her mood has slightly changed because she has really bad cramps, or her mood has slightly changed and she isn’t menstruating at all. Tellingly, the term is applied regardless of where a
woman is in her cycle—regardless, even, of whether she menstruates. ‘PMS has become a label for any “misbehavior,” detached from actual events of menstruation, and that menstruation itself is left with no room to be uneventful, unremarkable, or “normal.” Thus, women, however “normal,” turn to the term PMS for assurance, a certain kind of solace, as previously stated.

PMS exists as a completely normal condition for women in America because it is the popular discourse on women’s bodies that has been, and so can be, reinforced and seamlessly integrated into societal norms and expectations. As stated, it is seldom disputed by authority figures such as doctors, who women look to for answers about their bodies, and popular media does nothing to dispel the myth. Luckily, certain researchers and theorists have been interested in undermining some of the concepts that have been put in place. In the next chapter, I will discuss a number of studies that have worked to clarify the realities of PMS, its implications, and new perspectives on it.
Chapter Three
Research on menstruation, mood, and cognition

All of the aforementioned information has piqued the interest of many researchers who want to slice through the prevalent notions of PMS. By getting to the bottom of PMS as it exists in America through studies, these researchers show a number of facets of PMS—however capaciously defined—that Dalton’s theory overlooked. The discursive, economic, ideological, and cultural creation of PMS, and the subsequent DSM inclusion of PMDD, leaves us with a number of questions about menstruation and all that surrounds it: What is PMS? Is there anything inherently wrong with women because they menstruate? What do actual women think about PMS? How has this term come into play in popular culture? There are many others, but the remainder of this thesis tries to examine what’s at stake with PMS in order to answer some of these questions, or at least to fill in some of the blanks through examining American-based and cross-cultural studies.

American Studies
Mood fluctuations associated with the menstrual cycle prove to be a point of intervention for many American researchers interested in uncovering truths about PMS. McFarlane, Martin, and Williams performed a 70-day prospective and retrospective study on women’s and men’s moods. The objective of the study was not disclosed to participants to prevent biases in response. Over the course of 70 days, 15 women using oral contraceptives, 12 normally cycling women, and 15 men reported their moods—the
stability, arousal, and pleasantness of them on a daily basis. At the end of this period, the participants recalled their “average mood” for each day of the week. Women were asked to also identify their moods during each phase of their menstrual cycle. Prospectively, the women who were “normally cycling” reported more pleasant moods in the follicular and menstrual phase than did the men and women who were taking oral contraceptives. Retrospectively, women recalled having more pleasant moods in the follicular phase and more unpleasant moods during their premenstrual and menstrual cycle. They also exaggerated weekend highs and Monday blues, but none of this was consistent. As McFarlane et al. note, “retrospective reporting for both the menstrual cycle and days of the week suggests the influences of stereotypes about moods” (202). The men’s moods fluctuated over the days of the week, as well.

In this study, McFarlane et al. address the mood component of PMS. While their sample was small, this study is useful because it sets a precedent for the useful concept of retrospective/prospective mood reporting in relation to women’s menstrual cycle. This study shows that men are moody too, which most people do not know or think possible. McFarlane et al.’s claims appear to hone in on the bias that women have toward their own moods in relation to menstruation. According to societal expectations for women (prescribed, in part, by Dalton), women behave in a particular way during their premenstrual phase. Also, men do not cycle hormonally according to stereotype, thus ‘moody’ is not a masculine trait. Therefore, when asked about their moods in relation to their menstrual cycle, women will align their responses with the expectations set forth for them. This is a woman-specific phenomenon, and there is no parallel, gender-specific expectation of mood change in men. But both women and men did show mood
fluctuation. McFarlane et al. underscore and undermine a cultural assumption: that women are moody, men aren’t. Furthermore, this study addresses embodiment in relation to PMS. Specifically, this study illuminates how concepts about the body alter the way in which women “read” or understand their own bodies. Embodiment will be drawn on later in this thesis.

Davydov, Shapiro, and Goldstein pick up on some of the ideas of McFarlane et al. and add another component: personality. Davydov et al. found overall that mood changes may arise from other impetuses, not solely ‘premenstrual symptoms,’ over the course of the menstrual cycle. Their participants, all female, did self-report their moods: happy, sad, depressed, tired, and anxious. These reports were obtained on two work and two off days during the luteal (premenstrual) and follicular phases of the menstrual cycle. In general, their conclusions were similar to McFarlane et al.’s: women’s moods were not affected by the menstrual cycle.

For certain personality “types,” hostility and personality varied with the phase of the menstrual cycle. They concluded that "regardless of other factors, moods are clearly affected by stress level" (11). In other words, women’s mood changes were greatly affected by external stressors, rather than symptomatic of PMS. Davydov et al. relied on structured self-reports, in the same way McFarlane et al. did, rather than assessing their views on PMS with a standardized questionnaire, such as the Premenstrual Tension Questionnaire, as other researchers often do. Like McFarlane et al., Davydov et al. wanted to understand the moods in a very raw way. Unlike McFarlane, they did not ask any questions about PMS, and this sheds light on the effectiveness of McFarlane et al.’s strategy. In the present study, the participants were not influenced by direct questions
concerning PMS, so they ended up proving that menstruation doesn’t actually affect one’s mood on its own. Both studies are important in that one validates the other.

Many studies about menstruation directly address cognition and whether women’s ability to concentrate, attend, or remember is diminished immediately prior to or during menstruation. Morgan, Rapkin, D’Elia, Reading, and Goldman did a study where they evaluated this very notion of women’s ability to perform cognitive functions while menstruating. Thirty women, who met criteria for having PMS as defined by the researchers, took part in the study. There were 31 controls and participants kept daily diary recordings. The participants were tested on two occasions, during follicular days and luteal days. Their test included performing complex cognitive functions such as “measures validated previously for the assessment of ‘executive’ frontal-lobe functions” (961). The women also completed a Beck Depression Inventory to measure each individual woman’s level of depression. They found that even as women with PMS had mild forms of premenstrual depression, there was no statistical significance between women with PMS controls for attention, memory, cognitive flexibility, and overall mental agility. Consistent with most research done on cognition and menstruation, Morgan et al.’s showed that women with PMS, as shown by this study’s assessment, do not have diminished cognitive function, despite the participants’ feelings of inadequacy.

What have all these studies tested? Popular perceptions about what PMS does to a woman. What have they all concluded? That none of these popular perceptions are accurate. Why, then, do women feel like they can’t think when they’re menstruating? Because they’ve embodied stereotypes about mood, menstruation, and cognition.

In one of the most useful studies on PMS, Lisa Cosgrove and Bethany Riddle try
to pin down the embodiment of femininity and menstrual experience, and breathe life into it through their study. Cosgrove and Riddle used both quantitative and qualitative analysis. They measured women’s self-perceived femininity with the Bem Sex Role Inventory, which assesses the degree to which one identifies with his or her gender, and the total distress score on the Menstrual Distress Questionnaire (37). Participants included women who were self-described PMS-sufferers and women who did not identify themselves as PMS-sufferers; there were thirty participants in total. For the qualitative component, women were asked questions in a semi-structured interview. The questions dealt with each woman’s personal experience with PMS, her perception of PMS, how she understands her experience, etc. This method constitutes a departure from the ones previously mentioned. Cosgrove and Riddle confronted, rather than observed, some of the “symptoms” of PMS and did so by asking individual women about their personal experiences.

Cosgrove and Riddle found many indications that PMS exists as a societal construct linked to ideas of womanliness, rather than a medical disease. In their discussion, they write, “The positive correlation between negative affect and femininity provides further support for the idea that women who try hardest to live up to idealized constructions of femininity are more likely to position themselves as PMS sufferers” (47). These women, they noted, are keenly aware of gender-appropriate behavior. Also, Cosgrove and Riddle used Ussher, Hunter, and Browne’s findings to further illustrate the “real me/not me” dichotomy. Women hold themselves accountable for “real me” behaviors whereas ‘not me’ behaviors are what they are not, what is socially shunned, and what they do not feel comfortable with. PMS-self, for instance, is the “bad,” “not
me” when women pay close attention to their bodies and notice bloating, and feel more irritable, this feeling like they’ve lost control (49). When women explain how they think about themselves premenstrually, they use their “real self” to make a stark contrast and convey how “good” they are under non-menstrual circumstances. Basically, Cosgrove and Riddle discovered and so eloquently unfolded what McFarlane et al. were only approaching with their notions about prospective/retrospective mood tracking: embodiment and multiplied constructions.

There we have it. Women’s bodies are not pathologically doomed. Cosgrove and Riddle illuminated the strong effect of gender roles and assigned behaviors as such, and astutely correlated this with investment in the realness of PMS. This should not be taken lightly. In their discussion, Cosgrove and Riddle urge us to conceptualize PMS as “both lived and social construction” (54). Such a statement indicates the complexity of PMS as both a theoretically perplexing concept and material reality, which makes both parts equally important to consider when examining the teleological purpose and place it has in American society. This study corroborates the claim that PMS keeps gender roles glued together. For the sake of women’s body image and self-esteem, I think this glue is worth dissolving.

**The Cross-Cultural Component: PMS and USA Pair Better**

While examining American studies underlines the embodiment of gender roles and expectations, it is useful to take note of trends surrounding menstruation in other countries and cultures. In many ways, Cosgrove and Riddle’s idea of PMS as a “both lived and social construction” is best illuminated through acknowledgment of the lived
experience of menstruation within other societies. In what follows, two cross-cultural studies will be briefly discussed.

In their article “Attitudes toward and experience with menstruation in the US and India,” Hoerster, Chrisler, and Gorman conducted a study on students from a university in Southern India and a liberal arts college in New England (in America). Each group of women was given a standardized questionnaire to assess their individual attitudes toward and beliefs about menstruation. All women were given an Indian version of the Menstrual Attitude Questionnaire by Chandra and Chaturvedi (1992) and a test of knowledge of the menstrual cycle, which was derived from the Miller-Fisk Knowledge Questionnaire and from a questionnaire by Gorman, one of the researchers. Women were also asked about how they obtained knowledge about menstruation. All questionnaires and conversation where conducted in English.

The results of this study reflected American women’s negative regard to menstruation, while Indian women did not have the same attitude. Indian women also scored higher than American women on two of the MAQ’s attitude subscales: Menstruation as a Natural Event and Denial of the Effects of Menstruation. This means that Indian women do not perceive menstruation as a negative facet of being a woman, as American women typically suggest in studies (McFarlane et al., for example). It is interesting to note that the authors call this a “denial of the effects of menstruation” scale instead of “menstruation as uneventful.” This indicates that the authors believe menstruation should or does have effects that participants might notice. Furthermore, even research showing cultural variability can be undermined by the beliefs and opinions researchers share about women’s bodies and menstruation.
The results showed that Americans possessed greater for preparation for and knowledge about menstruation than Indian women did. The two groups of women tended to learn about menarche from different places, as well. While American women mostly learned about it in school, Indian women mostly learned about menarche through books or pamphlets. Both groups of women reported magazines as a source of knowledge. Hoerster et al. suggest that Indian women “might deny the effect of menstruation because they have been exposed to less information that [then allows them] to expect certain negative changes in emotions or behaviors” (89). They add that Indian women do not see “symptom” as a menstrual-related word either. Hoerster et al. report that Indian women have received “less information,” but the kind of information they are exposed to differs from that of American women. Indian women perceive and, more importantly, accept menstruation as a natural event, which indicates that their books and pamphlets do not equate Indian women’s femininity with their experience and behavior around menstruation. Put simply, this study problematizes American women’s experience of menstruation and gender roles as “natural” phenomena for all women. It is clear that Indian women, at least, do not regard menstruation in the same way as American women do.

The experience of menstruation is much more complex than “positive” or “negative.” Echoing Cosgrove and Riddle once again, it is essential to focus upon the experience of menstruation, with or without a PMS-model, as a real and lived one. In “Menstrual symptom reporting in three British ethnic groups,” Van den Akker, Eves, Service, and Lennon highlight the cultural difference among three groups of women and its effect on each group’s perception of menstruation.
There were three different ethnic groups who lived in North London: 48 participants were Afro-Caribbean, 73 were Caucasian, and 32 were Asian. The participants were rated on a positive/negative affectivity scale, and later gave a retrospective assessment of PMS symptoms and daily symptoms over the course of a 35-day period. The subscales of the positive/negative affectivity scale were as follows: mental performance, psychological mood, physical symptom, pain, and social behavior.

Overall, the mean for menstrual distress was much higher in Caucasian women. Asian women had higher average mean of severity of symptoms during their menstrual period, with Afro-Caribbean women showing a very similar arc. On the other hand, Caucasian women tested much higher severity during the premenstrual, rather than menstrual phase. The difference in timing is crucial because it underscores different between cultural notions of menstruation. Rebecca Young, Ph. D, further extends an analysis,

There is no physiological explanation for why these ‘symptoms’ would be associated with different parts of the cycle in different cultural groups. In fact, this defies the hormonal explanation of mood changes and menstrual cycles, and suggests that ‘symptom patterns’ are cultural rather than physiological” (personal communication).

Young problematizes cultural concepts of “explanations” of PMS as hormonally-based and therefore “real.” As shown in this and other studies, there is a complete and distinctly different set of cultural rules and concepts played out on women’s universally-hormonal bodies.

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3 “Oriental” is used in the article. Due to well-noted colonial associations with Oriental, I will use “Asian” in place of “Oriental.”
Other points of analysis include the following: both Caucasians and Afro-Caribbeans reported greater change in mood, body symptoms, and pain, but no difference in mental performance or social behavior. Also, the positive/negative affectivity dimensions did not show a significant difference among the three groups. In general, the intermenstrual symptoms were about the same for all three groups, while Caucasian women reported more premenstrual and menstrual symptoms than did women of the two other ethnic groups, and Caucasian women also reported more symptoms retrospectively than did women from the other two ethnic groups.

While Van den Akker et al.’s study suggests that the three ethnic groups experience similar menstrual syndromes. It also suggests that Caucasian women, more than Asian or Afro-Caribbean women, adhere to the cultural expectations set for women. As stated, Asian women reported higher severity of symptoms during their menstrual phase, while Caucasian women reported high severity of symptoms during their premenstrual phase and menstrual phase. All three sets of women menstruated, which means their physiological processes were nearly, if not entirely, identical, yet each group’s perceived experience of menstruation varied along cultural divisions.

Van den Akker et al.’s study corroborates Cosgrove and Riddle’s emphasis on PMS as a lived and social construction. Although the focus of this thesis primarily centers on American women’s experience and perception of menstruation, it is relevant to realize that other cultures have particular expectations and experiences surrounding

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4 By “physiological process” I mean the following: in the follicular phase, the endometrial lining is shed, and this process is known as “menstruating.” Next, the endometrium rebuilds itself and with the presence of luteinizing hormone, ovulation begins, in which an ovum moves down the fallopian tubes. The luteal phase is the “premenstrual” phase. Hormones circulate through the body at certain times. This is a common physiological occurrence in women’s bodies.
menstruation that are unique to each particular culture, despite the universality of the physiological process of menstruation. Hoerster et al. attest to the difference in cultural perception and subsequent physical experience through their study as well.

Cross-cultural data is crucial for a project like mine because it illuminates the division between what is considered “natural” and what is considered to be culturally constructed. These studies provide a lens through which the reader can understand the effect of embodiment theory as applied to PMS: American and British Caucasian women have “symptoms” of premenstrual syndrome and correlating expectations of femininity because both sets of women were native to cultures in which such ideas are embraced. Such cross-cultural data appropriately sets up the remaining portions of this thesis: the methods of the project and the results, where embodiment theory will be applied.
Chapter Four

The Workshop: Intervening in a Theory

Leading up to this chapter, a great deal of information has been put onto the hypothetical table. In the beginning, we reviewed “just the facts” about menstruation and PMS, and the evolution of our understanding of the term from pseudo-clinical concept to that of cultural construct. Then, these facts contoured into a more critical framework, buttressed by analyses of key studies on American women's responses to PMS and menstruation, and reflections on the meaning of embodying stereotypes. Cross-cultural studies were then referenced in relation to American women's experiences, which led to a brief discussion of embodiment theory. This information is not necessarily additive; rather, each portion comprises a specific and essential piece of the collective puzzle. To understand the magnitude of the project undertaken, the relevance of all these facts, observations, and critiques must be fully comprehended.

Creating the Project

Instead of replicating a study on PMS, a notion early rejected, I decided I wanted to connect with and, ultimately, attempt to interrupt American women's ideas about menstruation and PMS and their cyclic reinforcement in a more hands-on manner. Because I hypothesized negative body image in women as affected by cultural ideas surrounding menstruation, I thought this would be an interesting approach to destabilizing socially accepted gender roles. Some of this may seem like a stretch, but with the great help of my adviser, Professor Rebecca Young, I devised a plan to act on
in this very notion.

In order to interrupt the pervasive discourse on PMS in America, an interactive intervention was necessary. A workshop, we thought, would be the most appropriate mechanism to employ. Originally, I wanted to have several workshops involving 20-30 women from varying age groups (one for pre-menstrual teens, one for the 20-30 year age range, and one for menopausal or post-menopausal women). Due to lack of funding and time, this was not feasible for my project. Regardless of age-group, the workshop's content would be standardized: discussion about physical pain and its effect on mood and cognition (and, then, these perceptions in relation to PMS); definition building of PMS, historically and currently, naming its functions and meanings, and assessment of group's familiarity of concept; and engagement with critical literature and embodiment. Depending on the age group, the facilitator would attune her approach to the participants' PMS and menstruation literacy.

Following the workshop, I thought it would be useful for the participants to continue communicating ideas, reactions, and reflections of the subject matter in a space exclusively made for this purpose. Not only would this reinforce the ideas shared during the discussion, it would have the potential to inspire people to think about their own experience, and perhaps more politically about the larger issue of gender roles and the cycle of reinforcing behavior. In order to create an ongoing discussion forum, I suggested a Courseworks-like site that would preserve anonymity of the participants. Ideally, the participants would post every other day for at least one month, though a longer discussion would be useful in assessing the longitudinal impact of material assessed, absorbed, and forgotten from the workshop. Again, due to lack of time, an extended discussion was not
possible for the present project.

Once I finalized my project, I submitted a protocol to the Human Subjects Review at the IRB. Because I possessed limited resources, I narrowed the scope of my project to 10-30 Barnard women. The protocol included an overview of the project, a sample flyer, a consent form, both questionnaires, and an e-mail script. My project was exempt because the participants would not be divulging their identity to me or anyone else in questionnaires or postings, unless they chose to do so\(^5\). To begin my project, two Women's Studies professors reviewed my protocol and approved it.

**The Project in Motion**

*Overview*

As noted, the project consists of many pieces and portions. First, the workshop occupies a large part of the project. Within the workshop, the participants completed a consent form and an initial questionnaire. Also, during the workshop, they received a handout about menstruation, mood, and cognition. Second, the online discussion required participants to post every other day for two weeks. Third, a final questionnaire was e-mailed to each participant and returned through campus mail or alternative methods.

*Materials*

The first material given to participants was the consent form. It delineates the procedure for the study to which they are committing for two weeks. Also, the

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\(^5\) As part of the directions, each participant came up with her own unique identifier that will only be recognizable to her; this ensures the anonymity of the questionnaires. This code is composed of her month and date of birth, her shoe size, and her mother’s initials.
participant's rights are listed. Participants completed this consent form and gave it to me. I immediately put the consent forms in a folder, as to remain separate from the questionnaires, so that the identities would remain anonymous.

The initial questionnaire aims to be both thorough and concise. The majority of the questionnaire focuses on the participant's positive, negative, and/or neutral experiences with physical and mental health. Menstruation and PMS appear only in the final two pages where the participants are asked about their personal experiences, ideas about definitions of PMS and PMDD, and percentage of American women who have PMS. The initial questionnaire was administered at the very beginning of the workshop. It took between 10 and 15 minutes to complete. When asked if participants had comments, questions, or concerns about the questionnaire, they did not respond with critiques. Six women completed this questionnaire and subsequently participated in the entire project.

Participants received a handout that listed basic information that was described during the workshop. I intended the handout to provide participants with tangible knowledge to bring home after the completion of the workshop. It included definitions of menstruation, premenstrual syndrome, and embodiment, functions of PMS for women, brief synopses of notable studies, and discussion of PMDD and dysmenorrhea, and where we are now with PMS. It was double-sided. In addition to the handout, a sheet listing information about posting on the LiveJournal was provided. See Appendix II for all workshop materials including the consent form, handout, initial questionnaire, and final questionnaire.

The online discussion happened on a LiveJournal (http://barnardworkshop).
livejournal.com/). I posted open-ended questions relating to topics addressed in the workshop or those inspired by comments from participants. For example, one post addressed cross-cultural data and asked the participants how this affected their views of embodiment and PMS. I asked, “How does this make you think about PMS and menstruation? Your own experience and the experience of others?” In theory, the LiveJournal should have provided a comfortable space for which the participants could share their thoughts, emotions, and questions pertaining to the material covered.

Once the two weeks had come to an end, I sent a final questionnaire to participants via a mass, blind-copy e-mail. In this questionnaire, women are asked again about the definitions of PMS and PMDD, whether the workshop changed their ideas about PMS and menstruation, and about their bodies. This questionnaire also asked participants to critique the workshop and discussion. Questionnaires were collected via campus mail, my residence hall, the barnard bulletin office, or (one) through e-mail.

Recruitment

For various reasons later addressed, it was difficult to recruit participants at Barnard. At first, I tried to put up flyers around the student center, McIntosh, Barnard Hall, and on the various campus posting places. When this attempt failed, I wrote an e-mail about my workshop that Professor Young sent to over 100 students who are taking or have completed women’s studies classes. This, too, was unsuccessful. My last resorts were to forward the e-mail I had written to a club I am involved with and to simply ask people I knew to partake in the workshop. In the end, only six women participated in the study, an issue that will also be later discussed.
Also, the project was never formally advertised as a workshop about menstruation and PMS ideology. Instead, I decided to frame it as a workshop about the effect of physical health on mood and cognition. In our idealist phase prior to unsuccessful recruitment tactics, we both decided advertising the workshop as PMS-centric might only attract individuals invested in the topic; Professor Young and I envisioned a sample composed of PMS-sufferers, PMS-believers, and people who do not think either way about PMS. In my last and most desperate attempts to recruit people, I began framing the workshop as one where we would discuss PMS. This, too, was ineffective. See Appendix I for a full discussion of the recruiting process, and more reflections on why it was so difficult. In the end, six women completed the study, including questionnaires, workshop, and online discussion.

Workshop

On the evening of February 28, I conducted the first workshop with three participants. I handed each participant a consent form, followed by the questionnaire, and then read aloud the directions for the questionnaire. Each participant finished the questionnaire in about 12 minutes. Once I collected and separated their paperwork, I introduced myself, the requirements for participation (the workshop, LiveJournal discussion, and two questionnaires), and reiterated the topic of discussion. The workshop lasted for about one hour and was recorded by both a digital and tape recorder with the consent of the participants.

The workshop loosely dealt with a few main topics: cultural perceptions and definitions of menstruation, PMS and PMDD; studies of menstruation, mood and PMS;
and embodiment. The conversation began with women discussing their perceptions of PMS and menstruation. I posed a question about whether menstruation is a positive thing in our society, and one of the participants responded, “You see commercials [on TV] with women who can’t wear bikinis because they’re menstruating. It’s kind of ridiculous. It’s such a stigma.” Another participant echoed her suggestion by identifying her take on menstruation representation: “It’s a disorder and that just implies our syndrome and that something is wrong. I would only understand it as something that’s bad.”

From here, the conversation leapt into a logical talk about whether any of the women thought that they actually had PMS. “I would say I have symptoms. I would be hesitant [to name it PMS],” said one woman. Then I continued, “In our society, [PMS] is not a medical term, it’s as pseudo-medical term. It’s a social construct.” I find this worthy of mention because one of the participants immediately responded, “It’s constructed off of actual medical symptoms. The impression I get from in Our Bodies, Ourselves is that women do get cramps. If your doctor denies it, find a different doctor.” Here, this participant challenged, and would continue to challenge at times, what I was trying to disrupt with my definitions, my studies, and my discussion of theories. It wasn’t that she blindly supported Dalton’s theory about PMS; she did not necessarily. Her intention appeared to be similar to mine (recognizing women’s bodies): parallel to, rather than intersecting, my own.

The participants had much to say about the studies, in particular Cosgrove and Riddle, although McFarlane et al.’s study did encourage head nodding around the table. I told them about the results of Cosgrove and Riddle’s study. In particular, I talked about how some participants in that study separated and pushed away from the PMS-self, and
embraced the “normal” self. I then noted that PMS-sufferers were participants who scored highest for femininity. Immediately, one participant called the PMS-/normal-self phenomenon “Dr. Jekyll and Mr. Hyde” to which another participant observed, “They had a need to separate themselves.” The “Dr. Jekyll” commenter then responded “Right. An escape hatch.” As later discussed in the analysis portion, the “escape hatch”\(^6\) is a recurring theme of this group’s conversation and consciousness.

From here, a participant asked the whole table if anyone had ever seen this in real life (what a great question!), and the momentum of the conversation quickly turned this question into “does PMS and femininity ever come up with your friends.” One participant said this kind of “sharing” occurs a lot on her hall in her dormitory: “Yeah, it’s like horror-story forum. If you bring up stitches, everyone will have a story. It’s like that with PMS. My one friend said she cries in the bathroom when [she gets her period]. It’s so weird.” Another participant noted that there might be an age-threshold when this kind of conversation openly happens: “I remember it coming up a lot in middle school. I guess you expect it to happen, and it’s this stable concept. [As someone who does not have symptoms of PMS], I thought I wasn’t a woman or that I hadn’t hit womanhood. [In college], I feel like no one really talks about it because most of us are like ‘I don’t know, is this really relevant?’”

After discussing personal experiences, the group conversation transitioned into a collective brainstorm of “where we’re at now” in terms of menstruation and current terms for menstrual disorders. I brought up PMDD and one participant asked about treatment.

\(^6\) “Escape hatch” is analyzed later with the Live Journal portion. Briefly, this participant noted the PMS-/normal-self need offered an “escape hatch” for women—a reprieve wherein women obtain the ability to “step outside” their “normal selves.”
As with many topics discussed, the representation of disorders such as PMDD became an inlet into a more analytical conversation. A participant, in disbelief, shared, “I saw a commercial for PMDD. There was a woman in a corner. And it was for medication.” Another participant expressed her concern about the treatment of something like PMDD, which, as I told them, may exclude mentally unwell people from receiving proper care: “In treatment, you have to be on most drugs all of the time. Have you come upon anything as to why PMDD hasn’t been referred to something like MDD [Major Depressive Disorder]? So maybe there’s a stigma.” This participant seemed to address the placement of PMDD versus a depressive disorder on the continuum of socially acceptable mental illnesses.

The conversation officially ended with questions, comments, or final thoughts from the participants. In response, one particular participant brought up the effectiveness of a workshop like this in changing the way society thinks about menstruation and PMS. She said,

Women would probably be able to better understand the kind of things we’re talking about. I think they’d be more ready to admit it’s not a stable concept because they might not have it personally. But how are you going to convince men? I think the mystique of women’s bodies and how they work is part of the cultural currency of a disorder like PMS.

This comment concluded the workshop. In the following day, I had a slightly less formal workshop with two other participants who became contributors to the online discussion. Our conversation took a similar arc. Though the anecdotes were different, there were many overlapping points of interest, such as Dalton’s theory, the studies, and PMDD. I
met with one other person individually about this information as aforementioned (see “Recruitment” in Appendix I). In Appendix III, there are more reflections on the workshop and the creation of a safe space.

**LiveJournal Discussion Board**

The LiveJournal component of my project was a Web site on which I posted open-ended discussion questions, and participants responded anonymously. The discussion lasted for approximately two weeks. I made an account on LiveJournal.com called “barnardworkshop.” I am the only holder of the password. Also, I could not block everyone in the world from seeing the discussion board because then I would block the participants. LiveJournal has an option called “friends only,” which excludes anyone who is not your “friend” (as in, a person who has a username on LiveJournal) from viewing your journal. I did not request for each participant to make her own username on LiveJournal due to a time crunch and because I wanted the process to be as easy as possible for them. When I created my account, I did my best to limit the “tracking features” such as interests, groups, or any other affiliations as to minimize the chance of a stranger stumbling upon my board.

At the workshop, I gave participants a handout that had instructions on how to post a comment on the LiveJournal. Their first post following the workshop was about initial reactions. On average, I posted questions every day to every other day. I did not want to overwhelm them, but given the short amount of time available, it seemed urgent to engage with them more frequently for a few reasons. Each time I put a new question.

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7 I thought it was a good idea to keep an ongoing dialogue in order to reinforce workshop
on the discussion board, I sent a blind copy e-mail to the group informing them of the question and asking them to post as soon as they could. As participants posted on the discussion board, I received notifications in my e-mail inbox from LiveJournal. Most posting occurred shortly after I sent out an e-mail about a new post.

*Debriefing the LiveJournal Discussion Board*

Overall, participants responded well to this component of the workshop, although a few remarked their postings did not appear on the discussion board. Some participants said that the LiveJournal Web site did not always “submit” their postings. For obvious reasons, this was problematic, but mostly because some participants did not immediately realize their posting had been lost. One participant noticed the trend and ended up sending her proposed entry to me via barnardworkshop@gmail.com inbox, which I then posted, and then deleted that e-mail from inbox. In the future, I would consider creating a Web site for this sole purpose rather than using an open forum like LiveJournal. By designing my own Web site, data would hopefully not get lost by a faulty server; the participants would know we were the only ones viewing the page; and I could then program codes for each participant so that they would be tracked automatically.

When this project finally got underway, I was not entirely certain as to how the LiveJournal entries would fit into my analysis. Of course, I wanted them to be part of the analysis, but these were my questions: Do I want to follow each “voice” on the discussion board from beginning to end of the conversation? Do I want to trace the participants’ questionnaires to the “voices” on the discussion board? Am I only using this board to materials and stimulate thought. Also, the discussion-period was very short, so higher posting frequency became essential for data purposes, as well.
examine the various themes from the workshop that are brought in and then taken beyond this venue? In the end, I have chosen the latter due mostly to limited planning time. Since the end of the posting term, I have tried to ask participants to indicate which postings are theirs through a kind of symbol or number, but one participant felt this plan would potentially breach the anonymity and confidentiality under which this project was conveyed to her. In the future, I would suggest that people include their special identifier and specify a shorter symbol on their questionnaire, so that, when they post on the discussion board, they can just add their particular symbol. By tracing each participant’s “journey” from initial questionnaire through discussion board to final questionnaire, I would be able to identify the change in individual knowledge and beliefs. I am aware that this is important and would have been a nice complement to my analysis, but I do believe the “progress” of the group as a collective is as, if not more, important than each individual’s progress. A discourse cannot be fully destabilized by just six individuals; I believe the energy of the collective is powerful to employ change. The questionnaires at beginning and end are intended to gauge each individual’s progress. Like the workshop, the discussion board is interactive and engaging. I am interested in both the group’s arc over the two weeks and the affect the workshop and the discussion board had on each individual. In other words, I should have better planned the discussion board to lend a more specific analysis, but I am certain the themes of this board will speak to the content of each individual’s final questionnaire.

In the next chapter, I will analyze the data from the questionnaires and discussion and draw conclusions about the impact and effectiveness, or lack thereof, of my project.
Chapter Five

Analyzing Data and Drawing Conclusions

Primarily, the aim of this project centers on realigning women’s perception of subjective experience through testing a particular conglomerate of consciousness-raising strategies. Through the workshop and, mostly, the LiveJournal discussion board, I sought to convey accurate information about menstruation while reinforcing it through conversation. Both initial and final questionnaires gauged the “effectiveness” of the implementation of both the workshop and the LiveJournal.

In this chapter, I will separately analyze the LiveJournal discussion board and the questionnaires. Then, I will draw a comprehensive analysis from both sets of qualitative data. I will delineate conclusions from these analyses and offer suggestions for future studies.

Analysis: LiveJournal Discussion Board

Post-workshop, the LiveJournal discussion board became the central place for participants to voice thoughts, opinions, and concerns about the workshop material. With each question I posted, I intended to challenge participants to think about our previous discussion and to share it through the lenses of their own subjective experiences. To my surprise, participants ended up touching upon several different themes over the course of the discussion board term, all of which relate to workshop material or take those discussions a step further.

The LiveJournal discussion will be analyzed through a lens of embodiment
theory. In “Discrimination and Health,” Nancy Krieger defines embodiment as “[a theory that] asks us how we incorporate biologically—from conception to death—our social experiences and express this embodiment in population patterns of health, disease, and well-being” (Berkman, 39). Embodiment theory suggests social constructs influence the way we think, behave, and feel through processes of structural reinforcement. Krieger’s article discusses how health is dispersed among difference social groups and formations. While this may not pertain to this project superficially, Krieger points out that “discrimination” can mean “those who discriminate, restrict, by judgment and action, the lives of those whom they discriminate against” (Berkman, 39). To explore the LiveJournal and questionnaires, I will align myself with Krieger’s understanding of embodiment and discrimination. Theories, or theory, more correctly, restrict women’s bodies through reinforcing ideas such as PMS; these ideas are incorporated into “normative” beliefs and behaviors for men and women, thus they are embodied. Many of the themes in the following section touch upon embodied notions of gender.

Theme: Monolith vs. Diverse, or Uniform vs. Individual

Throughout the online discussion, certain ideas about “monoliths” and “uniform” surfaced in various forms such as woman-ness and Western-ness. I asked participants about the reality of 'PMS' and whether PMS is normative for women. One participant wrote, “PMS is a uniform condition among women because it relates to her woman-ness, which is her essence. How could woman-ness be anything but monolithic?” In this participant’s response, I detect a sense of irony that indicates she is aware that women’s

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8 It is possible to read this participant’s response without seeing “irony” in it. Given its
bodies are perceived as uniform. She draws attention to the problem of making blanket statements about women by using blanket statements. This participant disrupts the embodied notion of women as monolith, yet other participants may not have sensed this participant’s sarcasm:

I think that it isn’t monolithic because each of us has our own experiences, which may deviate from the norm seen as monolithic. We might think it is monolithic, but our own lives and exchanges should break the mold, even though culturally, from hallway conversations to magazines to health books, it is totally reinforced.

Because her post seems to be crafted in opposition to the first participant’s, she clearly acknowledges that the first participant’s “blanket statements” come from a real, viable perspective. Her denouncement validates these blanket statements through recognizing how external forces "totally" reinforce ideas about PMS as a uniform experience, and how "we" should highlight specific differences in response. However construed, both participants recognize a problem in framing women and their experiences with PMS as broad, monolithic, and totalizing conceptual realities. They both underscore the problem with blanket statements as a valid response to my initial question.

Beyond statements, participants applied broad, uniform, and often loaded terms like “western” and “American” to PMS. In reference to some information I posted about cross-cultural studies, one participant wrote,

This just continues my belief that the US is in a cultural bubble … The US is typically oblivious to other cultures, however we regard ourselves as one of the foremost authorities on women’s rights.

case and exaggerative use of critically-loaded terms, it seemed very deliberately ironic.
Here, she sets up a dichotomy: US vs. “Other cultures.” With this, she denigrates the monolithic “US” for its ignorance, yet writes “we regard ourselves as one of the foremost authorities on women’s rights,” rather than writing “the US regards itself …” While she clearly conveys a strong critical opinion of the US, she includes herself as an individual in the uniform nation. Another participant performs a similar rhetorical move:

It kind of makes me feel like American women are wussy. We force ourselves to be debilitated by our bodies and ruled by them in a way that is not necessarily avoidable. It seems stupid and pointless.

This participant appears to take up the same dichotomy the aforementioned participant has, and she, too, includes herself in the criticism. Of course, both women are American citizens, yet they keep a certain distance from the uniform idea of the US and volunteer themselves as the “we” when referring to American women. This conveys a sense of ambivalent self-inclusion these participants harbor toward uniform concepts such as “American.” Through this sense of ambivalence, they express an internal critique of belonging to monolithic structures and their position in relation to them.

The participants suggest the following: “We” don’t want to be part of a monolithic experience that is part of “American” ignorance, yet “we” also participate in constructing the uniform discussion. The first “we” means “individual women who differently experience the world and don’t want to be part of one totalizing idea.” The second “we” means “individual women who are part of a collective American lifestyle.” How do we negotiate this? The next theme raises that very question of the responsibility of the collective versus that of the individual.
Theme: Collective vs. Individual – Women, Men, People

Participants hovered around the topic of the collective’s responsibility to incite and enact change versus the individual. They talked about a women’s collective and a men’s collective, both discussed as monolithic entities. In response to “American women are wussy,” one participant wrote,

I don’t think it can be seen entirely as the fault of women on individual basis. However, individual women within the collective group are the ones who create and support the idea/stereotypes ... So I think the collective needs to stop, think, and re-focus with new standards for behavior and for each individual to shift their thinking to this and behave in accordance with it.

Rather than being complicit in the situation, this participant points out that the collective group (“we”) can be empowered. She puts the onus of making change on the collective, and sees the participants as followers of the collective’s direction. Later, she writes, “Then, someone needs to inform the men’s collective.” A vision of change divided by gender.

In response to the last posting on the discussion board, one woman expressed her final thoughts about sexed bodily functions. She writes,

I was recently thinking about the fact that many men fetishize ejaculation, which many women find gross. Why haven’t women fetishized menstruation? I mean, not necessarily in the mainstream, but I can’t imagine that if it exists, such a fetish is anywhere near as popular as that of the “money shot.”

This participant wants to know why “women,” a monolith, haven’t taken the responsibility as a group to “fetishize” menstruation. This coincides with the other
participant’s idea for the women’s collective to “stop, think, and re-focus with new standards for behavior,” yet takes it a step further to the point of romanticized fixation. Here, participants recognize the power and necessity of a monolithic “woman” in order to create change and negotiate representations.

**Theme: PMS as an ‘Escape Hatch’**

Participants discussed the usefulness of PMS in American culture. One quoted Roseanne’s famous line about menstruation: “Women complain about PMS, but I think of it as the only time of the month when I can be myself.” She went on to write,

> According to pop culture, women are supposed to be nice and sweet to one another, but when they have their periods, they turn into bitches. I don’t think this cultivates a sisterhood. When women are oversensitive or irritable and blame it on their period, I don’t feel sympathy for them. I feel annoyed.

This participation doesn’t name this as an escape hatch, but she recognizes the “outlet” PMS creates for women to stop acting “nice and sweet to one another.” In accord, another participant followed similar logic:

> I agree that PMS becomes an escape hatch for American women. I’ve used it, even when I’ve never thought that I actually experience it. And this definitely reflects back on the way women are expected to behave, about both good and difficult experiences. Why do we use PMS as an escape route so often?

This participant echoes Cosgrove and Riddle’s study, and furthermore, *lived* the “constructed” experience that they urged us to remember. Both participants draw on expectations of behavior in order to illustrate their dissatisfaction with the ‘escape hatch,’
and recognize the limited behaviors “allowed” to women.

**Theme: Getting her Period: Pain vs. Relief**

Participants were asked how they were menstrually on the discussion board and discussed whether it was a relief or a pain to menstruate each month. One participant wrote,

I was more than a week late, and it made me crazy. I’m not having sex, so I know that I wasn’t pregnant, but I was just antsy and moody until I got my period.

When I did, it was like a sigh of relief, sort of as if my body had hit a re-set button.

This participant associates getting her period with starting fresh, or hitting “a re-set button” on her body. This woman has embodied expectations and fears pertaining to menstruation that may touch upon embodied ideas about sexuality (pregnancy: where is my period? How effectively have I avoided getting pregnant?). Menstruating is associated with “relief” in this participant’s posting, but another participant disagrees: “I used to get my period every 14-18 days, and even though I always knew it was coming, it wasn’t a relief at all.” This participant has an unique perspective on menstruation as she once menstruated every two weeks; her body doesn’t “mean” the same as the other participant’s does. She took the question very literally and answered based upon her very real experience. In the first participant’s post, she does not specify having an irregular period, which means her menstrual experience was not similar to the other participant’s, but more like the experience of “most American women.” Due to her different experience, the second participant does not acknowledge embodied ideas about
menstruating as a regulatory process for women “once a month” because her lived experience has constructed her views against the “once a month” ideology. She hasn’t come to embody these things in the same way because the second participant’s model of menstruation varies from the first participant’s. The assumptions surrounding PMS have been overridden by the lived experience.

The discussion board created a space in which the participants could discuss theories of embodiment consciously. As some participants rationally defended ideas shaped by the workshop, they simultaneously showed how much “American” sentimentality they’ve internalized. The participants exhibited high competence of the material as discussed in the workshop, and contributed many colorful and insightful additions that brought a sense of human-ness to the virtual table.

Comparing the Questionnaires

In this project, a questionnaire was administered at the beginning of the workshop, and the final one was given at the end. The first questionnaire is deeply rooted in mind-body relationships in order to raise the salience of these connections as discussed in the workshop. At the end of the first questionnaire, participants found one page devoted to questions pertaining to their personal menstrual history and ideas about PMS and menstruation. Within the analysis, the menstruation part of the first questionnaire will be compared with the second one. Points of analysis include definitions and analyzing the responses to questions about changes as found in the final questionnaire.
Definitions and Percentages of Perception

Both questionnaires asked participants to define PMS and PMDD. In addition, women were asked to assess how many American women have PMS. Overall, participants had a grasp of the definition of PMS at the beginning, and generally did not know the specific definition of PMDD. Of the six participants, five knew the definition of PMS and three knew the definition of PMS when they came to the workshop. The final questionnaire reflected some improvement of PMDD knowledge. One participant did not come to the workshop knowing the definition of PMS and did not provide a specific enough definition in the final questionnaire either. Another, who could not define PMDD on the initial questionnaire, reported a correct definition on the final questionnaire. In general, the quality and accuracy of the definitions were more technical and correct in the final questionnaires than in the initial ones. While PMDD was mentioned in the workshop, it was not at all discussed in the online discussion board, which may be attributed to its peripheral status in the workshop and the project on a whole. Thus, this does not indicate the participant who did not have an accurate and specific definition is not necessarily without other knowledge from the workshop and discussion.

Participants were asked to report the percentage of women they thought had PMS. One participant’s percentage remained the same (60%), another woman’s increased from 10% to 20% since she said she “didn’t realize how prevalent it was” in her final questionnaire. Two women’s estimate decreased by half (50% to 25%, 40% to 20%), while another’s estimate decreased from 15% to 10%. The sixth participant began with 20%, and, in the final questionnaire, wrote, “75% think they do, and 30% have PMDD.” The point of the PMS estimate is to gauge how prevalent or common participants think
PMS is. Half of the participants reported a lower percentage than they started with, which indicates that these participants interpret behaviors, cultural ideas, and the reality of menstruation differently than they did at the beginning of the workshop.

*Changed Ideas: Menstruation, Body, PMS*

The final questionnaire asked participants to think about whether their beliefs and ideas about menstruation, their bodies, and PMS were influenced by the workshop. Only two out of six reported changed beliefs about menstruation; two out of six also reported changed ideas about their bodies; five out of six said that their ideas about PMS had changed. One participant whose ideas and beliefs about her body were influenced by the workshop possessed ideas about menstruation and PMS that were changed as well. The other participant who said she thought about her body differently agreed that her ideas about PMS were influenced, but her thoughts on menstruation remained the same. The one participant whose ideas about PMS were not influenced also did not think or feel differently about her body or menstruation.

In its most fundamental goal, this workshop succeeded. Most of the women’s ideas about PMS changed. Ostensibly, this was the point of the workshop: to change women’s ideas about PMS. The material within the workshop mostly centered on PMS. On the most superficial level of this project, it is a success in that it’s changed the way five women perceive PMS. The participant who did not feel at all influenced may have walked into the workshop agreeing with everything that was said. She knew the definitions of PMS and PMDD in the first questionnaire, so she may have shared similar ideas about PMS and menstruation before participating in the workshop. There is no way
to assess this since the questionnaire does not ask any background questions about participants’ prior knowledge of the subject. The final questionnaire, however, gave participants the opportunity to provide feedback for me. This participant said she wouldn’t change a thing about the workshop and “thought the information about how different cultures perceive PMS was fascinating, and the chance to participate in an open discussion with other women was even better.” What was missing?

To some, the workshop may have felt inaccessible on some levels, which may explain why many participants’ beliefs about menstruation and their body did not change. The language used in the workshop was, as aforementioned, directed at challenging ideas about PMS. Most participants may have not understood the connection of this information about PMS to menstruation directly, or this information was not as well connected within the workshop. Two participants reported that the workshop influenced their thoughts and feelings about their bodies, which is monumental. On the most global scale, this project is intended to “improve” the way women think about bodies—theirs and others—through realigning their perspective on PMS and menstruation. This is a substantial success for this project, albeit small in numbers.

While the workshop may not have affected women’s perceptions about everything intended, they all found it more useful than not. Overall, the group found the workshop very interesting. One participant noted that “it was enlightening and extremely worthwhile,” while another thought the information was not “particularly useful in the near future. Beyond that, you never know when some info might be good to have.” Another participant found the workshop reassuring and immediately useful. She wrote, “It was nice to see that the fact that I don’t really experience PMS is normal. I don’t get
mood swings or anything like that, but I’ve always been told that I should.” While she responded “no” to a global question about changed body perception, this response explains a sense of newfound comfort with her menstrual experience through her experience in the workshop.

As stated, most participants said they enjoyed the workshop—some more enthusiastically than others—but two participants did make useful recommendations for the future. One said, “I really liked the workshop. Everyone was so smart and the facilitator always made me feel validated with my comments, which made me want to share more. In this sense, I will miss the workshop and only wish that perhaps it could continue and expand.” Her remarks—flattering, yes—speak to a part of the workshop that isn’t evaluated: the role of the facilitator. Although that has slipped under the radar, it is good to know the facilitator was effective in encouraging participants. Another participant also found the facilitator valuable and said, “Make [the workshop] longer. I really enjoyed the posting experience. It might have been cool to have met as a group a second time.” Clearly, these participants demand a longer workshop and discussion session, which is a good sign. They find this topic interesting enough to continue talking about it with each other. At best, I can only hope these participants may bring this conversation outside the workshop and discussion board and into the real world, with real friends.

Since that participant recommended a final meeting, I have contacted all six participants and we are currently in the process of setting a date to meet again to discuss what we’ve learned, understood, challenged, and re-learned through this experience. With 20/20 hindsight, I see that a closing meeting with the group together in person is as
essential as the first workshop. I am happy my participants have been integral in improving this project.
Conclusion

For this project, the particulars of questionnaires have not been the core of my analysis in determining whether this intervention has been at all effective. It is the discussion board and open-ended questions found in the final questionnaire that speak most to the effectiveness of this method. Initially, the workshop educated participants about PMS discourse. They challenged these ideas and their own on the discussion board. Without much guidance, these women took up and analyzed themes about women’s bodies in relation to the world, each other, the self. Some of them may have come to the project with much of the information or the willingness to confront societal norms; but most reported leaving with new knowledge and having enjoyed the enlightening discussion. It is successful in that anyone’s ideas about anything had changed.

Ideally, this workshop would have been larger; the discussion might have lasted longer; a group closing would have sealed the information tight within their brains and senses. Simply put, that is beyond the scope of this project. We can only measure it by the feasibility of its enactment. If only one woman felt change, this would have been effective enough. A function of this project is culture change, which often takes a ripple effect. One person’s changed ideas can affect or change somebody else’s. As stated, all of the women took some form of knowledge with them. Barnard women are upward moving in this world, so I wouldn’t be surprised if ideas from this workshop ended up taught in high school classrooms, brainstormed in newsrooms, or discussed at pharmaceutical companies. The sample for this project was ideal in that the women participating it were smart, beautiful Barnard women.
In the future, I’d like to see this workshop done everywhere, with every type of sample possible, including men. Why not? Change cannot be made through but a portion of the population—especially the oppressed half. There is much potential for this form of education since it provides the participants more agency in lieu of a hierarchical structure (i.e. teacher and students). Also, PMS and menstruation does not have to be the point of intervention in working toward a new discourse on women’s bodies. There is much to talk about, and as the participants requested, a longer, more global workshop and discussion would be more desirable and effective for participants.

Though the idea of a workshop implies a small sample, change must begin on an individual level. The workshop-and-discussion board model allows participants to shape and bend the knowledge they are receiving so that it best suits them. This model is appropriate for topics ranging from women’s health to sexuality, from sexual violence to processing hate crimes and beyond. In the workshop, ideas are shared, and the arc of the conversation depends on the personal touch each member of the group contributes. Then, the discussion board allows participants to express the ideas and their beliefs about them with their own words. I believe this model was extremely effective, and I would anticipate successful longitudinal results if I were able to keep in touch with these women five to ten years from now. It is useful to note that immediate reactions may not be the best way to gauge “effectiveness” for this kind of project. For those women whose ideas did not change by the end of the workshop, this does not indicate that their beliefs will never change. They now have “good” information about their bodies that they may take wherever they go.
Katharina Dalton continues to re-publish her *Once a Month* and most teen magazines instill phrases like “period woes” into the minds of pre-pubescent girls. Academics such as Anne Fausto-Sterling and Emily Martin address these issues with brilliance and elegance to people like Barnard women. Cosgrove and Riddle provided much of the groundwork for this kind of project to be possible, but who, other than academics, has read Cosgrove and Riddle? Not the audience of *Seventeen*, and they’re the ones who could use a dose or two of Cosgrove and Riddle.

Once upon a time, PMS provided a “safe space” wherein women could *feel* and be validated accordingly, but then PMS turned into PMDD and women’s *feelings* sounded like complaints, symptoms, disease, and even hysteria all over again. Where can we turn now? Few venues exist wherein women may discuss their bodies without the male gaze affecting their word choice. The workshop and discussion board afforded women the opportunity to speak freely about their bodies while learning and internalizing a new lens through which they may perceive the world. Together, these venues provided validation to women’s feelings, ideas, and beliefs while deconstructing pathological “escape hatches” like PMS. With high hopes, this project sought to bridge the gap between academic and “real” people. It is as if the “lived and social construction” comprised my focal audience, rather than the topic discussed. Clearly, the world has not changed with this one project. The success of these women’s involvement, however, sheds light on the possibility for critical interventions to become less “critical”: one day, they may become “normal,” too.
APPENDIX I  
Recruitment Process and Debriefing & Flyers

Recruitment Process

Originally, I envisioned flyers to be the best way to recruit Barnard students. Because they are ubiquitous, I thought mine would at least be as effective as (if not more than) posters for SGA Town Halls or club meetings. I made three separate flyers; each featured a different photograph of one of three women: a young girl making a funny face, a worn-looking college student, and a girl with a hat over her face. The photos correlated with a statement about the photograph. For example, the flyer picturing the funny-faced young girl says, “How are you thinking today? Tough question? Looks like it.” Each flyer also had a common phrase: “Join us for a conversation with other women about bodies, brain, and emotion!” At the bottom of each flyer, there were tabs with contact information (e-mail barnardworkshop@gmail.com today!) for interested parties. I wanted to preserve my own identity during the recruitment process so I made a Gmail account, barnardworkshop@gmail.com, specifically for my project. Because Barnard is relatively small, I did not want my identity to be easily traced or deciphered through the flyers; I was hoping to seek people interested based on their own interest, rather than their hypothetical connection to me or anyone else involved with this project.

Through Special Events, I reserved the Spanish Room, 207 Milbank. Due to limited time, the flyers were up for only four days prior to the workshop. One person showed. She and I waited for about 15 minutes for other people to show. We had an informal “mini-workshop,” and she said she would commit to the study when it was underway.
As an alternate to flyering, I asked Professor Young for her assistance in getting the word out to other students. The e-mail framed the study as follows: “For my senior project, I am conducting a workshop about women's physical health and how it is affected by mood, emotion, and cognition. In particular, the workshop will investigate the physiological and psychological changes that occur during menstruation, and find out what's going on there.” It also informed students the date of the workshop, and that interested parties should anonymously e-mail barnardworkshop@gmail.com for more information. Professor Young sent this e-mail to about 120 students; three replied asking for more information about the workshop and the time commitment, only one committed. One of my peers, a Barnard senior and Residential Assistant, offered her assistance by forwarding my e-mail to all of her residents. None replied. Also, several individuals verbally said they would attend the workshop, yet none followed through.

For a week prior to its scheduled date, February 28, 2006, the room for the workshop had been reserved. This was the third time I had reserved a room with Special Events. The other two scheduled dates had fallen through due to lack of turnout. As February 28 approached, I realized people were not enticed by my e-mail. I forward my e-mail to the editorial board and staff members of the barnard bulletin. One person committed. Next, I asked a few friends, giving a similar description to that of the e-mail. One of my roommates committed; she brought a friend. At this time, I had four people committed to the workshop—a small number, but enough to generate a conversation within the workshop and on the discussion board; one of the participant's friends also
agreed to partake in the workshop, but they were both unable to attend the workshop February 28.¹

The first-year class dinner took place February 28 within the James Room, near the seminar room in which I held my workshop. In the very last attempt to attract participants, I entered the first-year class dinner as it waned and spoke with women at every single table in the room: “Hi, my name is Nicole. I'm a senior—so you're wondering, what am I doing here? I'm holding a workshop about menstruation, PMS, and women's physical health across the hall for the next hour or so. Would you like to join?” Every woman with whom I spoke said she did not have time, that she had a midterm the next day, or some simply shook their heads and continued talking with their peers.

*Debriefing the Recruitment Process*

The many failures of the tested recruitment strategies indicate a number of things about the audience to which I was advertising, the presentation of the topic in the advertisements, and possibly the topic in general.

My flyers appeared very similar to flyers seeking participants for graduate studies—ones with grant funding. In general, studies advertised on campus involve monetary compensation for the participants' time. Because I did not have a grant for my study, I could not entice people with the prospect of earning an amount of money upon completion of my final questionnaire. At first glance, my flyers may have appeared more visually inviting, but they did not offer any kind of compensation for the student's time.

¹ On March 1, I discussed with these two women the same topics and regarded them with a similar if not exactly congruent tone.
Students at Barnard budget their time on tight schedules; if they're going to schedule in something extra, then it had better be worthwhile. As a Barnard student myself, I can attest to that.

Also, the flyers should have been more pervasive, obvious, and long-standing than they were. Because they were up for only a few days prior to the workshop, this dramatically decreased my chances of attracting any participants.

As far as the e-mailing is concerned, this should have been one of my first attempts at recruiting individuals. Paired with the flyering, the e-mail might have been more effective. I made a concerted choice to advertise the workshop as a discussion about women's physical health, but I am aware that this concept may not have been attention-grabbing or interest-piquing enough. It is difficult to identify whether the methods of recruitment were poorly executed or if the topic itself did not say enough about the essence of the workshop. The flyer advertisements needed to make a constant and convincing presents on Barnard's campus and they did not. However, there should have been a place on the flyers for 'PMS' and “menstruation.”

When I approached individuals, especially women at the first-year class dinner, I told them the workshop was about PMS, menstruation, and women's health. Nobody was interested in participating in the workshop that was occurring at that very moment across the hall. I attribute this to several causes: First, these women may have used the first-year class dinner as a study break and needed to return to their work. Second, they did not find a PMS and menstruation discussion interesting because they thought they knew everything about it. Third, the women did not think there was anything to say about PMS and menstruation. I'd like to highlight the second and third reasons and link them to the
point of the study. Are these women who should have come to the workshop? Absolutely. If these women took lightly the topic of PMS and menstruation for either of those two reasons, they are the women whose consciousnesses needed interruption. As stated in chapter two, ‘PMS’ appears as an alternative-less monolith that exists to these women; a concept that does not require (or deserve) dispute. Of course, my hypothesis may not accurately portray the actual thinking process of these women. Based on the critical analyses of PMS discourse and embodiment theory, however, it is possible these women did not participate because of their perceptions surrounding PMS and menstruation, rather than any singular, traceable idea.
are women moodier than men?

whether you answered ‘yes’ or ‘no’, if you think this is an important question, come learn more and engage with others about it.

join an interesting conversation with other women about bodies, brains, and emotion!
how are you thinking today?

tough question?
looks like it.

it’s as important a question as ‘how are you feeling today.’ often times, these two questions are more similar than they initially seem.

want to learn more about this connection?

join an interesting conversation with other women about bodies, brain, and emotion!
frustrated because you have a headache and homework to do?

- does physical pain distract you from schoolwork or other parts of your life?

- do you ever notice a change in your moods when you are not feeling 100%?

- want to join an interesting conversation with other women about bodies, brains, and emotion?

if you’ve answered ‘yes’ to any or all of these questions, you might be interested in participating in a workshop about the effects of physical pain on mood and cognition.

please e.mail barnardworkshop@gmail.com today for more information.
APPENDIX II
Workshop Materials

Consent Form

COLUMBIA UNIVERSITY
Consent Form

Workshop: On Physical Health and Mood and Cognition

Principal Investigator: Nicole Bufanio, Barnard College senior

Co-Investigator: Rebecca Young, Ph. D.

You have been invited to be in this research study because you have expressed interest in [the relationship between physical discomfort or pain, on the one hand, and mood and cognition, on the other]. The purpose of this study is to explore this topic, with a special focus on women’s cognitive and emotional functioning. The study will last for three months starting today. Approximately 30 subjects will be enrolled in the study.

The study includes four parts: a pre-workshop questionnaire, a 3 hour workshop, participation in an online discussion over the course of 4 weeks, and a final questionnaire. Each section is described briefly below.

PRE-WORKSHOP QUESTIONNAIRE: The questionnaire will assess participants’ initial beliefs and experiences regarding physical pain, discomfort, and the relationship between physical conditions and cognition or mood. The questionnaire will require approximately 10-15 minutes to complete.

WORKSHOP: The workshop will consist of sensitivity exercises, brief educational presentations, and facilitated group discussions about the study topic. All participants will be asked to agree to ground rules that include mutual respect and honoring the confidentiality of other participants’ statements.

ONLINE DISCUSSION: The online discussion will be facilitated via an online journal website for which only the workshop participants will have the address. Participants can post anonymously, or may choose to identify themselves, at their own discretion. The purpose of the online discussion is to engage participants in ongoing reflection about topics raised in the workshop, and to explore whether the workshop has any impact on participants’ experiences or beliefs afterwards. Participants will be asked to post once per week, and their post should be at least 3 sentences in length.

FOLLOW-UP QUESTIONNAIRE: The final portion of this study includes a questionnaire that will ask you to reflect on the workshop and the subsequent online discussion. You can complete this follow up questionnaire via email; it will take approximately 15-20 minutes.

CONFIDENTIALITY: Due to the nature of this study, the participants will not be anonymous to one another in the workshop. All information gathered for the research, however, will be kept in strict confidence throughout the duration of the study and thereafter. You will create a unique identifier that will be used on both of your questionnaires; your name will never be attached to either of these questionnaires. All contact information that I have for you will be kept separately from all data gathered for the study, and will not be shared with anyone else for any purpose. You may choose to make all online contributions anonymously. If you do choose to identify yourself in any online posts, you should be aware that I will strip all names from any online comments prior to preparing my research report.
RISKS AND BENEFITS: This study should not cause you emotional discomfort. However, if it does, inform the head investigator at any time during the study and you will be excused.

You may or may not personally benefit from being in this study. However, by serving as a subject, you may help us learn how to create effective interventions to lesson the cognitive and emotional impact of various physical conditions.

YOUR RIGHTS: Your participation is strictly voluntary. You have the right to withdraw from this study at any time with no questions asked. If you have any questions regarding this study now or in the future, contact Nicole Bufanio at 908.578.1762. Because this research involves interview data only, and all identifying information will be kept confidential throughout the duration of the study and thereafter, it is exempt from human subjects review. However, if you have any questions regarding your rights as a research subject, you may contact Robert Remez, Co-Chair of the Barnard College Institutional Review Board, at remez@columbia.edu or 212-854-4247. You do not have to join this study. If you do join and later change your mind, you are free to leave at any time. We will give you a copy of this signed form.

Your signature below indicates that you have read this entire form and consent to participate in this study.

__________________________________________
Name                                                                                         Date

Print name here:
Definitions

**Menstruation:** A woman-only process wherein the lining of the uterus passes through the cervix and out of the vagina.

**Premenstrual Syndrome, or PMS:** A term to describe women’s physical, mental, and emotional changes (that are absent during other times of her cycle) in the days before she begins menstruating. Dr. Katharina Dalton, the person who coined the term, has estimated that there are up to 150 symptoms of this condition including backache, irritability, asthma, epilepsy, weight-gain, tension, and depression.

**Embodiment:** As applied to this issue, embodiment theory is one that states that an idea or concept about or associated with the body can become part of or, in fact, change the way the body “works.” For example, menstruation exists; there are ideas about how menstruation exists; the way women experience menstruation (on both physical and mental/ emotional levels) is changed by these notions of how menstruation exists in America.

**Function of PMS for Women**
An excuse (for behavior, to not go to work, to not participate in physical activity etc.)
A way to reclaim one’s body.
To compartmentalize (“label”) mental and bodily symptoms.
To indicate how to act in a feminine way (Cosgrove & Riddle).
To separate “good” behavior from “bad” behavior (Cosgrove & Riddle).

**Notable research**

*McFarlane, Martin & Williams*
- Had 15 women using oral contraceptives, 12 normally cycling women, and 15 men report their moods every day over the course of 70 days.
- At the end of 70 days, participants were asked to identify their “average mood” for each day of the week. Women were also asked to identify their moods during each phase of their menstrual cycle.
- Prospectively, “normally cycling” women reported more pleasant moods during the menstrual phase than anyone else.
- Retrospectively, all women recalled having more unpleasant moods during their premenstrual and menstrual cycle.

**Conclusion:** stereotypes influence the way women regard and experience their menstrual cycle.

**Cosgrove & Riddle**
- Thirty women participated, some of whom were self-described PMS sufferers and others who were not PMS.
- In part, the study involved interviews with the participants about each woman’s personal experience with PMS, perceptions of it, and how she understands her experience.
- Another component of the test was the Bem Sex Role Inventory, which determines where on the “masculinity-femininity” continuum people situate themselves.
- Cosgrove & Riddle found that those who positioned themselves as PMS sufferers were most aware of gender-appropriate behavior. These women also described their “PMS-self” as exhibiting bad behavior, in contrast to the “normal self,” which is good.

**Conclusion:** embodiment of stereotypes not only affects experiences of menstruation, as McFarlane found, but also shows how dependent women are on PMS-stereotypes to determine how they should behave. PMS is both a lived and social construct, as Cosgrove & Riddle write.

**Where We Are Now**

PMS began as a pseudo-clinical term and has become more of a cultural concept (i.e. PMS is not something generally diagnosed by a doctor, but rather *Cosmopolitan*). Today, ‘PMS’ manifests itself in two ways:

**PMDD:** “mental/emotional component” – PMDD, or Premenstrual Dysphoric Disorder, is listed in the DSM-IV as a “depressive disorder.” PMDD is a form of PMS marked by “intense” physical and emotional symptoms, but, comparing it to Major Depressive Disorder, it looks very similar. (Paxil has been prescribed to treat PMDD.)

**Dysmenorrhea:** “physical component” – Often synonymous with “painful periods,” dysmenorrhea includes symptoms such as nausea, abdominal pain, diarrhea, and headaches. (Motrin has been a way of treating dysmenorrhea.)
LIVEJOURNAL Posting

The point of this is to generate a dialogue about what was discussed in the workshop and how this fits into your lives (if at all). You will have the opportunity to communicate with your peers in the workshop about your feelings and ideas on the subject.

Please post on LiveJournal as often as possible. If you can do it every other day, that would be ideal.

URL: http://barnardworkshop.livejournal.com/

I will post open-ended questions every day or two. To respond, simply “leave a comment.” I suggest viewing other people’s comments before posting your own. You can post anonymously. I will review each post before it is visible for others to see on the Web site.

As soon as you get home, please e-mail barnardworkshop@gmail.com saying that you will post on LiveJournal. I’ll need your e-mail addresses so that I can send you the final questionnaire at the end of the two week period.
Initial Questionnaire

GENERAL INSTRUCTIONS: PLEASE DO NOT LOOK AHEAD IN THE SURVEY! Complete each section before turning to the next section.

There are many questions about your health, your bodily experiences, and how these are related to other aspects of your life. This is not a medical history and you are not meant to spend a great deal of time or thought with any of these questions; please just answer with your first impression and move through the material with thought but without agonizing or attempting to be completely exhaustive.

Please make a unique identifier for your survey using the following three questions:
What’s the month and date of your birth? (mm/dd) _ _ / _ _
What is your shoe size? _____
What are your mother’s initials?

Example: 09/08, 8.5, KG Therefore, my unique identifier is 09088.5KG.

A. Experiences of Change

The first few questions are about the kinds of physical changes you may have experienced this year, and how those have affected you.

1. Which of the following physical changes have you experienced in the last year? (check all that apply)
   ___ Weight gain or loss
   ___ Increase in height
   ___ Increase or decrease in appetite
   ___ Increase or decrease in muscle mass, tone, or definition
   ___ Increase or decrease in energy
   ___ Changes in what you want to eat (not amount, but kind of food)
   ___ Change in vision
   ___ Change in hair texture or color (without your intervention!)
   ___ Change in hearing
   ___ Increase or decrease in flexibility
   ___ Change in the amount of sleep that you need to feel rested
   ___ Change in skin texture or sensitivity
   ___ Change in ability to breathe easily through your nose
   ___ Seasonal change in skin tone (tanning, paleness)
   ___ Other bodily changes: __________________________________________________

2. Did any of these changes affect your life in positive ways? If so, which ones?
What were the positive effects?

3. Did any of these changes affect your life in negative ways? If so, which ones?

What were the negative effects?

Mental Experiences

4. Which of the following have you experienced in the past year? (check all that apply.)
   _ __ Change in ability to concentrate
   _ __ Irritability
   _ __ More or less sociable
   _ __ Feelings of more/less capable
   _ __ Change in acuity (keen awareness, quickness, sharpness)
   _ __ Increase or decrease in sexual desire
   _ __ Depression
   _ __ Increase or decrease in empathy
   _ __ Sadness
   _ __ Increase or decrease in level of aggression
   _ __ More or less assertive
   _ __ Increase or decrease in level of patience
   _ __ Change in general outlook (from pessimistic to optimistic, or vice versa)
   _ __ Increase or decrease interest in work
   _ __ Increase or decrease of self-esteem

5. Did any of these changes affect your life in positive ways? If so, which ones?

What were the positive effects?

6. Did any of these changes affect your life in negative ways? If so, which ones?

What were the negative effects?
B. Symptoms and Problems
The next few questions are about physical problems you might sometimes have, and how these affect your life.

7. Which of the following problems or symptoms have you had in the past year? (check all that apply)
   - Stomach upset or digestive problems
   - Abdominal cramps
   - Other muscle cramps
   - Tooth or gum pain
   - Dizziness, fainting, or feeling faint
   - Fever
   - Vaginal itching or unusual discharge
   - Skin breakout or acne
   - Rashes, extreme dryness or other skin problem
   - Vision problems
   - Hearing problems
   - Difficulty breathing
   - Back pain
   - Stiffness or pain in joints
   - Other tingling, numbness, or pain (if yes, where: ____________________________)
   - Migraines
   - Other headaches
   - Diarrhea
   - Bloating or water retention
   - Pain or burning with urination
   - Problems sleeping
   - Extreme thirst
   - Cough
   - Any other physical problems: ____________________________________________

We are especially interested in how these physical problems might have affected your daily life, including your ability to work and concentrate, your relationships, and your mood and/or feelings about yourself.

8. Have any of these physical problems ever affected your ability to work or concentrate? Briefly explain which ones have (if any), and how often this has occurred.
9. Have any of these physical problems ever affected your relationships with other people? Again, briefly explain which ones have (if any), and how often this has occurred.

10. Have any of these physical problems ever affected your mood or your feelings about yourself? Again, briefly explain which ones have (if any), and how often this has occurred.

11. In the past year, can you recall a time when a physical change or problem might have caused you to behave in a way that is unusual for you? Briefly describe one such experience.

If yes, do you think other people may have judged you because your physiological problems affected your behavior or mood?

Yes ___  No ____
C. Experiences with menstruation

12. Do you menstruate?  ____ no  ____ yes
   (IF YES, please continue; IF NO, please skip to question 15)
   Do your menstrual periods cause you any problems?  ____ no  ____ yes
   IF NO, please skip to question 15.
   IF YES, please describe all specific problems you experience with your periods:

   How often do you experience these problems?______________________________

13. Would you say you have ‘PMS’?  ____ no  ____ yes

14. Has anyone ever diagnosed you with a menstruation-related problem?
   ____ no  ____ yes
   IF YES, What was the diagnosis? _______________________________________

15. What does ‘PMS’ mean? (Be as specific and detailed as you can.)

16. Do you know what PMDD is?
   ____ no  ____ yes
   IF YES, please define or describe it:
17. What percentage of menstruating women do you think experience PMS? _____
(please take your best guess.)

THANK YOU FOR YOUR TIME!
Appendix II

Final Questionnaire

Please answer the following questions candidly and to your best knowledge. Thank you for participating in the workshop and discussion.

Again, please make a unique identifier for your survey using the following three questions:
What’s the month and date of your birth? (mm/dd) _ _ / _ _
What is your shoe size? _____
What are your mother’s initials?

Example: 09/08, 8.5, KG Therefore, my unique identifier is 09088.5KG.

1. What does ‘PMS’ mean? (Be as specific and detailed as you can.)

2. Do you know what PMDD is?
   ____ No  ____ Yes
   IF YES, please define or describe it:

3. What percentage of menstruating women do you think experience PMS? _____
   (Please take your best guess.)
4. Have your beliefs about menstruation changed over the course of the workshop and discussion? (NOTE: This question is about menstruation, not PMS; I ask specifically about PMS below.) ___ No ___ Yes
   If YES, please describe this change.

5. Have your ideas and feelings about your body changed? ___ No ___ Yes
   If YES, please briefly describe.

6. Did you find the information presented in the workshop useful? Please explain.
7. Do you think the workshop has influenced and/or changed your ideas about PMS?
   ___ No ___ Yes
   If YES, please describe.

8. Would you change anything about the workshop? Please explain.

THANK YOU FOR YOUR TIME!
Relative to difficulties with recruitment, the workshop occurred with few, if any, challenges, but more people would have improved the experience for this project, and, more important, the participants. The initial workshop would have benefited from having all six, rather than three, participants present. After reading the LiveJournal, I found that all six women had unique voices, and they readily collaborated in discussing these topics and searching for solutions even if that meant challenging one another. I would have liked to have seen this in motion during a workshop, rather than just on the discussion board. Once the LiveJournal term ended, a few participants expressed interest in getting together with all six involved in this project to talk about what they learned. To me, this indicates that connections were forged even in cyberspace, which makes me wish they had all started together. Having started together, each individual in this group may have found her “safe space”\(^1\) within the group earlier through face-to-face discussion in the workshop, and thus the group as a collective may have taken these topics to greater heights.

In general, I hypothesize that more participants would have made a more robust, well-rounded discussion possible, yet I do believe the intimate climate of a three-person discussion created space for women to share more intimate experiences and feel safer about it. While the women in the workshop did not necessarily know one another, we

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\(^1\) When I use “safe space,” I mean a place where trust and confidentiality is established among the participants. This means that the group agrees to acknowledge other people’s experiences and ideas without undermining their value. This also means the group must agree to preserve anonymity when discussing the workshop outside of it.
could relate in that we were all students and I believe the close-knit environment helped to create an initially warm, intimate atmosphere. Because I was preserving anonymity, we did not go around and say our names or anything about ourselves. In the future, when this kind of model is used solely as a consciousness-raising tactic and not a thesis project, I would recommend introductions and, for example, an invitation for each member of the group to say one thing other people might not know about them by looking at them. For this kind of discussion where personal experiences guide parts of it, I find it essential for the participants to feel more personally connected with one another. This project is primarily concerned with the subjective experience of the individual, and how this might direct the realigning of one’s perspective. In other words, without the “real” experience of women, I cannot conceive of a way to introduce a “new” discourse to them without understanding and working with their current perceived discourse, thus a strong sense of safe interpersonal connections is essential to forge that path. In the discussion I had with just two participants, they were roommates and therefore knew each other quite well. While I, as the facilitator, was the clear “outsider,” I think it had little effect on the candid nature of their responses due to the already established connection the two women had with one another.

While I am a firm believer in talking “with” people, rather than “at them,” I do not think it is possible to integrate a completely new discourse into their consciousness without their trust in the facilitator. I believe I have succeeded in helping to encourage and create a “safe space” despite anonymity, but, as aforementioned, our indirect and direct connections to one another also contributed to a more engaging environment.
Works Consulted


