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The Role of Premenstrual Dysphoric Disorder in the Subjectification of Women

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This paper will examine the way in which premenstrual symptomatology has been represented and regulated by psychology and psychiatry. It questions the "truths" about women's premenstrual experiences that circulate in scientific discourse, namely the fictions framed as facts that serve to regulate femininity, reproduction, and what it is to be "woman." Hegemonic truths that define Premenstrual Dysphoric Disorder (PMDD) and its nosological predecessor Premenstrual Syndrome (PMS) are examined to illustrate how regimes of objectified knowledge and practices of "assemblage" come to regulate individual women through a process of subjectification. Five interconnected "truths" are presented as objects of scrutiny: PMDD is a thing that can be objectively defined and measured; PMDD is a pathology to be eradicated; PMDD is caused and can be treated by one factor; PMDD is a bodily phenomenon; PMDD causes women's problems or symptoms. I examine the way in which these hegemonic truths function in framing the reproductive body as a cause of disorder or distress that leads women to interpret premenstrual experiences within a pathological framework deserving medical or psychological treatment. Finally, I offer an alternative framework drawing on Eastern models of selfhood that provides a more empowering model of women's premenstrual experiences.

KEY WORDS: Premenstrual Dysphoric Disorder; Premenstrual Syndrome; femininity; reproduction; hegemony; assemblage; psychology; psychiatry.

INTRODUCTION: THE GENEALOGY OF PMDD

In 1994 premenstrual symptomatology became officially reified as a psychiatric disorder, with the appearance of Premenstrual Dysphoric Disorder (PMDD)

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in the DSM-IV (American Psychiatric Association, 1994). This marked the culmination of centuries of scientific discussion and investigation concerning the connection between psychopathology and woman's reproductive cycle. The genealogy of PMDD can be traced back to Plato and Hippocrates, who documented the deleterious influence of the "wandering womb," recommending "passion and love" followed by pregnancy, as the cure for "all manner of diseases" the womb "provoked" (Veith, 1964, p. 7). Nineteenth century commentators described menstruation as the moral and physical barometer of the female constitution (Burrows, 1828, p. 147), or a source of "moral and physical derangement" (Maudsley, 1873, p. 88).

The focus on the premenstrual phase of the cycle as a time of particular vulnerability and on premenstrual symptoms as a sign of psychiatric illness can be traced to 1931, when the diagnostic category of "premenstrual tension" (PMT) first appeared. Robert Frank, the gynaecologist commonly credited with establishing the existence of PMT, attributed the combination of physical and psychological symptoms occurring in the days immediately prior to menstruation, to accumulations of "the female sex hormone" estrogen (Frank, 1931). Feminist psychoanalyst Karen Horney described "premenstrual tension" as a psychological response to the anxieties and fantasies associated with pregnancy, combined with frustration caused by the cultural restrictions surrounding the expression of female sexuality, with symptoms triggered by the physiological processes of preparation for pregnancy (Horney, 1931, p. 7). While Frank viewed premenstrual tension as a dysfunction, Horney asserted that it was not a pathological process. This was because, she argued, the fluctuations in mood, as well as the anxiety, irritability, and "intensities of feelings of self deprecation to the point of pronounced feelings of oppression and of being severely depressed" occurred in "otherwise healthy women" (Horney, 1931, p. 2). This same debate was to be repeated at the end of the century when PMDD, the successor to PMT, and its more recent nomenclator PMS (premenstrual syndrome), entered the annals of psychiatric nosology as a diagnosis applied to up to 40% of women.[3] For those within the psychiatric profession who had initiated the move to include PMDD in the DSM, there was no question about the issue of pathology, or of the expert's right to intervene. For the many feminist critics and psychiatrists who had vociferously argued against this (see Figert, 1995, for analysis of the DSM controversy), premenstrual symptomatology, if it was accepted as existing at all, was seen as a normal part of women's experience. PMDD was positioned as merely the latest in a line of diagnostic categories that acted to pathologise the reproductive body (Caplan, McCurdy-Myers, & Gans, 1992; Parlee, 1991; Nash & Chrisler, 1997; Ussher, 2000a, b). This paralleled broader debates in critical psychology and psychiatry where all forms of mental illness or

[3]While estimates of the number of women experiencing premenstrual symptoms vary from 5–95%, recent epidemiological research suggests that up to 40% of women experience moderate to severe premenstrual symptoms that have a serious disrupting effect on daily life, one of the key criteria for PMDD.

madness were positioned as social constructions that regulate subjectivity (Foucault 1979; Ingleby 1982; Ussher, 1991; Fee, 2000).

The feminist deconstruction of PMDD as a discursive construct, a nosological category that allows particular aspects of women's experience to be deemed "symptoms," is a necessary part of any attempt to understand the way in which women's reproductive bodies are positioned as dysfunctional. The dethroning of experts who pathologise women's psychological or bodily experiences, or women's responses to the circumstances in their lives, is also an essential aspect of any progressive form of explanation for distress or unhappiness. For while premenstrual symptomatology does exist, testified by the high percentage of women who seek treatment, it does not have to be classified as a psychiatric syndrome or as a pathological disorder (Nicolson, 1998: Ussher, 1989, 1992).

However, in addition to deconstructing psychiatric discourse associated with the premenstrual phase of the cycle, a critical psychological approach to this area must also look at the process by which women come to take up the position of PMDD (or PMS) sufferer.[4] A need exists to unravel the process by which women come to understand the reproductive body as a cause of disorder or distress and to interpret bodily or psychological symptomatology within a pathological framework that deserves medical or psychological treatment.

PMDD AS A PROCESS OF SUBJECTIFICATION

In this paper, I will argue that this process takes place through "subjectification." Drawing on Foucault, Nikolas Rose describes subjectification as "regimes of knowledge through which human beings have come to recognise themselves as certain kinds of creatures, the strategies of regulation and tactics of action to which these regimes of knowledge have been connected, and the correlative relations that human beings have established within themselves, in taking themselves as subjects" (Rose, 1996, p. 11). It is through the process of subjectification that truths about women's bodies and menstruation are reproduced and lived by women: the fictions framed as facts that serve to regulate femininity, premenstrual experience, and the very experience of what it is to be "woman."

The regimes of objectified knowledge circulated by the psychiatry and psychology professions that reify PMDD (or its derivatives) as a pathological problem and provide the framework within which women come to understand themselves as PMDD sufferers, originate from a number of related spheres. Aetiological theories and practices of intervention are produced by researchers and clinicians in medicine, psychiatry and psychology and then reproduced or described in a

[4]In this paper I will use the term PMDD to include current and past diagnostic categories used to classify premenstrual symptoms. PMT was renamed Premenstrual Syndrome (PMS) by Greene and Dalton in 1953, "late luteal phase dysphoric disorder" (LLPDD) in the appendix of DSM-III, and "Premenstrual Dysphoric Disorder" (PMDD) in the DSM-IV (Gold & Severino, 1994). I will use the term PMS where it was used by specific researchers. This does not imply a different "disorder."

popularised form by journalists and other authoritative experts, in newspaper or magazine articles, and self help books. In this paper, I will examine five hegemonic truths about PMDD, and then look at the implications of this for the subjectification of women, including the way these truths appear in women's narratives, drawing on interviews with women who have sought treatment for premenstrual symptoms.

The interviews were part of a study of PMDD treatment efficacy, conducted with 108 British women who met DSM criteria (see also Ussher, Hunter, & Browne, 2000). Narrative interviews were conducted before and after treatment, the aim being to examine women's subjective experience of premenstrual symptoms and the category PMS, as this was the commonly used nomenclature in Britain at that time. In order to elicit narratives, an open-ended question was asked: "In this interview I'd like to explore some of the meaning PMS has for you, and the part it plays in your life. I'd like to start by asking 'what does PMS mean to you?"' The interviewer then followed the woman's lead, asking questions of clarification as and when necessary. The interview was thus framed as a dialogue between two people, rather than a question and answer situation.

In this paper I am drawing on the pre-treatment interviews, which were analysed within a framework of thematic decomposition (Stenner, 1993, p. 114). This is a close reading which attempts to separate a given text into coherent themes or stories which reflect subject positions allocated to or taken up by a person (Harre & Davies, 1990). It is based on the assumption, common to most discursive and narrative analysis, that stories told do not simply mirror a world "out there," but that they are constructed, creatively authored, rhetorical, replete with assumptions and interpretations (Potter & Wetherell, 1987; Reissman, 1993, p. 5). Drawing on poststructuralist theory, it was assumed that narratives act to construct subjectivity; they provide interpretations of experience. In the telling we make sense of phenomena and are assumed to be doing particular "identity work" through constructing subject positions for ourselves and others. It is assumed that the narratives were acting to construct an account which is consistent and compatible with wider cultural discourses about femininity, premenstrual symptomatology, mental health and PMDD.

After transcription, interviews were coded, line by line, thematically. Themes were then grouped together, and then checked for emerging patterns, for variability and consistency, and for the function and effects of specific narratives. The interpretation of these themes was conducted by a process of reading and re-reading, as well as reference to relevant literature and consultation with colleagues.

REGIMES OF OBJECTIFIED KNOWLEDGE THAT CONSTRUCT PMDD

In examining the relationship between hegemonic representations of PMDD in scientific and popular discourse, and women's presentation of their own

symptomatology, I will take five inter-connected "truths" as objects of scrutiny: PMDD is a thing that can be objectively defined and measured; PMDD is a pathology to be eradicated; PMDD is caused and can be treated by one factor; PMDD is a bodily phenomenon; PMDD causes women's problems or symptoms.

PMDD as a Thing That Can Be Objectively Defined and Measured

> We *live* with it but we're . . . distraught about it and, and it's my God, you know, is this sort of a thing we've got to live with? And it's just worn us out. Utterly worn us out . . . and it's devastating in a traumatic way I suppose. We hate it. . . . I wake up one day and I'm feeling a bit grotty and I think, Oh, what's this? and I, you know, I count the days and I think, oh yeah. Of course! That again!

PMDD is conceptualised as an identifiable condition, "a thing we've got to live with," a "thing" that women have or don't have, in women's talk, as we can see from the above quotation. This is also how it is represented in hegemonic discourse on PMDD, as is evidenced by the way in which women are unequivocally categorised as PMDD sufferers, or as non-sufferers, in epidemiological surveys and in individual clinical examinations. In the same vein, researchers and national working parties have expended an inordinate amount of time and energy attempting to establish consensus definitions of PMDD. They have debated the precise definition of length of the premenstrual period, the number of cycles to be measured, as well as the necessary and sufficient symptoms, or the degree of impairment, needed for diagnosis (see Bancroft, 1993 and Walker, 1995, for reviews of this literature). This reifies the assumption that there is a "thing" to be identified and categorically measured, the only question being which is the most accurate or objective means of doing so.

One of the implications of "thingifying" PMDD in this way is that many women who seek help for premenstrual symptoms do not meet the objective diagnostic criteria set out by expert panels, and are thus defined as "not having" PMDD, despite their own reports of premenstrual symptoms. For example, in a study of 80 PMDD clinic attenders, Hammerback, Backstrom and MacGibbon-Taylor (1989) reported that only 30% could be diagnosed as having "pure PMS," 56% "premenstrual aggravation," and 14% "no significant cyclicity." In another study of 670 women attending clinics for premenstrual symptomatology, Hurt et al. (1992) reported that only 14% met the criteria for "LLPDD" using the "absolute severity method" (where a clear 30% increase in symptoms is observed premenstrually), and 45% using the "trend analysis method" where there is a trend towards increased symptoms premenstrually (Bancroft, 1993). The women who fall outside the diagnostic guidelines yet report symptoms are positioned as "false positives" (Hamilton & Gallant, 1990), or as stoic, healthy or hypervigilant (Blechman & Clay, 1987), and are often excluded from treatment. The implication of this is that only the experts, with their careful methods of categorisation, have the right to

decide who "has" PMDD and who has access to treatment, and women's knowledge of their own bodies or minds is ignored or dismissed.

Within the positivist-realist epistemological standpoint that dominates biomedical and psychological research (Ussher, 1996), the establishment of valid and reliable indices that can accurately measure this "thing" PMDD has been of major concern. This has led to the development of a range of standardised inventories and questionnaires (see Buderi, Wan Po & Dornan, 1994). Women are invariably asked to categorise key symptoms on a three-five point scale, as occurring or not occurring on each day of the menstrual cycle in order to identify if they "have" PMDD. There is no room within this model for examination of the complexity of women's subjective experiences of premenstrual symptoms. Equally, as factors such as the unconscious, women's identification with hegemonic representations of femininity, the body, reproduction, or mental health cannot be easily measured, or their influence objectively assessed, they are ignored or dismissed.

If women do not have access to a language or a framework that allows the complexity of their premenstrual experiences to be explored, we should not be surprised to find that they report "symptoms" in the categorical way found in standardised questionnaires. In our study, when asked in an open ended questionnaire, "describe your PMS," women re-produced the key symptoms found in academic and popular texts on PMDD. They reported tiredness, depression, anxiety, anger, loss of control, pain, bloating, cravings, and skin problems. One simple explanation of this is that these are the symptoms that women experience. However, it is arguable that in presenting us with PMDD as a set of key symptoms, women were describing, and simultaneously interpreting, their premenstrual bodily and psychological experiences within the narrow symptom checklist model of PMDD presented by the psychiatry/psychology professions. For when given an opportunity to present their own interpretations of their premenstrual experiences in the open ended narrative interview, the same women presented a much richer and contextualised picture of their symptomatology. They talked spontaneously of issues such as problems in relationships, problems at work, needing time to themselves, feelings of overwhelming responsibility, and failing to cope and be in control at all times as PMS (see Ussher, 2002b, c; Ussher, Hunter, & Browne, 2000). This demonstrates that the framework provided by experts will significantly affect the way in which women interpret and categorise experiences as PMDD (Ussher, 2003).

PMDD Is a Pathology to Be Eradicated

The reification of PMDD as a psychiatric disorder positions it as a pathology that needs to be eradicated or managed, hence the emphasis on myriad forms of treatment in academic and popular texts, as well as the perpetuation of a notion that one day a "cure" will be found. The aim is to rid women of variability in

symptomatology over the menstrual cycle. Implicit in this assumption is the notion that subjectivity is consistent, that there is a core that should remain constant, and that any fluctuation in mood, in sensation, in reactions to others, or in bodily experiences, is a failing or a pathology. This is something that features very strongly in women's accounts of their premenstrual symptoms where *change* is positioned as a sign of illness.

> I feel quite introverted, whereas normally sometimes . . . I, I think I'm quite extroverted. So a *real change* of personality.
>
> I think because I react differently . . . I might be more intolerant with him or shorter or abrupt . . . a bit difficult to put words to. There, there's a *change* in me.
>
> I find that particular time of the month very difficult and I'm sure everybody else around me finds it very difficult. There's a *big change* in me and it makes me feel as if I'm not in control.
>
> I know it's a *big change* in me and it makes me feel as if I'm not in control of my own body and that's quite an issue and I find that quite worrying really.

A range of feelings or behaviours manifests this "change." These include anger, irritation, depression, isolation, violence, loss of confidence, moodiness, lack of concentration, sadness, intolerance, desire for security or comfort, tearfulness, desire to be alone, not wanting to be touched, loneliness, hyper-activity, and increased sensitivity, amongst other feelings. What marks these out as PMDD is the fact that some of the time women *don't* experience these difficult emotions. When they *do* experience them, they position this as not their "true" selves, such as:

> I'm not me when I'm premenstrual.
>
> I'm not the same person as I was or I am the other two weeks of the month . . . So . . . by the third day of my period it's beginning to lift. I'm beginning to feel more like my old self.

When we think of experiences as symptoms, as "things" that are separate from us and that need to be eradicated, we foster a sense of alienation or distance from ourselves (Epstein, 1996, p. 144). This is what is happening when certain emotions and behaviour are split off as "not me," or as the "PMDD self," something that the hegemonic truths about PMDD encourage women to do. What the women are measuring themselves against here is not arbitrary. It is an idealised construction of femininity, a woman who is never angry, needy or irrational. She is calm, in control, always able to look after others, and never loses her temper or breaks down in tears. She is never self-centered, desiring only to spend time on her own, responsibilities eschewed. As with the "core" symptoms of PMDD on standardised questionnaires, these are experiences that define and regulate the boundaries of idealised femininity. PMDD thus comes to stand for all that is deviant, all that is outside the norm; the "other" against which all women are measured, against which women measure themselves. It is through this that PMDD performs a regulatory function in women's lives. Women thus position themselves as "PMDD

sufferers" as a way of interpreting and explaining the behaviours and emotions that are deemed deviant within the regimes of knowledge that construct both idealised femininity and mental health. Feeling out of control, unable to cope, having difficulties in relationships, thus becomes split off and pathologized. The woman positions herself, or is positioned, as blameworthy.

> I feel really *awful* about it myself. I feel awful that I'm actually making . . . somebody else feel *bad* about something and blamed for something that really it's nothing to do with them or it's so trivial that they must think she's gone mad [laughs] or something, do you know what I mean.

What this functions to do is reinforce the belief that women (or their bodies) are responsible for problems, meaning that alternative forms of negotiation or working through of problems are not examined. The woman, or her body, also becomes the focus of attention in causal explanations for premenstrual symptomatology, and in treatment.

PMDD Is Caused and Can Be Treated by One Factor

> Q: What do you think, um, causes your pre-menstrual symptoms?
>
> A: . . . . . hormones! Hormone imbalance. But I do, well yeah, I think hormones. I mean I'm forever saying, "It's hormones. It's hormones." But I'm inclined to think it is. And I, I don't really know that much but I know that your estrogen level drops . . . at the time before your period (and) then it starts to rise again. And *certainly* my mood tends to go in (with that) curve, especially I think there's (a period like when) estrogen gets its peak time is about day twelve or thirteen or something like that, and that's the time when I'm feeling very good and when it comes back down again.

Medical and psychological experts in the field of PMDD almost without exception advocate unilinear models of etiology and treatment. This has meant that over the last twenty years, hundreds of studies have been conducted examining the relationship between individual biological (see Parry, 1994) or psychosocial correlates (see Goudsmit, 1988; Richardson, 1991) of PMDD and premenstrual symptoms. Etiological assumptions are then made on the basis of statistically significant relationships between reporting of symptoms and the particular dependant variable of interest, or on the basis of treatment efficacy. For example, in a study which reported the positive benefits of fluoxetine, Menkes et al. (1993) reported findings that "support the proposed role of serotonergic hypoactivity in the etiology of PMS" (p.101). Similarly, in a study of estradiol patches, Watson et al. (1989) argue that their positive result "supports the earlier observation of a link between premenstrual syndrome and ovarian function" (p. 731).

However, the finding that a particular treatment reduces premenstrual symptoms does not necessarily have implications for etiology. Aspirin is an effective cure for headache, and inhalation of Co2 an effective treatment for panic attacks,

yet we would not propose that either aspirin or Co2 are implicated in the etiology of either disorder. The very premise of a causal relationship is also flawed, as the discovery of a *correlation* between premenstrual symptoms, and a particular hormone does not mean that the hormone *caused* the symptoms. Each may be related to a third variable, such as stress, or not related at all (Gannon, 1981). It is probable that there is a complex and fluid interaction between a number of different factors, which cannot be encapsulated within this narrow positivist frame. The adherence to unilinear models of cause and effect again blinds us to the complexity of women's premenstrual experiences.

This complexity is also absent in the diagnoses offered to women by individual clinicians, as uni-dimensional explanations and treatments are advocated, with women being treated on a trial and error basis (Hunter, Swann, & Ussher, 1995; O'Brien, 1993; Walker, 1995). Thus, if a woman reports to a clinician complaining of premenstrual symptoms, she may be offered a sympathetic ear and general lifestyle advice, or she may be offered medication, according to the clinician's own view of the problem (Reilly, 2000). Given this, we should not be surprised to find that when asked "what do you think causes your PMS," the majority of women in our study adopted this same unilinear model, with "hormones" being the predominant answer, as is illustrated in the example given above. A small number of women also mentioned "stress" or "lifestyle," the model that is increasingly being put forward by self-help PMS texts (e.g., Armstrong & Sutherland, 1987; Lever & Brush, 1981; http://www.pmssolutions.com). However, whatever the explanation, the majority of women positioned PMDD as a thing that is within the body, caused by a third factor. This means that women look to an outside factor to "cure" their PMDD.

PMDD as a Bodily Phenomenon

Within a positivist/realist paradigm, the body is implicitly considered to be more fundamental or "real" than psychosocial variables, resulting in the emphasis on measurable aspects of biology (Ussher, 1996). This has led to the disparity between the number of biomedical and psychosocial etiological theories and therapies for PMDD: Biomedical interventions reported in the research literature currently outnumber psychosocial interventions by a factor of approximately 20:1. In a similar vein, in multi-factorial models the body is invariably given pre-eminence, or considered to be the starting point of any analysis. Social or psychological factors are seen as secondary influences, affecting the perception of bodily symptoms (e.g., Blake, 1995), or the woman's vulnerability to physical changes (e.g., Bancroft, 1993). In what is a totally reductionist viewpoint, the body or biology is conceptualised in terms of physical processes—the action of hormones, neurotransmitters, or ovarian function, considered separately from any meaning, or from social-cultural contexts. If women take up this position in relation to their

premenstrual symptoms, they see themselves as being at the mercy of their hormones, as if they are being attacked from within. The body thus becomes alien to the woman, something that is a cause of frustration, as is illustrated below.

> Q: And what are you thinking about when you're feeling this sort of tension and the pressure?
>
> What am I feeling? I guess [sighs] my feelings are one of, I'm annoyed with myself. I want to stop the way that I am but I can't. I mean that's, it's quite, it's, I get quite frustrated with my body, um, 'cos I *know* I'm doing it and I know there's no *reason* for me to do it but I can't stop. And as much as this tells me to stop, very difficult. Very very difficult. And, and since I've been on this programme and I've been filling out and thinking about what I've done, it's almost even *worse* now because I'm thinking, "Yes. Now come on. You shouldn't be doing this." It's highlighted it more.

There have been many critiques of the notion of the body, or biology, as objective entities which can be understood as separate from sociohistorical knowledge, experience or subjectivity (see Foucault, 1979; Henriques et al., 1999; Stainton-Rogers, 1991). Individuals do not experience symptoms in a sociocultural vacuum. The bodily functions we understand as a sign of "illness" vary across culture and across time (Payer, 1988; Sedgewick, 1987). Women's interpretation of physiological and hormonal changes cannot be understood outside of the social and historical context in which they live influenced by the *meaning* ascribed to these changes in a particular cultural context (Martin, 1987; Ussher, 1991). Reinforcing the importance of cultural context, there is much evidence of differences across cultures in both women's reporting of premenstrual symptoms, and their perception of these as signs of PMDD (e.g., Chandra & Chaturvedi, 1989; Dan & Mongale, 1994).

Equally, expert knowledge and understanding of the influence of hormones is socially and historically situated. For example, it was in the context of the "discovery" of sex hormones in 1905 (Oudshoorn, 1990), that hormonal theories of PMDD, and arguably the very existence of PMDD as an illness, evolved. Rather than accepting the body as something which exists above and beyond the measurement tools and definitions of science, it can be argued that the aspects of biology and the body we are allowed to "know" are those which meet the criteria of the measurement tools currently in use. The development of new technologies for calibrating the body will undoubtedly lead to a new set of meta-theories for PMDD. Genome explanations cannot be far away.

PMDD Causes Women's Symptoms

> I: (And) what do you think your life would be like if you didn't have your pre-menstrual experience?
>
> T: Um . . . much happier . . . content. Peaceful. Um . . . just like any other normal human being. Just normal.

In an apparent paradox, PMDD is both signified by the existence of symptomatology, and is positioned as a thing that *causes* the symptomatology women

experience in the premenstrual phase of the cycle. Historically, behaviours as diverse as violence, accidents, mood change, suicide attempts, and examination failure, have been attributed to PMDD (Sayers, 1982; Ussher, 1989). Whilst there is actually little empirical evidence that any of these behaviours vary consistently with the menstrual cycle (Walker, 1995), women themselves position PMDD as a thing that causes the problems they experience. These are considerable. When asked, "What are the effects of PMS on your life," the most common responses were difficulties in relationships, not being able to perform well at work, not wanting to be sociable, feeling unhappy, angry or anxious.

After eight sessions of psychological therapy where women were encouraged to examine the meaning of PMDD in their lives, their explanations for what caused their symptomatology, and what they could do to alleviate it were somewhat different.

> I have made changes that have made time available to pursue the things that give me satisfaction and fulfilment, a general feeling of well being which helps the premenstrual phase to feel less threatening. I've got a greater understanding of those around me and how they perceive my PMS.
>
> I decided to make some major changes. 1: to give up things I do because I "ought" to, 2: do things to pleasure me, 3: make more space for my family, 4: do less chores, 5: work on having some fun with my husband, children and generally, I acted on some of those and I felt quite good really at doing it, instead of just thinking about it.

This demonstrates the way in which women can shift their understanding of their symptomatology when alternative regimes of knowledge to those that predominate in the biomedical sphere are made available. This then opens up very different avenues for attributing causation and dealing with difficulties—ones that are not blaming the body, nor focusing on one single cause or treatment.

CONCLUSIONS

In examining the discursive construction of PMDD (or its derivatives—PMS or PMT) in women's talk and in the official annals of psychiatry and psychology, we can see that PMDD is a rhetorical accomplishment: it is constructed through women's narratives, and through the public and private discourse produced by experts, that together forms the body of objectified knowledge under scrutiny here. Yet PMDD is not a phenomenon that exists simply at the level of discourse. It is bound up in a set of institutions and practices that Rose, drawing on Deleuze and Guattari, terms "assemblage": a complex of "apparatuses, practices, machinations and assemblages within which the human being has been fabricated, and which presuppose and enjoin particular relations with ourselves" (1996, p.10).

It is through this assemblage, the practices and institutions that regulate women's reproductive bodies, that PMDD has a material impact on women's lives. The inclusion of PMDD in the DSM provides legitimation of a set of truths that

clinicians and researchers draw upon in their interpretation of women's premenstrual experiences as pathological. It legitimates the examination, diagnosis, and treatment of individual women. It acts to position certain women, those diagnosed, as ill, as unstable, or as "mad." The material consequences of this in relation to the potential effects on employment, family relationships, and women's subjective experiences of symptomatology are considerable.

This assemblage also mediates the relationship between the PMDD expert as "knower" and the woman's body as object to be known. This is a relationship situated in the particular organisation of power and knowledge that allows psychiatrists and psychologists to judge, and positions women as patients to be judged and cured. For as Rose argues, the psy complex grants powers to "some to speak the truth and others to acknowledge its authority and embrace it, aspire to it, or submit to it" (1996, p. 175). So the woman who wishes to understand her premenstrual experiences is expected to turn to the experts for answers; to the regimes of objectified knowledge that provide the "truth" about her experience. And this is a proscribed truth, that tells a particular, narrow story, as we have seen above.

I don't want to end on such a negative note. In a spirit of affirmative poststructuralism (Rosen, 1996), where we move beyond deconstruction, I would like to suggest an alternative framework for understanding premenstrual symptomatology in a non-pathological, non-blaming way by reconstructing premenstrual symptomatology from Eastern models of mental health. Hegemonic truths about PMDD not only serve to regulate femininity (Ussher, 1997); they also serve to regulate the model of normal selfhood that underpins late twentieth century Western[5] notions of mental health, where stability of affect is held up as the norm, consistent happiness the ideal we should aspire to. Any deviation from this stable norm is deemed illness, a state to be avoided or cured. To illustrate that this is an historical and cultural construct, we only have to look to the model of the self that underpins Eastern models of mental health, such as that found in Buddhist meditation and psychotherapy. Here the illusion of a core consistent "me," which is always positive and good, is directly confronted (Borysenko, & Bensen, 1985; Epstein, 1996; Kornfield, 1993; Kutz, 1985).

Rather than eradicate "symptoms," this model would suggest that through the practice of mindfulness, an appreciation of the temporally based dimension of self is arrived at, by paying attention to bodily based experiences and sensations *as they occur* (Epstein, 1996, p. 144). There is no reaction or judgment of these experiences or sensations, merely a witnessing of them, an awareness Epstein describes it as "quite literally a coming to one's senses" (1996, p. 144). What we discover in this awareness is that feelings are rarely constant. There is always fluctuation and change. Premenstrual changes would thus be seen as a normal

[5]By Western I am referring to Anglo-American constructions of mental health as framed by the DSM and ICD. These are constructions that have a wider influence beyond the "West," but stand in contrast to Eastern models of the self, such as those in Buddhist philosophy.

part of women's experience—something that needs to be taken seriously, but not something that is pathological, needing psychiatric diagnosis or "cure."

This framework doesn't encourage women to repress their feelings—a legitimate critique of treatments which "manage" PMS. Indeed, the reverse is the case. Central to this approach is the notion that difficult feelings and emotions arise in the normal course of life, and that if we try to repress or deny them, this will only be a temporary solution, as they will invariably emerge at times when we are vulnerable or under pressure. Or, when there is a socially sanctioned reason for expressing them—such as PMDD, as we see below.

> It might build up throughout a day and my, um, something might annoy me on this day or just get at me, and I'll feel like reacting. I'll feel like reacting aggressively. And I'll control it. And I'll think, "No. It must be the time of the month." And I can control it to a certain extent. But it then might build a bit, um, another thing might happen (and) another thing might happen. And then eventually one small thing will just (top) the whole lot off. That is often the case.

The premenstrual phase of the cycle may be one of the few times when women allow themselves to express "difficult" emotions. Within an Eastern model of mental health, the advice would be to feel these emotions, to be with them, rather than split them off or repress them. This doesn't mean passive acceptance, however. It could be the first step to acknowledging pain, distress or anger, and then working on the various causes of it, or making changes to life to deal with issues that are associated with the problem. The argument here is not that women can rid themselves of premenstrual emotions or feelings, but that we can understand them, learn to reduce them, or to live with them. They become part of us, rather than a feared or hated "other" that we want to medicalize and cut out. Developing deepening awareness and coming into relation with the body and with emotion could also act to prevent the sense of panic and of being overwhelmed which is so common in women's reports of PMDD.

Understanding premenstrual symptomatology in this way would allow us to understand the complex roots of the symptoms that women present with, yet also offer suggestions for amelioration through a combination of symptom based approaches. It is a more empowering approach than many others that are currently offered to women, as it reframes premenstrual symptoms outside of a pathological framework. It is thus one approach that is compatible with a critical feminist analysis of PMDD.

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