

# GENDER, PSYCHIATRY, AND THE RHETORIC OF SCIENCE

By

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(Under the direction of Kevin DeLuca)

## ABSTRACT

Throughout history, women's identities have been closely linked to their reproductive capacity and hence their bodies while men are associated with the mind and abstract reason. In this binary, women's bodies are thought to infect their capacity to reason and leave them susceptible to diseases of the mind. This project examines historical manifestations of the associations between women and madness and specifically dissects diverse discourses related to current instances of this association. Specifically, the recent psychiatric diagnosis premenstrual dysphoric disorder (PMDD) carries on this tradition dating back to early Greek times when women's wombs were thought to wander about their bodies causing various and sundry ailments. The analysis examines medical documents, television discourses, and advertisements to understand both the continuities and ruptures of this modern female malady in terms of its historical development. The current malady is dangerous because it encourages women to view their bodies as the source of social ills and mitigates against individual activism and collective change.

**KEYWORDS:** gender, psychiatry, rhetoric of science, premenstrual syndrome

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## CHAPTER 1

### INTRODUCTION

Only recently have mental disorders been considered medical and biological in nature. In 1982, just a few years before Prozac came on the market, R.D. Laing, a Scottish psychiatrist, predicted that more ways of classifying “undesirable mental and emotional activity” in conjunction with advances in neuroscience will usher in “a new era of much more subtle control of the mind through the body than our technological knowhow permits at present” (41). This prophecy has turned out to be eerily accurate. Psychiatry has nearly cemented its alliance with medical science and has grown in influence in astounding ways. Of the \$11.1 billion made off of antidepressants in 1999, Eli Lilly and Company pocketed \$2.6 billion from Prozac profits alone (Jarvis) and the number of psychiatric disorders continues to proliferate at an astounding pace (American Psychiatric Association 1980; 1987; 1994).

In this meta-institutional network, not all consumer-patients are targeted equally. Women are most aggressively targeted by the psychiatric industry, particularly middle-class white women. Most recently, women have gained their own disorder and treatment with the July 2000 approval of Sarafem, a drug indicated for premenstrual dysphoric disorder (PMDD). Notably, this is the only time the FDA has ever approved an indication for a disorder that is not officially recognized. PMDD has been, in varying formations, included in an appendix in the *Diagnostic and Statistical Manual (DSM)* published by the American Psychiatric Association (APA). However, because it is controversial for

scientific and social reasons, it has not been officially recognized and is ostensibly included in the appendix only to outline the parameters for further research. Though definitions of PMDD vary, it is generally conceptualized as a severe form of PMS where the primary complaint is mood rather than physical symptoms, the symptoms interfere with work or social activities, and their timing supports an association with the menstrual cycle. The *DSM-IV* criteria for PMDD are included in an appendix at the end of this document.

Elaine Showalter states that if “‘depression’ is soon viewed as a meaningless catchall category, another female malady will appear to take its place for another generation” (*The Female Malady* 249). Anne Fausto Sterling similarly writes, “Sometimes I think there must be a limit on our supply of new ideas. Occasionally an idea seems to disappear from our repertoire. But then, suddenly, some years later, it reappears in modern garb” (*Myths* 225). Women have been associated with sickness, disorder and malfunction from the earliest historical epochs—the ancient Greeks believed that a woman’s uterus traveled about her body at will causing various forms of troubles wherever it happened to visit. PMDD is a manifestation of this malady. Current psychiatric theory posits that the cause of PMDD is normal female ovarian function, a theory which leaves all women susceptible to the diagnosis. Once again, science has linked women, biology and madness and deemed itself the appropriate exorcist. Once again, unfeminine behavior is explained as a biological abnormality while appropriate behavior is chalked up to women’s essential feminine identity. Once again, women are encouraged to understand their discontent as an intrapersonal problem to be ‘cured’ rather than a symptom of an unjust society. And once again, the authority of science is

employed to legitimize inequality and cast women as second-class humans inferior to the male norm.

The association between women, their bodies and madness is so ancient and so enduring, it is sometimes difficult to recognize the modern manifestations. The ideology of scientific progress further obscures the historical patterns that inform current understandings of women's minds. A primary purpose of the following analysis is thus political. By revealing the constructedness of entities that play a major role in our culture and society, these very concepts can be denaturalized and understood in their complexity as things that can potentially be different. The goal is not to isolate the significance of PMDD just within the scientific or clinical setting, but to undertake a more comprehensive analysis of the ways in which myriad discourses operate throughout and among different spheres. Scientific arguments do not remain in the technical sphere and when they are translated down into lay terms they frequently decline in precision while elevating in authority.

Critical to the scientific enterprise is the notion of consensus. As Gross writes, it is consensus over methods and procedures "that, finally, differentiates reports in the sciences from political and scholarly discourse" (32). Psychiatric science depends on a unique brand or degree of consensus. There are no objects in the traditional sense to observe that can evidence any particular theory. Psychiatric diagnoses are made on the basis of interpersonal interactions and biological malfunction is determined on the basis of social dysfunction communicated by the patient. Which behaviors are normal and which are pathological is designated by psychiatric consensus, not empirical research. The scientific consensus regarding PMDD is ostensibly that it is not a proven or official

disorder. This uncertainty, however, is rarely translated into the public domain. Instead, PMDD is represented as a wholly real disorder validated by scientific discovery and confirmed by psychiatric consensus.

As the following analysis traces the construction of PMDD through such diverse arenas as talk shows and advertisements, it is clear that decisions made by scientists have far-reaching impact and their consequences can neither be wholly predicted nor controlled by the decision-makers. Though the PMDD controversy occurred rather recently and is in fact still ongoing, the existing discourses indicate how a theoretical construct becomes reified as it circulates throughout different spheres. For instance, in 2000 Eli Lilly gained FDA approval to market Sarafem as a treatment for PMDD. In these advertisements, PMDD is portrayed as a ‘real’ disorder firmly backed by scientific consensus. In this situation, it is difficult to hold any particular agent responsible for the consequences of the label. When scientific claims are divorced from their authors, they can take on a life of their own and mutate in substantial ways. As time obscures the details, the specific historical circumstances surrounding the diagnosis are lost and it increasingly becomes seen as real and valid, divorced from the context of its creation.

This analysis is primarily historical and rhetorical as it traces the history of the women/madness association and links these previous manifestations to the PMDD diagnosis. It is rhetorical because the documents examined are important discursive texts. The rhetorical nature of the psychiatric enterprise necessitates an approach sensitive to issues of language, persuasion, and the situatedness of truth claims. Rhetorical scholars have increasingly recognized the importance of psychiatric discourse. Richard Vatz notes that psychiatry is “a rhetoric enterprise masquerading as a scientific one.” Thomas Szasz

has documented the metaphorical foundation of the psychiatric institution and Dana Cloud has articulated the therapeutic nature of psychiatric discourse. This analysis is also informed by the feminist tradition. Throughout history, women's inferiority has been socially constructed through discourses positing an innate feminine identity and categorizing deviations from this identity in pathological terms.

Though many women resist the dominant PMDD discourses, not all women are opposed to the diagnosis and its treatment. Lilly sales figures indicate that the treatment for PMDD has been relatively popular. This fact highlights the double-bind feminist critics of the PMS and PMDD labels face. On the one hand, feminists want to believe what women say—too often, women's expressions of discomfort are dismissed and women have been told that their suffering is “imaginary.” Many women feel that ‘PMS’ aptly describes their experiences and is a helpful category for sorting out their thoughts and emotions. On the other hand, feminists want to challenge the stigmatizing effects such labels have on women collectively. These challenges, however, can easily be read as criticisms of individual women ‘duped’ by the psychiatric enterprise. There is no clear resolution to this tension, but this analysis will tentatively explore several propositions. First, it is impossible to determine a feminist ideology solely on the basis of what women say. Women say lots of different, often conflicting, things. The fragmentation of the feminist movement is evidence of this. Second, to say or imply that certain women have been influenced by powerful discourses is not the same thing as saying that women are stupid. Women's understandings of their worlds are shaped and constrained by the sets of available discourses in ways that cannot be entirely controlled or even predicted. This is true of all people as no one is completely uninfluenced or aloof from prevalent social

ideologies. The idea that absolute autonomy is desirable, or even possible, is related to the idea that rhetoric is unsavory and persuasion deceitful, an idea that implies that there is some pure realm of isolated abstraction free from the taint of human communication. Finally, oppression does not merely channel itself in chains and whips, it also takes the form of negative standards and images that are internalized by the oppressed. For Sandra Bartky, “false consciousness” does not signify merely a “false” identity that implies the existence of some real or essential “true” consciousness. Rather, this type of consciousness involves falsely attributing one’s discontent to oneself:

To take one’s oppression to be an inherent flaw of birth, or of psychology, is to have what Marxists have characterized as “false consciousness.” Systematically deceived as we are about the nature and origin of our unhappiness, our struggles are directed inward toward the self, or toward other similar selves in whom we may see our deficiencies mirrored, not outward upon those social forces responsible for our predicament. Like the psychologically disturbed, the psychologically oppressed often lack a viable identity. Frequently we are unable to make sense of our own impulses or feelings, not only because our drama of fragmentation gets played out on an inner psychic stage, but because we are forced to find our way about in a world which presents itself to us in a masked and deceptive fashion (31).

This concept of consciousness explains why women find PMDD discourses attractive—in an age where identity is hard to come by, psychiatric theory promises security and stability in pill form. To note that our self-concepts are shaped and constrained by social discourses and that some of these discourses are more dangerous than others is not to be

dismissive of the very real distress women frequently experience. These discourses are dangerous because they articulate a therapeutic logic where women are encouraged to view their biology as the problem, thus occluding analysis of unequal social relations.

In psychiatric theory, there is no room for any concept of a false consciousness. The motto for Sarafem is “More like the Woman you are.” This is a clear instance of science stepping beyond its empirical boundaries and making metaphysical pronouncements. If a chemical can make a woman more like the woman she “is,” then logically femininity and womanhood are chemically and biologically determined. There is no room for rhetoric or the influence of social persuasion. If chemicals determine identity, interpersonal interactions lose their importance in theories of individual psychology. Psychiatry becomes a ‘science,’ but what do humans become?

The following analysis begins in Chapter Two with an examination of the historical pattern of the women/madness/biology association. Primary texts are not specifically examined, rather this section constitutes a literature review of just a few of the many books written that document these associations. Women have consistently been associated with their bodies, irrationality, and madness, and this association is often cast in scientific discourse. The second part of the chapter reviews the medical literature on PMS. Premenstrual syndrome or symptoms is the predecessor of PMDD, and much of the literature used to support PMDD’s inclusion is actually research done on PMS. Further, the terms are frequently used interchangeably in the literature. There are some significant exceptions to this conflation--a major argument used by opponents of the diagnosis is that it risks pathologizing all women. When confronted with this argument, proponents frequently respond by emphasizing the distinctions between PMS and PMDD, implying

that PMDD is rare and only affects a very few women. The review of the PMS literature reveals that the scientific research is methodologically flawed in significant ways. There is no clear definition of PMS and the only way to diagnose PMS is through self-reports which do not qualify as objective measures of illness. The sheer number of proposed theories and treatments highlights the lack of scientific consensus concerning PMS. This section also examines a few of the critical positions related to the PMS research--for instance, studies indicating that social suggestion plays a major role in women's categorization of their experiences. The third and final section of this chapter specifically analyzes one of the dozens of self-help books published on PMS. The book, by noted researcher Katharina Dalton, reveals how notions of gender roles are critical to scientific theories of PMS and how these theories, translated into lay terms, reify age-old stereotypes concerning appropriate feminine behavior and women's natural roles. This section lays the groundwork for later sections examining how popularizations of PMS and PMDD research communicate particular messages to women concerning their bodies and identities.

Chapter Three examines the specific dynamics of the PMDD controversy. The first section reviews the scientific literature authored by the *DSM-IV* Task Force on PMDD (then called LLPDD, late luteal phase dysphoric disorder). This literature is plagued by many of the same problems endemic to the PMS research. This research further illustrates the conflation of PMS and PMDD even in medical articles. This section also reviews critical examinations of the PMDD literature, namely an exhaustive study by Paula Caplan and colleagues. The second section examines some of the medical literature documenting the efficacy of antidepressants in the treatment of PMS/PMDD. It is this

research that is used as evidence for theories saying that low serotonin activity is the cause of PMDD. Because SSRIs (selective serotonin re-uptake inhibitors) make many women feel better, theories abound that lack of serotonin is the cause of their initial discontent. Interestingly, the very existence of this research casts doubt on claims made by Eli Lilly, the manufacturers of Sarafem, that the treatment is new and the result of recent scientific advance. In fact, antidepressants have been used to mitigate premenstrual discomfort for over a decade. The final section steps back from the scientific research and examines ‘ordinary’ women’s perceptions of PMDD and the *DSM* process. Paula Caplan, a leading feminist psychologist and the one who spearheaded much of the PMDD opposition, initiated petition campaigns to protest the inclusion of PMDD in both the *DSM-III-R* and the *DSM-IV*. She received substantial support, including millions of petitions in both instances. This section examines a few of these petitions and points to some concerns that appear to be common to many women regarding the PMDD category. Though a feminist ideology cannot be formulated solely on the basis of women’s opinions, these voices are extremely important for a more comprehensive understanding of the entire PMDD process. These petitions stand as instances of resistance as well as indications of how ‘lay’ persons understand the psychiatric enterprise. In discussions of how science is translated into the public sphere, there is often little attention given to how actual people understand and assimilate such discourse. Throughout this project, women’s narratives are included to increase understanding as well as examine ways in which dominant discourses are resisted.

Chapter Four examines an episode of *Donahue* that appeared just a few months before the publication of the *DSM-IV*. The guests are Caplan and Judith Gold, the chair of

the APA Task Force on LLPDD/PMDD and one of the strongest proponents of the diagnosis. In addition, many women and a few men share their perspectives on PMS, PMDD, and the implications of a psychiatric diagnosis throughout the show. This chapter not only examines how appeals to scientific authority are employed in the public sphere, it specifically examines how these appeals are transmuted through the medium of television, particularly a talk show. It is impossible to debate the merits of empirical research in such a format: the time constraints of the talk show and more generally the “soundbite” quality of television inhibit such dialogue. In these venues, scientific authority is based not on the merits of science but the rhetoric of science and the relative capital and prestige of the speakers. In this show, the psychiatric position is portrayed as the side of “science” while the opposition is represented as politically motivated and susceptible to ideological manipulation. The talk show, however, is also an important site of democratic discourse and resistance to scientific authority from ordinary women.

Chapter Five moves from the talk show to direct-to-consumer (DTC) advertisements for Sarafem. Corporate persuasion irresponsibly employs scientific rationales to sell products. Specifically, Lilly makes a number of claims in their advertisement that blatantly contradict both the psychiatric research and the facts of the matter as stated by Gold on the talk show. Psychiatry and industry are codependent and their relationship is symbiotic, thus psychiatrists have little incentive to oppose the distortions of their own arguments. Finally, this chapter examines the visual and verbal strategies employed in the Sarafem advertisements—the corporate author is distanced through tactics which foster the illusion that the viewers of the ads are engaging in a dialogic encounter with a person very similar to themselves.

Chapter Six concludes the analysis by reexamining conclusions, suggesting certain themes, and articulating possible alternative visions of the psychiatric enterprise and human subjectivity. The critics of modern biological psychiatry fall into two basic categories: those who, like Thomas Szasz, object to biological theories of human behavior on the grounds that they deny human autonomy and eradicate notions of individual responsibility, and those who, like Caplan, object on the grounds that they mitigate against collective action by making problems intrapersonal and using science to justify an unequal status quo. I do not want to fully embrace the individualism espoused by Szasz, yet I also want to avoid losing the individual to theories of either biological or social determinism. The question of free will contra determinism is as old as philosophy, and it is impossible to answer or even fully explore in this analysis. A model is needed that neither denies individual choice and human volition nor occludes social criticism and attention to very real structural inequality. Regardless of one's position in this debate, biological reductionism is dangerous because it accomplishes both: individuals and their societies are exonerated for their behaviors, the consequences of their organizations, and their singular and collective decisions.

## CHAPTER 2

### HISTORICAL MANIFESTATIONS OF THE FEMALE MALADY

#### Introduction

In 1886, Nietzsche stated that binary oppositions are foundational for much of human thought and organization: “The fundamental faith of the metaphysicians is *the faith in opposite values*” (10). Far more recently, Derrida has revealed the extent to which these oppositions govern us, noting specifically that the opposition between nature and culture runs through philosophical accounts since before Plato: “it has been relayed to us by means of a whole historical chain which opposes ‘nature’ to law, to education, to art, to technics--but also to liberty, to the arbitrary, to history, to society, to the mind, and so on” (282-3). Feminist theorists have been particularly interested in these oppositions as they are gendered. Simone de Beauvoir wrote, “Otherness is a fundamental category of human thought” (xvii). Specifically, she argued that men defined their own identities by positing ‘woman’ as an alien and subordinate category, and further that women participated in this schema in part because of powerful socialization mechanisms. The opposition between men and women is maintained by a far more complex set of binary oppositions, gendered though not intrinsically linked to the categories ‘man’ and ‘woman.’ Elaine Showalter details these oppositions, arguing that women are situated on the side of irrationality, nature, and body while men occupy the side of reason, culture, and mind. Despite social and economic change, these associations remain relatively

constant, albeit manifesting themselves in slightly different forms in different historical epochs.

One of the most consistent manifestations of female “otherness” is the association between women and madness. Throughout history, women’s close associations with their bodies and thus nature have made them vulnerable to the labels mad, crazy, insane, and hysterical. As Showalter writes, “While the name of the symbolic female disorder may change from one historical period to the next, the gender asymmetry of the representational tradition remains constant” (*The Female Malady* 4). Indeed, from the early Greek era to the Scientific Revolution through the rise of modern psychiatry, the linkages between women and madness persist despite social and economic discontinuities. These linkages are frequently related to the pathologizing of women’s reproductive processes and specifically the menstrual cycle. Menstruation is an overt and visible marker of women’s difference and is thus a frequent target of these associations. The following chapter is divided into three sections. The first section reviews some of the literature documenting the associations between women and madness. The second section examines medical theories about premenstrual syndrome from 1931 to the present. The final section looks at a popular PMS self-help manual to see what messages women receive about their bodies from these discourses.

### Women and Madness: An Historical Legacy

Quite often, it is scientific discourses that most firmly and authoritatively perpetuate the linkages between women’s inferior bodies and women’s less capable minds. The scientific voice is an authoritative voice that derives its status from its supposed ability to speak the truth of nature. As women are more firmly associated with

the natural and the biological, science has had a great deal to say about women. In later chapters, it will be evident that some proponents of the PMDD category present this decision as an advancement for women and they decry the lack of research done on women. This section, however, will reveal that a great deal of research has been done on women and it has not been universally empowering.

In *Hysteria: The History of a Disease* (1965), Ilza Veith provides a genealogical survey of hysteria, one of the oldest and most persistent forms of the women/madness association. Even today, though the term “hysterical” has largely lost its scientific meaning, it connotes femininity and irrationality. The idea of “hysterical women” still has considerable currency today. Veith notes of hysteria, “Like a globule of mercury, it escapes the grasp” (1). Hysteria has been such an ambiguously defined disorder with no single definitive cause, it is difficult to determine what it is at any given moment in history with any sense of precision. Yet, Veith argues that despite discontinuities, “the manifestations of disordered minds have displayed an amazing resemblance in all cultures and throughout the span of observed human conduct” (viii). Hysteria, whether conceived of in biological, spiritual, or neurological terms, is consistently linked to female sexuality and hence the female body. The very term “hysteria” was initially derived from language used to describe the female body. Hysteria comes from *hysteria*, the classical Greek term for uterus. According to ancient lore, a woman’s womb roamed hungrily about her body, producing various and sundry ailments wherever it happened to be visiting. For the Greeks, hysteria was related to bodily disorder and not what might currently be called a psychosomatic disorder. As Veith documents, “hysteria in antiquity was viewed as a tangible, concrete, and logical reaction to a temporary organic imbalance

of the body” (42). Thomas Lacquer, however, argues that these early speculations were not literal theories but metaphorical explanations for women’s discontent. He notes that leading early medical authorities did not believe in the wandering womb hypothesis and that “whatever they were debating when they pondered whether the womb wandered, it was not a discussion about the actual travels of an organ from its ligamentary anchor below, up through a foot and a half of densely packed body parts” (112). Regardless of actual beliefs in a wandering womb, metaphorical or literal, it is clear that the uterus was an early anatomical marker of women’s difference from men and became associated with a variety of ills.

Yet, hysteria did not remain solely within the province of the body. Veith speculates that Augustine sparked the change from viewing hysteria as bodily disorder to viewing it as a religious or spiritual crisis, a change “from a sick human being beset with emotional needs and physical distress into someone more or less wilfully possessed, bewitched, in league with the devil, and even heretical” (46-7). In medieval times, hysterics were no longer sick individuals, but deviants under the authority of the Church and madness was largely seen as punishment for sin. In the 14th and 15th centuries, mad persons were seen as witches and subject to torture and execution during the Inquisition and witch hunts. Again, women were to bear the brunt of this violent zealotry. In the infamous *Malleus Maleficarum* (*Hammer of Witches*), written by two monks and published in 1487, the authors write, “All witchcraft comes from a carnal lust which in women is insatiable” (quoted in Conrad and Schneider 42). The similarities of the early medical perspective and the spiritual viewpoint are striking. In both instances, troubled

minds and behaviors were linked not only to women but women's flesh, specifically women's sexuality and reproductive capacity.

Eventually, with the rise of modern science, "the neurological phase became dominant" (Veith 156) and explanations for hysterical behavior once again were posited in biological, specifically neurological, terms. However, the move from uterus to soul to brain did little to sever the tightly soldered links between women's bodies and mad minds. Even when the brain is posited as the seat of women's madness, it is still linked in various ways to women's reproductive organs and sexuality. Catharine MacKinnon writes that in the ideology underlying these theories "lies the sexual sadism that is at the core of misogyny, here in its medical form. Women's bodies are dirty, women's minds are polluted by their bodies, women's sexuality is diseased, sex is evil because women are sex" (xi). This ideology did not merely shape women's psychological development in harmful ways: it resulted in very real abuses done in the name of science. Jeffrey Moussaieff Masson's *A Dark Science: Women, Sexuality and Psychiatry in the Nineteenth Century* is a gripping anthology of medical documents graphically detailing the 'treatments' that were justified on the basis of scientific authority. *Women of the Asylum*, edited by Jeffrey Geller and Maxine Harris, is in some ways a counterpart to these tales. It offers vivid accounts from women who were confined to asylums on the basis of their supposed insanity and reveals the horror of psychiatric treatments from the perspectives of women themselves.

Though hysteria is no longer a term connoting medical or scientific precision, Showalter argues that modern manifestations of hysteria exist and are cast in different jargon. She specifically examines chronic fatigue syndrome and Gulf War syndrome as

instances of these modern manifestations. She states that hysteria has consistently served as “a form of expression, a body language for people who otherwise might not be able to speak or even to admit what they feel” (*Hystories* 7). Hysteria is thus logically linked to femininity and thus women because women have consistently been denied forms of expression and silenced. Women’s behavior is consistently attributed to their reproductive biology; similarly, women’s reproductive biology is used to determine women’s behaviors by designating their appropriate social roles. Women have historically been excluded or underrepresented in the public sphere and thought to function best in private, namely domestic, settings. Because the public sphere has been inaccessible to women, they have been denied an important avenue of expression. The socialization processes that confine women to the domestic realm also shape the ways in which women speak (Campbell; Gilligan). Women’s expression is not as valued in the public realm where decisions of considerable import are made. Thus, women are doubly disadvantaged--they are denied access to traditional forums for public speech, and their speech is not valued as highly as men’s. Showalter’s hypothesis is a plausible explanation for the gendered manifestations of hysteria and also accounts for instances of hysteria in men.

The symptoms of hysteria, even in antiquity, are numerous and have included “coughs and loss of voice; pains in various parts of the body; tics and twitches; paralyses, deafness, blindness; fits of crying; fainting; convulsive seizures; and sexual longings” (*Hystories* 15). The exhaustive array of symptoms indicates two things about hysteria in light of Showalter’s hypothesis. Initially, people who are unable to express themselves through traditional verbal channels are forced to rely on other avenues. Notably,

Showalter does not imply that these latter avenues are chosen deliberately. Such a position would run the risk of glorifying madness as a valid means of social protest and turn those suffering from hysteria into revolutionaries. It is quite consistent to say that people suffer from hysteria while holding that hysteria is a socially-constructed phenomenon. Second, the endless symptoms indicate that when individuals resort (even unintentionally) to alternative forms of expression, this expression is deemed pathological. This might seem obvious, but it illustrates the degree to which medical and scientific discourses direct and enforce social organization.

Showalter's most interesting hypothesis is that hysteria is a mimetic disorder: "it mimics culturally permissible expressions of distress" (*Hystories* 15). Legitimate symptoms, as well as prototypes of typical patients, are literally advertised through iatrogenic medical discourses, and those feeling emotional distress are subtly encouraged to interpret their distress through the proffered lens. Showalter does not claim that hysteria is a rigidly imposed category forced on vulnerable patients by authoritative physicians--just as it is not a pattern of behavior freely chosen by individuals--rather, it is a dialogic disorder constructed through persuasive discourses. She explains:

Initially, patients are people with a bewildering set of troubling symptoms and a wide range of explanations for them. Once they see their problems reflected in a prototype, come to believe that the laws of a disorder describe their lives, and seek the aid of a therapist, some patients rewrite their personal narratives (*Hystories* 19).

This hypothesis has considerable heuristic import. It explains why symptoms vary from epoch to epoch, and it also explains the significant gender disparity in patients seeking

treatment. As gender oppression is a relative constant throughout history, it is logical that women will be more likely to feel unexplained symptoms of unease and discontent and display these symptoms in the most acceptable manner. Women are likely to internalize some of the dominant discourses associating women with their bodies--they are likely to pay more attention to their bodies than men and are more likely to attribute their own experiences and behaviors to these bodies. Further, individuals desire explanations for their experiences. They want to understand the reasons behind what can be very perplexing experiences, and they would like to feel that they are normal, or that their experiences are connected to the experiences of others. Showalter's hypothesis is a specific theory of a type of consciousness in which women (and others) come to attribute their experiences to the causes posited by dominant beliefs.

This hypothesis is also consistent with a theory of false consciousness that takes biology into account. Throughout the discourses examined in this project there runs something of a dilemma: when women state that they experience particular physical or emotional symptoms, critics of the dominant explanation are in some cases bereft of an alternative explanation that neither dismisses what is very real suffering as imaginary nor buys back into dominant explanations. Theories explaining how social factors shape biological processes offer something in the way of a remedy to this dilemma. For instance, Joan Jacobs Brumberg notes that in the 19th century, menarche generally occurred around the age of 15 or 16, whereas today, the average age is just over 12. She writes, "Menarche's new timetable demonstrates the power of the socio-economic environment to shape something as 'fixed' as the human body" (4). Similarly, Anne Fausto Sterling argues that "sexuality *is* a somatic fact *created by* a cultural effect"

(*Sexing the Body* 21). In these models, social events and ideologies can literally alter material phenomena. This suggests that both women's biology and women's understandings of their biology are shaped and mediated by social discourses. These models allow a positing of a consciousness that internalizes oppressive discourses that does not dismiss suffering as imaginary.

One of the most recent examinations of hysteria is Juliet Mitchell's *Mad Men and Medusas: Reclaiming Hysteria* (2000). Mitchell, like Showalter, argues that hysteria is a mimetic disorder: "what was once called hysteria manifests itself in new forms more attuned to its new social surroundings" (ix). Also, like Veith and Showalter, Mitchell notes the highly gendered nature of the concept as "it is hysteria which has been bound with bands of steel to femininity, and hence very largely to women" (ix). Though hysteria cannot be pinned down, its current definition generally encompasses the alternatives to what are considered normal behaviors. Because men are understood as the human norm, these are behaviors most frequently exhibited by women. In religious times, hysteria was manifested in rituals and spiritual displays, but with the rise of modern scientific medicine, hysteria most frequently manifests itself as an illness. Mitchell describes the purpose of her account:

My question, however, is different: Why is hysteria linked to women? Using the psychoanalytic understanding of hysteria as an exemplary case, I challenge the assumption that there is an equivalence between femininity and hysteria, arguing instead that hysteria has been feminized: over and over again, a universal potential condition has been assigned to the feminine; equally, it has disappeared

as a condition after the irrefutable observation that men appeared to display its characteristics (7).

Because the concept of hysteria has been feminized, each manifestation of the disorder is only useful and valid if it can be primarily confined to the feminine condition. Each time it becomes apparent that the diagnosis can apply equally to men, a new symptomology must be 'discovered.' This hypothesis is interesting in light of later examinations of the pathologizing of the menstrual cycle: because men do not menstruate, associating hysteria with the menstrual cycle is seemingly a foolproof method for feminizing the disorder. The research on men, hormones, and cyclicity is scarce though it offers a potential avenue for challenging current manifestations of the women/madness association.

Though these accounts of hysteria differ somewhat in approaches and explanatory theories, several themes are apparent. First, hysteria is a wastebasket diagnosis found in some form or another in virtually every historical epoch. Second, hysteria is largely a mimetic disorder, in other words a disorder that can literally be produced in vulnerable patients through persuasive discourses. Finally, hysteria is consistently linked to femininity and thus manifests itself far more frequently in women, a fact these theorists explain not by referring to women's innately inferior biology, but women's inferior social positions. From the wandering womb to the 1952 exclusion of hysteria from the *DSM*, hysteria is an ambiguous category linked to female malfunction.

Dominant interests have not solely relied on hysteria to encapsulate the women/madness association. The Scientific Revolution resulted in a variety of methods of reinforcing this linkage. Bacon, widely regarded as the father of modern science,

articulated his theories through metaphors associating science with masculinity and passive nature with femininity. Carolyn Merchant explains that Bacon's imagery "treats nature as a female to be tortured through mechanical inventions [and] strongly suggests the interrogations of the witch trials and mechanical devices used to torture witches" (81). Scientific discourse cemented the link by associating women with wild, untamed, and irrational nature; scientific method perpetuated this understanding by treating women as Merchant describes science as treating nature. Thus, the problem is not merely that science focuses too minutely on women, rather that masculine norms are endemic to the enterprise.

Evelyn Fox Keller offers a somewhat different reading of Bacon, noting the dialectical nature of his metaphors. Science is not only to conquer nature, but to seduce her into revealing her own secrets without ostensible coercion. She writes, "Not simple violation, or rape, but forceful and aggressive seduction leads to conquest" (37). This reading better accounts for current medical practices as physicians are not perceived as coercive, but rather, their assistance is usually sought out voluntarily. Yet, myriad discourses circulate throughout society that subtly and overtly persuade individuals to seek out this assistance in various circumstances.

These associations of women and nature in scientific discourse are often articulated in the terminology of female reproduction. Because women have unique procreative functions, they are seen as closer to nature (and their bodies) than men. Sherry Ortner argues that this association is a cultural and historical constant and explains the universal subjugation of women. Barbara Ehrenreich and Deirdre English explain

how medicine's conquest of the female body is a synecdoche for science's conquest of nature:

Everything that seems uniquely feminine becomes a challenge to the rational scientific intellect. Women's body, with its autonomous rhythms and generative possibilities, appears to the masculinist vision as a "frontier," another part of the natural world to be explored and mined. . . . Women's psyche, of course, becomes an acknowledged scientific enigma, like the inner substance of matter, or the shape of the universe (19).

Fausto Sterling writes of current theories of women's psyches, "Today we turn to the brain rather than the skeleton to locate the most fundamental sources of sexual difference. But, despite the many recent insights of brain research, this organ remains a vast unknown, a perfect medium on which to project, even unwittingly, assumptions about gender" (*Sexing the Body* 118).

Women's bodies are acted upon in order to conquer the "frontier" of women's minds. Theories positing an innate biological cause for women's experiences justify experimentation on women's psyches through the manipulation of their bodies. This is the specific context in which the PMDD discourses developed. In 1985, Judith Gold wrote, "Thus, women remain to some extent a mystery to psychiatry. Instead of accepting the enigma, through ongoing research we will increase our knowledge and offer more potentially beneficial treatments to those who require them" (*Psychiatric Implications* xiv). Women are an "enigma" and a "mystery" but science is nonetheless determined to understand women fully.

In these accounts, women are passive objects to be probed by medical devices and scrutinized under scientific eyes. By associating women with nature, these tactics are justified on the grounds that science is ultimately for women's benefit. By understanding women's experiences, science will be able to manipulate these experiences in increasingly precise ways. Because women's experiences are defined negatively, this project must ultimately be of benefit to women. Ludmilla Jordanova notes the interdependence of these ideas: "The notion that women are closer to nature than men combined numerous elements, including the claims that women are more emotional, credulous, superstitious, and less analytical than men" (21). Science, by feminizing nature as a frontier to be conquered, also naturalized women's association with madness and women came to share the characteristics of nature--wild, untamed, irrational, and unpredictable.

Elaine Showalter (1987) further explores the intricate connections between science's conflation of nature and the feminine and specific ideologies of oppression. For instance, in the Victorian era, science and the political order were mutually reinforcing. Science supported the view that women, controlled as they were by their reproductive organs, were unstable and more susceptible to mental maladies. Simultaneously, these discourses produced an image of a normal, natural woman: the "ladylike values of silence, decorum, taste, service, piety, and gratitude" played a large role in defining sanity and normality (Showalter, *The Female Malady* 79). These values were not only taken to be markers of sanity, they were forced on women incarcerated in asylums. Showalter summarizes the theories of T.S. Clouston, a follower of Darwin who adapted evolutionary theory to conceptualize women's minds:

By *nature*, then, woman was constituted to be “the helpmate and companion of man”; her innate qualities of mind were formed to make her man’s complement rather than his equal. Among these qualities, Clouston believed, were the cheerfulness, vivacity, and powers of endurance that made woman capable “not only of bearing her own share of ills, but helping to bear those of others” (*The Female Malady* 123).

Scientific understandings of women are directly linked to common beliefs that women are naturally maternal and self-sacrificing. Such a belief justifies inequality and maltreatment of women. If women suffer disproportionately it is okay because it is a part of their nature. Paula Caplan explores modern manifestations of this belief in the norms of true womanhood in *The Myth of Women’s Masochism* (1985). She writes:

The myth serves two purposes: It leads both women and men to believe that women are deeply, inevitably pathological--for is it not sick to enjoy misery?--and it is a powerful block against social action that could help women. Because of the myth, women’s problems can be attributed to our deep-seated psychological needs, not to the social institutions that really are the primary causes of the trouble.

Women have been placed in a tragic, catch-22 situation. We are told in a thousand ways that “real women don’t blame others,” whether the “others” are individuals close to us or larger, impersonal social institutions. *Real women* are patient, selfless, and able to give whatever it takes to make a relationship or job successful. Women who do not behave in those ways usually faces a painful fate. Developing a sense of their identity and self-worth is difficult, for a woman who

does not take the blame for her troubles is not “feminine,” and femininity traditionally constitutes a significant portion of a woman’s identity (10).

These accounts illustrate how science and social oppression are mutually supporting. Science associates women with nature, women’s discontent is thus natural and a part of their identity, not the result of unequal socialization mechanisms. Social ideologies depict women as sick and inferior, justifying scientific practices that are presumed to be beneficial for women.

Phyllis Chesler further explores the relationships between social roles and scientific practice with regards to modern psychiatry in her groundbreaking *Women and Madness*. She explains the disproportionate number of female patients as a result of the impacts of social oppression on women’s psyches as well as the fact that the role of patient is compatible with “the conditioned female role of help-seeking and distress-reporting” (148). Because masculine norms define what it is to be healthy, any female role can be identified as sick whether women accept or reject this traditional role--if women defy it, they are unnatural and disordered, if they accept it they are sick because the role itself implies weakness and inferiority.

Though Chesler aptly posits social causes as responsible for women’s disproportionate representation as psychiatric patients, the biological theories dominant in current psychiatric practice give short shrift to social factors and instead focus on biological explanations for women’s discontent. Current scientific theories of mental distress are little better than the folklore of antiquity blaming women’s feeble minds on a wandering uterus: in both instances, the blame is placed somewhere in women’s bodies and in both instances women’s bodies are weaker vessels than men’s. In these theories,

though the brain is the primary focus, women's reproductive organs are still the predominant explanatory language for the activities of women's brains. For instance, Elizabeth Young et. al. (December 2000) note that research consistently demonstrates a 2-fold greater prevalence of depression in women and they suggest the "reproductive hormones may play a role in modulating depression" (1157). Though women's psychic disorders are neurological diseases in these accounts, they are still linked to women's reproductive capacities by way of hormonal fluctuations. Fausto Sterling writes of hormones, "Chemicals infuse the body, from head to toe, with gender meanings" (*Sexing the Body* 147). As she points out, hormones affect numerous organs in the body and are not specific to either gender--the very concept of sex or reproductive hormones reveals the political ideologies at play in scientific theories of gender difference. Subtly yet surely, women's reproductive organs are brought to bear in explanatory theories of women's defunct minds. The uterus no longer wanders, but it has not yet given up the reins of control over women's psyches. Fausto Sterling concludes that to change gender, science must be changed: "But of course, such changes can only occur as our social systems of gender change. Gender and science form a system that operates as a single unit--for better and for worse" (*Sexing the Body* 194).

Though the above account is not exhaustive, it highlights the continuities in the way the science/gender system operates. Throughout history, scientific theory has focused on women's bodies as explanations for discontent and psychic malfunction. Women's close associations with their bodies simultaneously associates them with nature and characterizes them as wild, unpredictable, and irrational, an untamed frontier waiting to be conquered, or seduced, by scientific prowess. Current theories positing the origin of

mental disorder in the brain are not free from these assumptions. Even when the brain is the locus of mental activity, women's reproductive capacity still plays a role in their mental constitution. Supposed "sex hormones" are a currently popular explanation for how the uterus still manages to exert power over women's experiences and behaviors. These theories are directly related to the PMDD discussion. The predecessor of PMDD is PMS and PMS is frequently conceived of as a hormonal disorder resulting from women's reproductive capacity that negatively affects women's minds.

### The Modern Malady: Premenstrual Syndrome

The scientific literature on PMS is daunting: hundreds of thousands, if not millions, of articles have been published on the subject and hundreds of popular accounts inform women of the latest scientific findings and treatment options. These theories attest to the lack of scientific consensus regarding PMS. Though for short time periods a particular theoretical approach might take hold of the collective scientific mind and constitute the "truth" for that time, theories of PMS are varied and constantly changing. For the most part there is little agreement as to what it is, what causes it, and how to treat it. Despite this disarray, it is consistently theorized as a biological problem that negatively affects women's psyches and in many cases completely usurps control over their minds. Over 200 symptoms have been documented, ranging from physical discomfort to psychic distress to behavioral abnormalities. Further, these theories consistently link "unfeminine" behavior to the menstrual cycle and hence women's reproductive organs. PMS has a lot in common with earlier manifestations of the female malady: it is a wastebasket diagnosis and its etiology changes as norms of femininity undergo alteration.

Though the menstrual cycle has received attention from medicine and science for centuries, PMS made its debut in the modern medical literature in 1930 with Robert T. Frank's publication of "The Hormonal Causes of Premenstrual Tension." Frank notes that "a large group of women . . . are handicapped by premenstrual disturbances of manifold nature" which signal "the close connections between the ovarian function and systemic manifestations due to other organ systems" (1053). This PMS, specifically linked to the reproductive organs, "handicaps" women and designates them as inferior and incapacitated. Further, these organs have the ability to determine the function of other organs. In this account, ovaries are the center of a woman's body and they are the most powerful organs in this body. Frank describes the symptoms, "unrest, irritability, 'like jumping out of their skin' and a desire to find relief by foolish and ill considered actions" (1054). These symptoms are exacerbated by the fact that women are able to identify their stricken status and "they feel conscience-stricken toward their husbands and families, knowing well that they are unbearable in their attitude and reactions" (1054). Implied is that a woman's natural state is one of cheerful service to her husband and family, a submissive role where self-sacrifice is a defining factor of feminine identity. Frank attributes this unpleasant behavior to women's sexuality, specifically an excess retention of female sex hormone, and in the following abstract discussion Dr. Edith Spaulding recommends either increased sexual activity for married women or "the lessening of the sexual drive" in single women (1057). In this theory, hormones are specifically gendered (Frank refers to "female sex hormone" in the singular, implying that there is one hormone that determines women's sexuality) and the scientific position is infused with social

judgments--treatments for married and single women differ not for scientific but moral reasons.

Frank's publication sparked a wave of new theories on the menstrual cycle, but his own theory, that an excess of female sex hormone produced unbearable sexual tension, was quickly cast aside, at least for the time being. In 1953, Linford Rees published "The Premenstrual Tension Syndrome and Its Treatment," an article cataloguing the proposed theories and treatments to date. He notes that "the aetiology of the condition is still obscure" and gives a brief list of the proposed explanations: faulty leutinization of estrogen, progesterone deficiency, water retention, an unstable nervous system, personality instability, and other ambiguous hormonal changes. Most theories still hold hormones accountable, though many of the earlier theories did attribute the symptoms to women's psychic instability, an explanation implying that their symptoms were in some ways imaginary and not wholly real. In all accounts, PMS is not clearly defined and it covers a vast range of symptoms. Further, it is described as a negative aspect of female biology.

Because there is no consensus or convincing evidence concerning the etiology of PMS, a constant concern has been how to identify or diagnose the disorder. Physical tests cannot reveal the presence of PMS as scientists do not know what they are looking or testing for. In 1968, Rudolf Moos published an important article, "The Development of a Menstrual Distress Questionnaire." This study and the designed Moos Menstrual Distress Questionnaire (MDQ) are still widely referred to in the literature and used in some PMS studies though similar questionnaires and charting mechanisms have since been developed. Echoing Frank, Moos notes that "many women [are] handicapped by various

premenstrual disturbances” and proposes a questionnaire, to be filled out by women, to determine whether or not their complaints are related to the menstrual cycle (853). Moos’ purpose is to standardize diagnostic tools as well as come up with estimates concerning the prevalence of PMS. The MDQ lists 47 symptoms and women are to rate them on a six-point scale throughout their monthly cycles. This publication set the standard for diagnosing premenstrual syndrome and even today the only method of diagnosing PMS and PMDD is through charts kept by women or their companions.

Despite the standardization of the diagnostic process, Moos did little to resolve the contentious and often unfocused debate on the precise causes of the disorder. In 1981, Reid and Yen published “Premenstrual Syndrome,” an article again cataloguing the proposed theories to date. They note that symptoms range from “marital discord, baby battering, and criminal behavior” as well as “absenteeism and work inefficiency” (85). They estimate that 70-90 % of women suffer from PMS, with 20-40% suffering from severe symptoms described as “mental or physical incapacitation” (86). Theories reviewed include estrogen excess, progesterone deficiency, vitamin deficiency, hypoglycemia, endogenous hormone allergy, fluid retention, psychosomatic disorders, and other neuroendocrine imbalances. They propose a new theory based on “the central and pituitary role of the neuropeptides” (97). In the reviewed theories, women’s hormones are most frequently employed as the explanation for behavior as diverse as baby battering, marital problems, and lack of efficiency at work. By implication, healthy women are maternal, submissive wives and productive and cheerful workers. When they fail in these capacities, their inferior bodies are held accountable and unfeminine behavior is chalked up to women’s erroneous biology.

To date, the confusion over precisely what PMS is and what causes it remains. The beginning phrases of medical literature sound strikingly familiar: “To date, the etiology and the most effective treatment are unknown” (Laughlin et al. 1984); “premenstrual syndrome research has been characterized by confusion as a result of the failure of investigators and clinicians to define carefully the entity under investigation” (Rubinow, 1987); the syndrome “may defy precise description even by the patient” (Berga, 1998); “more than 150 symptoms have been associated with PMS, and no confirming laboratory test exists” (Fry et al. 2000); and, “practically every symptom that has ever been described as experienced by anybody under any condition has at one time or another been attributed to PMS” (Rubinow 1987). Like hysteria, PMS is as slippery as a globule of mercury--scientific research has faith that it exists but it continues to elude definitive articulation.

The proposed causes and thus treatments have proliferated as well, with causes including serotonin synthesis (Brzezinski 1996), effects of gonadal steroids on serotonin metabolism (Parry 2001), and metabolism of progesterone (Berga 1998). Treatment proposals include estradiol (Soares et al. 2001), flumazenil (Melledo 2000), pyridoxine (*American Family Physician* 1984), agnus castus fruit extract (Schellenburg 2001), and antidepressants (Dimmock et al. 2000). With this baffling array of contradictory literature, two things are clear: the definition of PMS is so ambiguous and broad almost any woman feeling any change throughout her cycle could potentially qualify for the diagnosis. Additionally, any woman who seeks treatment could be subject to a frightening array of medical treatments, most with little empirical support. Perhaps most baffling is why the medical profession continues to cling to the PMS label as if it were a

valid diagnostic category with a proven etiology and treatment. After over 70 years of uncertainty and contradiction, the researchers are no closer to pinning down the menstrual malady than the Greeks positing a wandering womb. Not all research on PMS, however, has aided the dominant scientific position, and critical perspectives on PMS research are a critical guide to understanding the literature.

Soon after Moos' publication, Mary Brown Parlee offered a comprehensive critique of the questionnaire: by focusing only on negative symptoms, the questionnaire promotes stereotypic beliefs about the menstrual cycle and shapes women's responses. Parlee gave the questionnaire to groups of men and women and asked them to rate perceived changes in a women's menstrual cycle. She concludes, "In all instances where the difference was significant, males' ratings indicated 'greater symptom severity' than females" (235). Parlee hypothesizes that a woman's responses on the MDQ do not represent neutral reports of her experiences throughout the cycle. Rather, attitudes concerning menstruation are so strongly shaped by societal beliefs and expectations that women often attribute experiences to the menstrual cycle as a result of this social conditioning.

Diane Ruble (1977) has further challenged the validity of self-report data. She notes that most objective measures of performance do not support the theory that women experience lesser functioning before their periods. Ruble gathered female patients and told them that the researchers could estimate the beginning of the women's menstrual cycles with an EEG (this cannot actually be done). She had all of them fill out the MDQ, telling some that their periods were due in 1-2 days and others that they were due in 6-7 days. She found that women who believed they were premenstrual indicated higher

symptom ratings than the other women. Thus, “it appears that learned associations or beliefs might lead a woman either to overstate what she is actually experiencing or to perceive an exaggeration of naturally fluctuating bodily states . . . when she believes she is premenstrual” (292). Like hysteria, PMS can be conceived as a mimetic disorder as social discourses persuade women to articulate their discontent in terms of individual pathology related to reproductive function.

Anthropologist Mary Rodin concurs with the findings of Ruble and Parlee, arguing:

The fact that the medical establishment treats PMS as a legitimate disease category (by applying for research funds, proceeding with research, treating patients, and maintaining PMS clinics) despite the lack of agreed upon definition and contradictory research findings, suggests that shared cultural knowledge, as opposed to scientific facts, informs researcher understandings of what constitutes PMS (52).

For Rodin, then, PMS is not a valid construct but the result of cultural stereotypes related to anxiety over women’s reproductive functions and the age-old belief that women’s bodily differences make them irrational, unpredictable, and susceptible to mysterious uncontrollable natural forces. The currency of PMS in modern scientific discourse indicates that science is not separate from cultural beliefs and dominant ideologies, rather it is intimately related to specific ideologies of gender inferiority. PMS is an antecedent of centuries of discourse associating women with their bodies, nature, madness, and hence inferiority. These discourses simultaneously construct the prototypical normal

woman. Deviations from this norm are attributed to biology and conformity is seen as ‘proof’ that the traditional feminine role is an innate part of women’s identities.

### PMS: The Popular View

It is not surprising that women hold stereotypic beliefs about menstruation given media preoccupation with the negative aspects of the cycle. Several analyses of media portrayals of PMS conclude that the media consistently promotes stereotypic negative beliefs about menstruation, beliefs that are frequently internalized by many women.

Parlee (1987) finds that characteristic media coverage of PMS focuses on physical symptoms and negative moods, undesirable antisocial behaviors, and biological causes and treatments. She concludes that stereotypic beliefs are transmitted to many women and “can serve as a basis by which she comes to interpret the psychological meaning of the bodily changes of her menstrual cycle” (197). Because these popular accounts mediate scientific accounts of PMS, women do not hear of the rampant uncertainty and confusion plaguing medical research--they hear news bites portraying a high degree of certainty and consensus within the scientific community.

Chrisler and Levy (1990) examine popular press accounts of PMS, arguing that the media is one of the most important sources of health information, especially for young women. News accounts are shaped by definitions of newsworthiness. Negative symptoms are considered more newsworthy than positive functioning: “It is not news that most women cope well with premenstrual changes. It is news when a woman cannot restrain her violent urges or becomes too depressed to go to work” (91). Though media reports focus on the negative instances, these portrayals are so common that the images presented are widely seen as representative of all women. Chrisler and Levy found that

even more symptoms were attributed to PMS in popular literature than medical theory and include sore throats, bruising, conjunctivitis, and changes in perfume scent. Many symptoms concern physical attractiveness, for instance greasy skin, weight gain, and circles under the eyes. They suggest that these media accounts persuade women to actively seek a PMS diagnosis. This hypothesis is supported by Ruble and Jeanne Brooks-Gunn, who note that “as PMS received increasing attention and publicity, therefore, the likelihood increases that PMS will be part of girls’ premenarcheal expectations.” (247).

Popular news accounts are important but they are not the only source of information on PMS available for popular consumption. Premenstrual syndrome has been a popular topic for self-help manuals, books aimed primarily towards women and intended to increase women’s coping skills and familiarize them with medical research on the disorder. These manuals replicate the approach that has been critiqued in media representations. They focus on negative symptoms, biological causes and treatments, and present scientific speculation as proven fact. One of the most striking aspects in these accounts is the subtle yet thorough construction of the “normal woman.” As Randi Koeske explains, “negative behavior exhibited premenstrually is perceived as evidence for the prevailing negative stereotype of female emotional behavior while positive behavior is ignored as something to which biology is irrelevant” (140). Undesirable behavior is attributed to women’s inferior bodies while positive behavior consistent with feminine norms is chalked up to who women are. Chrisler and Levy make a similar point, noting that symptoms are often appearances of women stepping out of stereotypically feminine roles: “Good (read ‘normal’) women do not show aggression, rage, hostility,

anger, violence, or short tempers” (97). This is a fascinating phenomena--when women act as women are expected to act, there is no mention of biology (such behavior does not even need explanation), yet when women step out of their designated feminine roles, suddenly their weak flesh is to blame.

An analysis of a popular self-help manual reveals that what is promoted is not an innocent guide to seeking treatment for a proven disorder, but a normative theory of what women should be and how the proper woman should act. As Bonnie Dow notes, despite advances in women’s rights, “the qualities, responsibilities, and/or characteristics associated with ‘woman’s place’ in the private sphere are still expected from women . . . Such qualities include specific caretaking behaviors ranging from cooking, cleaning, and child-rearing to more general qualities of nurturance and emotional support” (xxi).

Katharina Dalton’s *Once a Month: The Original Premenstrual Syndrome Handbook* illustrates this dynamic. Originally published in 1979, Dalton’s manual is currently in its sixth edition (1999). *The Independent* describes Dalton as “a former gynaecologist and doyenne of PMS research” and refers to *Once a Month* as “a pioneering book about PMS” (Price 8). *The Guardian* reports that Dalton has testified as an expert witness in over 50 trials where PMS was being used as a criminal defense (Boseley 4). *The Daily Telegraph* attributes current understanding of PMS to “a remarkable thesis” by “a world authority on the subject” (Daneff 17). *The Los Angeles Times* calls Dalton “the recognized pioneer in the field” (Sullivan 1) and the *Washington Post* describes her as “the British physician who practically single-handedly gave premenstrual syndrome its medical legitimacy” (Rovner B5). *The New York Times* refers to her as “an eminent consultant who pioneered research into premenstrual tension” (C3, 1981). Dalton’s work

is highly respected, she is widely recognized as an expert in the PMS field, and her handbook is widely read. Thus, this work is exemplary of similar manuals and the ways it constructs women are replicated by other such books. Finally, Dalton's book is presented as an authoritative, scientifically backed text. Dalton is a medical doctor and her preface includes numerous references to the scientific basis of her book.

Dalton's manual begins in a foreboding tone, "Once a month, with monotonous regularity, chaos is inflicted on American homes as premenstrual tension and other premenstrual problems recur time and time again" (1). In the first sentence, it is clear that the primary locus of premenstrual problems is the home, long considered to be woman's proper place and the proper focus of her energy and attention, despite changes in perceived gender roles. This account is written in the passive voice--chaos is "inflicted" by a yet unnamed source, further highlighting the idea that women are victims controlled by their biology rather than active agents. Dalton continues, "Wonderfully happy and often long-term marriages and partnerships break up under the strain, because one partner is an unpredictable, irrational, or violent woman suffering from premenstrual syndrome" (1). Woman's faulty biology is already pinpointed as the cause of marital discord and divorce and neither men nor social arrangements play any role in the demise of typically happy marriages. Not only does Dalton represent marriage as an empowering and blissful state for (normal, healthy) women, she implies that healthy women are predictable and peaceful. A woman's lack of docility is evidence of biological abnormality.

Dalton describes her project, however, as one that is liberating for women, a project that breaks down dangerous folklore and liberates women with the truth: "The image of women as uncertain, fickle, changeable, moody, and hard to please needs to be

replaced with the recognition that all these features can be understood in terms of the ever-changing ebb and flow of woman's menstrual hormones and the hormonal changes they cause within her body cells" (1-2).

Yet, Dalton reinforces rather than replaces these traditional understandings. In her account, women are still unpredictable and irrational. Now, they are also sick. The old ideas are recast in new scientific terminology and this reissue is presented as progress for both science and women. Women's changes can be understood as "the ever-changing ebb and flow of woman's menstrual hormones," hormones which have the ability to produce more "hormonal changes" in other parts of her body. These scientific accounts are described as empowering because they remove women's responsibility for their undesirable behavior, attributing such behavior to hormonal changes beyond a woman's direct control. Women are not responsible, but no one is responsible in these accounts, neither individuals nor society. According to Dalton, faulty biology can produce alcoholics, baby batterers, husband beaters, shoplifters, window smashers, criminals and neurotics. Already in her introduction, Dalton has identified the themes recurrent throughout her book and similar manuals. Premenstrual syndrome is a defect of women's biology and hence outside of their control. Further, it is the cause of a variety of social ills ranging from divorce to criminal behavior. Finally, it is typically unfeminine behavior that is attributed to the biological malady. Normal behavior, including happy marriages, devotion to children, and calm demeanor, does not need to be accounted for in any terms. It is women's presumed normal state absent biological interference.

Dalton acknowledges that at least 150 symptoms are related to PMS, including hair pulling and mood swings. She writes that the symptoms "seem to cover the majority

of medical specialties” and thus the majority of physical symptoms (29). The reproductive organs can influence literally every other organ in the body. Dalton writes that many “able caregivers” cheerfully perform their duties “until one day they snap” (29). Normal women are “able caregivers,” responsive to the needs of others. When they are frustrated with these duties, it is a sign of premenstrual syndrome. Dalton describes one woman’s symptoms as “being a failure as a wife and mother” (33). In this account, failed interpersonal relationships are symptoms of women’s biological malfunction and as a consequence there is no account of communication or social influences. Another woman describes her symptoms, including feeling reluctant to lift her two sons and dress them and sometimes letting them sleep in bed for the entire day. Another is quoted, “Just before a period . . . a sleepiness takes over me and all I want to do is sit down and sleep, so that no housework or proper cooking gets done” (39). Yet another woman describes the days before her period as “the ‘take-out’ meal days, and ‘wash-up tomorrow’ days” (39). All of these descriptions have in common a failure to perform domestic duties: failure to take care of children and failure to clean and cook. By implication, this is the appropriate domain for women and these are the activities performed by normal, healthy women.

Dalton also describes marital discord as a PMS consequence. She states, “Too many cases end up with visits to a marriage counselor or in divorce” (40). She quotes one woman, “My husband is at his wit’s end. He doesn’t know what to do with me, not knowing what I’m going to do next, and is ready to leave me . . . I keep telling him that I’ll be good the next time, but I never am and I just can’t control myself” (40). Unpredictability is a symptom of illness. By implication normal women are predictable

and “good” as judged by their husbands. This narrative indicates an unequal relationship as the husband has the control, the power to leave or stay in the relationship as he sees fit. He is able to solicit promises of future good behavior by threatening to remove himself from the relationship. Dalton notes that women are more likely to lose control of themselves “when preparing the evening meal or waiting for the husband if he is later than usual” (41). Women are again presumed to operate primarily in the domestic sphere and perform domestic duties while their husbands are active in the public sphere. Norms of feminine submission are again implied here--women’s normal behavior is to be so self-sacrificing that they would go hungry rather than eat without their husbands.

Dalton describes menstruation as “a failed pregnancy” (68), implying that for women, success is pregnancy--the allusion to “failure” has a negative connotation and implies that maternity is a natural role for women. Women are not only mothers by nature, they are unfit for activity in the public sphere because of the influence of the menstrual cycle on their behaviors, thoughts, and emotions. She writes of adolescent girls: “those girls who were unfortunate enough to take their examinations in the paramenstruum . . . had fewer passes, lower grades, and fewer distinctions” (103). If PMS can inhibit girls from taking tests, what consequences might it have for adult women in positions of responsibility? Dalton explains the negative attitudes young girls have concerning menstruation as a consequence of their recognition of male superiority and their resulting desires to be men. She explains, “Many girls do not like the body changes that Nature has decreed. They object to the rounded contours and would prefer the broad shoulders and wiry limbs of boys” (112). Menstruation is thus problematic for women not

only because it is an undesirable biological intrusion, it is problematic because it represents women's difference from--and hence inferiority to--men.

Dalton returns to relationships and the effects PMS has interpersonally. She includes a detailed prediction of marital problems that might arise in a relationship where a woman suffers from PMS:

As on other mornings, you get up and cook breakfast while your husband is in the bathroom. You climb wearily out of bed and trudge down the stairs, a vague feeling of resentment growing within you. The sound of a cheerful whistling only makes you feel a little more cross. Without any warning, the toast starts to scorch, and the sausages, instead of happily sizzling in the pan, start spitting and spluttering furiously. Aghast, you rescue the toast, which by this time is beyond resurrection and fit only for the trash. The sausages are charred relics of their former selves and you throw those out too. Your unsuspecting husband opens the kitchen door expecting to find his breakfast ready and waiting, only to see a smoky atmosphere and a thoroughly overwrought wife (128).

Interestingly, Dalton's description of the breakfast sausages mirrors her description of women. Women begin their cycles happily fulfilling their domestic duties then undergo sudden change and begin "spitting and spluttering furiously"--they are but shadows of their normal selves. Dalton continues to predict that the husband in this scenario might "arrive at work hungry and unable to do his work properly, eventually returning home tired and frustrated" (129). Though women's proper place is the domestic sphere, their faulty biology can perniciously extend its influence into the public realm through marriage relationships. Again, a patriarchal relationship is indicated--not only is the

woman serving her husband (she is preparing “his,” not “their,” breakfast), the account implies that he has reason to be upset at his wife’s failures to perform her duties. He is “ready and waiting,” implying a demanding and impatient attitude, “expecting” his breakfast but instead ending up hungry and unable to work properly. Both men’s and women’s lack of productivity at work is the result of women’s faulty biology. For women, inefficiency is a symptom of a disease and for men, it is the result of women’s failure to serve them adequately and maintain the domestic sphere. Further, the stark separation of the public and the private spheres is notable here--the man is apparently unable to find sustenance anywhere but his home. Published in 1999, this account takes little notice of the context of social organization. Though women are still defined in terms of their private roles in many discourses, it is also true that the burgeoning service industry fulfills some analogous functions. There is little account of the social at all in this account--the two settings here are the home and the man’s workplace. There are no restaurants, drugstores, or locations that might transcend the public/private dichotomy, only home and work.

Dalton advises husbands to “try to be a substitute mother as well as a father” during the PMS times (130). She suggests ways that husbands can help with the housework and care for the children to assist their incapacitated wives. Dalton assumes that women are naturally cooks and caregivers and any hesitation about graciously accepting these roles is the result of PMS, a hormonal abnormality. The father is the worker who goes out of his way to assist with domestic duties during unique circumstances. These stereotypical roles are never questioned, but taken for granted as men’s and women’s natural modes of being. The women’s movement was strong even

before the first publication of this manual in 1979 and it is striking that Dalton's account reflects a complete inattention to feminist challenges to traditional gender roles. Dalton altered the book considerably for the 1999 edition. She writes in the preface, "The need for yet another edition of this book reflects the numerous scientific advances of the last few years that have been related by the problems of PMS" (xv). She even acknowledges that since the first publication, "there have been sociological changes involving women in the workplace, altered dietary habits, and media influences" (xv). She does not explain these changes or detail these influences. Since the women's movement, feminists have made some advances though gender oppression is still significant. Dalton claims that her book reflects scientific advances, but it does not reflect social advances. Women are portrayed in stereotypical ways despite the questionable accuracy of these stereotypes in describing what women actually do in modern times. Further, the only possible acknowledgement of social struggles lists workplace advances, diet changes, and media "influences." The feminist battle for sexual harassment regulations is presumably the same type of progress as the greater availability of vitamins. What constitutes "media influences" is entirely unclear in this preface.

Dalton further suggests the consequences female biology has for marital harmony: "How many wives batter their husbands during their paramenstruum is unknown, nor do we know how often the husband is provoked by her premenstrual anger and batters her" (132). She suggests that husband battering is "the most unreported crime" and affects 20% of husbands (133). Husband battering is portrayed as a silent epidemic with an unknown victim count and domestic violence inflicted by men on women is portrayed as a natural response to women's erratic behavior sparked by her female hormones. She

states, “one wonders how often these wives were also victims of their own hormonal imbalance” (133). Women are masochistic whether they are healthy or ill. When they are healthy, they are self-sacrificing caregivers and submissive wives. When they are sick, they inflict suffering by provoking violence from their husbands. This horrifying argument completely absolves men of any responsibility for their behavior. Also, this narrative resembles the initial story of the fall as told in the Bible. A woman is seduced by the devil or she is susceptible to another evil force--her female sex hormones. In both narratives, women then influence men to participate in sinful behavior themselves, through subtle persuasion or provocative behaviors. Placing responsibility for what is considered bad, sinful, or deviant in individual women is not a new strategy.

These accounts further illustrate the degree to which conceptions of appropriate social roles infuse Dalton’s scientifically inspired account. The descriptions of PMS behavior are often descriptions of behavior considered normal for men--symptoms include irritability, violence, and dissatisfaction with one’s life. In Dalton’s own accounts men exhibit these behaviors. In the above narrative, the man is irritable (tired and frustrated), Dalton notes that men are frequently violent and abuse their wives, and the men are frequently dissatisfied (the one in the narrative is expectant and waiting to no avail for his breakfast). Yet, her causal theories excuse this behavior in men as a normal response to their situations and place the cause solely on women’s hormones.

Attributional bias theories reveal that personality bias is employed in explanations of the behavior of an out-group member, but situational bias is the norm for in-group actions. In other words, if an ‘outsider’ performed an undesirable action, the activity is likely to be attributed to their identity or personality. If a peer or member of a dominant group

performs an identical action, their behavior is attributed to social circumstances and they are exonerated for the action. Dalton's account reveals the ideology permeating society that men are the "in group" and it is not only men who have been convinced by this fiction.

Finally, Dalton's predictive narrative trivializes the very real problem of domestic violence. Though men are sometimes the victims, it is not true that this situation constitutes a "silent epidemic." By portraying this as a silent epidemic, Dalton can avoid substantiating her claim--presumably statistics are irrelevant because men do not report their experiences of victimhood. This assumption further points to the ways in which dominant stereotypes define Dalton's account. By implication, men's masculine roles and self-esteem inhibit their willingness to admit that they do not have a monopoly on physical force. Statistics on domestic violence do point to the disproportionate impact on women. Statistics indicate that 95% of assaults on spouses or ex-spouses are by men on against women and women are five to eight times more likely to be victimized than men (Flowers 15, 18). Almost one-third of all women are estimated to suffer from abuse at the hands of men in their lifetimes (Jukes 18). The claims that men are also victims in large numbers are simply unsubstantiated. Hague and Malos concur that "all the evidence points to the widespread abuse of women by men" (15). Experts typically estimate that only 5% of domestic violence cases involve women victimizing men (Gosselin 16). These statistics are all from relatively neutral organizations. Dalton's account naturalizes domestic violence and trivializes its impact on women while denying its connection to patriarchal society, intimating that men are the real victims both when they inflict violence and when they are attacked themselves.

Husbands are not the only victims of women's hormones. Children are also affected. Dalton writes, "The mother is the linchpin of the family" (143). She describes a hypothetical household victimized by PMS: "The usually tidy house is not picked up, the beds aren't made, dirty dishes sit on the kitchen table, and there might be a burned cake by the sink. Perhaps the children went off to school late, in yesterday's clothes, and chances are that meals will not be ready on time" (143-4). Again, women's natural duties are domestic and include keeping a tidy house, caring for the children, and cooking. Dalton further cites child battering as a consequence of PMS, noting that women naturally have "strong maternal feelings" which are overwhelmed by the changes wrought by hormonal fluctuations (148). Women are naturally mothers and any unease with this role is attributed to a biological disorder. Portraying child battering as the result of female activity also obscures that fact that men are far more likely to abuse their children than women. Over 95% of child abusers are male (Jukes 18). By portraying women as the initiators of domestic violence, Dalton whitewashes and distracts from the violent patterns of behavior exhibited by men.

Dalton does spend some time discussing the implications of PMS on women who do work outside of the home. This discussion is isolated in a single chapter, "Women at Work and Play" and throughout the rest of the text, women are presumed to be homemakers with domestic responsibilities. Here, Dalton discusses the significant "cost to industry" and estimates that it costs U.S. industry 8% of its wage bill (159). There is literally no social ill that cannot be blamed on female biology--even economic downturn is the result of women's unpredictable hormones. Dalton states that the industries most impacted include "the clothing industry, light engineering, transistor and assembly

factories, and laundries” (159). Several of these jobs mimic activities performed in the domestic sphere, for instance working with clothing and doing laundry. The other jobs are largely undesirable and low-paying positions that require little creativity and offer little in the way of autonomy, for instance working on an assembly line. In restaurants, Dalton cites “the premenstrual clumsiness of waitresses” as a significant financial drain (160). Even when women are depicted outside of the home, they are not subjects with any degree of social power or influence in the public sphere. In these accounts, the restaurants, laundries and assembly lines are very similar to the domestic sphere as described by Dalton--they involve routine tasks and they are places where there is little mention of men. Women operate in isolated realms while men are active in the outside world of civilization and culture.

Some men do appear in these accounts. Dalton includes an anecdote about theatrical performers:

One great impresario always attended rehearsals wearing a top hat and smoking a cigar. On one occasion his leading lady was making a fuss and was obviously in her paramenstruum. The great man stood up in the center of the auditorium, ground his cigar to dust under his feet, and hurling his hat on the floor, stamped on it, crying out, “Woman! I don’t know why I employ you--you drive me to distraction!” (162).

The woman’s behavior is not detailed--she was “making a fuss” and somehow it was obvious to any observer, including this “great man,” that she was being victimized and controlled by her hormonal activity (any observer could infer this woman’s biological state from her behavior--her behavior is a transparent window into the functions of her

internal biology). The man's behavior is detailed--he puts a cigar out inside on the ground and throws a tantrum, throwing his top hat on the ground then stomping on it and yelling. Yet, this man is described as "great" in two instances. When women behave in unexpected ways, they are making a "fuss" as a result of their biological processes. For men, such behavior is normal or even great. This account further reveals the sexism inherent even in Dalton's account of women in the working world. The woman has a male boss who speaks to her in an insulting manner, yelling at her and calling her "woman" and questioning her abilities.

Dalton continues, "PMS syndrome can affect a woman's chances of getting employment, holding down a job, and receiving a promotion--or losing it unnecessarily" (163). If women are confined to low-paying jobs and do not enjoy status in the public sphere, this is a consequence of PMS, not discrimination. She offers recommendations to industries to cap their financial losses suggesting that "women can be assigned to less-skilled jobs such as packing and stacking during their vulnerable days, rather than remaining on tasks that are more complex and harder to correct later" (165). Women are a risky venture for employers as their hormones can intrude at any time and obliterate their ability to perform complex tasks. For instance, it is difficult to imagine industries paying women fairly when they must leave their jobs each month and retire to "packing and stacking." Dalton implies that the only capacities premenstrual women have are simple tasks that take little or no thought. It is difficult to imagine universities hiring women professors if a considerable portion of their career must be spent "packing and stacking" rather than researching and teaching. Throughout, unequal social arrangements are portrayed as the natural and inevitable consequence of women's hormones.

Dalton continues to discuss the impact of PMS on sports, hobbies, shopping, and entertainment in the same chapter. This placement implies that for women, working outside of the home is analogous to a shopping spree or a trip to the movies. Even when women's work outside of the home is acknowledged, it is not valued. The chapter title, "Women at Work and Play," implies that the boundaries between these two endeavors are thin and permeable. Both are extracurricular activities that serve as distractions from--but not alternatives to--a domestic existence. Dalton includes driving in this chapter, though it is not clear whether it is an example of work or play or both. She writes, "Driving is a complicated task, requiring coordination of many skills, which are slower during the paramenstruum" (168). She claims that women suffer a loss of hearing and decreased vision during their premenstrual periods though she cites no evidence. Dalton states that a woman may "become impatient . . . with an elderly person crossing the road" (168). The suggestion that women suffering from PMS might deliberately mow down elderly ladies crossing the street highlights the irrationality women suffer from as a result of their hormones. Though men are considered greater insurance risks, Dalton highlights women as dangerous drivers. This further raises questions about women's abilities to participate effectively in public life if they are not able to transport themselves. She continues to suggest that walking is also a risk for women, effectively confining women to the home because they have no means of mobility: "Even as a pedestrian, she is more vulnerable in her paramenstruum, and she may cross the road without the usual precautions. As a mother, she may not be alert enough to protect her child from dangers on the road" (168).

Dalton also describes the impact of PMS on shopping, reinforcing gender stereotypes: "A woman may become an indecisive, hesitant shopper who tries on all the

shoes in the shop, finds they won't fit her swollen feet, and leaves empty-handed" (169). Women during the paramenstruum also lose their sense of style, further impeding effective shopping, "It is possible that her color sense and appreciation of shape and size deteriorate during this phase of the cycle" (169). Other women make excessive decisions. Dalton gives the example of a woman who purchased two full-length mink coats. In this account, it is again unclear if shopping is considered women's work or women's play, but these images reinforce stereotypical images of women who are fickle and obsessed with fashion and style: women have natural senses of style that "deteriorate" during certain hormonal cycles. Dalton further describes the impact on entertainment ("Social entertainments may not be too successful during the paramenstruum" (169)) and vacations ("Vacations are . . . sometimes complete disasters" (171). In short, Dalton effectively confines women to the home during their paramenstruum by articulating the negative consequences of virtually all forms of social interaction. These latter accounts also reveal the implicit construction of the normal woman Dalton envisions. This woman is middle- or upper-class as evidenced by her shopping habits, her attendance at cocktail parties, and her ability to afford vacations. This is interesting given that the section on work portrays women of a lower class, women who must work in the laundries and on assembly lines. Though Dalton blurs the boundaries between work and play for women, it is unlikely that many women choose to work at such jobs just as they might casually choose to buy two mink coats. Rather, these are jobs that people work because they have to. Dalton's implicit class bias colors her perception of normal women and the behaviors appropriate to them.

Dalton's manual is typical of other self-help books on PMS (DeRosis and Pellegrino; Friedrich; Hahn; Lauersen and Stukane; Norris and Sullivan; Wade; Weiss). Her book is widely acclaimed and read by many women all over the world. These accounts of PMS are not merely informative accounts that assist women in understanding their experiences, they include many messages that reinforce traditional stereotypes about women's proper roles. In Dalton's account, the normal and healthy woman is a meticulous homemaker, a genteel mother, and a dutiful wife. She operates in the domestic sphere, though traditional feminine diversions such as shopping might be available to her. She is not an attorney, a corporate CEO, a professor, an author, a physician, or a rational agent able to act effectively in society. When women fail to meet these norms, their biology is articulated as the cause. The very concept of premenstrual syndrome is linked to earlier manifestations of women's madness such as hysteria. Both PMS and hysteria are wastebasket diagnoses with hundreds of possible symptoms, poorly defined categories used to explain any behavior that falls outside of social expectations. The same behaviors exhibited by men are either normal or appropriate responses to social circumstances. It is only women's hormones that control their very persons.

### Conclusion

One of the most clever satires of this injustice is Gloria Steinem's "If Men Could Menstruate: A Political Fantasy," originally published in 1978. Steinem reflects on what society would be like if men, rather than women, were the ones to menstruate. She predicts that "menstruation would become an enviable, boast-worthy, masculine event" and would be considered a necessary characteristic of soldiers, politicians, and religious leaders. Male intellectuals would be more benign, recognizing that women cannot be

blamed for their inferiority as it is the result of an innate biological lacking, the absence of a menstrual cycle. She writes, "In short, the characteristics of the powerful, whatever they may be, are thought to be better than the characteristics of the powerless--and logic has nothing to do with it" (43). To pathologize menstruation, an inevitable biological process experienced by women, implies that the standards devised for judging normality are based on a male norm. Further, this framing of PMS and women's biology reveals that science is not separate from gender, rather, as Fausto Sterling states, gender and science constitute one system. PMS research is premised on enduring stereotypical notions of women's proper place and women's appropriate behaviors. When women deviate, biological theories are offered as explanation--for men, the behaviors chalked up to women's PMS are perfectly normal and rational. These accounts reveal the messages that women receive concerning their bodies and their experiences, messages that apparently issue from a scientific authority but are deeply influenced by social biases.

The next chapter examines the medical discourse on PMDD and some 'grassroots' resistances to dominant narratives. The PMDD research is very similar to the PMS research and there are few distinctions between either the disorders or the research methodologies, thus the PMDD research is susceptible to many of the same criticisms formulated about the PMS literature. I will highlight a few ideas that will be relevant to understanding later developments. First, though some medical theories do not posit female hormones as the culprit in PMS, in most theories female hormones play a leading role and in the popular accounts PMS is almost universally conceived of as a hormonal disorder. Thus, the very label "premenstrual" connotes female hormonal activity. Second, PMS is poorly defined in the research and could potentially be used to account for almost

any undesirable behavior. Third, the only method of diagnosing PMS is through women's reports and women are subject to numerous negative discourses concerning their menstrual cycle. There is no way that has been found to do PMS research where women are unaware of the purpose of the study, thus it is possible that their attitudes have been shaped by society and science to the extent that these reports are subjective and less a reflection of a woman's experience than her understanding of social norms. Finally, the empirical research on PMS is bountiful but very, very thin. Even the rhetoric of scientific articles betrays a lack of understanding of the purported category, its causes and treatments. Though many feminists challenge the authority of scientific research, in this case the research fails to meet even mediocre standards for what constitutes "good science" by scientists themselves--in other words, even judged on its own grounds, the scientific research is dismal. This indicates that social conceptions of appropriate roles are strong enough to shape and constrain scientific theories and research agendas.

## CHAPTER 3

### THE CONSTRUCTION OF A MENTAL DISORDER: SCIENTIFIC AND POPULAR PERSPECTIVES ON PMDD

#### Introduction

The primary purpose of this analysis is to examine the emergence of PMDD as an accepted diagnostic category in order to lay the groundwork for the subsequent criticisms. Specifically, three sets of materials will be examined: medical/scientific research on PMDD; medical/scientific research on treatments for PMDD, particularly antidepressants; and finally, women's narratives concerning the potential diagnostic category. Throughout the analysis, several themes are important. First, many conclusions concerning PMDD are drawn from research done on PMS, and the distinctions between PMDD and PMS are fluid and often absent. Second, there are strong challenges to the empirical basis of the PMDD category. Though many critics point to social implications of the category, much of the controversy relates to issues of scientific rigor and robustness of methodology. Third, even the scientific articles confront issues not directly related to empirical data, namely the impact the diagnostic category will have on women. Feminist critics face a complex situation. Though many feel that the PMDD and PMS categories stigmatize women, feminists are also concerned with believing what women say about their experiences and many women report PMS symptoms and find the label helpful or reassuring. The proponents have capitalized on this tension, framing their research efforts in terms of its positive impact on women's health. Finally, much of the

controversy concerns whether or not PMS/PMDD should be categorized as a psychiatric or mental disorder rather than a biological disorder. Though psychiatrists insist that there is no difference between a mental and a physical illness, the scientific controversy as well as women's stories indicate that this equation has not taken hold among the general population. In summary, this analysis looks at diverse texts to examine the ways in which scientific research is formulated, understood, and framed in the public sphere.

### PMDD: The Creation of a Mental Disorder

In 1987, LLPDD (Late Luteal Phase Dysphoric Disorder) was included in the appendix of the *DSM-III-R* as a category needing further research. The decision was controversial and Caplan organized a successful petition campaign in which over 6 million men and women, professionals and lay people, voiced their concerns about the potential category (Caplan, *They Say* 96). Ultimately, the controversy resulted in the decision to put LLPDD (previously called Periluteal Phase Dysphoric Disorder) in the appendix rather than the main text of the manual. By putting LLPDD in the appendix, the stated purpose of the APA was to encourage more research that would use the specific LLPDD criteria thus making the research efforts comparable. A major problem with the PMS literature was (and is) the lack of any clear definition of the construct making it impossible to draw broad conclusions from the literature.

Soon after the publication of the *DSM-III-R*, the APA began work on the *DSM-IV*, chaired by Allen Frances. A specific Task Force on LLPDD was designed, chaired by Judith Gold, M.D. The Task Force included Gold, Sally Severino, Jean Endicott, Ellen Frank, Barbara Parry, and Nada Stotland. In addition, the Task Force included several

dozen consultants, including Caplan for a short period. A memo from Frances to the different *DSM-IV* groups described their project:

Essentially we are undertaking a scientific assessment project, not unlike the treatment and technology assessment projects undertaken by . . . other medical and scientific societies. It is essential that our efforts proceed in as systematic and scientifically based a manner as possible.

Throughout the *DSM-IV* process there runs a marked rhetorical emphasis on the *scientific* nature of the undertaking. Given psychiatry's tenuous and newfound scientific status, this is not surprising. Further, because psychiatry differs from other medical disciplines in significant ways, rhetoric is one of the most important means psychiatrists have of affirming and maintaining this scientific ethos. A memo from Gold to her work group contains similar appeals:

If it is decided that the scientific evidence indicates that there is adequate evidence and sufficient data to support a diagnostic category then we must consider the name for such a category (none of us want to continue with the name LLPDD) and finally on the criteria for such a diagnosis.

It is science that is designated as the guide to subsequent decisions. Notably, Gold never articulates the reasons why no one is happy with the LLPDD moniker, though Caplan suggests that the frequent name changes are rhetorical strategies used to dodge critical scrutiny (*They Say* 91). The overtly scientific *DSM-IV* process was to include a comprehensive literature review of existing research, a reexamination of existing data sets, and finally any field trials that might be necessary.

The LLPDD literature review examined research done using both the PMS and the LLPDD construct. The literature review (LR from here on) states that prior to the *DSM-III-R*, “the research literature was viewed as inadequate, contradictory, lacking in etiological findings or treatment efficacy, and unclear in defining the entity” (3). The hope, then, was the *DSM-III-R* inclusion would spur research that addressed these problems and accounted for these methodological deficiencies. The LR again highlights the scientific nature of the process:

The *DSM-IV* process for all diagnostic criteria involves systematic, lengthy and careful procedures. Explicit documentation of the rationale and evidence on which decisions are based must be provided. In addition, the clinical utility of a diagnosis must be demonstrated. Expert opinion alone is not enough to establish a diagnosis: criteria must be substantiated by research data. Only clear and convincing evidence for a set of criteria is acceptable for a new diagnosis to be considered for inclusion in *DSM IV* (3).

I highlight this emphasis on science for two reasons. First, psychiatry gains much of its scientific status from its scientific rhetoric. This emphasis is a double-edged sword for psychiatry. Though psychiatrists can use this rhetoric to bolster their scientific status, such devices also raise questions about the validity of such a status--the continual insistence on being ‘scientific’ raises skepticism. It is difficult to imagine physicists, for instance, going to such pains to write and talk about the fact that their activities constitute science. Second, these instances of scientific rhetoric can be compared with the actual processes and results of the *DSM-IV* process: the disjunction between rhetoric and practice offers a useful wedge to challenge psychiatric authority.

The LR goes on to note that because the term LLPDD was only introduced in 1987, there are few studies specifically using those criteria (the LR was distributed in October of 1990, a mere three years after the *DSM-III-R* publication). Most studies refer to PMS “and some do not define how that diagnosis was made,” further, the “symptoms of PMS have not been defined exactly” (6). The LR also notes that there is no data describing how frequently LLPDD is diagnosed in clinical settings, thus no data on how reliable the criteria are. The LR does find data indicating that the criteria are sufficient for clinicians to identify LLPDD sufferers, but the clinical procedure must be extremely rigorous and include several evaluations, daily ratings, and a variety of diagnostic assessments to distinguish LLPDD from other psychiatric and medical disorders (8-9).

The LR indicates that the research to date is inadequate, primarily because of the lack of consistent criteria. The primary methodological problems found in the existing literature include lack of diagnostic specificity, small sample sizes, lack of control groups, the use of prospective daily ratings which result in overdiagnosis, lack of population surveys, failure to delineate timing of the symptoms with precision, and other flaws. The LR states:

While many researchers and clinicians are convinced of the existence of a severe dysphoric disorder associated with the menstrual cycle, there are many limitations and problems in the data used to support this conviction. . . . The confusing terminology in the literature also adds to the controversy about the validity of the diagnosis. Until a number of well-designed studies are reported, using the same stringent diagnostic criteria, it will remain difficult to interpret or accept their findings (13).

The LR then includes six specific sections on research concerning biological differences between PMS/LLPDD sufferers and normal women, an analysis of literature on comorbidity (women who have another disorder in addition to LLPDD), and a review of proposed treatments. Finally, the Work Group report included a section intended to address the social and legal ramifications of the proposed disorder. The report acknowledges that “there is also the danger that any reification of PMS as a psychiatric disorder will stigmatize nearly half the population” (3). The report further acknowledges the deficiencies in both retrospective and prospective daily ratings:

A major difficulty is the reliance on self-reports. Prospective daily ratings are more reliable than retrospective data, but are subject to the same bias. People have symptoms they expect to have. Women are not blind to their own menstrual status. Most studies have been performed on women who believe they have a premenstrual syndrome (6).

The report indicates that given the fluidity and inherent ambiguity of the diagnostic process, “there will be a tremendous temptation for psychiatrically unsophisticated and/or unscrupulous practitioners to use this label to attract, gratify, and inappropriately treat patients” (8). Finally, the report concludes that the lack of similar attention to male hormones signals a possible gender bias.

From the rather dismal conclusions of the LR, it is surprising that LLPDD/PMDD made it into the *DSM-IV* at all. With such a negative literature review, what happened to either change the tide of psychiatric opinion or dismiss the scientific objections raised by the APA’s own Task Force? Other studies were undertaken to further investigate the validity of the LLPDD construct. The findings of the subsequent research are available in

*Premenstrual Dysphorias: Myths and Realities*, published by the APA in 1994. Jean Endicott discusses the reliability of the diagnosis and concludes, “The percentage of women who are found to meet the criteria for LLPDD will vary greatly, depending on the clinical setting . . . , referral sources, chief complaints, and diagnostic methodology” (13). In other words, despite the pronounced precision of the LLPDD criteria, there is no determinate limit to the number of women who might potentially receive the diagnosis. Schnurr, Hurt, and Stout examine diagnostic methodology, specifically self-reports. As they state, the most obvious method to determine reliability of diagnostic procedure is to compare self-reports to a true indicator (objective criteria), but “there is no such ‘gold standard’ for diagnoses related to the menstrual cycle” (20). In their study of 648 women (95.5% white), the researchers found no accurate measure to distinguish LLPDD women from PMS sufferers and normal women: “What is troubling, however, is the failure of the methods we used to produce clear and consistent differences between women with and without LLPDD” (41). They continue, “A possible interpretation for this failure is that LLPDD is not a valid diagnostic category. We think that such a conclusion is premature” (41). Given Gold’s assertion that the Task Force would not assume the validity of LLPDD at the outset of the *DSM-IV* examination, such a statement is problematic. Though the research effort found that daily ratings did not distinguish between women with and women without LLPDD, the authors conclude, despite the obvious conclusion, that LLPDD is a valid diagnostic category.

This report continues to state, “None of the approaches currently used to diagnose either LLPDD or PMS specifically attempts to determine whether a given symptom interferes with occupational or social functioning” (42). This is significant because one of

the criteria established to distinguish LLPDD from PMS is severity, determined by significant interference with daily activities and social relationships. This study concludes that without a functional impairment criteria, 14-45% of women who seek help for PMS could qualify for a diagnosis of LLPDD. This is not only a broad range (14 to 45 of every 100 women is a significant difference), it is a far greater estimate of prevalence than that given in the *DSM-IV*, which states that only 3-5% of women suffer from the more severe form of PMS. This study also indicates the close ties between PMS and LLPDD--the same diagnostic methodology (daily self reports) is used to establish the existence of both and this method is not able to clearly distinguish between PMS and LLPDD.

The inability to specify any LLPDD population is a problem that runs throughout the LLPDD/PMDD/PMS literature. In this same volume, Barbara Parry reviews studies examining the biological correlates of premenstrual complaints. The evidence is inconclusive in all arenas, though it is suggested that serotonin plays a role in the negative affective changes experienced premenstrually. Parry concludes, "The lack of standardized procedures for diagnosis is the rate-limiting factor in furthering the search for biological differences in these individuals" (62). Because different definitions and diagnostic procedures are used, it is impossible to compare data from different studies. This inconclusiveness translates into uncertainty concerning appropriate treatments as well. Rivera-Tovor et. al note the numerous proposed etiologies of LLPDD and state that "treatment strategies mirror the numerous proposed etiologies of PMS/LLPDD" (99-100). In other words, the explanation for such a variety of proposed treatments is that many different causes for PMS/LLPDD have been posited--no conclusions can be drawn because these studies are so varied in their methodology and conceptual definitions.

The volume does include some critical commentary, including a comment on the literature review by renowned PMS researcher Mary Brown Parlee. Her reading of the APA's literature review leads her to two conclusions regarding the empirical facts about PMS/LLPDD. Initially, the only method that researchers use to identify women with PMS or LLPDD are self-rating reports filled out by the women themselves. She explains that though PMS and LLPDD have a variety of meanings in popular and clinical settings, in the research arena "they are (are only, until otherwise demonstrated) a particular pattern of responses made by a woman on self-rating scales" (154). Thus, the operational definition of PMS or LLPDD has not been externally validated. Self-rating data are not objective measures, they are highly subjective. Further, because it is practically impossible to have women fill out these self-reports without communicating to them in some manner that the research concerns the menstrual cycle, the entire PMS methodology is cast into doubt. If women are influenced to notice negative symptoms more by social factors, this self-rating itself might influence women to attribute more negative symptoms to their premenstrual period.

Several other studies have been done concerning the validity of self-reports for LLPDD diagnosis. In the first of a two-part study, Gallant et. al. find that of self-reported PMS sufferers and self-reported non-sufferers, only the latter group is likely to be influenced by research expectations in terms of daily self-reports. Their hypothesis is that the former group, consisting of women who report suffering from PMS, is so affected by PMS that study expectations can do little to alter their experiences. The second part of the study concludes that self-reports are not a valid way of distinguishing between LLPDD sufferers and non-sufferers. They specifically use the 30% change severity marker

established by the NIMH in 1983, but find that this criteria was met by more than half of the PMS sufferers and almost half of the non-sufferers. They state:

What is surprising is that even applying a more conservative standard and requiring a greater degree of change did not result in significant differences between the groups. . . . These findings suggest that identifying oneself as having severe PMS has less to do with degree of change in premenstrual moods or physical state than one would expect and raise concern about using any of these criteria as a standard of confirmation (177).

In other words, there is no valid way of distinguishing between LLPDD women and women who claim not to suffer from PMS at all. Both have very similar reporting patterns and degrees of change correlating with the premenstrual period. Again, questions are raised as to the validity of the diagnostic category itself. If there is no reliable or predictable way to determine who will receive the diagnosis, its potential application is limitless and its status as a distinct entity is highly questionable.

Though a woman's narrative is a critical component of the diagnostic process, women's narratives are shaped and constrained in specific ways through the authority of a physician. A recent article published in a major psychiatric journal states, "Because patients are typically unaware of scientific definitions of clinical syndromes, they may have an inaccurate perception of what their primary problem is" (Ling 9). Ling continues:

Such patients [unaware of the PMDD diagnosis] have not intellectually tied their symptoms to their menstrual cycle. . . . Often, the correct diagnosis will be dependent on extensive patient education and, in some situations, replacing previously received information (9).

This focus on a physician's "educational" role raises further doubts concerning the reliability of self-reporting data. Physicians are encouraged to actively pursue a PMDD diagnosis--women who do not report symptoms associated with the premenstrual period have not "intellectually tied" their negative feelings to their biological processes and it is a physician's responsibility to reeducate these women and recast their experiences in terms of "scientific definitions of clinical syndromes."

A subtle feminist rhetoric pervades Ling's piece. The act of encouraging patients to participate in the diagnostic process is portrayed as empowering for women. Ling recommends using self-reports but states, "Regardless of what method is used to document symptoms, the active involvement of the patient proves helpful as she is less a victim and more a part of the diagnostic process" (10). He further writes, "It is particularly relevant for a patient to be made aware of the scientific basis" regarding her diagnosis and treatment (12). Immediately after this sentence, however, he states, "Currently, without definitive evidence of the exact pathophysiology of this condition, the 'best guess' as to what may be triggering the clinical phenomena may prove useful in discussing treatment options with the patient" (12). Although a woman's participation is necessary to the construction of a psychiatric diagnosis, this participation is cast as an empowering activity for women. Physicians are not coercing women to understand their experiences in a vocabulary compatible with a diagnosis, they are offering women an empowering opportunity to participate in the discovery of the origins of their own behavior. Further, Ling's insistence that the patient be made aware of the scientific basis of the physician's conclusion is somewhat odd when followed by a sentence indicating

that the scientific basis is in fact a “best guess.” It is scientific rhetoric that is encouraged despite the lack of actual empirical data concerning the etiology of PMDD.

In Parlee’s commentary, her second conclusion is that “the placebo effect is reliable, ubiquitous, and substantial” (157). This high placebo effect also raises questions concerning social attitudes towards premenstrual syndrome and its supposed biological correlates. The observed placebo effect in premenstrual research is higher than it has shown to be in other medical research. Possible explanations for this include the fact that women’s attitudes concerning menstruation are highly influenced by societal beliefs and suggestion. Women who believe their negative biology is being suppressed show marked improvement even if they are recipients of a sugar pill. As Parlee concludes, “It seems reasonable to hypothesize that the cultural interpretation of a particular body state influences an individual’s subjected, embodied experiences of a physical condition” (159).

Even in her article in this volume, Gold notes that LLPDD “is a particular pattern of responses made by a woman on a self-rating scale that is method dependent for diagnosis. The external validity of self-rating data has not been fully established. Women view symptoms differently and so differ in their scoring of severity” (179). Despite this fact, Gold concludes, “Women deserve to have PMDD researched, identified, and treated” (181). This pro-women rhetoric presumes the existence of PMDD (it is undeniably there--women *deserve* to have it discovered) despite Gold’s own conclusion that there is no valid method of determining the existence of PMDD/LLPDD. This pseudo-feminist rhetoric merely distracts from the utter lack of empirical basis informing the APA’s position. Stotland, another committee member, also writes, “People have the

symptoms they expect to have and attribute these symptoms to the etiologies their culture accepts” (194).

Severino, also a committee member, concludes the volume:

The difficulty in deciding on a name reflects the difficulty we are having in understanding women and in changing our values. On one level, to those who value ‘nosology,’ the threat is losing a psychiatric diagnosis they believe in, so they fight for classification. To those who value ‘women’s rights,’ the threat is losing credibility, so they fight against stigmatization. . . . Both want to help women. The fight should not be to crush each other’s view, but to support each other as we develop new convictions. We must negotiate a name and a process for understanding the condition that is acceptable to all those threatened by the change, while not sacrificing the goal of understanding and helping women (223).

This fanciful vision of psychiatrists and feminists joining in hands to work for a better future is simply utopian. The differences between the two positions are far deeper than a superficial lack of understanding. Further, Severino’s characterization of the controversy again employs women’s rights rhetoric to characterize the APA’s mission. Both those who value “women’s rights” and those who value “nosology” are simply trying to help women. In her concluding sentence, Severino argues that a name must be developed that will not further threaten those who are against change (implying that the feminist opposition is comprised of stalwart conservatives) and will also achieve the implied goal of the APA, “understanding and helping women.” The APA position is consistently portrayed as progressive, for instance, there is reference to the “development of new

convictions” and “changing values.” By implication, those who oppose the category are those who refuse to move forward with the rest of the scientific community.

Despite certain rhetorical devices, the empirical literature on LLPDD/PMDD-- specifically, the empirical literature interpreted and published by the APA--appears to be fraught with problems. In 1992, Caplan et al. published a critical review of the literature on LLPDD which comes to much the same conclusions as one might expect from the APA given their own framing of the research data. The purpose of Caplan et al.’s review is to examine the research done, specifically using LLPDD criteria and, more generally, to make clear to feminists that the empirical basis of the category is lacking. In other words, the critics are not merely concerned with social implications, they are highlighting bad science. Caplan et al. note the complexity of the issue. For many women, the label of PMS “provides feelings of relief and anxiety reduction” because they are used to being ignored and told that their experiences are imaginary (28-9). Yet, the label can exacerbate anxiety because it pathologizes women and tells them that a natural process is fraught with negative and uncontrollable consequences. Caplan et al. do not come to a conclusion regarding this complexity. They simply point out that a premature conclusion is not supported by the medical literature.

Caplan et al. begin by documenting the problems with conflating PMS and LLPDD (a far greater number of women risk being pathologized if the latter loses its specificity) and bring to light compelling evidence that the distinction between the two is arbitrary and confused. All of the studies they examine use daily reports or prospective self-ratings. They found only five studies that did empirical research using the LLPDD criteria. In all cases, the research proceeded without attention to the question of the

validity of the category. All assumed it to be a valid category and proceeded in this manner instead of trying to establish its validity. Caplan et al. list numerous methodological problems with each study, including such factors as small sample size, inflated statistics, failure to meet LLPDD criteria, and methodological ambiguity. The analysis is exhaustive and specific reiteration is beyond the scope of this analysis. However, despite the stronger framing of Caplan's critique, she makes many of the same arguments that are evidenced in the LR and the subsequent APA publications.

Parlee comments on Caplan et al.'s literature review and offers some criticism of her own. Parlee is concerned that Caplan's challenge will not be persuasive to the psychiatrists who have the decision-making power. What she terms the rhetoric of pseudoscience, rhetoric attacking the scientific evidence on its own grounds, is unproductive because research never meets the criteria it ideally should meet. She states that the key issue should not be what PMS is called, but "how we can understand (theorize) the material and social conditions under which 'PMS talk' occurs and with what effects for women, and how, practically, we can intervene" (107). While Parlee's criticism is valid, it does not follow that critics should not bring to light the deficiencies of scientific research on its own terms. Caplan specializes in research methods, and just because Frances and Gold are unlikely to change their position does not mean her efforts are futile. Further, what Parlee refers to as "PMS talk" often occurs in a scientific context and even when PMS talk circulates in the public sphere, references to scientific authority are often employed and understanding the basis (or lack thereof) for these claims is important.

Caplan eventually resigned from the Task Force because she felt that the committee was not proceeding in a scientific manner. Caplan was not the only one unpersuaded by the scientific data supporting PMDD's inclusion. The APA committee was unable to come to a consensus regarding PMDD's status and Frances decided to call in two outside members who were not on the committee to decide instead. These individuals were John Rush, a specialist in depressive disorders, and Nancy Andreason, a leading proponent of biological theories of psychiatry. These two outsiders decided that PMDD should be listed in the appendix as a category warranting further research; however, in the *DSM-IV* and *DSM-IV-TR*, PMDD also appears in the main text under "depressive disorder not otherwise specified," though a woman could qualify for a PMDD diagnosis without having depression as a symptom.

Several conclusions can be drawn from the scientific literature and the *DSM-IV* process. Despite the emphasis on the scientific nature of the process, the conclusions were not supported by scientific data. The APA's own LR and subsequent analyses are decidedly pessimistic concerning the validity and reliability of the category, so much so that the committee on LLPDD was unable to come to a consensus. PMDD's presence in the *DSM-IV* is less a result of scientific rigor than the ideologies of two non-committee members, Andreason and Rush. Second, there is no clear distinction between PMDD and PMS. Even research using LLPDD criteria is forced to use diagnostic methods identical to those manufactured for PMS. Further, these methods are consistently unable to distinguish between LLPDD sufferers and the normal population. Third, the proponents frame their research in terms of its beneficent impact on women, a strategy which distracts from the lack of empirical data and presupposes the existence of the disorder

despite the paucity of evidence. Finally, the challenges to the LLPDD/PMDD diagnosis are not merely articulated in terms of its negative impact on women--they are specific and thorough challenges to the scientific integrity of the diagnosis. These conclusions will be important later in examinations of how the PMDD controversy is translated into the public sphere as the proponents are considered to be scientists and the opponents anti-science feminists.

### Premenstrual Syndrome and Antidepressants

Prescription drugs are approved by the FDA for specific disorders, but physicians can prescribe any approved drug for any reason they see appropriate. Corporations, however, can only market drugs for the purpose for which they have been approved. If Drug X is FDA-approved to treat insomnia, Corporation Y can advertise Drug X only as an insomnia treatment, but a physician could prescribe Drug X for insomnia, tuberculosis, depression, and overeating. In 1987, Prozac (fluoxetine hydrochloride) was the first SSRI (selective serotonin reuptake inhibitor) approved by the FDA. Initially approved to treat depression, SSRI's and other antidepressants have since been used to treat PMS even though they have not been specifically indicated for PMS.

The first study examining the efficacy of SSRI's for treating PMS/LLPDD was published in 1991, just three years after Prozac came on the market. The study, by Stone et al., diagnosed LLPDD on the basis of self-reports completed over two menstrual cycles. Of the 152 women who completed the self-reports for two months, 110 were found to meet LLPDD criteria--a whopping 72.39%. Throughout the article, PMS and LLPDD are conflated and LLPDD is treated as a specific definition of PMS, not a distinct category. The study first ran a single-blind placebo trial to weed out what they term

“placebo responders.” In other words, the researchers were all aware and the subjects all unaware that all of the subjects were receiving a placebo. Those who showed improvement (judged on the basis of self-reports and interviews) were excluded from the subsequent study. Of the 25 women ultimately chosen to be involved in the study, five women were excluded during the single-blind placebo trial. Thus, this study had only 20 participants, with 10 put on a placebo and 10 on fluoxetine in a double-blind study. In the study, about half of each group experienced negative side effects. The study concluded that fluoxetine was more effective than the placebo because only one in the placebo group improved significantly, compared to 9 in the fluoxetine group.

Though this study has glaring methodological errors--the small sample size and, more significantly, the exclusion of placebo responders at the outset--it illustrates how both the diagnosis and the treatment efficacy are determined solely on the basis of a patient's narrative, namely self-report data. It is thus entirely subjective data that determines what treatments are considered appropriate and what disorders are surmised to be present. Meir Steiner published a similar study in 1995 and reported positive results, though he did not draw attention to the fact that the women experienced a considerable drop in improvement after three cycles, from 55% to only 37% (Luesden). Freeman et al. followed with a study comparing SSRI's to the older tricyclic antidepressants (TCAs) and concluded that SSRIs are more effective at alleviating symptoms than are TCAs (1999). In this study, PMS and PMDD are terms used interchangeably and there is no clear distinction between the two. Dimmock et al. published a review of the literature on antidepressants and premenstrual dysphoria in 2000. They conclude that SSRIs are appropriate first-line treatments for PMS.

Meir Steiner published several articles on SSRIs and PMS in 2000. Steiner is a leading PMDD researcher, and his acknowledgements read like a list of Fortune 500 companies. He concludes an article in *The Lancet*:

I am on the speaker's bureau of Eli Lilly, SmithKline Beecham, Pfizer, Novartis, and Organon and a consultant to Eli Lilly, Pfizer, and SmithKline Beecham. I also hold grants from Eli Lilly, Pfizer, SmithKline Beecham, Glaxo-Wellcome, Merck Sharp and Dohme, Proctor and Gamble, and Berlex.

These companies are all involved in the marketing and production of various psychotropic drugs. In his *Journal of Clinical Psychiatry* article, published in the same year, Steiner does not include this list of corporations. The article does acknowledge that the article was originally presented at a conference in Florida sponsored by Lilly and supported by an "unrestricted educational grant," also from Lilly. Steiner uses PMS and PMDD interchangeably. His *Journal* article states that though the etiology of PMS is "still uncertain," there is growing agreement that PMS and PMDD are "physiologic phenomena, biologically determined and only partially influenced by psycho-social events" (17). His theory is that normal ovarian function "triggers biochemical events both in the brain and peripherally, which in turn unleash the premenstrual syndromes" (18). It is women's normal reproductive cycle that "triggers" the "unleashing" of mood disturbances and physical discomfort. His *Lancet* article (2000a) reviews studies on SSRI's and PMS and states that PMDD is recognized as a "unique disorder" that is "no longer trivialized." He writes that "the political dust seems to have settled ('male physicians have invented and medicalised PMS to further discriminate against women'), and most women with the disorder (and their partners) are extremely grateful that

effective treatment is finally available." Steiner effectively dismisses the "political" opposition--their position sounds ridiculous, simplified as it is in Steiner's article. Further, his assertion that "most women with the disorder are grateful" is not only unsubstantiated in his article, it presupposes the existence of a category the APA has not even officially endorsed. It is not women who are grateful, but specifically women with PMS/PMDD. Again, feminist rhetoric is employed to portray the proponents as the true feminists while the opponents are misguided, backwards, and politically motivated. This framing distracts from the poverty of empirical support for the category.

Subsequent studies have confirmed that SSRI's are an appropriate treatment for PMS/PMDD. Parry (2001) concludes, as per Steiner, that the cause of PMDD is normal hormonal function's effect on the serotonergic system; there is no way to specifically measure serotonin activity. Serotonin levels can be measured in some cases, but these are not accurate measures as most serotonin is found in the gastrointestinal tract and, further, there is no established "normal" level of serotonin. Additionally, even if serotonin levels could be accurately measured, there is no definitive evidence proving how these levels would translate into serotonin activity which is the posited culprit in PMDD and other psychiatric disorders. Further, in this research, the cause is hypothesized from the results in fallacious fashion. Because women feel better when taking SSRIs does not mean serotonin deficiency is the cause of their symptoms. There are many substances which make people feel better and it does not follow that lack of these substances constitutes a causal theory of disorder.

The research on antidepressants is daunting, and Kingwell notes that the serotonin hypothesis is "as question begging as the medieval humors" (92). Indeed, serotonin has

been linked to a variety of disparate psychiatric disorders, including antisocial alcoholism (Laplainen et al. 1998), winter depression (Scwartz et al. 1998), and major depression (Yatham et al. 2000). An unsuccessful attempt has even been made to link serotonin activity to personality differences between African Americans and European Americans (Gelernter et al. 1998). Though the primary purposes of the subsequent criticisms are to understand how scientific discourses circulate in the public sphere and examine how psychiatric diagnoses are constructed rhetorically, the actual impact of SSRIs on women's health is a concern. As David Cohen notes, major new advances in psychiatric treatment are heralded but these celebrations lack a sense of history and context. He writes:

History and context sometimes reveal that a 'revolutionary breakthrough' is a formerly tried and abandoned remedy, a clever marketing strategy, a mass-media-reinforced consumerist pursuit, an uncomplicated placebo effect, an iatrogenic disaster in waiting, or all of the above (206).

Chlorpromazine was heralded as just such a revolutionary breakthrough in 1952, and it was not until the 1980s that the debilitating side effects, namely tardive dyskinesia, were fully documented and appreciated by the psychiatric community. It took thirty years for psychiatrists to recognize that their miracle drug produced far worse disorders than it could possibly take credit for curing. Though the SSRIs have been lauded as particularly safe psychotropics, the long-term side effects are simply unknown. Prozac has only been on the market for less than fifteen years. Given the dark past of psychiatric medications, blind faith in the saving power of SSRIs is premature. The designation of different mind-altering substances as legal and illegal is a highly political and financially influenced

process--to designate unproven remedies as scientifically validated and backed by medical and government authority is a form of subtle coercion that limits individual's free choice. In a country with a "war" on drugs and numerous commercials aimed at diluting the peer pressure many individuals face concerning drug use, it is unfortunate that none of this zealotry is aimed at eliminating the peer pressure constituted by a network of powerful industries, the government, and scientific institutions.

### Women's Voices

In debates over psychiatric diagnosis and treatment, often the voices of those most likely to be affected by the resulting decision are lost. The following is a brief relation of the opinions "everyday people" have expressed concerning the PMDD diagnosis. Caplan initiated petition campaigns to keep PMDD out of the DSM-III-R and the *DSM-IV* and received millions of responses each time. The petitions were sent from professionals and lay people alike, men and women; some were carefully typed, many were handwritten, and one was even hastily scrawled on the back of a napkin and sent in. The opinions expressed in these positions are not a representative sample of the population as they were expressly written to oppose the PMDD inclusion, and the examination of them does not constitute a scientific experiment. However, these petitions are a valuable source for understanding how professionals and lay persons alike understand the DSM process and the potential implications of the PMDD diagnosis. Notably, most of the women acknowledge experiencing premenstrual symptoms, however, they do not want it classified, particularly as a psychiatric disorder.

Cecilia Settino writes, "While I do believe in PMS and the suffering it causes, I do believe that identifying it as a psychiatric disorder will stigmatize women." Rhonda

Harris similarly expresses, “The last thing we need is to have this labelled a psychiatric disorder. As an frequent sufferer of PMS, while I am definitely out of order, I can assure the esteemed medical profession that I am not crazy.” Lynda Lewis writes, “While I do believe that women who suffer from PMS must have their experiences validated, this must happen from a biological and not a psychiatric perspective.” She continues, “It’s not surprising that once again the medical world is attempting to hang a negative label on a normal female experience. What’s frightening is the repercussions of such a move.”

These women, like many others, express a belief in PMS but oppose its categorization as a psychiatric disorder. Though psychiatrists increasingly insist that the differentiation between mental and physical disorders is fallacious because mental disorders are biologically based, this conflation does not seem to have caught on among the general public. Though psychiatrists and politicians revile the “stigma” associated with mental illness, attitudes towards psychiatric disorders are more complex than knee-jerk discrimination. The theory of psychiatric disorder as biological dysfunction implies a lack of control and rational decision-making capacity. To say that PMS symptoms constitute this level of malfunction is to risk portraying women as completely lacking in agency. J. Ruth Hopkins expresses concern that the PMDD diagnosis “could be yet another stumbling block to your equality in the workplace.” Women cannot be trusted in high-level positions if they are susceptible to a disorder that results, according to current scientific theory, from normal hormonal function.

Another concern is the gender-specificity of the diagnosis. Donna Daitchman writes, “Women are connected to their bodies in a way that men are not. If we experience mood swings and food cravings that are cyclical, that does not make us mentally

unstable. We are women; we are not crazy!” The PMDD diagnosis implies that men are the model humans. If women’s normal hormonal function makes them susceptible to psychiatric abnormality, men’s hormonal function is the implicit norm. Women have been trying to upset this notion that men are the norm and women are an inferior copy for centuries, apparently to little avail. Sherry Eshom writes, “The last thing women need is to find another ‘mothers little helper’ in Prozac. We don’t need to be *cured* of a natural biological occurrence! Helped to understand it yes, but treated like a dysfunctional human, no!” Eshom’s comment indicates the rage women feel at being treated like second-class humans compared to a male norm. By correcting a disorder resulting from normal female functioning, the PMDD diagnosis attempts to cure women of their own femaleness and bring them closer to the desired male norm.

Though scientific ideology holds that researchers discover and do not construct or create phenomena, much of the objections to the PMDD diagnosis center around the impacts of the label or category--the implications that the name has for women. Lynda Burke writes, “I find this ‘label’ *oppressive* and *disempowering* of women.” It is women as a collective group that will suffer from the PMDD category. Though Steiner and others insist that individual women will benefit from the diagnosis, women collectively risk stigmatization as they are once again linguistically linked to their inferior bodies in an authoritative discourse. Sharon Haxton agrees, “There is a real danger here that all women will be labelled as mentally ill for at least part of the month. This is nonsense of the first degree.” Blaming women’s discontent on biology obscures any analysis of the material conditions of women’s oppression. Sharon Abbey writes, “The ‘simple’ answer is chemicals to mask the symptoms and sweep them under the rug. I have only recently

given *myself* permission to be angry about this!” A biological theory of women’s discontent implies a biological solution—in this case, medication. The reference to “mother’s little helper” sets the PMDD diagnosis in an historical context where women have frequently been medicated to ‘assist’ them in adapting to their natural female roles.

Elaine Henderson writes, “I totally agree with you and, furthermore, why is it that the men of this world are the ones that are making some major decisions on our behalf. It’s time that we, the women of the world, take charge of our own destinies.” B. Kolar echoes that sentiment:

I say let the gender that suffers from the ‘disorder’ study it and fund appropriate conclusions. Females are at the mercy of male points of view in all areas--from the household to the office to courtrooms to social circles. It is no wonder that we rely on each other to understand how it is that we really feel without being given negative labels such as ‘crazy.’

These women make some important points--they do not dismiss entirely the concept of PMS or the idea that many women experience premenstrual discomfort. They do strongly object to the framing of these experiences by men in terms that imply women are not only second-class humans but irrational and unable to control their own behavior. What these women argue for are new definitions, new rhetoric, to speak about these experiences--rhetoric reflecting women’s experiences that does not simply categorize them as suffering from a biological malady sparked by their oft-blamed ovaries.

Of the millions of petitions, these few samples indicate just a few of the issues of concern to women concerning the PMDD diagnosis. The tone of most of the petitions is angry, indignant, and sarcastic with regards to the APA, but most signal a sense of

solidarity with other women. They speak of the impact to women collectively and their writing implies a similarity among women's experiences. Interestingly, there were no major "pro-PMDD" activities of a grassroots nature among women. Though industry and psychiatry speak the rhetoric of women's empowerment, the basis for these claims is unclear. Just as there is no gold standard for diagnosing PMDD, there is no gold standard for determining what is of benefit and what is of harm for women as a collective group. Even speaking of women as a collective group can get one into trouble for being "essentialist" or crushing diversity. However, a critical problem with the PMDD diagnosis is that it does essentialize women by pathologizing normal female biological processes. The many petitions Caplan received indicate that women do judge psychiatric research on the basis of its social consequences for a disadvantaged group. These narratives are included not to prove definitively that PMDD is bad for women, but to suggest that many women from varied walks of life identify similar concerns about the potential diagnosis.

### Conclusion

The primary purpose of this chapter has been to lay the groundwork for subsequent criticism. In the *Donahue* show and in the Sarafem advertisements, scientific authority is frequently employed and it is necessary to have some basic knowledge of what the actual scientific research says. Science changes as it moves from the technical sphere to the public sphere, often in dramatic and even frightening ways. There are several conclusion to keep in mind that will illuminate arguments made in future chapters. First, there is no clear distinction between PMS and PMDD in the medical literature. The APA's LR examined literature on PMS to come to conclusions about

PMDD; the diagnostic methods are identical, and even current research uses both terms interchangeably. Second, the empirical basis of the PMDD category is weak. The APA committee members own rhetoric indicates a lack of consensus concerning etiology, prevalence, and diagnostic reliability. The fact that the committee was unable to reach a conclusion and the *DSM-IV* decision was ultimately made by outsiders further supports the idea that the science, much less the politics, is poor. Third, the proponents of the diagnosis frequently frame their position with feminist rhetoric, portraying PMDD and the diagnostic process as empowering for women and appreciated by women. Though some women might appreciate the APA decision, large numbers of women are highly concerned about the implications of such a decision for women collectively. Though feminist face something of a double-bind--they want to believe women's narratives while also challenging a stigmatizing label--they are right to criticize the concept of PMDD as a psychiatric disorder. In a society where women still are not equal, such a category is far more likely to be used against women than to their collective benefit.

## CHAPTER 4

### PMDD IN THE PUBLIC SPHERE: PMDD COMES TO DONAHUE

#### Introduction

In the public sphere, science is largely understood as the voice of nature and the unique arbiter of truth or reality (Bird; Fahnestock; Lessl, “Priestly”; “Naturalizing” ). Yet, scientific information changes as it is translated from the technical sphere to the public realm. Dahlgren defines the public sphere as “the historically conditioned social space where information, ideas and debate can circulate in society, and where political opinion can be formed” (ix). Currently, the major institution or locus of the public sphere is television (Carpignano et al.; Dahlgren; Peck). Within the communication discipline, there is considerable debate over the political consequences of television’s prominence. Scholars have pointed to talk shows as a specific genre of television discourse and thus a critical site for examining television’s democratic potential (Carbaugh; Carpignano et al.; Dahlgren; Peck). Carpignano et al. argue that talk shows refute traditional criticisms focusing on television’s negative impact on civil society. Talk shows are a place where the public is the protagonist and conversation and common knowledge are privileged over conflict and expertise. The public depicted as the audience on talk shows can be seen as an extension of the viewing public, “a segment of a generalized collective of common disclosure” (49). Peck contradicts this premise, arguing instead that talk shows provide the illusion of dialogue and participation but are in fact a harmful manifestation

of therapeutic logic where personal solutions are highlighted, occluding social alternatives.

In the following analysis, I examine an episode of *Donahue* entitled “Psychiatrists Want to Classify Women With PMS as Crazy.” The show aired just months before the *DSM-IV* was published and features Paula Caplan, leading opponent of the PMDD classification, and Judith Gold, the APA’s Chair of the Task Force on PMDD for the *DSM-IV*. The show features commentary from audience members and callers as well, thus ‘ordinary’ women are given the opportunity to express their opinions and experiences concerning PMS and PMDD. Despite the controversy over the democratic potential of talk shows, most scholars agree that talk shows, and *Donahue* in particular, are important texts for communication scholars. Though the show is no longer running, at its peak it aired in more than 200 markets and was viewed by 7 to 7.5 million viewers per day (Carbaugh 3). Current talk shows are measured by their success as compared to *Donahue*, and indeed Phil Donahue set the standard for audience-oriented talk shows. Carbaugh writes:

Just as we have learned about Roman society by studying orations in the Assembly, and Colonial society by studying negotiations in the town hall, so we should learn much about contemporary American society by studying the kind of talk that is heard on *Donahue* (6).

There are several notable features about the *Donahue* show. First, the primary audience is white, middle-class women (Carpignano et al.; Peck). *Donahue* has a unique appeal for these women (Carbaugh), and talk shows in general are typically aired after soap operas, slots where many women viewers are expected. Further, the “feminine” format of talk

shows might attract women. These characteristics include open-ended dialogue, a conversational style, a privileging of lay opinion, and a focus on social and relational issues. Second, the success of the show is determined by the host's ability to elicit participation from the audience. Donahue states in his autobiography, "Without the audience, there's no *Donahue* show!" (236). Further, a magazine study found that Donahue spends less than 22.2% of the show speaking himself, a lower percentage than Oprah, Jerry Springer, Joan Rivers, Geraldo, Maury Povich, and Montel Williams (*Pittsburgh Post-Gazette* D7).

In the following analysis, I come to ambivalent conclusions concerning the emancipatory potential of talk television. The inherent nature of the television medium makes it unsuitable for conveying information of a scientific or technical nature. Limitations include time constraints and the necessity of making information intelligible to a popular audience. Nelkin notes that popular depictions of science often ignore the actual substance of the research and focus on more 'newsworthy' topics such as miracle cures and social controversies. When research is noted, it is referenced in such a way that it appears as "an arcane, esoteric, mysterious activity that is beyond the comprehension of normal human beings" (17). In the show, Gold and Caplan do not have time to fully develop their positions or explain the scientific research they reference. Further, Donahue frames the controversy in such a way as to give credence to Gold's perspective as supported by scientific research carried out in the technical sphere while Caplan is represented as politically and ideologically influenced.

Despite these limitations, the show provides an important forum for women (and men) to air their perspectives on the controversial diagnosis and share their own

experiences of PMS. Ordinary women are heard and they are able to challenge expert authority with the evidence of their own experiences. However, despite this potential opportunity for empowerment, it is unclear if such talk show resistance has an impact beyond its therapeutic function. Despite widespread protest by women, the decision to include PMDD in the DSM was made by psychiatrists on the basis of “science” and women’s objections were irrelevant to this decision. Thus, even if talk shows function in a democratic manner, it is unclear that they have the ability to affect concrete decisions that have considerable social import.

### Scientific Controversy and Media Framing

Though the show features Caplan and Gold, audience members and callers interrupt frequently and the experts’ dialogue is interspersed with commentary and questions from the audience. In the first part of this analysis, I will examine the way Donahue mediates the debate between Gold and Caplan and the rhetoric the two experts use to frame their arguments. In the second section, I will turn to examine the content of this ‘lay’ commentary.

The title of the show, “Psychiatrists Want to Classify Women With PMS as Crazy,” is notable. Talk shows thrive on presenting controversial and interesting topics, and the PMDD controversy is portrayed in as colorful a fashion as possible. The differences between PMS and PMDD are completely abolished—it is PMS, an experience common to many women, that is the subject of potential classification. Further, these psychiatrists want to classify PMS-sufferers as “crazy,” a characterization of mental disorders far from the neutral, scientific language preferred by the APA. Donahue begins his show by stating, “A lot of women have PMS. And it isn’t funny if

you have it . . . Show me a woman with PMS and I'll show you a woman who has a problem with her head." Donahue deliberately portrays the controversy in dramatic terms—women with PMS are crazy and have problems with their heads.

Almost immediately, Donahue is challenged. An older woman asks why a woman with PMS should be said to have a problem with her head. Donahue's opening statement is indicative of his overall aim of eliciting participation from the audience. He consistently portrays things in dramatic and extreme terms in the hopes of eliciting responses. This immediate challenge also indicates that the audience is familiar with the norms of talk shows, particularly *Donahue*, and are not afraid to speak out of turn or interrupt even their host. Donahue responds to this woman:

Because the brain is a hormonally, biochemically charged organ and some women, at a certain time of month, get moody, get cranky, start to create fights and other things happen that don't happen throughout the rest of the month.

Donahue does not specifically reference science in making this claim, but it is the implied authority for his argument. The terms "hormonally" and "biochemically" are medial and biological terms, and Donahue asserts their relevance to PMS as if it were a proven fact. Though Donahue might just be trying to elicit further response and interaction, these subtle appeals to scientific 'reality' appear throughout the show. In this instance, he does elicit a response from the elderly woman who replies, "Well, then, by the same token, if you have something wrong with you and your hormones are not balanced, you've got something wrong with your head." The audience is predictably amused—their ensuing laughter again testifies to the informal nature of the show where Donahue is less of an authority than a mediator of dialogue.

Donahue turns to introduce Caplan, psychologist, specialist in research methods, and previously a member of the APA's committee to determine the status of PMDD. Donahue segues by asking her if she agrees with the outspoken audience member. Here, the expert is asked if she agrees with the lay opinion—her authority is not presupposed in this forum. Caplan replies:

She made, actually, the key point, which is what we know is that both men and women experience some cycles in their hormones and their behavior changes accordingly. And the American Psychiatric Association is just saying that women have a mental disorder when this happens to them. If I told you, Phil, that black people and white people have these hormonally-based cycles, they change their behavior, but we're just going to say that black people are psychiatrically disordered, you would be appalled. You would see that that's deeply racist. Nobody at the American Psychiatric Association is talking about sexism in just saying that women are mentally ill in this way.

Caplan continues to perpetuate the informal atmosphere of the forum. She refers to the host on a first name basis and avoids scientific jargon and technical rhetoric. She privileges the lay audience member by portraying the audience member's commentary as the articulation of the critical point at the heart of the PMDD conflict. However, Caplan does not challenge the concepts of science or scientific research. Her use of "we," for instance, "what we know," situates her as a member of the scientific community and a committed researcher. Her implicit argument is not that science is harmful in itself, rather, it is a *selective* enterprise—certain issues are focused on and become intelligible objects of research while others are ignored. Even if research can reveal underlying

causal mechanisms of human behavior, a point Caplan explicitly makes, focusing on only one group, namely a disadvantaged group, is a political decision and has nothing to do with the veracity of scientific methodology.

Second, though some critics have frowned on analogies comparing women with blacks, Caplan's analogy is apt. Because the associations between women, hormones, and erratic behavior are so firmly engrained in most people's worldviews, she must defamiliarize this perception and persuade her audience that such a belief is not 'true' but in fact discriminatory. By comparing the APA position with a racist ideology most will recognize as problematic, Caplan is attempting to sever the links between women and their hormones that appear natural and commonsensical to most people.

Donahue responds:

But why do you care what someone may do with what is the reality of a mood-altering situation that millions and millions of women feel? . . . To hell with the people who want to [distort the category]. For example, you wouldn't call me racist if I told you that blacks are more likely to get sickle-cell anemia than—than Caucasians. . . . So, if that's the case, why should it be any different with something that happens to the brain?

Donahue is maintaining the informal nature of the show (his use of "hell" would be unprofessional in a more formal setting), but his response indicates a growing antagonism between Donahue and Caplan. Despite Caplan's analogy and other attempts to defamiliarize the linkages between women and their hormones, Donahue remains fixated on the 'reality' of this link throughout the show and this is consistently revealed in the ways he frames the conversation. In his response, the theory that premenstrual symptoms

are the result of a physiological brain malfunction precipitated by hormonal activity is taken for granted as a “reality.” Further, Donahue responds to Caplan’s race analogy by using sickle-cell anemia, a known physical disorder, as a counter-example. This again naturalizes the idea that PMS is caused by biological factors and is analogous to a physical disease such as diabetes.

Donahue’s counter-example does not respond to the argument implicit in Caplan’s analogy. Caplan is arguing against the selectivity of research and classification. Research has been done concerning sickle-cell anemia in other populations and has not been isolated to black populations. However, hormone research is done almost exclusively on women. Donahue’s response further indicates the extent to which he takes for granted the women/hormone links—like sickle-cell anemia, he assumes that the linkages have been definitively proven through accurate and unbiased research. Donahue further portrays an image of scientific research as a neutral activity divorced from political and social concerns. PMDD is a “reality,” and those who would manipulate this “reality” and use it for negative political ends are not the same individuals who discover and document this reality. Scientists carry out a function of divining truth from nature and cannot be responsible for the consequences of the truths that they reveal.

Caplan responds, stating that two types of women must be considered—those who have primarily physical symptoms and thus have a medical problem and then “we’ve got some women who describe themselves and experience depression or irritability or anger or whatever and it seems to them that that is worst just before their period. Now, even if-” Donahue interrupts, “Are you denying that that happens?” Already, Caplan’s motives are cast into doubt. Her dialogue indicates that women reporting PMS symptoms are

reporting subjective experiences, how things “seem to them,” a statement that psychiatrists and researchers do not deny. Yet, Donahue takes this noting of the subjectivity of self-reporting data to be a refutation of women’s narratives and by implication a lack of respect for women who claim to have PMS. Caplan replies:

I believe what women tell me, but what I—I want to say two things. One is that the research shows that when women say, “I have PMS. My moods gets worse at this time of the month,” if they are studied, if they’re asked to keep records and so on, it turns out that isn’t what happens. And secondly, I want to say that—

Donahue again interrupts, adamantly asking, “So what they say happens doesn’t happen?” and Caplan responds:

No. No. They—because they are told that women are the prisoners of their raging hormones, they feel—they often feel that it must get worse then. And a lot of women—and this has been documented in research—a lot of women who say that they have PMS, what they’re doing is they’re feeling normal or justifiable anger or irritability or depression. Their life situations have been shown to be bad. And they feel that because they’re female, in order to get angry or act irritable, they have to blame it on something because they’re not supposed to be acting that way.

The dialogue, better characterized as a debate here, continues:

D: But why would you choose a false motive to describe the real symptoms that these women feel?

C: It’s not women making it up. It’s—

D: It if comes at a certain time of the calendar month, of the lunar menstrual cycle, whatever we want to call it—if it comes on the 16<sup>th</sup> day or whatever it is, 14<sup>th</sup>, I mean, isn't the evidence incontrovertible that the—

C: No.

D: --hormonal changes undergone by women during a time of menstruation in some cases alters the hormonal balance in the brain and causes certain resulting mood swings.

C: Well, it—

D: What's so mysterious about this?

C: But first of all, the research has shown that, for example, depression doesn't happen more premenstrually. And secondly, the research has shown that if you—somebody took a questionnaire with all the menstrual symptoms. They took out “breast tenderness,” because that's only applied to women. They asked women and men to keep a record of their moods and behavior and so on every day for several months. The men were reporting more symptoms, especially irritability—than the women. . . . We—our society encourages women to blame their anger and irritability on their hormones because then we don't have to deal with the real reasons women get upset. . . . And they discourage men from saying, “Oh, my testosterone must be up so I'll stay away from my wife so I won't beat her.

In this exchange, Donahue is implicitly constructing a specific version of science that simultaneously casts a negative light on Caplan's motives. Donahue's position is clear: something “really” happens to women, determinate experiences that can be transmitted linguistically in a definitive form. There is nothing “mysterious” about this

process, no ‘more than meets the eye’ factors that might influence a woman or scientists. In this image, women reporting their symptoms in this manner have not been influenced or persuaded in any fashion, there is no power of suggestion at play in this reporting, it is the neutral and accurate transmission of “reality.” The charting schematics used to document PMS are the language of nature or reality, and any other template to interpret women’s experiences has something to do with unsavory persuasion and “false motives.”

Donahue categorizes Caplan’s position as “false motives,” but it is unclear what he is referring to. The concept of “motive” implies deliberate intent, and it is unclear whose intentions are “false.” Throughout, Donahue implies that Caplan is politically motivated and has some hidden agenda that drives her opposition to neutral scientific research. His characterization further reveals the extent to which the women/hormones linkages are naturalized and thought of as common knowledge—he refers to the “incontrovertible” evidence though he does not specifically describe what evidence he is referring to.

Donahue’s framing puts Caplan in a difficult position. This is an example of the double-bind feminist critics of medical categories face (described in previous chapters). If critics object to the political consequences of classifications, they are accused of denying the reality of women’s experiences and turning a cold shoulder to women’s narratives. It is difficult to articulate the consequences such categories have on women collectively without falling victim to charges that one is hostile to individual women. In the talk show format, it is even more difficult to articulate this position given the time constraints and the constant interruptions and accusations of the host. Caplan’s argument is not that women do not have particular experiences, instead she is arguing that some women are

persuaded to view their experiences in a particular way and understand them through particular lenses. She does cite and describe research indicating that both men and women feel particular symptoms but only in the case of women are these symptoms attributed to biology, as only for women do these symptoms violate one's 'natural' role. Men are not encouraged to interpret their experiences through similar prisms as their 'symptoms' are consistent with prevailing norms of masculinity.

Donahue introduces Judith Gold, who begins with the statement:

The task force looked very carefully at research regarding PMS. However, we're not really interested in premenstrual syndromes by themselves. Most women do have some premenstrual symptoms. They are not mentally disordered. Most women have premenstrual symptoms. They might have bad times in the month. But that's the way it is. It happens for a few days. You do various things and life goes on. What we're talking about is a very tiny group of women who get severely depressed for eight to ten days every month most of the year and who normally cope very well. They're usually very competent mothers, at work or whatever they do, and then something happens and all of a sudden you get a woman who is really, really, depressed. She doesn't want to get out of bed in the morning. She can't eat. She can't sleep. She can't concentrate. She's forgetful. She might even be suicidal. She has a true depression and she only gets it just before her period and once her period starts, within a day or two it all vanishes.

From the outset, Gold is attempting to distinguish PMDD from PMS. Though her group examined the PMS research, they were "not really interested" in PMS. PMDD is characterized not as a hormonal imbalance but a "true depression." According to Gold's

characterization, the symptoms of PMS are common and relatively minor while PMDD is rare and the symptoms are truly debilitating. This strategy of distancing PMS from PMDD is in tension with the surrounding dialogue and the title of the show. Gold, however, has an incentive to make the distinction to avoid the claim that PMDD pathologizes all women—by her own admission, practically all women suffer from PMS. Further, by characterizing PMDD as a depression, Gold sets the groundwork for justifying the inclusion of PMDD in a manual of mental disorders as opposed to a traditional medical manual.

The ensuing dialogue illustrates the confusion:

D: But you don't want to call that a mental disorder. Is that your grievance with my explanation?

G: We are calling—no, I'm sorry. We are calling that tiny group of women “depressed” related to the premenstrual period. However, we are not moving it anywhere in the manual. . . . But we have not moved it anywhere in the manual. All we have done is said—before, in the manual, it was “unspecified illness.” Now it's—we've just put it under “depression, unspecified.” We have done nothing else.

In a format centered on a lay audience, Gold's response is unduly confusing. She states that the APA is not moving the disorder, yet she also states that they are moving it from “unspecified illness” to “depression, unspecified.” The audience is unlikely to be familiar with the precise meanings of “unspecified” and the significance of where the disorder is placed in the manual. Further, Gold's attempts to differentiate PMS from PMDD fall on deaf ears. Immediately after her introduction, Donahue cites statistics, shown to the

audience and the television viewers in the form of a graphic, illustrating the prevalence and common symptoms of PMS. Gold states:

I'm saying that premenstrual syndromes are not a mental illness and in no way constitute a mental illness. . . . All we're talking about, as psychiatrists who are very concerned about women's health and very concerned that women get proper treatment, that it's a small group of women, perhaps fewer than 3 percent of the general population, actually get so depressed that they might kill themselves, then I think that we have a problem we should look at and treat. And you can't treat it if you don't define the thing.

Gold again emphasizes the minimal impact of PMDD and its distinction from PMS. Also, this is the first time that Gold begins to frame the APA's position as empowering for women. The psychiatrists are interested in women's health. Further, this is the beginning of discussion about the significance of the PMDD label. According to Gold, "you can't treat it if you don't define the thing." Yet, this statement presupposes the existence of PMDD, a "thing" in need of a name. Gold states that PMDD cannot be treated if it is not named, but she does not explain this assertion. At the time of the show, Sarafem was years from FDA approval and probably had not yet entered the heads of Lilly marketers. There were no distinct treatments for either PMS or depression related to the menstrual cycle. Thus, it is unclear from Gold's remark why the PMDD label is necessary.

A later encounter between Gold and Caplan further illustrate the confusion surrounding Gold's attempts to distinguish PMS from PMDD:

C: The problem is—you see I believe that women get depressed and I believe that women get irritable but, A, let's not forget, so do men. And B, if there's a

hormonal link—you see how dangerous it is to say, “Oh, it’s hormonally based,” because only women can go crazy in this way or can be mentally ill in this way.”

G: We’re not saying it’s hormonally based. It isn’t hormonally based.

C: Then if it’s not hormonally based, then don’t link it to PMS. Say they’re depressed. Well, there’s already depression in the DSM.

G: Well, Paula—Paula, it’s linked—it’s not hormonally based. Research has shown very clearly that estrogen and progesterone have nothing to do with it. The link it has with the premenstrual cycle is that that’s when it happens to occur during the month. It is a depression. It just happens that it only occurs in women.

And, as Phil said, men don’t menstruate. . . . Maybe men are cyclical, but whether they are or not, we can’t take away the fact that some women do have this. . . .

And why do we always have to look at men? Why can’t we make sure women are all right first?

C: Because why do we always have to look at women and say they are sick?

Gold claims that PMDD is not hormonally based which is significant since much of the research on PMDD cited in the previous chapter makes just this link as do the Sarafem advertisements that will be explored in the next chapter. Caplan is objecting to the *name* of the category as the very word “premenstrual” connotes a hormonal linkage. Gold responds that PMDD is a depression that only occurs in women. The only link to the menstrual cycle is the time at which the depression occurs. According to this articulation by Gold, women’s menstrual cycles are taken to be the definitive orientation around which their lives operate and even events that are by all other accounts unrelated to menstruation are best articulated in terms of their relation to this cycle. Gold further

characterizes her position as pro-women by asking why research on men must be done as women “do have this” regardless of whether men are cyclical or not. By implication, research done on women is inherently empowering and beneficial for women regardless of its theoretical position or its conclusions.

A similar encounter occurs later:

C: And anybody, whether it’s a psychiatrist or a general practitioner—if you call it “premenstrual dysphoric disorder,” they’re going to be thinking about your hormones.

G: But we would not call that “premenstrual dysphoric disorder” because she’s already upset and worried about something and it gets worse just before her period. That is not premenstrual dysphoric disorder.

D: Dr. Caplan, it does look as though you are very, very influenced—and I don’t want to convict you for this—why can’t we just have the medical research happen and—and express itself in double-blind studies and however they’re doing it now—for its own—for its own virtue of—of discovery and to hell with who may bastardize the research or use it to—as a prejudice against women? It is not the psychiatric community’s responsibility to be intimidated or in any way influenced by what some male-dominated culture may do to women because of what they understand the APA to have come to a conclusion about regarding PMS.

Again, Caplan’s objection is to the name for the proposed category as the very label “premenstrual” connotes hormonal linkages. Donahue’s response to Caplan’s objections is indicative of the ways the media often frames science as an arcane and otherworldly activity that provides a neutral basis for social policy. In his reply, there is no agent doing

the medical research, it simply “happens.” The research does not rely on any interpretive activity, it “expresses itself” and has some intrinsic “virtue” that is irrelevant of its consequences or conclusions. Further, the scientific activity is portrayed as something inaccessible to the lay community and uncontaminated by the social realm. Donahue’s reference to “double-blind studies or however *they’re* doing it now” implies that what scientists do is beyond the precise grasp of the lay person and is progressing at such a rate that the ordinary person simply could not keep up. Scientists have no responsibility for the consequences of their research activity—they are explicitly reprimanded for potentially being “influenced or intimidated” by the male-dominated society. This phrasing implies that scientists stand outside of this society and are pure from social influences. Scientists cannot be the same ones who “bastardize” the research—those who deliberately distort scientific findings are at fault but science merely speaks nature’s truths. Scientists are wholly innocent, it is malicious societal forces who are to blame for undesirable consequences.

Though the psychiatric community is to avoid influence and intimidation, Donahue states that Caplan seems “very, very influenced.” Despite Caplan’s consistent references to scientific research that calls into question the validity of the PMDD diagnosis and its classification, Donahue consistently portrays Caplan as politically motivated and opposed to scientific activity. Though scientists are exempt from the pernicious effects of persuasion, Caplan has been “influenced” into thinking that the category is problematic. By implication, she is unable to see with pure vision the truths nature will reveal, she is blinded by social influences. As Nelkin notes, science journalists frequently portray science as pure and arcane while those heretics challenging the

dominant view are portrayed as feminists, Marxists, or otherwise deceived. Donahue makes a similar challenge to Caplan later:

C: We've got to realize it's a society that is more biased against women than men, so anything that can be used against women is used against women.

D: So therefore you seem to be arguing for an arresting of the research that's—

C: No! I think we should take an honest look at the research and the research shows that men have hormones and cyclical behavior as well. . . . This is a very political definition of mental illness. And we were talking about it being applied to millions of women. That's the danger.

Caplan is refuting Donahue's presumption that science is a neutral activity justly exonerated from its social and political consequences. She consistently draws attention to the selectivity of the scientific enterprise—only women are presumed to have negative hormonal fluctuations, while men's cyclicity is ignored. Yet, Donahue interprets this criticism as an opposition to the entirety of the scientific enterprise, despite the fact that Caplan enjoys a prominent career as a scientist. He accuses her of “arguing for an arresting of the research,” again implying that research has intrinsic virtue regardless of its chosen parameters or potential social implications.

Gold enters this exchange:

I'm sorry. We're trying to do something in the benefit of women's health. You know that there's been almost no research in this country into women's health, other than into breast or ovarian cancer. All the research studies are on men.

Research into heart disease, that tells women what they should and shouldn't eat and what they can do, has all been done on men. All the cholesterol research that

tells you what your cholesterol level should be, that's all been done on men. There is nothing—somehow, it just hasn't occurred to anybody to do research on women. We aren't saying—look, some women, a tiny group of women, get really depressed. We have encouraged research in the area. . . . We're benefiting women.

Gold echoes Donahue's assertion that research is beneficial in its own right. It has an intrinsic normative value completely independent of its consequences. Further, Gold's remark is internally contradictory. As the past two chapters have illustrated, there has been an incredible amount of research done on women, particularly women's menstrual cycles. The assertion that "it just hasn't occurred to anybody to do research on women" ignores centuries of research done specifically on women and their biological differences. Psychiatric research in particular has focused most extensively on women (Lunbeck). Gold's examples of research gaps are heart disease and cholesterol research and her tone is somewhat dismissive of the research that has been done on women in the areas of breast and ovarian cancer. These latter two areas are women-specific diseases—Gold is generally castigating scientists for ignoring women in research areas that implicate both genders. Yet the research she is promoting is more research focusing on women's difference, not research intended to rectify the lack of women in gender-neutral areas. Gold does not explain how the APA is "benefiting women," it is simply assumed that research done on women will help them, a decidedly ahistorical claim.

To this point, the analysis has focused on the exchanges between Caplan, Gold, and Donahue. These exchanges illustrate how science is framed in the media. Donahue portrays science as a neutral and pure activity carried out in a sphere inaccessible to the

general public. He does not specifically describe any research, he merely assumes that it substantiates the ideas that many people take for common sense, historically conditioned ideas linking women's undesirable behavior to their hormones. When challenges to this position arise—even when they are substantiated by actual descriptions of scientific research—they are portrayed as political and “influenced.” Gold further this framing by highlighting research on women as an inherent good regardless of its selectivity. Now, I would like to turn and examine the comments made by audience members and callers. These comments are enlightening and they help to understand how the general public, particularly women, understand the scientific enterprise and the implications of the PMDD categorization more generally.

#### Talking Back: Diverse Perspectives on PMDD

As evident in the initial exchange between Donahue and an audience member previously described, ‘talking back’ is a normal part of talk shows. Donahue, the host, has no special authority and he functions as an intermediary though he is able to frame the conflicts in particular ways. The visual aspects of the show encourage an informal and intimate encounter, the fact that the audience is called ‘guests’ and Donahue a ‘host’ further this atmosphere. The show set-up is similar to an intimate amphitheater. Though the featured guests are seated on the ‘stage,’ there is no clear front and back. Donahue constantly moves about among the guests, and the camera moves around the theater to further the illusion of an informal chat that might occur in a living room or garden room. Even when the experts speak, the camera frequently pans in to close-ups of audience members’ faces, illustrating that the audience is the true center of the show and their reactions are the standard for judging the outcomes of the conflicts that arise between the

experts. Viewers can see the camera and sound crew in the background at times—this gives the impression that the show is not ‘staged’ but is an actual, live encounter. The viewers are able to see everything that the audience can see and are subtly encouraged to identify with the audience. As Peck notes, viewers of talk shows frequently state that the audience members ask the same questions they would like to ask, indicating that these identificatory strategies are successful. Throughout the show, the audience interrupts the expert dialogue with laughter and applause, a constant reminder of their presence and their centrality in the show. In this particular show, the camera pans an audience largely composed of middle-class, white women. Most appear to be middle-aged. For the most part, the men on the show are also white and are clumped together in the back rows. Further, two ‘lay’ women sit on the stage with Caplan and Gold and share their experiences with PMS, again emphasizing that expert and scientific knowledge do not have the authority here that they might enjoy in more formal settings.

One of the first audience members to speak up states, “I think the psychiatrists or psychologists in the *DSM III* is helping, not hurting. I think you’re—you’re making it very negative. I think it’s to help women that are having trouble with this--” Donahue interrupts to clarify that she is addressing Caplan and she continues, “I think—I mean, not—not to be rude or anything, but I think that it’s true. You know, there have been studies that show that women do commit suicide more when they do have PMS.” This initial response further illustrates the participatory nature of the talk show. This woman does not speak in an expert or even particularly confident manner—she prefaces her statements with “I think” and states that she does not want to be rude in challenging Caplan’s perspective. Her sentences are not all grammatically correct, yet she still talks

back to Caplan, introduced as an expert, and even goes so far as to tell Caplan what the state of PMS research is. This audience member is one of the few, however, that is sympathetic to the diagnosis.

Later in the show, a caller voices her opinion:

I wanted to say that I think it's absolutely appalling that doctors like Dr. Gold want to classify PMS as a mental disorder. I am 22 years old and I suffer from PMS. My mother also suffers from PMS severely. I don't think it's a mental disorder. I think I am a physical human being, just—just as a male, who is—who can possibly be labeled “cyclical,” too, but they're not labeled “mentally ill.”

This woman and many others on the show express that they suffer from PMS or some form of premenstrual discomfort but are troubled by the categorization or classification proposal. Though Gold replies to this woman, stating that mental and physical disorders are equivalent, “If you have a mental illness, it's like any other physical illness. There's no shame to it,” the audience is not receptive to this equation. The concept of a “mental disorder” still carries a stigma in the general public, and the selectivity of the PMDD diagnosis heightens the apprehension over this classification.

Another caller shares her experiences:

Extreme anger. I have a lot of aggressive feelings that I don't usually feel the other times in the month; very, very irritable. I get—very, very stupid things that wouldn't ever bother me ordinarily—completely knock me down and—

D: But you're nervous about the APA putting this in some—

Caller: Sure, because there's a lot of people that would misconstrue that and would—be prejudiced—right, would be very prejudiced against hiring or in any other respect. It would be horrible.

This caller experiences PMS but fears the social ramifications of a psychiatric classification. Her expression of PMS is similar to that voiced by other women—aggressive feelings and irritability.

Another caller states:

I wanted to say that I'm home today with PMS. . . . And it is very irritating when you get an employer who will dismiss your comment because they'll be saying that you're PMS'ing. We are a tight group of people that are working together and they'd be saying, "Oh, you're PMS'ing. Let's"—you know. "You're getting upset over nothing."

This woman experiences PMS, but she is angered that the classification is used to dismiss any and every form of discontent she might express. Women desire to have their physical experiences validated and understood, yet they also want space to express true discontent and displeasure without having this behavior attributed to a PMS classification.

Lori Eastman, one of the women sitting with Gold and Caplan, shares her PMS experiences. A male coworker hung up the phone on her:

I was angry. I headed for that room and my boss had already heard about it and she met me at the door and she tried to soothe it over. And I listened to her and the minute she walked away, I headed for this guy and I said, "Don't you ever hang up the phone on me again or you're going to have a power outage!" And he said, "You can't talk to me like that." And I said, "I just did" and walked off. And

that was very normal for me to behave like that. [but the next day] “What was I so angry about?” But in a way, for a while, that behavior was applauded. I got my job done. I got people to do what I wanted them to.

This narrative attests to the ambivalence women often have regarding their own experiences. This woman attributes her angry behaviors to PMS, but she acknowledges that they were useful and possibly even necessary to complete her job adequately and “get people to do what I wanted them to.” Further, the initial cause of her anger appears entirely justified—a coworker rudely hung up on her then condescendingly declared that she “can’t talk to me like that.” Though this woman’s narrative is heuristic on its own, it is possible that this woman is uncomfortable behaving in ‘unfeminine’ ways as required by her job and feels that this behavior must be attributed to her biological processes.

A later caller is particularly outraged at the APA proposal:

Yes. I just want to say that, like, that man in the audience was very angry. He’s saying he’s defending men. But men—these symptoms these women are talking about are what men do all the time. They’re violent towards women. They beat up on women. They start fights to go after each other. They’re always and they even write off their little promiscuous behavior, their sluttish behavior as, “Oh, that’s all. They’ve just got to have sex because of their hormones.” Women suffer from men’s HTS, high testosterone syndrome, and nothing is ever said about that.

Though Donahue and Gold portray science as a neutral activity without social responsibility, many of the women who speak indicate a concern over the social consequences of the category. This concern is born from their experiences with the PMS classification. This woman specifically expresses a concern over the selectivity of the

PMS/PMDD classification—symptoms men display all of the time are pathological when they are exhibited by women.

A younger woman says:

Like, you know, women can have bad days because guys classify it as PMS. You know, every time girls have bad days, they're, like, you know, the guys are, like, "Oh God," you know, "she's having a bad day, PMS. Go give her some Midol. But guys don't take this seriously. The always—Midol and, you know, it's like, girls do have bad days and we do suffer from it, but guys are always like, classifying it and—

Again, though this woman's response is somewhat muddled, her comments illustrate the ambivalence felt over PMS classifications. Though women suffer from PMS, society, specifically "guys" in this account, uses the classification to dismiss undesirable behavior of all sorts. This trivialization of PMS not only allows the category itself to function in dangerous ways, it means that actual premenstrual discomfort is not taken seriously. These narratives indicate that the double-bind faced by feminist critics is also a tension felt by ordinary women concerning their own experiences. The dilemma is finding a way to validate women's experiences that will not result in another method of discrimination. Though women express experiences that can be described as "PMS," they are deeply troubled about the way the label itself functions in social interactions.

These narratives indicate that the attempted distinction Gold tries to make between PMS and PMDD does not resonate with the lay audience. Women object to the PMDD classification on the basis of their negative experiences with the PMS classification, and the relation of PMS experiences indicates that PMDD is understood as

a psychiatric categorization of PMS. Further, the scientific authority Donahue attributes to the psychiatric community is not a persuasive appeal for most of the audience. The concerns expressed are related to the social implications of the categorization and there is an implicit understanding that the psychiatrists are responsible for any ammunition they provide to a male-dominated society. Gold's position that the research will benefit women is specifically challenged by these narratives. These women use their own experiences as authority, not scientific data.

Campbell defines feminine style as displaying a personal tone, using personal experience, anecdotes, and examples, encouraging audience participation and identification. In these narratives, women speak in intimate, casual and informal tones, drawing on their own life experiences to challenge scientific data. Dow and Tonn note that because the demands of the public discourse favor a male rhetor, women are often excluded from expressing themselves. On the *Donahue* episode, women are able to express themselves in their 'native tongue,' relying on their own experiences to speak back to the authority of science. Thus, the show indicates that the APA position is not hegemonic. Proclamations made by scientists are not heralded as definitive truth and in the talk show forum science is not given any particular authority. Traditional feminine modes of speaking are valued more than the scientific voice and women are able to express themselves in a public realm without conforming to masculine standards. These narratives indicate that women do resist the PMDD classification and the APA's scientific rhetoric is hardly omnipotent.

### Conclusion

As highlighted above, the conclusions are ambivalent. The *Donahue* show reveals that science is understood and portrayed in particular ways in the media. Donahue portrays science as a neutral and beneficent activity that is carried out in an inaccessible technical sphere. Objections to the dominant beliefs are portrayed as political and biased in opposition with pure science. The television medium is poor for conveying scientific disputes—throughout the show, research is mentioned and used as an authority but there is limited time to articulate the precise dimensions of the research. Yet, despite these framing techniques, talk shows do have some democratic potential. Throughout the PMDD debate, rarely are the voices and opinions of actual women heard. In this show, women can speak and not only share their experiences but challenge the expert positions. Though this discourse is therapeutic in some sense—women share their personal experiences and disclose intimate information—the emancipatory nature of the show goes beyond these therapeutic elements. In women’s challenges, there is a marked focus on the social nature of discrimination and the social consequences of the psychiatric classification. Therapeutic discourse, by definition, posits that individual change is necessary rather than a social focus. In these discourses, there is much attention paid to the social. Though talk shows might structurally operate in therapeutic fashion, they also operate in democratic function and they do not structurally exclude social criticisms. This liberatory potential only goes so far. Despite the resistance of women, the APA did put PMDD in the *DSM-IV*. Though individual women might not ‘buy in’ to this mentality, they are subject to the very social consequences they predicted. Thus, though talk shows

might be a democratic site, it is unclear that the participants have any real power to affect the decisions made that have considerable social import.

## CHAPTER 5

### SELLING SARAFEM: THE NORMALIZATION OF PMDD IN POPULAR DISCOURSE

#### Introduction

Though rhetorical scholars have noted a reluctance on the part of scientists to popularize science or speak about scientific research to a lay audience (McCall; Dunwoody and Ryan), the public sphere is suffused with appeals to scientific authority. Often, these appeals are made by corporations and politicians--science has achieved an institutional centrality in modern life and it is increasingly difficult to draw distinctions between science, government, and industry. Thomas Szasz coined the term "therapeutic state" in 1963 to denote the union of medical science and the state. Dana Cloud has also seized on the idea of therapy to develop a rhetorical theory. Therapeutic discourse features depictions of the social as the personal and stymies social change and collective action by encouraging individuals to turn inward in the search for answers. Modern psychiatric discourse is an instance of therapeutic rhetoric and, institutionally, the alliance of psychiatric, corporate, and political interests constitutes a therapeutic state. The purpose of the following analysis is not to document this alliance as others have excelled in this area,<sup>1</sup> but to examine how this therapeutic rhetoric operates at the social level.

Though mental disorders are constructed by scientists, one of the major sources of information accessible to the public about psychiatric disorders and available treatments

is direct-to-consumer (DTC) advertisements for pharmaceutical products. Advertising is a type of "social glue" that brings together certain parts of society and communicates social norms and taboos (Cook; Goffman; Merskin). As Cortese writes, "Advertising is one of the most powerful mechanisms through which members of a society assimilate their cultural heritage and cultural ideologies" (2). Cloud indicates that advertising itself is a form of therapeutic rhetoric--by portraying the acts of purchase and consumption as empowering, attention is diverted from changing social structures. Pharmaceutical advertisements are unique since prescription drugs can only be purchased with the authorization of a physician. Thus, they cannot encourage consumers to purchase the product directly, instead they must persuade their audience to seek a physician's advice and obtain permission to purchase the product. Though many advertisements employ scientific appeals, prescription drugs advertisements enjoy a uniquely powerful scientific ethos as their products are backed by medical authorities. DTC ads have recently proliferated, and FDA oversight is often inadequate due to resource shortage and lack of accurate information (Afield 2001; Breggin 1991; Nadal 2001; Terzian 1999; Thomas 2000; Valenstein 1998). DTC advertisements significantly alter the structure of the medical enterprise and statistical and anecdotal evidence indicates that DTC ads successfully encourage patients to ask for drugs by name. This activity displaces the traditional authority given to medical practitioners.

DTC ads do not target all consumers equally. In their study of DTC ads, Cline and Young found that targeting strategies were likely to reflect stereotypic beliefs about consumer populations. For example, in psychiatric ads, female models were depicted two-thirds of the time as compared to male models (33). Women are far more likely than

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<sup>1</sup> See for instance Breggin (1991); Valenstein (1998); Szasz (2001); and Kirk and Kutchen (1992; 1997).

men to be diagnosed with a mental illness, though there are some exceptions. NARSAD research reports that one in ten men will suffer depression, compared to one in four women. A 1998 article in the *Archives of General Psychiatry* notes "a female preponderance of depressive disorders" (Gater et al. 1998) and Young et al. argue that gender differences in depression are due to reproductive hormones (2000). DTC advertisements for Sarafem are unique in several ways. Since Sarafem is indicated (or approved) for PMDD, it is solely marketed to women. Second, Sarafem was approved by the FDA as an indication for a disorder with an ambiguous status, the first time a drug has been approved for a condition listed primarily in the appendix of the *DSM*. Third, the active ingredient in Sarafem is fluoxetine hydrochloride, identical to Prozac. Both Sarafem and Prozac are marketed by Eli Lilly and Company (Lilly from here on). While Prozac is green and yellow, Sarafem is pink and lavender. Lilly gained approval for Sarafem in summer of 2000, only months before its patent on Prozac expired, leading to speculation that the action was "an astute marketing maneuver" rather than the result of scientific advancement (Hsu). Indeed, Sarafem generated \$33 million in sales during its first five months on the market, in part due to an aggressive advertising campaign in which Lilly spent over \$17 million on DTC advertising alone (Vedantam). Since Lilly lost its patent protection on Prozac, generic fluoxetine is available at considerably reduced cost. Thus, women who buy Sarafem (an average of \$100 a month) are literally paying for an 'identity'--a drug with especially feminine colors and an equally feminine name.

Though the Sarafem ads include television, magazine, internet, and pamphlet advertisements, I will primarily focus on the pamphlet. First, the pamphlet is highly

accessible to women and is found in many general practitioners' offices as well as most gynecologists' offices. Second, the FDA requires Lilly to make further information available to those who view the television commercials. This pamphlet is the information provided to those who express interest. Third, the pamphlet is typical of the other advertisements. It includes similar text and visual elements. However, I will examine some of the additional features of the internet advertisement and review the magazine and television ads to provide a more comprehensive picture of the marketing strategies employed by Lilly. Three important conclusions will be drawn from the analysis. First, the Sarafem advertisements reveal that DTC ads for psychiatric medications constitute a therapeutic rhetoric that is gendered. Women's discontent is channeled into self-scrutiny and self-discipline rather than alternative forms of social or collective action. Second, these advertisements operate to normalize psychiatric diagnosis. Though the scientific perspective on PMDD as revealed in Gold's *Donahue* address and the medical literature insists that PMDD is not an official diagnosis and is distinct from PMS and limited in its application, these caveats are absent from the corporate advertisements. In the Sarafem ads, PMDD is treated as an official disorder backed by scientific consensus and the associations with PMS are elevated rather than denied. Third, related to the second, the advertisements reveal how appeals to scientific authority are employed irresponsibly in the public sphere, in this case for financial gain. The pharmaceutical companies and the APA have a symbiotic and codependent relationship. The APA depends on the success of pharmaceutical agents for its scientific status and the pharmaceutical companies depend on the scientific ethos of the APA to legitimize their products. In this network, it is

difficult to pin down precisely what "science" is and thus difficult to hold any recognizable party responsible for the consequences of decisions.

### The Sarafem Pamphlet: A Dialogic Encounter?

The front of the Sarafem pamphlet features a smiling woman dressed in nondescript casual gray cotton. The woman, with one hand behind her head and the other flung out behind her, appears to be swinging her body around, as if she were a child 'spinning' to get dizzy. She is white, appears to be middle-class, and unlike many ad models, she is not particularly thin or glamorous--in fact, her hair appears to be slightly mussed. This woman is a typical "everywoman," the woman who is not particularly noticeable and is not overtly sexualized. She could be a mother, a sister, or a corporate executive on her day off. Because pharmaceutical ads must portray a level of scientific ethos, an eroticized or unusual model--the type that sells liquor and hairspray--would be at odds with these scientific ideals. Further, a typical model might alienate potential consumers. As the PMS and PMDD literature indicates, Lilly's target population is middle-class, white, and approximately 32 years old with husbands and children.

This woman's posture indicates that she is happy, yet her 'swinging' also suggests a childish role. Erving Goffman notes that women are often depicted in such a manner in advertisements: "The note of unseriousness struck by a childlike guise is struck by another styling of the self . . . namely, the use of the entire body as a playful gesticulative device, a sort of body clowning" (50). This pose suggests a light and happy mood, but it also points to the femininity of the woman depicted. Though she is not overtly sexualized, she is at least partially infantilized through her unprofessional and playful gestures. The text above the woman enhances this perception. The words "mood swing"

appear with the "mood" crossed out in vivid green ink to read simply "swing." The reader is led to infer that mood swings, a common symptom of PMS, have been alleviated in this fortunate woman so that she can merely "swing" with happy abandon.

Below this header, in orange, the ad queries, "Think its PMS? Think again. It could be PMDD." A common advertising strategy is the use of "you," a strategy that mirrors the discursive tactics of religious evangelism (Cook). Advertisements have an incentive not to draw attention to their sender, particularly in the case of psychiatric advertisements. The desired impression is not that of a corporation marketing a product, but a benevolent and nameless helper offering information and valuable counsel. By using paralanguage, visual strategies that simulate face-to-face interaction, readers are led to feel that they are conversing with an actual person, a woman much like themselves, rather than consuming propaganda from a faceless multinational corporation. Though it is not clear, it is easily implied that the swinging woman is the addresser in this scenario. The act of viewing an advertisement thus appears dialogic instead of hegemonic--the reader is drawn into a simulated relationship with one who addresses them specifically, asks questions, and makes suggestions.

In this instance, the use of "you" is implied, not direct, adding to the ambiguity of the address and fostering a deeper identification between the viewer and the presumed speaker. By looking out of the advertisement at the viewer, this woman can take on the role of either the addresser or the addressee (Cook 159). She can be the one who has previously been asked, "[Do *you*] Think it's PMS?" or the voice asking the viewer to examine her own experiences. This duality expands the room for identification between the viewer and the depicted woman. The visual presence of this woman also shifts

attention from the actual addresser, Eli Lilly and Company, and fosters the illusion of a dialogic encounter. The colloquial language (the implied use of "you" suggests an informality) further enhances the appeal to enter into conversation with this fictional, swinging woman who presents herself as a trusted confidante instead of a design dreamed up at a table of highly-paid marketing specialists.

Notably, this subheading directly suggests a strong association between PMS and PMDD. The letters "PMS" and "PMDD" are juxtaposed, inviting viewers to associate the two acronyms of very similar composition. This juxtaposition is embedded in an ambiguous discourse that implies both authority and commonality: the address assumes a familiar relationship but contains a connotation of expertise. Women are told to "think again," to reevaluate their previous understandings of their experiences. The only implied distinction between PMS and PMDD is this simple act of "think again"--a simple reexamination of one's previous position can bridge the gap between a common experience and a presumably severe mental disorder. All women who believe that they suffer from some form of PMS are encouraged to consider the 'fact' that it "could be PMDD." Eli Lilly has a direct incentive to lower the threshold for the diagnosis because the more people diagnosed means more potential profits. As Kirk and Kutchens write, "For drugs companies, these unlabeled masses are a vast untapped market, the virgin Alaskan oil fields of mental disorder" (*Making* 13). The scientific precision proclaimed by Gold and others is diluted by corporations who have an incentive to maintain a scientific ethos while obliterating the perimeter that limits their client base.

The bottom of the pamphlet cover includes the Sarafem logo: the word "Sarafem" printed below a green and yellow daisy. Below the logo, the active ingredient is listed

(fluoxetine hydrochloride), and at the very bottom, in red cursive, is the word "Lilly."

The very name, Sarafem, connotes a feminine identity as well as a religiously inspired ethereal bliss. "Sara" is a feminine name, followed by "fem" as in "feminine" or "female" or even "feminism." The word is closely associated with the word "seraphim," a religious term connoting otherworldly bliss and angelic peace. The very identity of the drug seems to promise relief from the toils and troubles of common routine and drudgery. Flowers are frequently a sign of femininity, and the daisy indicates not only femininity but happiness and lightheartedness. Finally, it is interesting that the corporate logo reads simply "Lilly" instead of "Eli Lilly" or "Eli Lilly and Company." This decision enhances the perception that the advertisement functions in a dialogic manner. Lilly could be the name of the woman who is inviting readers to come swing with her instead of the nickname of a large corporation. The full name "Eli Lilly" sounds more like a senile, curmudgeonly grandfather figure than the energetic young woman depicted in the ad.

As viewers open the pamphlet, they are faced with another smiling young woman--also white and middle-class. This woman is wearing casual jeans and a button-down shirt open over a white T-shirt. She has short, curly ringlets and is posed casually, with her hands in her back pockets. Her head is cocked slightly to one side, and she stares directly out of the page into the eyes of the viewer. Again, this woman is attractive but she is not a sexual icon. She is not especially thin and her quirky ringlets and casual pose give the impression that she is fun-loving and approachable, perhaps the mother of toddlers or an accountant on her day off. Though this woman is not swinging, her tilted posture enhances her childlike and feminine persona. Goffman writes that women are often depicted with their heads and bodies tilted to one side: "Given the subordinated and

indulged position of children in regard to adults, it would appear that to present oneself in puckish styling is to encourage the corresponding treatment" (48). This woman is content, but her happiness has a childlike aura suggesting that she, too, is in some ways infantilized and vulnerable.

The heading above this puckish woman reads "irritability" marked through in green to read "ability." This 'x-ing out' strategy suggests that "irritability" and "ability" are mutually exclusive: if one is irritable, they cannot be able; likewise, an able woman is not irritable but is as content and enthusiastic about life as an eager child. Next to the woman is the Sarafem logo, identical to the daisy-flourished "Sarafem" on the front cover. To the left of the woman are three questions in orange, followed by answers in green ink. It is unclear who is asking and answering these questions though several possibilities are suggested by the close presence of the curly-haired woman. The woman could be asking the questions, or sharing the questions that she has asked, and receiving answers from some unknown third party, perhaps Lilly. The second, and more probable, suggestion is that these are questions the viewer is asking and the woman is answering. This understanding heightens the dialogic illusion that is central to the Sarafem advertisements. Further, this understanding is suggested again by the casual tone of the responses, for instance the use of "you." However, despite the casual tone, the response indicates that the woman has some expert knowledge and the benefit of scientific data at her disposal.

The first question and answer section reads:

Could it be PMDD?

Irritability, sadness, sudden mood changes, tension, bloating. Perhaps you suffer from symptoms like these every month. But before you dismiss your symptoms as PMS, or just part of being a woman, you should realize you could be suffering from PMDD (Premenstrual Dysphoric Disorder), the intense mood and physical symptoms right before your period.

The tone of this response is ambivalent. The casual language suggests a familiar relationship and an informal dialogue. The addresser uses the imprecise term "perhaps" to suggest that the addressee might suffer from certain symptoms, highlighted in a bold print. The next sentence begins with "but," again an informal linguistic strategy that suggests a relaxed encounter of equals. Women are addressed directly (You, your) in an informal manner. Further, the reference to "part of being a woman" suggests both a level of intimacy between addresser and addressee and a similar gender--implied is that the addresser is a woman who understands what it is like "being a woman." At the same time, the response resonates with a scientific and authoritative ethos. Women are told that they "should realize" that they "could be suffering"--the addresser is more knowledgeable than the women concerning even their own experiences. The capitalization of PMDD (interestingly it is not capitalized in the *DSM-IV*, nor is "depression" capitalized in advertisements for Prozac) emphasizes the scientific nature of the diagnosis and the implied authority that accompanies medical expertise. This ambiguity allows the authors of the advertisement to employ scientific authority to lend credibility to their product while keeping their own role in the background. Viewers are invited to enter into a dialogue with a woman similar to them and to take advantage of the superior knowledge

this woman has gained through her own experiences with the diagnostic procedure and Sarafem.

Further, the existence of some premenstrual malady is presumed in the question: could "it" be PMDD. Again, this enhances the suggestion that PMS and PMDD are not distinct, rather what is taken to be PMS is actually PMDD. "It" is not defined until the end of the response, and again the existence of PMDD is taken for granted. PMDD is defined as "the intense mood and physical symptoms right before your period." The imprecision of this definition is striking. Not only are these symptoms only vaguely referenced in bold at the beginning of the response, this statement is in a casual and grammatically incorrect form. A more correct yet less colloquial phrasing would read: "the intense mood and physical symptoms *that occur* right before your period." As it is, the definition implies that these symptoms do and must exist for the viewer--there is no linguistic space for questioning or denying the symptoms that simply *are* "right before your period." By omitting the grammatically required "to be" verb, the advertisement further reinforces the presumption that all women have certain negative symptoms premenstrually.

A strong association is again implied between PMS and PMDD. The question, "Could *it* be PMDD?" implies that whatever premenstrual symptoms a woman experiences could constitute this disorder. The symptoms listed in bold print are broad and indeterminate, symptoms not only indistinguishable from PMS but symptoms that anyone, male or female, might feel from time to time. The wording of the response heightens the suggestion. Women who believe that they have PMS are "dismissing" their symptoms, prematurely concluding that they have come to the most accurate

understanding of their experiences. Implied is that PMS is not serious enough, important enough, or rigorous enough to account for women's experiences. Further, "dismissing" one's experiences by attributing them to PMS is equated with dismissing them as "just part of being a woman." Here is an instance of the subtle 'feminist' rhetoric that pervades the PMDD discourse. Dow notes that advertisers have incorporated feminist rhetoric into their appeals to enhance the power of therapeutic rhetoric. Cloud and Dow concur that feminism in a therapeutic society, or postfeminism as Dow terms it, becomes equated with identity, personal choices, and self-help opportunities instead of consciousness-raising or collective action. Ehrenreich and English argue that advertisements promote an image of a "new woman" whose liberation is typified through her identity to reconcile the competing demands of feminism and the traditional norms of womanhood. Here, the Sarafem advertisements indicate that dismissing one's discomfort by attributing it to PMS is similar to attributing it to "just being a woman." By implication, women who settle for any explanation other than PMDD are selling themselves short and not taking advantage of the emancipatory opportunities offered by psychiatric science. To dismiss something as part of being a woman is to accept a lesser role for oneself, to reconcile oneself unnecessarily to second-class status.

The second paragraph reads:

What is PMDD?

PMDD is a distinct medical condition that affects millions of women. It happens the week or two before your period, month after month. Its many symptoms clearly interfere with your daily activities and relationships. And left untreated, it

can worsen with age. But by understanding what may cause PMDD and what can be done to help relieve its symptoms, you can feel more in control.

The strategy of juxtaposing an informal tone with a scientific ethos is continued here. The familiar use of you as well as beginning sentences with "and" and "but" imply a casual dialogue at the same time the declarative sentences and references to medical jargon indicate scientific authority. Though PMDD is, according to the APA, a category needing further research and not an official diagnosis, this definition of PMDD presents the disorder as a valid and real entity proven by empirical research. PMDD is a "distinct medical condition," a phrase that implies a determinate etiology for PMDD. Though the *DSM-IV* states specifically that PMDD, if valid, is estimated to affect only 3-5% of menstruating women, this advertisement boldly states that the condition "affects millions of women." This statement is patently false according to APA research and the *DSM-IV*, but it is a strategic device on the part of Lilly. Not only does it cement the "official" status of the diagnosis (PMDD *does* affect women, thus its existence cannot be questioned), it encourages women to consider themselves as candidates for the diagnosis--if so many women are victimized by the illness, perhaps the viewer is too. The precision of the PMDD diagnosis highlighted by the APA is further diluted by the imprecision implied here. PMDD is the symptoms that happen "a week or two" before your period, implying a loose and flexible diagnostic procedure. The "many symptoms" are not detailed and nowhere is it mentioned that candidates are supposed to meet a very specific set of criteria to receive the diagnosis. The only clear symptoms in this paragraph are interference with "daily activities and relationships," presumably a broad array of problems.

This paragraph is an example of therapeutic rhetoric. Women are encouraged to associate relational problems and general discontent (problems with daily activities) with a mental disorder, a problem localized in their own bodies, instead of turning to social explanations. Psychiatric discourse is a unique manifestation of therapeutic rhetoric. This discourse encourages individuals to turn inward to find solutions to their problems, but psychiatric rhetoric posits an internal, biological cause of behavior, locating the origin of social problems not only within the individual but beyond the control of the individual. Women are encouraged to seek out Sarafem so that they might "feel more in control"--by implication, PMDD usurps women's self-control. This idea is supported by scientific framing of PMDD and PMS. Judith Gold writes, "This biological control supersedes any self-mastery a woman may develop, and to some degree she is always susceptible to its vagaries" (*Psychiatric Implications* xiii). Cloud notes that therapeutic rhetoric restrains social activism because it places the cause of social problems simultaneously within the individual and beyond the control of the individual--women are literally possessed by PMDD and it is not within their power to root out this intruder.

Further, this paragraph highlights the use of therapeutic discourse because it normalizes current social relations. PMDD is problematic because it interferes with daily activities and relationships. There is no room for questioning the normative value of the daily activities women are expected to perform. Implied is either that these activities are normal, natural, and simply the way things are or that women have freely and voluntarily chosen their daily activities outside of the parameters of cultural influence. Both of these assumptions are highly questionable. Women are still expected to do the majority of the housework, childcare and other domestic tasks. Many women who work outside of the

home are required to balance the dual burdens of career and domesticity. The very naturalness of work structures is also normalized: there is no room in these discourses to challenge economic structures which are unequal and unjust. Marx noted the alienation produced in many people by the pure drudgery of uninspiring and routinized jobs. The Sarafem discourses would state that these workers suffer from a mental disorder and prescribe serotonin re-uptake inhibitors instead of class revolt. Finally, many women are involved in abusive and unfulfilling relationships. These discourses naturalize these relationships and place the cause for malfunction within the female body.

The final paragraph reads:

What causes PMDD?

While PMDD is not fully understood, many doctors believe it may caused by an imbalance of a chemical in the body called serotonin. The normal cyclical changes in female hormones may interact with serotonin and other chemicals that may result in the mood and physical symptoms of PMDD. And although it may seem like you only suffer a few days a month, over time these days can add up to almost 25 percent of your childbearing years. The good news is, your doctor can now treat PMDD symptoms with a new treatment called Sarafem.

This short paragraph uses the word “may” four times when discussing the state of scientific research on PMDD. To counteract this dilution of the certainty of the ‘facts’ presented, the ad indicates a degree of scientific consensus that exists on the matter.

Though PMDD is “not fully understood, many doctors believe” that it is caused by a serotonin imbalance. Again, the existence of PMDD is taken for granted—it is a discernible and identifiable entity that is partially, if not completely, understood. The use

of “not fully understood” implies that scientists are merely at the early stages of unleashing the brain’s mysteries—complete knowledge is hinted at as a future event though one not arrived at yet. The attribution of PMDD to serotonin is important. The success of SSRIs (selective serotonin re-uptake inhibitors) in treating mental disorders has led to a proliferation of causal theories positing serotonin deficiency as the reason for the mental illness, leading one critic to comment, “Lack of aspirin is not the cause of fever; lack of water is not the cause of fire” (Skrabanek 236). In fact, psychiatry’s status as a medical science is largely dependent on the success of psychotropic drugs (Karson, Kleinman and Wyatt 495; Millon and Klerman 7; Shorter 262; Szasz, *Pharmacracy* 12; Valenstein 5-7). Though the Sarafem ads employ appeals to scientific consensus to persuade consumers of the efficacy of the medication, this consensus has been brought about by the success of the medications. The cyclical network of support benefits both psychiatry and industry. Indeed, none could survive without the other.

The scientific rhetoric employed here is at odds with the actual ‘consensus’ reported in the APA research. As evidenced on the *Donahue* show, Gold firmly denies any hormonal role in PMDD. This is in part because of a lack of supporting data and no doubt in part to further distance PMDD from PMS, commonly assumed to be associated with hormones. Here, it is not only hormones who are the culprit, it is “female” hormones. Yet, both men and women have the same hormones—to label a hormone a “female” hormone is to further perpetuate the link between women and a faulty biology. It is “normal” changes in female hormones that cause PMDD, again insinuating a broad diagnostic criteria that potentially any female could meet. Further, the reference to “normal” hormonal changes indicates that women are “normally” susceptible to mental

disease—the way the female body operates leaves women vulnerable. Though the notion of a hormonal *abnormality* is perhaps problematic, the attribution of PMDD to normal hormonal activity is far less palatable because it pathologizes all women.

The suggestive aspects of the advertisement are not subtle. Women who might dismiss their experiences as PMS or part of being a woman might think that they do not suffer severe enough symptoms to warrant the PMDD diagnosis. Yet, the ad implores women to consider the cumulative effect of their discomfort over their entire lives. Instead of viewing premenstrual discomfort as an occasional, passing phase, women are asked to quantitatively consider the impact of this discomfort: one-fourth of their lives might be lost if they do not seek treatment for this disorder. Additionally, instead of referring to women's vulnerable years as "menstruating years," the ad refers to women's "childbearing years," associating menstruation with childbearing and subtly naturalizing the idea that women are primarily mothers. Finally, the paragraph states "the good news" that PMDD can be treated with "a new treatment called Sarafem." Yet, Sarafem is not, by most definitions, a new treatment. Fluoxetine hydrochloride has been on the market since 1988 and physicians have regularly prescribed antidepressants to treat problems related to menstruation for years. What is new is Lilly's recently gained permission to market fluoxetine specifically for PMDD; the other novel aspect is Prozac's costume change.

The next full page features yet another smiling woman. This woman is African American and though she is not obese, she is noticeably bigger than the previous two women. She stands laughing out at the viewer, posed as if in mid-stride. She is dressed in sweatpants and a sweatshirt with the sleeves casually pushed up and appears to be in the middle of a daily walk or other type of light exercise. Also unlike the previous women,

she is conspicuously married as evidenced by the ring visible on her left hand. The depiction of a black woman enhances the idea that PMDD is a disease that could potentially afflict any woman—it knows no racial boundaries. It is interesting that the black woman is the only one who is clearly married. Given the age-old associations between black skin and a bestial sexuality (see for instance hooks 1994), perhaps the marketers felt that a black woman would infuse the advertisement with too much sexuality unless marked as a woman whose sexuality is confined to acceptable marital relations. Above this woman, the heading reads “low energy” with “low” crossed through in the same green ink. Again, the verbal heading accompanies the woman. She looks as if she is energetic, dressed for physical activity and in motion. And, once more, the woman is accompanied by the Sarafem logo.

On the opposite page, another question is asked and answered and followed by a chart. The question and answer read:

How do you know if you have PMDD?

PMDD is a real medical condition that only your doctor can diagnose. And unless he or she is made aware of your symptoms, when they occur and their intensity, PMDD can go undiagnosed. To help determine what you should tell your doctor, ask yourself the following questions:

Earlier, the ad claimed that PMDD was a “distinct medical condition,” and here it is referred to as a “real medical condition.” The insistence that PMDD is “real” is so overt in this discourse, it raises questions as to the validity of the diagnosis and supports the claim that mental disorders are rhetorical constructs that gain their legitimacy through

discursive means. It is difficult to imagine an ad for a diabetes treatment insisting that diabetes is a “real” disease.

In this paragraph, women are encouraged to seek out medical assistance as “only a doctor” can diagnose PMDD. Yet, women must play an active role in this diagnostic procedure. Unless the physician is “made aware” of the symptoms, PMDD might go undiagnosed. Notably, the consequence of silence is not that a physician might fail to make a valid diagnosis of PMDD, it is that “PMDD might go undiagnosed.” Again, the language indicates that PMDD is an identifiable entity that is likely present though a woman must catalogue her ills and report them to bring this entity to the surface. Women are encouraged to ask themselves “the following questions,” which are then asked in the form of a chart which women can use to check off their responses and take in to their physicians. The chart is boxed off and reads as follows:

Think about how you feel the week before your period . . .

Are you bothered by intense:

Irritability/ Tension/ Sensitivity/ Sadness/ Feeling Overwhelmed/ Sudden mood changes for no reason/ Tiredness/ Bloating/ Food cravings/ Breast Tenderness

Do these symptoms cause problems with your:

Work/ School/ Social Activities/ Relationships (family, friends, etc.)

Do these problems go away soon after your period starts:

Yes/ No

If you’ve checked some of the boxes, discuss your answers with your doctor to help determine if you have PMDD.

Next to each of the listed symptoms is a small box women can check. The text below the chart reads:

Symptoms can vary from cycle to cycle. That's why it's recommended you keep a daily record of both your mood and physical symptoms and how you're feeling for two or three periods to help discussions with your doctors.

The colloquial use of "you" and informal language is similar to that discussed in the earlier paragraphs. The statement heading the chart, "Think about how you feel before your period . . ." is clearly in a casual tone. Notably, retrospective charging mechanisms have been robustly discredited by researchers of all political stripe, as evidenced in chapter three. When women are asked to reflect on their symptoms in past cycles, they are likely to attribute negative symptoms to their premenstrual phase far more often than when they keep current, daily ratings though the power of suggestion has been found to be high in both instances. This chart, however, asks women to casually think back over their past cycles and undergo a form of self-diagnosis that will aid their doctor in making an official diagnosis.

The chart exemplifies the unique nature of the psychiatric diagnostic process. Hypothetically, a patient suffering a physical disease could go into a physician's office and eventually be diagnosed without ever speaking. Of course, it is more likely that a patient will enter a physician's office and complain of particular symptoms which will guide the physician. Ideally, the physician will then examine the patient, observe any physical lesions, and prescribe the appropriate remedy. It is impossible for a psychiatric diagnosis to be given with a silent patient. In fact, a psychiatric diagnosis is made *solely*

*on the basis of* a patient's narrative and a physician's interpretation of that narrative. This procedure resembles the confession described by Foucault as:

a ritual of discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocuter but the authority who requires the confession . . . (*History* 61).

The confession is "a clinical codification of the inducement to speak" and the authority is "the master of truth" whose function is "a hermeneutic function" (65-7). A psychiatric diagnosis is based on a woman's narrative, but this narrative is shaped and constrained in specific ways by the mechanisms through which it is acceptable. The chart featured in the Lilly ads encourages women to articulate and document their experiences in a particular way that is intelligible in current medical discourse. Though a doctor cannot make a diagnosis without the cooperation of a woman, a woman cannot simply speak her experience in any way she chooses, nor can she diagnose herself on the basis of her experience. Instead, an expert must perform a hermeneutic function and channel her experiences into a valid diagnostic category.

Finally, the chart represents a significant instance of therapeutic rhetoric. Therapeutic rhetoric turns the focus inward, inside of the individual, obviating social criticism. In the Sarafem ads, women are encouraged to recognize their own illness through a meticulous self-examination then seek out corrective treatments and medications from authorized individuals. This self-surveillance puts the focus within the individual and has no room for examining social relations or interpersonal interactions,

except as affected by women's internal states. Women are told that true liberation lies within. They are encouraged to exorcise their demons through ritualistic processes of confession and medication. This process requires a heightened level of scrutiny of one's emotions and physical state—the ad suggest that women keep track of their symptoms for several months in order to enhance their consultation with a physician.

In this chart, there is no clear distinction between PMS and PMDD and compared to the *DSM-IV* symptoms, the symptoms presented here are far more broad and ambiguous. They lack even the linguistic precision offered by the APA. If women mark “some” of the boxes they are encouraged to seek medical attention. The threshold for a potential diagnosis is lowered, as in the *DSM-IV* women are required to have a very specific set and amount of symptoms. The symptoms are so broad that anyone, male or female, could qualify. For instance, “tiredness” and “feeling overwhelmed” are symptoms commonly experienced by both genders.

The next full page has no smiling woman, but instead includes a series of questions and answers about Sarafem. The first question and answer read:

Why Sarafem?

Sarafem is the *first and only* FDA-approved prescription treatment for both the mood and physical symptoms of PMDD. Taken daily, many physicians believe that Sarafem helps to correct the imbalance of serotonin that could contribute to PMDD. And for many women, Sarafem can bring relief of their mood swings, irritability, bloating . . . by their next monthly period.

Initially, the words “first and only” are italicized for emphasis despite the fact that Sarafem is not a nouveau treatment. The advertisement consistently portrays Sarafem as a new scientific discovery instead of the repackaging of an existing medication.

This section further uses appeals to scientific consensus to validate the treatment strategy. Sarafem is a good choice because doctors “believe” (they do not know) that Sarafem corrects a serotonin imbalance. Not only is the etiology of PMDD unknown the precise action of Sarafem is unknown—doctors simply concur that it operates in a particular manner by reducing causes that “could” be related to PMDD. This uncertainty is minimized by the scientific ethos predominant in these sections.

Finally, the application of PMDD is again expanded from the APA’s original *DSM-IV* criteria. The ad states that women could get relief from the symptoms “mood swings, irritability, bloating . . .” Here, the use of ellipses is suggestive—it implies that the list of symptoms is virtually endless, thus any manifestation of discomfort could be constitutive of PMDD and relieved by Sarafem. In other words, Sarafem is the cure for what ails or, as Breggin has described Prozac, a “jack-of-all-trades drugs” (152).

The second question asks, “What should you know about Sarafem?” and includes a summary of the potential side effects and adverse reactions in paragraph form. This is the information the FDA requires DTC advertisements to include, the small print found in magazine ads and pamphlets. The paragraph warns women to stop taking Sarafem if they develop hives; not to take Sarafem with other antidepressants; and lists the common side effects, including tiredness, nervousness, upset stomach, dizziness and difficulty concentrating. The common side effects listed are interesting as they are markedly similar to the symptoms of PMDD, for instance tiredness and nervousness. Further, the

information states, “Sarafem contains fluoxetine hydrochloride, the same active ingredient found in Prozac.” Here, buried in back of the pamphlet, is the only indication that Sarafem is identical to Prozac.

The final question on the page reads:

Is Sarafem right for you?

Talk to your doctor about the intensity of your symptoms, when they occur, and how much they interfere with your life to determine if you suffer from PMDD and if Sarafem can help.

Women are again encouraged to confess their distress to a physician who can decipher this narrative and determine if PMDD is present. This inducement is worded to encourage women to frame their experiences in a way that the existence of PMDD is presupposed—they are to relate “the intensity of [their] symptoms” as well as their timing and “how much they interfere”—these terms imply a level of degree (intensity, how much, when), not a question of existence. The existence of negative symptoms is presumed, the only question is how severe they are.

The opposite page includes a list of questions for women to ask their physician, including specific questions about Sarafem, for instance, “Could Sarafem help relieve my PMDD symptoms?” In these questions, the existence of PMDD is again presupposed. Further, these ads actively encourage patients to ask physicians for a brand name medication, displacing the traditional authority of the medical enterprise.

The bottom of the page features the Sarafem logo and a picture of a tiny pink and lavender capsule. Aside from the red cursive Lilly trademark, the pill provides the brightest colors in the pamphlet. The women are dressed in subdued gray and are not

shown in full color. The ink throughout is green and orange, with a particularly vivid green for the cross marks. The most visually prominent item in the pamphlet is the pill shown on the final page of the pamphlet, a stark relief from the subdued and depressive colors of the previous pages. The pill stands brightly as a potent symbol of relief from the mundane drudgery that has proceeded it, just as Sarafem offers to replace a routine and discontented existence with vibrant promise and angelic delight. Under the logo is the Sarafem motto, found in all Sarafem advertisements: “More like the woman you are.” This phrase does not constitute a full sentence and is plagued by considerable ambiguity. The implication is that women’s irritability, mood swings and lack of zest for life is the result of an invading presence, a disease outside of their control or responsibility. Sarafem is the method of exorcism for these intruding demons and the result is a return to one’s natural state. This natural state is an existence free from mood swings, irritability and low energy. Women’s presumed natural state is to be upbeat, energetic, and always smiling just like the women depicted in the ad. Once again, behavior that falls outside of norms of femininity is attributed to a faulty biology while positive behavior is simply who women are. Finally, this motto is also an exemplar of therapeutic rhetoric. Some essential female identity is posited, some natural state where the feeble and errant body no longer intrudes on the “real self.” Women are encouraged to seek liberation by recovering or becoming their essential selves rather than negotiating these identities through collective action of consciousness-raising practices. The very idea that there is some thing, some essence, that women “are” is problematic from a feminist perspective—this notion has been used too often to dismiss inequality as a justified response to the way women, men, and society ‘just are.’

### Magazine Advertisements: A Case in Contradiction

The Sarafem magazine advertisements are very similar to the pamphlet so I will only briefly discuss them. These ads are found in popular women's magazines including *Cosmopolitan*, *Glamour* and *Redbook*. The full page ads each feature a smiling woman leaning into the page, looking out at the readers. The headings vary and include "irritability" crossed out to read "ability" and "mood swing" crossed out to read "swing." Under the headings is the query, "Think it's PMS? Think again. It could be PMDD." The magazine ads then include an abbreviated version of the text found in the pamphlet. The ads include a number women can call to receive further information (the pamphlet), and the back of the ad contains the small print information required by the FDA. The ads also include a detachable card that mirrors the checklist found in the pamphlet. Women are to take this in to their physicians after examining their own state of health. Like the pamphlet, the magazine ads include the Sarafem daisy logo and a picture of the vivid pink and lavender pill.

The most notable difference between the magazine ads and the pamphlet is that while the pamphlet is discrete, the magazine ads appear in a context of other advertisements and articles about sex, fashion, and relationships. For instance, the April 2001 *Cosmo* includes a Sarafem ad only pages from the cover article "Meow! Why Acting Like a Cat Will Get People to Come to *You*." As the title indicates, this article encourages women to act "catty," hard to please, flirtatious, demanding and stubborn, in order to get their way in situations. This behavioral advice is in direct contradiction to the Sarafem image of a placid and content woman who regulates her hormonally-influenced serotonin levels to avoid conflict and unfeminine behavior. This ad is also sandwiched

between an ad for a lotion that eliminates circles under one's eyes and a treatment called "Blast Away Fat" that "starts incinerating your body fat" and "can destroy up to an incredible 2 lbs of enemy fat" so that women can say "*give me that bikini!*" The accompanying picture depicts an emaciated woman smiling seductively next to a pile of pills. The main ingredient in "Blast Away Fat" is apple pectin. The ad concludes, "Watch with your own eyes as your ugly, overweight figure becomes so slim and sexy all your friends will be jealous."

The juxtaposition of these ads is ironic. Just as Sarafem promises to change women into new beings by ridding them of undesirable thoughts and behaviors, Blast Away Fat promises rebirth by eliminating "ugly, overweight figure[s]." Further, though the Sarafem ads posit brain chemicals as the source of women's alienation, it is no surprise that women feel insecure and alienated given the messages they regularly receive about their bodies from such magazines. In the May 2001 *Cosmo*, the Sarafem ad is in between a SlimFast ad and an ad for another weight loss pill, Xenadrine, with ephedra as the active ingredient. These examples reveal that women do not receive information about Sarafem and PMDD in a vacuum—these messages are often viewed in a context where women are regularly told that not only their minds but their bodies are diseased or inferior and can be remedied through various disciplinary measures. Women are used to hearing messages that encourage them to pursue remedial measures to correct for their inferiorities. Though the Sarafem pamphlet stands alone to an extent, many messages about this treatment circulate among discourses that further emphasize the second-class status of women's minds and bodies. Though the PMDD discourses argue that women's alienation is the result of biology, these other discourses reveal that women's alienation is

at least partially the result of common media messages that encourage them to view themselves as projects to be completed or failures to be corrected.

### The Internet Ads: Psychiatric Evangelism

Those viewers familiar with the glossy pamphlet or the magazine ads will feel right at home cruising Lilly's Sarafem internet site as many of the same smiling models are featured. For the most part, the internet ad parallels the pamphlet though there are several novel features. Women can download two different "serene screen savers" and a "soothing sounds player" that plays various sounds on one's computer, including breaking waves and chirping birds. The sounds, which are far from soothing, play while a Sarafem daisy emanates eerily from the screen in hypnotic fashion. Aside from these questionable palliatives, the most significant addition of the internet ad is the inclusion of testimonies from women who have been helped, or are seeking help, through Sarafem. These testimonies reveal an inherent tension in psychiatric discourse. Though biological reductionism is the dominant theory, these narratives insert religious discourse and implicit metaphysical assumptions into this rhetorical arena that are at odds with dominant scientific ideology (Lessl, "Towards").

Each of the testimonials is situated next to a smiling woman—the same woman for each testimonial. This woman strides forward confidently, dressed in a suit and carrying a file folder or a stack of papers, presumably a businesswoman. Again, she is attractive but now a sexualized model. These narratives are highlighted as stories sent in by women who have had success with Sarafem or who are looking for help, and there is a place on the website for women to submit their own stories. Thus, this section is set off from the rest of the advertisement and this explains the use of the same woman for each

testimonial—to use different women would imply that the stories were the pictured women's stories story, diluting the appeal of “real” stories from “real” women. One narrative is entitled “Finally” and reads:

My mother was the first to suggest that I might suffer from PMDD when she saw the recent commercial for Sarafem. I was so glad to realize that it wasn't me, and could possibly be a physical problem that caused my mood swings and depression. . . . To think that there may be some hope of preventing the mental anxiety AND the physical pain is great news! Thank you so much!

Initially, this testimonial further heightens the illusion of a dialogic and personal encounter as opposed to the purchase of a corporate product—this woman is thanking some unknown person, presumably Lilly. Further, the narrative implies that this woman has not yet taken Sarafem—she is thankful for the thought that “there may be some hope” of alleviating or preventing her symptoms. She is thankful not only for hope but for the “[realization] that it wasn't me, and could possibly be a physical problem” that causes her undesirable thoughts and behaviors. This narrative reflects the ideology encapsulated in the Sarafem motto “More like the woman you are.” In this narrative, there is a distinct, identifiable woman who is possessed or controlled by her physical self, yet the source of this essential identity is unclear. This is a therapeutic discourse—this woman is relieved not by the eradication of her symptoms but by the promise that she is not to blame, it is some physical cause outside of her direct control. All she has to do is submit to the appropriate medical regimen to correct this physical disorder—nothing further, no structural change, is needed. This narrative mimics religious discourse—though psychiatric theory posits that the mind and body are one, this woman's true identity lies

somewhere beyond her material being. Even when her physical composition is undesirable, she still retains a sense of self that transcends this materialism and is not reducible to her physical and chemical make-up.

The next narrative is titled “LIFE IS GOOD” and reads:

I always knew there was something wrong with the way I felt. I was always on edge. I just thought it was part of being a woman except that I just lived with it. As I got older the way I felt got worse, to the point I was finding myself out of control. I could see that I was out of control and couldn't do anything about it. I saw the Sarafem commercial on TV. I went to my doctor and asked him about Sarafem. Since I received my prescription, I feel like a new person. I didn't realize just how bad I felt. Women listen up, it isn't in your head, it's real it's valid and the good news is, there is relief. LIFE IS GOOD.

Again, the ideology of essential identity is present. This woman found herself out of control—in fact she could observe herself and recognize her status as out of control but was unable to act on her own self to regain this control. Since she has found Sarafem, she is a “new person”—neither grace nor faith is necessary, merely SSRIs. In this account, Sarafem advertisements are heralded as benevolent evangelical efforts to being the “good news” to those in need. This woman has been saved and, as a new initiate, is now prepared to share the gospel of Sarafem herself. She calls, “women listen up,” and tells them that what they are feeling is “real” and not “all in their head,” an ambiguous statement considering the theory of PMDD places the cause of these feelings and behaviors squarely in the head. Others, too, can find salvation as this woman has and realize that “LIFE IS GOOD.”

The other testimonials are markedly similar to these two. In “Why me?” a woman states, “I realize now that I understand what really is going on with my body and mind. The week or two before my menstrual cycle was so intense that I could not stand to be in my own skin . . . From listening to a Sarafem commercial on TV, I realized that there is help for this crippling illness.” Another, in “Only being myself one week out of the month!” tells of her family problems and states, “My husband says that he wants his wife back. . . . I desperately need something to help me with this.” Another, in “Monster,” reports, “I saw a commercial and I said to myself that’s me! After seeing a doctor and getting a prescription, I am starting to take the Sarafem today. I hope it can help me before it is too late.”

Initially, these narratives mimic the salvation stories of religious evangelism. These women have literally been born again through the consumption of Sarafem—they are new persons, washed clean of the mood swings and physical discomfort they experienced in a previous life. They have been restored to their essential selves and exorcised the demons that took control of their identities and possessed their minds. These women express symptoms such as troubled marriage relationships, difficulty balancing childcare and career, general discontent and frustration—every arena of a woman’s life is affected and women become passive dupes at the will of their undisciplined bodies. A sense of urgency is also implied—one woman states that she hopes Sarafem can help “before it is too late.” The immanent threat is not identified, but again this discourse mirrors evangelical discourse where potential initiates are encouraged to accept the saving grace of God before it is too late, i.e. before the second coming. This evangelical discourse shifts attention from Lilly’s advertising tactics.

Television commercials for Sarafem are not crass marketing tools but a beneficent medium for sharing the good news. These narratives consistently draw attention to their gratefulness for the television commercials.

Overall, these narratives operate in a manner similar to that of the women depicted in the pamphlet. The testimonies from “real” women heighten the dialogic illusion provided by Lilly marketers. Viewers are not merely viewing carefully constructed corporate advertisements, they are hearing the voices of actual women. Fostering identification is a critical strategy in these instances—readers are encouraged to see themselves as similar to the depicted women and mimic their actions of seeking out medical assistance and specifically asking for Sarafem. This allows Lilly to distance themselves from their advertisements and keep their role as a corporation in the background.

#### Television Commercials and the FDA Crackdown

Lilly aired several television commercials for Sarafem after receiving FDA approval. These commercials no longer run and they are very difficult to access. Thus, I will only briefly comment on a single television commercial in this section. Overall, the television commercials employ very similar dialogue and text as the pamphlet, internet, and magazine ads. One of the earliest ads featured a woman angrily trying to pull a cart from a row of shopping carts. As she yanks in frustration, the text appears on the screen, “Think it’s PMS? Think again. It could be PMDD.” The commercial describes PMDD and Sarafem in rhetoric similar to that found in the pamphlet and other advertisements. At the close of the commercial, the voice-over tells women how to find more information and they are directed to a phone number that will eventually provide them with the

pamphlet analyzed above. At the end, another woman comes and easily extracts a cart much to the chagrin of the angry woman. This commercial did not run for long as the FDA required Lilly to pull it from the air.

The reasons given by the FDA for this action are enlightening. The letter sent to Lilly by Lisa Stockbridge, FDA regulatory reviewer, reads:

The graphics of the advertisement show a frustrated woman trying to pull her shopping cart out of its interlocked lineup in front of a store. The concurrent audio message states, “Think it’s PMS? It could be PMDD.” The imagery and audio presentation of the advertisement never completely define or accurately illustrate premenstrual dysphoric disorder (PMDD) and there is no clear distinction between premenstrual syndrome (PMS) communicated.

Lilly pulled this commercial at the recommendation of the FDA, but the reasons cited by Stockbridge apply equally well to the magazine, internet, and pamphlet forms of the advertisement. None clearly describe PMDD as it is defined in the *DSM-IV*, and none clearly articulate any distinctions between PMS and PMDD. Although the Sarafem ads deviate from the public APA position, psychiatrists have little incentive to challenge this distortion. They benefit professionally and financially as the ad encourages more patients to seek out physicians, and Lilly is a significant supporter of the APA. In fact, pharmaceutical companies are the single largest funder of psychiatric research in the U.S. (Valenstein 187).

### Conclusion

The Sarafem ads are exemplary of priestly discourse (Lessl, “Priestly”). These advertisements mix scientific appeals with colloquial language and dialogic

images. This discourse allows Lilly to encourage identifications between the (imaginary) depicted consumers of their product and potential patient-consumers while simultaneously grounding their appeals in an authoritative realm inaccessible to 'normal' women. This strategy allows Lilly to irresponsibly translate scientific research into popular discourses without specifying or evidencing these claims. Though many advertisements employ suasive scientific appeals, DTC advertisements are backed by medical authority and enjoy a unique brand of scientific ethos. Consumers cannot purchase the advertised products without the direct approval of a physician, someone widely considered to be an authoritative scientific practitioner.

Though the APA distinguishes between PMS and PMDD and has not yet approved PMDD as an official category, these qualifications are lost as corporations manipulate scientific research for their commercial appeals. The emphasis on colloquial language and images of 'normal' women are intended to create identifications with the potential consumers so that the commercial nature of the advertisement is masked and instead consumers participate in a staged dialogue with one like themselves who has experienced the benefits of scientific expertise. These strategies are problematic because they eliminate accountability as a standard of public discourse. On the *Donahue* episode, Gold claims that PMDD and PMS are distinct and the category is not yet official, yet the Sarafem advertisements employ scientific authority for their claims that PMDD is merely a form of PMS and is an official diagnostic entity. Though many advertisements make irresponsible or even false claims, in the instance of DTC ads this phenomenon is particularly pernicious because of the scientific ethos permeating this discourse. For instance, even if an advertisement for a particular brand of hairspray claims that scientists

have proven its ability to make women look like models, few are likely to be persuaded by such crude yet common tactics. Yet, because Sarafem ads sell prescription drugs dispensed by licensed physicians, their scientific status is more likely to be taken for granted.

The DTC advertisements are also an instance of therapeutic rhetoric. Women are encouraged to view their discontent as a result of their own biology and seek solutions that alter their internal environments, the neurotransmitters in their brains, rather than look for alternatives to their external environments. Problems that are clearly social in nature, for example relational difficulties and dissatisfaction with work conditions, are described as problems individual *women* have, not problems *society* has. Women are encouraged to adapt themselves to existing social arrangements rather than work to challenge these arrangements. Such therapeutic discourse naturalizes current social arrangements and puts the onus on women to expel their discontent through chemical alteration. This discourse promises no less than earthly bliss. By using strategies common to religious discourse, for instance confession and evangelical narratives, the advertisements guarantee women an earthly paradise bought not through social struggle but serotonin reuptake inhibitors.

## CHAPTER 6

### CONCLUSIONS

Though several philosophers and rhetoricians have recently come to the defense of science and castigated critics for threatening a successful and productive practice (Cherwitz and Hikins; Goldman), the primary problem with science is that it carries an enormous discursive authority while at the same time defying precise definition. In the public sphere, 'science' operates as a rhetorical 'gold term' that derives its authority from a sphere inaccessible to the general public. When the results of activity carried out in this sphere are articulated in the public sphere, they are often portrayed as certain, definitive and proven and descriptions of what actually constitutes scientific research are often absent. As scientific rhetoric rises in power, expansion of what constitutes science proceeds apace and science can be called in as an authority in increasing areas of human activity.

Though 'science' is an amorphous and slippery notion, scientific rhetoric has been employed to support and justify gender inequality consistently throughout history. As Susan Bordo notes, the "discipline and normalization of the female body" is perhaps the only manifestation of gender oppression that is a relative constant throughout historical and cultural variations and is "an amazingly flexible and durable strategy of social control" (166). Though this discipline and normalization takes different forms in different epochs, it is consistently constructed as something apart from the true self, "and as undermining the best efforts of that self" (5). Current psychiatric discourse posits that

normal female ovarian function results in unexplained interactions between female hormones and neurotransmitters, resulting in severe disruptions of women's normal identities.

In Chapter Two, I examined historical manifestations of this strategy and explored how gender operates within a system of binary oppositions where women are associated with their bodies, nature, irrationality and madness while men occupy the side of mind, civilization, and reason. Science has often been employed as an authority justifying these associations. For Keller and Fausto Sterling, science is not only gendered because it disproportionately constructs women as inferior humans, science is intrinsically gendered because its own methodologies and practices are imbued with masculine traits and nature is seen as a feminine frontier to be conquered or seduced into revealing her secrets. Because menstruation is a visible marker of women's difference and is also a sign of reproductive capacity, it is frequently a site for manifestations of the associations between women and nature's wild, untamed, and hence irrational, frontier. Premenstrual syndrome is an extension of this female malady--like hysteria, it is loosely defined and is employed to explain women's behaviors that fail to conform to existing current notions of femininity. Popular discourses indicate that the PMS construct is directly associated with norms of feminine behavior. Dalton's self-help manual, published as recently as 1999, articulates PMS as a broad diagnosis with symptoms ranging from marital discord to cooking disasters. The 'normal woman' portrayed in these discourses is submissive to her husband and family and operates primarily in the domestic realm, caring for children and keeping up the home.

Chapter Three examined the emergence of premenstrual dysphoric disorder and showed how PMDD is a direct descendent of PMS and the current generation's female malady. This chapter also illustrated how what is given the name 'science' is often dependent on political and rhetorical means. The scientific research on PMDD is unsound and the APA's decision to put PMDD in the *DSM* was so controversial their own committee was unable to reach a consensus. Further, antidepressants have been prescribed for premenstrual discomfort for over a decade. This research is important in contextualizing later claims about the 'new' status of antidepressant treatments for PMDD. The final section of this chapter reviewed petitions sent to the APA protesting the inclusion of PMDD in the *DSM*. These petitions illustrate that though many women report feeling some level of premenstrual discomfort, they are concerned about the social implications of the classification. Though science is ostensibly a neutral activity untainted by human communication and social organization, these narratives reveal the very real influence scientific claims have in the realm of the social.

Chapter Four turned to the public sphere to examine how the psychiatric controversy was articulated on a popular talk show. Though the opponents of the diagnosis presented challenges to the scientific veracity of the supporting research, media framing strategies presented these challenges as politically motivated and projected a view of science as an objective and neutral basis for the formulation of public policy. Though television is a unsuitable medium for a thorough discussion of scientific data, talk shows can function as a site with democratic potential. On this show, despite the framing strategies employed by the host, women challenged scientific authority with the evidence of their own experiences in feminine voices. Though this resistance has little

impact in the spheres where decisions are actually made, it does highlight that not all women place their faith in the dictates of science.

Chapter Five continued to examine the portrayal of PMDD in the public sphere by analyzing Lilly advertisements for Sarafem. These advertisements significantly distort the psychiatric position and they represent PMDD as a valid diagnosis similar or equivalent to PMS. The controversial status of the disorder is completely ignored. Further, these ads portray Sarafem as a scientific advance though the active ingredient has been available and used to treat premenstrual complaints for some time. In the Sarafem ads, the corporate authors distance themselves by projecting the illusion of a dialogic encounter, a strategy which allows them to retain a scientific ethos while encouraging identifications.

Though this analysis has pointed to the contradictory and even unethical nature of the pro-PMDD discourses, there are very understandable reasons why they are as effective as they are. The narratives of women examined in the petitions and on the *Donahue* episode indicate that many if not most women experience some levels of premenstrual discomfort including emotional difficulties. Though there are many social discourses about menstruation, these discourses are typically confined to medical and hygienic terminologies. For instance, tampon advertisements are publicly displayed, but they encourage women to celebrate the latest advances in tampon technology that will allow menstruation to remain a secret, hidden, and private event. Maxi pad ads inform women that they can remain clean with ever new deodorized inserts. Thus, there are few social discourses about menstruation that encourage women to share their experiences of menstruation as it relates to their identities, emotions, and thoughts outside of a medical or hygienic paradigm. The PMDD discourses are consistent with this paradigm. Women

are again encouraged to view their natural bodily functions as abnormal, problematic, and interfering with their normal lives and normal selves. In short, women have been conditioned to view these experiences in negative ways long before the advent of serotonin and psychiatric dominance.

These discourses are further persuasive because they operate in a context where 'quick fix' solutions are the normal way to deal with problems of all varieties. Dana Cloud notes that modern capitalist society thrives on "the ability to sell us identities like pairs of shoes . . . We enact rituals of self-definition and transformation to locate ourselves in an increasingly complex world" (165). Sarafem and other anti-depressants are not popular because they are as successful as the glossy brochures and flashy television commercials claim or because they fulfill the promises of ethereal bliss and peace on earth. They are popular because they offer a discourse in which people can situate themselves and feel secure about who they are. This is somewhat paradoxical, because it requires 'admitting' that one is not normal and is in fact diseased. Yet, this admission paves the way for rehabilitation through the simple ritual of ingesting a pill. These psychiatric discourses promise that insecurity over identity in an increasingly complex and fragmented world is unnecessary. Individuals 'have' identities that can be restored to them through medical technologies. Elaine Scarry writes:

Television is our national theatre; and the periodic commercial interruptions are like rhythmic recitations of the pledge of allegiance, affirming (in their succinct, thirty-second dramas of transformation) a political ideology whose central provision *is the power of alteration*. Give me your tired and your poor; Nothing need stay as it is; None of us need be what we are (16-7).

These discourses are part and parcel of a political ideology because they are premised on the notion that individuals are exempt from the consequences of both individual and collective decisions. If it is true that the current social--including economic and political--organization has endemic problems, and if it is true that individuals are not isolated from social influences, then it is to be expected that many members of our society will be discontent. Yet, psychiatric discourses promise individuals complete freedom from the taint of society by offering them the key not to eternal life but access to their true, pure, and abstract selves. The statistics on mental disorders are daunting and they testify to the pervasive appeals these promises of instant alteration hold. The lifetime prevalence of mental disorders in America has been estimated at 50%, meaning that at least half of all Americans will be diagnosed with a mental disorder at some time in their lives (McGuire and Troisi ix).

If it is true that people are drawn to psychotropic drugs not solely or even primarily for their actual effects but for the identities they offer, this explains why women purchase Sarafem though identical antidepressants are available at reduced cost. People do not merely purchase a chemical, they also buy into the discourse surrounding the particular chemical. Just as people regularly spend unnecessary money on brand name jeans that are practically identical to less-costly generic versions, people purchase brand-name antidepressants for the specific identities they offer. Women do not understand their experiences as typical depression, they understand them as closely related to their reproductive organs and their menstrual cycles. Sarafem allows women to situate themselves as a unique type of psychiatric patient, afflicted by a special type of problem particular to their bodies. Once prescription drugs are advertised in much the same way

as jeans and hair spray, the logic of brand names becomes equally applicable to each of the products. Women are not 'dupes' for buying Sarafem any more than consumers in general are guilty of idiocy for constructing their identities in the most readily available way, through the purchase and display of brand name products that offer not so much a superior product as constellations of discourses promising to restore the individual to their complete and whole 'self.'

Thomas Szasz has eloquently explored the dangers of critiquing a specific psychiatric diagnosis or treatment. Such a focus risks legitimizing the greater psychiatric enterprise by portraying the item under discussion as an aberration from the norm of psychiatric science. Though the specific focus has been on PMDD, this project can also be read as a broader critique of modern biological psychiatry. PMDD is a unique disorder--it applies only to women and has been especially controversial--but it also shares much in common with the rest of psychiatry. Though not all disorders are gender-specific, women are disproportionately diagnosed with psychiatric illness and treated with pharmacologic agents. Further, all psychiatric disorders are constructed on the basis of negotiation and consensus--there are no proven, observable causes for psychiatric disorders as there are for most physical disorders. Finally, just as the PMDD discourses posit that women are material beings controlled by their hormones and brain chemistry, psychiatric theory generally participates in an extreme degree of biological determinism.

These biological theories constitute a unique and especially pernicious incarnation of therapeutic discourse. The causes of both individual malaise and social disarray are said to be both internal to the individual and beyond the control of the individual. This therapeutic rhetoric indicates that psychiatry is an expansion of scientific jurisdiction

into such areas as philosophy, religion, and sociology. If human behavior is controlled by the biology of the brain, there is literally no aspect of human activity that science, specifically psychiatry, is not qualified to adjudicate.

Despite the institutional power of psychiatric discourse, such rhetoric is internally contradictory and provides the grounds for its own refutation. Recall Judith Gold's description of menstruation's impact on female psychology: "This biological control supersedes any self-mastery a woman may develop, and to some degree she is always susceptible to its vagaries" (*Psychiatric Implications* xiii). As is evident in Gold's *Donahue* address, part of the reason that biology is so powerful is that in current psychiatric theory, all aspects of humanity can be explained in the language of biology. Nancy Andreason, one of the two APA members who ultimately made the final decision about PMDD and the *DSM*, writes in her recent book, "The brain forms the essence of what defines us as human beings. To understand its structure is to understand ourselves" (41). Implied is that if we are only literate enough in the language of neuropsychiatry, we will understand our actions, our motivations, our emotions, in short our "essence" and thus be able to "exert control over our destiny" (89).

In this framework, there is little room for human agency or volition--humans are the products of chemical interactions outside of their control. Further, there is no room for persuasion or rhetoric--the very idea of persuasion entails a belief in the ability of an audience to make choices. Yet, the psychiatric enterprise is dependent on persuasion and human volition. Because psychiatric diagnosis requires a unique degree of patient involvement and communication, there is a presumption that individuals are not entirely controlled by their biological compositions despite the mandates of popular theory. If

women are stricken to such a degree by the vagaries of the menstrual cycle, what aspect of ‘woman’ remains to step outside of the ill vessel and catalogue its woes? The idea that a chemical can make one more like ‘the woman she is’ implies that what it means to be a woman can be defined in terms of chemical interactions. If this is accurate, how are women to be expected to rise above the call of their hormones and participate in such activities as self-charting and seeking out treatment?

When the brain is posited as the source of human “essence,” the brain loses its explanatory power just as biology loses its potential to shed light on events when it is called in as an explanation for behaviors as various and sundry as husband beating and hair pulling. As scientific jurisdiction expands, the specificity of scientific terminology is diluted. In the case of modern psychiatry, the brain becomes just as mysterious and question-begging a construct as the previous concepts of mind and soul. Attributing human activity to the ‘brain’ is no less mystifying than attributing human activity to ‘God’ or ‘Nature.’ As Szasz notes, “If . . . everything that happens to or is done by human beings is *biological*, then saying so is a meaningless truism” (*Pharmacracy* 104). Though scientific expansion is threatening because its mission is to replace religious and philosophical explanations of human activity, it also opens up new grounds for resistance. As science tries to explain more and more things in the language of biology, this language becomes so murky and opaque that it contradicts the stated tenets of scientific objectivity, precision, and empiricism.

Just as each new version of hysteria lost its theoretical appeal when it was delinked from the feminine condition, PMDD can eventually be recognized as a selective and biased disease construct. Behaviors that deviate from the norms of true womanhood

are considered pathological when exhibited by women but normal and natural when displayed by men. Though PMDD might become an entity as archaic as the wandering womb, the historical consistency in the associations between women, their bodies, and pathology suggests that broader challenges to the science-gender system are needed to fully sever these harmful links.

## APPENDIX: *DSM-IV-R* RESEARCH CRITERIA FOR PMDD

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### Research criteria for premenstrual dysphoric disorder

A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3), or (4):

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

Note: In menstruating females, the luteal phase corresponds to the period between ovulation and the onset of menses, and the follicular phase begins with menses. In nonmenstruating females (e.g., those who have had a hysterectomy), the timing of luteal and follicular phases may require measurement of circulating reproductive hormones.

B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (avoidance of social activities, decreased productivity and efficiency at work or school).

C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Dysthymic Disorder, or a Personality Disorder (although it may be superimposed on any of these disorders).

D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation).

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## BIBLIOGRAPHY

Abbey, Sharon. Petition sent to Paula Caplan. 13 March 1993.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington D.C.: APA, 1980.

---. *Diagnostic and Statistical Manual of Mental Disorders Revised*. 3rd ed. Washington D.C.: APA, 1987.

---. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, D.C.:APA, 1994.

---. *Diagnostic and Statistical Manual of Mental Disorders Text Revision*. 4th ed. Washington, D.C.: APA, 2000.

Andreasson, Nancy C. *Brave New Brain: Conquering Mental Illness in the Era of the Genome*. Oxford: Oxford UP, 2001.

Bartky, Sandra Lee. *Femininity and Domination: Studies in the Phenomenology of Oppression*. New York: Routledge, 1990.

Berga, Sarah L. "Understanding Premenstrual Syndrome." *The Lancet* 351 (1998): 465-6.

Bird, Stephanie J. "Neuroscience Research and Premenstrual Syndrome: Scientific and Ethical Concerns." *Premenstrual Syndrome: Ethical and Legal Implications in a Biomedical Perspective*. Ed. Benson E. Ginsburg and Bonnie Frank Carter. New York: Plenum Press, 1987. 31-45.

Blast Away Fat. Advertisement. *Cosmopolitan* April 2001.

- Bleier, Ruth. "Sex Differences Research: Science or Belief?" *Feminist Approaches to Science*. Ed. Ruth Bleier. New York: Pergamon Press, 1986.
- Bordo, Susan. *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley: U. of California Press, 1993.
- Boseley, Sarah. "PMS a Myth, Claim Researchers." *The Guardian (London)* 9 June 1997.
- Breggin, Peter. *Toxic Psychiatry: Why Therapy, Empathy, and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry"* New York: St. Martin's Press, 1991.
- Brumberg, Joan Jacobs. *The Body Project: An Intimate History of American Girls*. New York: Vintage Books, 1997.
- Burke, Linda. Petition sent to Paula Caplan. 17 March 1993.
- Campbell, Karlyn Kohrs. "Femininity and Feminism: To Be or Not to Be a Woman." *Communication Quarterly* 31: (1983): 101-8.
- . *Man Cannot Speak for Her* Volume I. New York: Praeger, 1989.
- Caplan, Paula J. *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*. Reading, Mass.: Perseus Books, 1995.
- . *The Myth of Woman's Masochism*. New York: E.P Dutton, 1985.
- Caplan, Paula J. and Joan McCurdy-Myers and Maureen Gans. "Should 'Premenstrual Syndrome' Be Called a Psychiatric Abnormality?" *Feminism & Psychology* 2.1 (1992): 27-44.
- Carbaugh, Donal. *Talking American: Cultural Discourses on Donahue*. Norwood, NJ: Ablex, 1989.

- Carpignano, Paolo et al. "Chatter in the Age of Electronic Reproduction: Talk Television and The 'Public Mind.'" *Social Text* 8.3 (1990): 33-55.
- Cherwitz, Richard and James Hikins. "Climbing the Academic Ladder: A Critique of Provincialism in Contemporary Rhetoric." *Quarterly Journal of Speech* 86 (2000): 375-385.
- Chesler, Phyllis. *Women and Madness*. 3rd ed. New York: Four Walls Eight Windows, 1997.
- Cline, Rebecca and Henry Young. "Marketing Drugs, Marketing Health Care Relationships: A Content Analysis of Visual Cues in Direct-to-Consumer Prescription Drug Advertising." Unpublished paper. Presented at the National Communication Association November 2001.
- Cloud, Dana. *Control and Consolation in American Culture and Politics: Rhetoric of Therapy*. New York: Sage, 1998.
- Cohen, David. "Psychiatrogenics: Introducing Chlorpromazine in Psychiatry." *Review of Existential Psychology and Psychiatry* 23 (1997): 206-233.
- Cohen, Lee S. "New Trends in Treating Premenstrual Dysphoric Disorder." *Journal of Clinical Psychiatry* (2000 suppl. 12): 3-4.
- Conrad, Peter and Joseph W. Schneider. *Deviance and Medicalization: From Badness to Sickness*. 2nd ed. Philadelphia: Temple UP, 1992.
- Corning, W.C. "Bootstrapping Toward a Classification System." *Contemporary Directions in Psychopathology: Toward the DSM-IV*. Ed. Theodore Millon and Gerald L. Klerman. New York: The Guilford Press, 1986: 279-288.

Cortese, Anthony J. *Provocateur: Images of Women and Minorities in Advertising*.

Lanham: Rowman & Littlefield, 1999.

Chrisler, Joan C. and Karen B. Levy. "The Media Construct a Menstrual Monster: A Content Analysis of PMS Articles in the Popular Press." *Women & Health* 16.2 (1990): 89-104.

Cook, Guy. *The Discourse of Advertising*. 2nd edition. New York: Routledge, 2001.

Dahlgren, Peter. *Television and the Public Sphere*. London: Sage, 1995.

Daitchman, Donna. Petition sent to Paula Caplan. 16 March 1993.

Dalton, Katharina. *The Original Premenstrual Syndrome Handbook*. 1979. 6th ed. Alameda, CA: Hunter House, 1999.

Dan, Alice J. and Lisa Monagle. "Sociocultural Influences on Women's Experiences of Perimenstrual Symptoms." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 201-213.

Daugherty, Janice. "Treatment Strategies for Premenstrual Syndrome." *American Family Physician* 58.1 (1998): 103.

De Beauvoir, Simone. *The Second Sex*. Trans. H.M. Parshley. New York: Bantam, 1953.

DeRosis, Helen and Victoria Pellegrino. *The Book of Hope: How Women Can Overcome Depression*. New York: Bantam, 1976.

Derrida, Jacques. *Writing and Difference*. Trans Alan Bass. Chicago: Chicago UP, 1978.

DeVane, Lindsay C. "Pharmacologic Characteristics of Ideal Antidepressants in the 21st Century." *Journal of Clinical Psychiatry* (2000): 4-8.

- Dickstein, Leah J. "Current Relationships Between Stress and Menstrual Disorders in University Students." *The Psychiatric Implications of Menstruation*. Ed. Judith H. Gold. Washington, D.C.: American Psychiatric Press, 1985. 45-48.
- Dimmock, Paul et al. "Efficacy of selective-serotonin reuptake inhibitors in premenstrual syndrome: a systematic review." *Lancet* 356 (2000): 1131.
- Donahue. 5 March 1993.
- Donahue, Phil and Co. *Donahue: My Own Story*. New York: Fawcett Crest, 1979.
- Dow, Bonnie J. *Prime-Time Feminism: Television, Media Culture, and the Women's Movement Since 1970*. Philadelphia: U of Pennsylvania Press, 1996.
- Dow, Bonnie J. and Mari Boor Tonn. "'Feminine Style' and Political Judgment in the Rhetoric of Ann Richards." *Quarterly Journal of Speech* 79 (1993): 286-302.
- Ehrenreich, Barbara and Deirdre English. *For Her Own Good: 150 Years of the Experts' Advice to Women*. Garden City: Double Day, 1979.
- Eli Lilly and Company. "Sarafem." Advertisement pamphlet. 2000.
- Endicott, Jean. "Differential Diagnoses and Certainty." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 4-14.
- . "History, Evolution and Diagnosis of Premenstrual Dysphoric Disorder." *Journal of Clinical Psychiatry* (2000 suppl. 12): 5-7.
- . "The Menstrual Cycle and Mood Disorders." *Journal of Affective Disorders* (1993): 193-200.
- Eshom, Sherry. Petition sent to Paula Caplan.

Fahnestock, Jeanne. "The Rhetorical Life of Scientific Facts." *Written Communication* 15 (1998): 330-50.

Fausto-Sterling, Anne. *Myths of Gender: Biological Theories About Women and Men*. Revised edition. New York: Basic Books, 1992.

---. *Sexing the Body: Gender Politics and the Construction of Sexuality*. New York: Basic Books, 2000.

Fink, Paul J. Foreward. *Premenstrual Syndrome: Ethical and Legal Implications in a Biomedical Perspective*. Ed. Benson E. Ginsburg and Bonnie Frank Carter. New York: Plenum Press, 1987. ix-xi.

Flowers, R. Barri. *Domestic Crimes, Family Violence and Child Abuse*. Jefferson, NC: McFarland, 2000.

Forna, Aminatta. "All in the mind? How dare you!" *The Independent (London)* 8 March 1998: 5.

Frances, Allen. Forward. *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. xiii-xvii.

---. Memo to *DSM-IV* Work Group. Memo. 19 December 1988.

Frank, Robert T. "The Hormonal Causes of Premenstrual Tension." *Archives of Neurology and Psychiatry* (1931): 1053-1057.

Freeman, Ellen and Karl Rickel. "Characteristics of Placebo Response in Medical Treatment of Premenstrual Syndrome." *American Journal of Psychiatry* (1999): 1403-1408.

- Freeman, Ellen et al. "Differential Response to Antidepressants in Women with Premenstrual Syndrome/Premenstrual Dysphoric Disorder." *Archives of General Psychiatry* 56 (1999): 932-939.
- Friedrich, JoAnn Cutler. *The Premenstrual Solution: How to Tame the Shrew in You*. San Jose: Arrow Press, 1987.
- Frye, Gladys et al. "Is it premenstrual syndrome?" *Post Graduate Medicine* 107.5 (2000): 151.
- Foucault, Michel. *The History of Sexuality Vol. I*. New York: Pantheon, 1978.
- Gallant, Sheryle and Debra Popiel, Denise M. Hoffman, Prabir K. Chakraborty and Jean Hamilton. "Using Daily Ratings to Confirm Premenstrual Syndrome/Late Luteal Phase Dysphoric Disorder. Part II. What Makes a "Real" Difference?" *Psychosomatic Medicine* (1992): 167-181.
- ."Using Daily Ratings to Confirm Premenstrual Syndrome/Late Luteal Phase Dysphoric Disorder. Part I. Effects of Demand Characteristics and Expectations." *Psychosomatic Medicine* (1992): 149-166.
- Gater, Richard et al. "Sex Differences in the Prevalence and Detection of Depressive and Anxiety Disorders in General Health Care Settings." *Archives of General Psychiatry* 55 (1998): 405-413.
- Gelernter, Joel et al. "Serotonin Transporter Protein Gene Polymorphism and Personality Measures in African American and European Subjects." *American Journal of Psychiatry* 10 (1998): 1332-8.
- Geller, Jeffrey and Maxine Harris. *Women of the Asylum*. New York: Doubleday, 1994.

- Gelman, Sheldon. *Schizophrenia and Medication: A History*. Piscataway, NJ: Rutgers UP, 1999.
- Gieryn, Thomas F. "Boudary-Work and the Demarcation of Science from Non-SCience: Strains and Interests in Professional Ideologies of Scientists." *American Sociological Review* 48 (1993): 214-227.
- Gilligan, Carol. *In a Different Voice: Psychological Theory and Women's Development*. 2nd edition. Cambridge: Harvard UP, 1993.
- Gold, Judith H. "Historical Perspective of Premenstrual Syndrome." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 171-184.
- . Introduction. *The Psychiatric Implications of Menstruation*. Ed. Judith H. Gold. Washington, D.C.: American Psychiatric Press, 1985.xi-xiv.
- . Memo to all members of the Advisory Group to the Work Group on LLPDD. Memo to Paula Caplan. 10 February 1989.
- Goldman, Alvin. *Knowledge in a Social World*. Cambridge: Oxford UP, 1999.
- Goffman, Erving. *Gender Advertisements*. Cambridge: Harvard UP, 1979.
- Gosselin, Denise Kindschi. *Heavy Hands: An Introduction to the Crimes of Domestic Violence*. Upper Saddle River, NJ: Prentice Hall, 2000.
- Gross, Alan G. *The Rhetoric of Science*. 2nd ed. Cambridge: Harvard UP, 1996.
- Hague, Gill and Ellen Malos. *Domestic Violence: Action For Change*. 2nd ed. Cheltenham, England: New Clarion Press, 1998.
- Hahn, Linaya. *PMS: Solving the Puzzle*. Evanston: Chicago Spectrum, 1995.

- Hamilton, Jean and Barbara Parry. "An Update on Premenstrual Depressions: Evaluation and Treatment." *The Psychiatric Implications of Menstruation*. Ed. Judith H. Gold. Washington, D.C.: American Psychiatric Press, 1985. 7-15.
- Harris, Rhonda. Petition sent to Paula Caplan.
- Haxton, Sharon. Petition sent to Paula Caplan. 17 March 1993.
- Healy, David. *The Anti-Depressant Era*. Cambridge: Harvard UP, 1997.
- Heilbrun, Alfred B. and Michelle E. Frank. "Self-Preoccupation and General Stress Level as Sensitizing Factors in Premenstrual and Menstrual Distress." *Journal of Psychosomatic Research* (1989): 571-577.
- Henderson, Elaine. Petition sent to Paula Caplan. 15 March 1993.
- Hooks, bell. *Black Looks: Race and Representation*. Boston: South End, 1994.
- Hopkins, J. Ruth. Petition sent to Paula Caplan. 16 March 1993.
- Jordanova, Ludmilla. *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries*. Hertfordshire: Harvester Wheatsheaf, 1989.
- Jukes, Adam Edward. *Men Who Batter Women*. New York: Routledge, 1999.
- Kalbfleisch, Pamela J., Karen Bonnell, and Tina M. Harris. "Media Portrayals of Women's Menstrual Health Issues." *Evaluating Women's Health Messages*. Ed. Roxanne Louiselle Parrott and Celeste Michelle Condit. Thousand Oaks: Sage Publications, 1996.
- Karson, Craig W., Joel E. Kleinman, Richard Jed Wyatt. "Biochemical Concepts of Schizophrenia." *Contemporary Directions in Psychopathology: Toward the DSM-*

- IV. Ed. Theodore Millon and Gerald L. Klerman. New York: The Guilford Press, 1986. 495.
- Keller, Evelyn Fox. *Reflections on Gender and Science*. New Haven: Yale UP, 1985.
- Kingwell, Mark. *In Pursuit of Happiness: Better Living From Plato to Prozac*. New York: Crown, 1998.
- Kirk, Stuart A. and Herb Kutchins. *The Selling of DSM: The Rhetoric of Science in Psychiatry*. New York: Aldine de Gruyter, 1992.
- . *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders*. New York: The Free Press, 1997.
- Klerman, Gerald L. "Historical Perspectives on Contemporary Schools of Psychopathology." *Contemporary Directions in Psychopathology: Toward the DSM-IV*. Ed. Theodore Millon and Gerald L. Klerman. New York: The Guilford Press, 1986. 3-28.
- Koeske, Randi Daimon. "Premenstrual Emotionality: Is Biology Destiny." *The Psychology of Women: Ongoing Debates* Ed. Mary Roth Walsh. New Haven: Yale UP, 1987.
- Kolar, B. Petition sent to Paula Caplan. 13 March 1993.
- Lacquer, Thomas. *Making Sex: Body and Gender from the Greeks to Freud*. Cambridge: Harvard UP, 1990.
- Laing, R.D. *The Voice of Experience*. New York: Pantheon, 1982.
- Lauersen, Neils and Eileen Stukane. *Premenstrual Syndrome and You*. New York: Simon and Schuster, 1983.

- Laughlin, Mary and Ramona Johnson. "Premenstrual Syndrome." *American Family Physician* 29.3 (1984): 265-9.
- Lappalainen, Jaako et al. "Linkage of Antisocial Alcoholism to the Serotonin 5-HT1B Receptor Gene in 2 Populations." *Archives of General Psychiatry* 55. (1998): 989-994.
- Lewis, Lynda. Petition sent to Paula Caplan. 16 March 1993.
- Lessl, Thomas. "Toward a Definition of Religious Communication: Scientific and Religious Uses of Evolution." *Journal of Communication and Religion* (1993): 127-138.
- . "The Galileo Legend as Scientific Folklore." *Quarterly Journal of Speech* (1999): 146-168.
- . "The Priestly Voice." *Quarterly Journal of Speech* (1989): 183-197.
- . "Heresy, Orthodoxy, and the Politics of Science." *Quarterly Journal of Speech* (1988): 18-34.
- Ling, Frank. "Recognizing and Treating Premenstrual Dysphoric Disorder in the Obstetric, Gynecologic, and Primary Care Practices." *Journal of Clinical Psychiatry* (2000 suppl. 12): 9-16.
- "Literature Review." To members and advisors of the LLPDD Work Group from Judith Gold. 24 October 1990.
- "Look Who's Talking on Talk Shows." *Pittsburgh Post-Gazette*. 7 June 1993: D7.
- Lunbeck, Elizabeth. *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America*. Princeton: Princeton UP, 1994.

MacKinnon, Catherine. Preface. *A Dark Science: Women, Sexuality and Psychiatry in the Nineteenth Century*. New York: Farrar, 1986.

Macklin, Ruth. "The Premenstrual Syndrome (PMS) Label: Benefit or Burden?" *Premenstrual Syndrome: Ethical and Legal Implications in a Biomedical Perspective*. Ed. Benson E. Ginsburg and Bonnie Frank Carter. New York: Plenum Press, 1987. 17-30.

Mallek, Henry. *The Woman's Advantage Diet*. New York: Pocket Books, 1989.

Masson, Jeffrey Moussaieff. *A Dark Science: Women, Sexuality and Psychiatry in the Nineteenth Century*. New York: Farrar, 1986.

Millon, Theodore and Gerald L. Klerman. Preface. *Contemporary Directions in Psychopathology: Toward the DSM-IV*. Ed. Theodore Millon and Gerald L. Klerman. New York: The Guilford Press, 1986.

Melledo, Jean-Michel et al. "Response to Flumazenil in Women with Premenstrual Dysphoric Disorder." *American Journal of Psychiatry* 157 (2000): 821-3.

Merchant, Carol. *The Death of Nature: Women, Ecology and the Scientific Revolution*. San Francisco: Harper, 1990.

Merskin, Debra L. "What Every Girl Should Know: An Analysis of Feminine Hygiene Advertising." *Growing Up Girls: Popular Culture and the Construction of Identity*. Ed. Sharan R. Mazarella and Norma Odom Pecora. New York: Peter Lang, 1999.

Millon, Theodore. "On the Past and Future of the DSM-III: Personal Recollections and Projections." *Contemporary Directions in Psychopathology: Toward the DSM-IV*.

- Ed. Theodore Millon and Gerald L. Klerman. New York: The Guilford Press, 1986. 167-189.
- Mitchell, Juliet. *Madmen and Medusas: Reclaiming Hysteria*. New York: Basic Books, 2000.
- Montgomery, Scott L. *The Scientific Voice*. New York: The Guilford Press, 1996.
- Moos, Rudolf. "The Development of a Menstrual Distress Questionnaire." *Psychosomatic Medicine* (1968): 853-867.
- Namenwirth, Marion. "Science Seen Through a Feminist Prism." *Feminist Approaches to Science*. Ed. Ruth Bleier. New York: Pergamon Press, 1986.
- Nelkin, Dorothy. *Selling Science: How the Press Covers Science and Technology*. New York: W.H. Freeman, 1987.
- Nelkin, Dorothy and Laurence Tancredi. *Dangerous Diagnostics: The Social Power of Biological Information*. New York: Basic Books, 1989.
- Nietzsche, Friedrich. *Beyond Good and Evil*. Trans. Walter Kaufmann. New York: Vintage, 1966.
- Norris, Ronald V. with Colleen Sullivan. *Premenstrual Syndrome*. New York: Berkley Books, 1984.
- Ortner, Sherry. *Making Gender: The Politics and Erotics of Gender*. Boston: Beacon, 1996.
- Paris, Joel. "The Classification of Personality Disorders Should be Rooted in Biology." *Journal of Personality Disorders* (2000): 127-36.

Parlee, Mary Brown. "Stereotypic Beliefs about Menstruation: A Methodological Note on the Moos Menstrual Distress Questionnaire and Some New Data."

*Psychosomatic Medicine* 36:3 (1974): 229-240.

---. "Commentary on the Literature Review." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 149-159.

---. "Media Treatment of Premenstrual Syndrome." *Premenstrual Syndrome: Ethical and Legal Implications in a Biomedical Perspective*. Ed. Benson E. Ginsburg and Bonnie Frank Carter. New York: Plenum Press, 1987. 189-205.

Parry, Barbara. "Biological Correlates of Premenstrual Complaints." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 47-62.

---. "Psychobiology of Premenstrual Dysphoric Disorder." *Seminars in Reproductive Endocrinology* (1997): 55-68.

Peck, Janice. "TV Talk Shows as Therapeutic Discourse: The Ideological Labor of the Televised Talking Cure." *Communication Theory* 5.1 (1995): 58-81.

Podgorski, Al. "More Than a Bad Mood: Researchers Seek Facts on Severe Menstrual Disorder." *Chicago Sun-Times*. 19 Nov. 1997: 73.

Prelli, Lawrence J. *A Rhetoric of Science: Inventing Scientific Discourse*. Colombia: University of South Carolina Press, 1989.

Price, Daisy. "'PMS Made Me Think I Was Going Mad.'" *The Independent (London)* 1 Feb, 2001: 8.

- Price, William A. and Lynn R. Dimarzio, Pamela R. Gardner. "Biopsychosocial Approach to Premenstrual Syndrome." *American Family Physician* 33:6 (1986): 117-122.
- "Pyridoxine Therapy for the Premenstrual Syndrome." *American Family Physician* 31.4 (1984): 314.
- Reich, Walter. "Diagnostic Ethics: The Uses and Limits of Psychiatric Explanation." *Ethical Issues in Epidemiological Research*. Ed. Laurence Tancredi. New Brunswick: Rutgers UP, 1986. 38-64.
- Rees, Linford. "The Premenstrual Tension Syndrome and Its Treatment." *British Medical Journal*. 9 May 1953: 11014-1016.
- Reid, Robert L. and S.S.C. Yen. "Premenstrual Syndrome." *American Journal of Obstetrics and Gynecology*. 1 January 1981: 85-104.
- Rivera-Tovoer, Renee Rhodes, Teri B. Pearlstein and Ellen Frank. "Treatment Efficacy." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 99-128.
- Rodin, Mari. "The Social Construction of Premenstrual Syndrome." *Social Science and Medicine* 35: 1 (1992): 49-56.
- Rovnor, Sandy. "PMS Update." *The Washington Post* 29 April 1983: B5.
- Ruble, Diane. "Premenstrual Symptoms: A Reinterpretation." *Science* 97 (1977): 291-2.
- Ruble, Diane and Jeanne Brooks-Gunn. "Perceptions of Menstrual and Premenstrual Symptoms: Self-Definitional Processes at Menarche." *Premenstrual Syndrome: Ethical and Legal Implications in a Biomedical Perspective*. Ed. Benson E. Ginsburg and Bonnie Frank Carter. New York: Plenum Press, 1987. 237-251.

Rubinow, David. "Premenstrual Syndrome." *Public Health Rep (Suppl)* 102 (1987): 103-5.

Sarafem. Advertisement. *Cosmopolitan* April 2001.

Sarafem. Advertisement. *Cosmopolitan* May 2001.

Scarry, Elaine. *Resisting Representations*. Cambridge: Oxford UP, 1994.

Schellenburg, R. "Treatment for the premenstrual syndrome with agnus castus fruit extract: prospective, randomized, placebo controlled study." *British Medical Journal* 322 (2001): 134-8.

Schnurr, Paula P., Stephen W. Hurt, and Anna L. Stout. "Consequences of Methodological Decisions in the Diagnosis of Late Luteal Phase Dysphoric Disorder." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 19-43.

Schwartz, Paul J. et al. "Serotonin 1A Receptors, Melatonin, and the Proportional Control Thermostat in Patients With Winter Depression." *Archives of General Psychiatry* 55. (1998): 897-903.

Severino, Sally. "A Focus on 5-Hydroxytryptamine (Serotonin) and Psychopathology." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 67-87.

---. "Commentary: Late Luteal Phase Dysphoric Disorder--Disease or Dis-Ease?" *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 219-225.

Shorter, Edward. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York: John Wiley & Sons, 1997.

Showalter, Elaine. *The Female Malady: Women, Madness and English Culture, 1830-1980*. 1985. London: Virago, 1987.

---. *Hystories: Hysterical Epidemics and Modern Media*. 2nd ed. New York: Colombia UP, 1997.

Skrabaneck, Peter. "From Language to Lesion." *Review of Existential Psychology and Psychiatry*. (1997): 234-253.

Slim Fast. Advertisement. *Cosmopolitan* May 2001.

Soares, Claudio et al. "Efficacy of Estradiol for the Treatment of Depressive Disorders in Perimenopausal Women." *Archives of General Psychiatry* 58 (2001): 529-534.

Spitzer, Robert and Janet B. W. Williams. "Having a Dream: A Research Strategy for *DSM-IV*." *Archives of General Psychiatry* (1988): 871-874.

Steinem, Gloria. "If Men Could Menstruate: A Political Fantasy." *Race, Class, and Gender: An Anthology*. Ed. Margaret Andersen and Patricia Hill Collins. 2nd ed. Boston: Wadsworth, 1995. 392-4.

Steiner, Meir. "Recognition of Premenstrual Dysphoric Disorder and Its Treatment." *The Lancet*. 30 September 2000: 1126-7.

Steiner, Meir and Teri Pearlstein. "Premenstrual Dysphoria and the Serotonin System: Pathophysiology and Treatment." *Journal of Clinical Psychiatry* (2000 suppl. 12): 17-21.

Steiner, Meir et al. "Fluoxetine in the treatment of premenstrual dysphoria." *New England Journal of Medicine* 332 (1995): 1529-34.

Stockbridge, Lisa L. FDA Letter to Eli Lilly and Company. 2000. [www.fda.org]

- Stotland, Nada and Bryna Harwood. "Social, Political, and Legal Considerations." *Premenstrual Dysphorias: Myths and Realities*. Ed. Judith H. Gold and Sally Severino. Washington, D.C.: American Psychiatric Press, 1994. 186-196.
- Stout, Anna L. and John F. Steege. "Psychological Assessment of Women Seeking Treatment for Premenstrual Syndrome." *Journal of Psychosomatic Research* (1985): 621-629.
- Stout, Anna L. and Tana A. Grady, John F. Steege, Dan G. Blazer, Linda K. George, Mary Lou Melville. "Premenstrual Symptoms in Black and White Community Samples." *American Journal of Psychiatry* 143 (1986): 1436-1439.
- Sullivan, Meg. "Premenstrual Syndrome Not Fully Accepted as a Medical Disorder." *Los Angeles Times* 23 Sept. 1986: 5.1.
- Szasz, Thomas. *Pharmacracy: Medicine and Politics in America*. Westport: Praeger Publishers, 2001.
- Tancredi, Laurence. "The New Technology of Psychiatry: Ethics, Epidemiology, and Technology." *Ethical Issues in Epidemiological Research*. Ed. Laurence Tancredi. New Brunswick: Rutgers UP, 1986.
- Tavris, Carol. *The Mismeasure of Woman*. New York: Simon & Schuster, 1992.
- . "Perspective on PMS; You Haven't Come Very Far, Baby." *Los Angeles Times*. 4 March 1993: B7.
- Taylor, Charles Alan. "Defining the Scientific Community: A Rhetorical Perspective on Demarcation." *Communication Monographs* (1991): 402-420.
- Ussher, Jane M. *The Psychology of the Female Body*. New York: Routledge, 1989.

Valenstein, Elliot S. *Blaming the Brain: The Truth About Drugs and Mental Health*. New York: The Free Press, 1998.

van Leusden, Huub. "Premenstrual Syndrome No Progesterone; Premenstrual Dysphoric Disorder No Serotonin Deficiency." *Lancet* 346 (1995): 1443-1444.

Vatz, Richard and Lee Weinburg. "The Rhetorical Paradigm in Psychiatric History: Thomas Szasz and the Myth of Mental Illness."

Vedantam, Shankar. "Renamed Prozac Fuels Women's Health Debate." *The Washington Post* 29 April 2001: A01.

Veith, Ilza. *Hysteria: The History of a Disease*. Chicago: U. of Chicago Press, 1965.

Wade, Carlson. *PMS Book*. New Canaan, CT.: Keats, 1984.

Weiss, Elizabeth. *From Female Depression to Contented Womanhood*. New York: Zebra Books, 1977.

Whisnant, Lynn and Leonard Zegans. "A Study of Attitudes Toward Menarche in White Middle-Class American Adolescent Girls." *American Journal of Psychiatry* 132 (1975): 809-814.

Yatham, Lakshmi et al. "Brain Serotonin<sub>2</sub> Receptors in Major Depression." *Archives of General Psychiatry* 57. (2000): 850-8.

Young, Elizabeth et al. "Alteration in the Hypothalamic-Pituitary-Ovarian Axis in Depressed Women." *Archives of General Psychiatry* 57 (2000): 1157-1162.

Xenadrine. Advertisement. *Cosmopolitan* May 2001.