

PREMENSTRUAL SYNDROME AS A WESTERN
CULTURE-SPECIFIC DISORDER

ABSTRACT. Premenstrual syndrome (PMS) has a phenomenology resembling many culture-bound (culture-specific) syndromes described in the anthropological literature. Viewed as a culture-specific syndrome, PMS is an appropriate symbolic representation of conflicting societal expectations that women be both productive and reproductive. By simultaneously denying either alternative, PMS translates role conflict into a standardized cultural idiom. Thus, despite obvious biopsychological determinants, PMS is best understood as a sociocultural phenomenon illustrating both the special status of women in Western culture and the ethnocentrism of Western anthropology which heretofore has only recently begun to identify culture-specific syndromes in its own back yard.

INTRODUCTION

For some years, anthropologists have written extensively about bizarre behavioral symptoms occurring in relatively specific cultural contexts. Such disorders as *pibloktoq*, *latah*, *koro*, *susto*, and *amok* have come to be known as "culture-bound syndromes" (Yap 1977). Although most Western writers view these behavioral deviations as localized variants of disorders common to Western psychiatric nosology (Dobkin de Rios 1981; Foster and Anderson 1978; Kennedy 1973; Kiev 1972; Kleinman 1978; Manschreck and Petri 1978; Moore et al. 1980; Rubel 1964; Teicher 1971; Yap 1964, 1967, 1969; etc.), they have also been attributed to physiological abnormality resulting from dietary deficiency (Foulks 1972; Wallace 1972), studied as symbolic manifestations of social status/role marginality (Kenny 1978; Lee 1981), or seen as "normal," culturally sanctioned behaviors without pathology (Carr 1978). Most recently, it has been suggested that the search for a *general* classificatory term, such as "culture-bound syndrome," be abandoned altogether because the phenomena so grouped are neither homogeneous *nor* distinctive, with the differences due to a "... failure of the diagnoses to include a thoroughgoing cultural analysis (to ascertain how deeply and in what manner the cultural dimension is embodied in observed behavior), than ... [to] distinctive pathologic structural differences" (Simons and Hughes 1985). Whatever the focus, and by whatever taxon, culture-bound syndromes have been widely described in other cultures.

Recently, anthropologists have been chastised from within their own discipline for only conceptualizing culture-bound syndromes as occurring

in other cultures, and for focusing only on nonorganic etiologies for their occurrence (Cassidy 1982; Ritenbaugh 1982). In characterizing Protein Energy Malnutrition (formerly termed *Kwashiorkor*) as a Western culture-bound syndrome, which cannot be understood from outside Western cultures because the concept is rooted in biomedical science, Cassidy (1982) exposes the assumption of biomedical scientists that their science is "culture-free," which explains, in part, the failures of strategies to alleviate hunger in Third World countries whose explanatory models of starvation systems are quite different. In a similar vein, Ritenbaugh (1982) demonstrates that obesity can be seen as a Western culture-bound syndrome, because the definition and treatment of the "disease" is so culture-specific, and she criticizes anthropologists for confusing the Western biomedical classification system with the biological data upon which it is based: although the latter can be derived from any organism, the former is highly culture-specific.

These two papers, and a third more recent paper which elegantly describes anorexia nervosa as a Western culture-specific disorder (Swartz 1985), advance a definition of culture-bound syndromes which involves a constellation of symptoms categorized by a given culture as a disease; the etiology of which symbolizes core meanings and reflects preoccupations of the culture; and the diagnosis and treatment of which are dependent upon culture-specific technology and ideology. Further, the definition holds that, while such symptoms may be recognized elsewhere, they will not be categorized as the same disease, and treatment which is successful in one cultural context will not be seen as successful in another. The reality of such *syndromes* is the result of a negotiation between those who treat it and those who suffer from it, even though *symptoms* may exist apart from the negotiated reality.

The purposes of this paper are to describe premenstrual syndrome (PMS) as yet another "Western" culture-specific disorder which fits this definition, and to further explore the idea that the failure to describe culture-bound syndromes in our own culture betrays a peculiar ethnocentrism and impedes our full understanding of both these phenomena and their relationship to the cultures in which they exist.

HISTORY OF PREMENSTRUAL SYNDROME (PMS)

Premenstrual syndrome (PMS) is a term which subsumes a constellation of symptoms of altered affective, behavioral, cognitive, and somatic functioning in women, which relate to the menstrual cycle. A list of

common symptoms of PMS is presented in Table I (Rubinow and Roy-Byrne 1984). Perhaps the first observation of a connection between the menstrual cycle and affective disorders was made by Hippocrates, who

TABLE I
Common Symptoms of Premenstrual Syndromes

<i>Affective</i>	<i>Autonomic</i>
Sadness	Nausea
Anxiety	Diarrhea
Anger	Palpitations
Irritability	Sweating
Labile mood	
<i>Cognitive</i>	<i>CNS</i>
Decreased concentration	Clumsiness
Indecision	Seizures
Paranoia	Dizziness
"Rejection sensitive"	Vertigo
Suicidal ideation	Paresthesia
	Tremors
<i>Pain</i>	<i>Fluid/Electrolyte</i>
Headache	Bloating
Breast tenderness	Weight gain
Joint and muscle pain	Oliguria
	Edema
<i>Neurovegetative</i>	<i>Dermatological</i>
Insomnia	Acne
Hypersomnia	Greasy Hair
Anorexia	Dry hair
Craving for certain foods	
Fatigue	<i>Behavioral</i>
Lethargy	Decreased motivation
Agitation	Poor impulse control
Libido change	Decreased efficiency
	Social isolation

(From Rubinow and Roy-Byrne 1984: 170)

theorized that symptoms were caused by agitated blood seeking a channel of escape from the womb (Wick 1941). Although genesis of the term "premenstrual syndrome" is often attributed to a paper, "The Hormonal Causes of Premenstrual Tension" read over fifty years ago at a meeting of New York Academy of Medicine (Frank 1931), in fact, only the term "premenstrual tension" appeared. The author described premenstrual tension as a feeling of "indescribable tension" and a "desire to find relief by foolish and ill-considered actions" (Frank 1931:1054). The author's

statements in context, however, presage much of the more recent debate about both medical and the social aspects of PMS:

My attention has been increasingly directed to a large group of women who are handicapped by premenstrual disturbances of manifold nature. It is well known that normal women suffer varying degrees of discomfort preceding the onset of menstruation. Employers of labor take cognizance of this fact and make provision for the temporary care of their employees. These minor disturbances include increased fatigability, irritability, lack of concentration, and attacks of pain (Frank 1931: 1053).

In short, although premenstrual symptoms exist cross-culturally and have been extensively studied (Janiger et al. 1972), the term "premenstrual syndrome" actually did not occur until 1953 in Great Britain (Greene and Dalton 1953). For a time, PMS was used synonymously with "premenstrual tension" or "premenstrual tension syndrome" (terms which tended to be used more in the United States, particularly in the Western states); only since the 1970s has PMS become a standard (albeit non-specific) taxon in both medical and lay disease classification systems in this country and in Europe. Endorsement of the term "PMS" represents not only a recognition that clinical symptoms involve more than depression, extreme fatigue, and irritability (the problems formerly subsumed under the term "premenstrual tension"), but also a redefinition of our disease classification system.

In the past ten years, PMS has become a major issue for both the professional and lay communities. Perhaps a strong impetus to recognition of PMS has been the development of special clinics for the study of infertility and other disorders of the menstrual cycle. Various lay support groups have also been formed to help women who believe they have PMS, and to pressure the medical profession and employers to recognize its reality. PMS also received worldwide attention in the early 1980s, when it was used successfully in the defense of two British women accused of murder. In one case, a thirty-year-old barmaid with a history of conviction for disruptive behavior was found guilty in the stabbing death of another barmaid, but because of testimony by her physician, was released on probation and ordered to receive daily injections of 100 milligrams of natural progesterone. In the other case, a thirty-seven year old woman with no history of violence or criminal behavior was accused of killing her drunken lover by running him down with the car. After careful evaluation by several physicians, who testified that the defendant suffered from "extreme premenstrual syndrome," the court ruled that she had committed the crime under "wholly exceptional circumstances," reducing her charge to manslaughter on the grounds of "diminished responsibility" due to PMS (Lauersen and Stukane 1983: 27). The details of each of case are not as

important as the fact that PMS has now become a medical-legal entity. Subsequently, numerous magazines and other lay publications have published articles about PMS and distributed questionnaires to document the prevalence of disruptive PMS symptoms.

Currently, PMS is a controversial disease entity. Many women welcome professional legitimization for longstanding and troubling symptoms which have been either dismissed as unimportant signs of "weakness" or "hysteria" by a male-dominated medical culture, or popularized as the central features of antifeminist jokes. The women's rights movement is understandably ambivalent about PMS, not wanting to deny its existence and the importance to women of research and treatment, while attempting to prevent social discrimination on the basis of sexual differences. But by asserting the reality of PMS, the existence of far-reaching biobehavioral differences between the sexes is implied. The feminist health care literature has also argued that PMS is yet another example of a disease constructed by physicians, who have vested political-economic interests in developing new disease entities to treat (Reissman 1983; Sicherman 1977), yet it has primarily been pressure from the lay public which has resulted in movement within the medical profession to specifically address PMS. Medical professionals find PMS troubling because it is an umbrella term with innumerable vague referents. Confusion currently exists about the cause(s) of PMS, as well as appropriate treatment(s). As one recent article describing the clinical approach to PMS for practicing physicians noted,

This syndrome has become a popular scapegoat for behavioral aberrations ranging from malaise to murder. The physician is hard-put to separate the mythology from the medicine underlying the complaints likely to be encountered in practice (Rose and Ablanap 1983).

THE PHYSIOLOGICAL BASIS OF PMS

In keeping with the Western biomedical tradition, research has been conducted in an attempt to define and measure PMS (Rubinow and Roy-Byrne 1984). The key issues which need to be addressed in defining PMS are the symptoms, their intensity, their relationship to menstruation, and the "baseline" upon which PMS symptoms fluctuate. Although these issues seem straightforward, they have proven to be exceedingly difficult to address systematically.

PMS symptoms, alone, are not clear-cut: by 1968, over 150 different symptoms were felt to be associated with the menstrual cycle (Greene and Dalton 1953; Moos 1968; Dalton 1964), but there had been no con-

sistency in either the number or frequency of reported symptoms due, in part, to the lack of any assessment methodology. The first and most utilized standardized assessment instrument, a 47-item Menstrual Distress Questionnaire (Moos 1968), was principally focused on somatic rather than on emotional or behavioral changes, and can be criticized because half of the normative sample used was taking oral contraceptives and 10% were pregnant (Parlee 1974). A subsequent instrument, which also included several psychiatric symptom rating scales (Steiner et al. 1980), defined PMS quite narrowly (five of eight major mood and behavioral symptoms were necessary for diagnosis of PMS, yielding a homogeneous but fairly narrowly defined group of PMS patients, which by definition excluded many patients who might otherwise claim PMS). Most recently, a 95-item premenstrual symptom assessment form has been developed (Halbreich et al. 1982) which more precisely differentiates changes in mood and behavior.

Even if the symptoms of PMS were clearly defined phenomenologically, very little has been done in terms of severity of symptoms (Sutherland and Stewart 1965), and these have been inconsistent in defining "premenstrual" temporally, with investigations focusing on the last six days of the luteal phase and the first two days of menstruation (Kramp 1968), or the five days before and following the onset of menses (Dalton 1964). Some women apparently have greatest affective symptoms prior to menstruation, with others reporting more symptoms after menstruation (May 1976); somatic scores have also been reported to be higher during menstruation, with higher psychological scores characteristic premenstrually (Moos 1968).

Other problems with defining PMS are establishing any relationship between symptom severity during the perimenstrum and the occurrence of symptoms at other times, and the relationship between symptom occurrence or severity and stressful life events. There are reports that women with PMS are also symptomatic at other times (Coppin and Kessel 1963; Sampson and Jenner 1977), and symptoms have been shown to vary with stress in women not diagnosed with PMS (Wilcoxon et al. 1976). Given that there is variance in symptom severity, it must be asked what levels of fluctuation are necessary for a "diagnosis" of PMS.

Finally, PMS studies have been conducted on women from various groups which could bias results, such as patients in "premenstrual tension" and infertility clinics (Sampson 1979; Benedek-Jaszmann and Hearn-Sturtevant 1976), women who have had gynecological surgery (Beumont et al. 1975), general practice patients without PMS complaints (Robinson et al. 1977; Clare 1977), and college students (Parlee 1973). Some studies have eliminated women with histories of psychiatric problems or irregular

menstrual cycles, all groups "reported to have a greater incidence of symptoms" (Rubinow and Roy-Byrne 1984: 165). Perhaps most importantly, most PMS studies rely on retrospective ratings for inclusion of study subjects, despite the fact that retrospective reports have been shown to overestimate symptoms, when compared to prospective ratings (Sampson and Prescott 1981). In short, "at present there is no generally accepted way of objectively rating a syndrome that more often consists of internally experienced symptoms rather than objective behavioral signs" (Rubinow and Roy-Byrne 1984: 165).

In addition to the difficulties in establishing definitional criteria for studying PMS symptoms, there also has been great disagreement about the etiology of those symptoms, and about appropriate treatments. A list of proposed etiologies and treatments for PMS is presented in Table II (from Rubinow and Roy-Byrne 1984: 170). Although abnormalities of endocrine function are most commonly implicated as the basis of PMS, in ten studies comparing progesterone levels in women with PMS symptoms and controls, five showed reduced mid-to-late luteal phase levels in symptomatic women (Backstrom et al. 1976; Backstrom and Carstensen 1974; Munday et al. 1981; Abraham et al. 1978; Smith 1975), one showed elevated levels (O'Brien et al. 1980), and three showed no abnormalities (Taylor 1979; Andersch et al. 1979; Anderson et al. 1977). The confusion of these results is further compounded by the aforementioned problems of variable inclusion criteria for study subjects and use of retrospective rating instruments, and methodological problems such as nonuniform blood sampling times and intervals (Rubinow and Roy-Byrne 1984: 165). Studies of estrogen levels in premenstrual symptoms are equally contradictory, with one study showing a correlation between elevated estrogen levels and symptoms such as anxiety and irritability (Backstrom and Mattsson 1975), but with contradictory reports of elevated estrogen levels, estrogen-progesterone ratios, prolactin levels, and aldosterone levels in PMS sufferers (see Rubinow and Roy-Byrne 1984: 166). Other hypothesized but unsubstantiated causes of PMS are cyclical glucose metabolism abnormalities (Morton 1950), deficiencies of B vitamins (Biskind 1943), premenstrual changes in endorphins (Bickers and Woods 1951), alterations in prostaglandins (Wood and Jakubowicz 1980), and changes in central nervous system neurotransmitters (Rausch and Janowsky 1982; Reid and Yen 1981). The present status of etiological themes of PMS is perhaps best summarized by Rubinow and Roy-Byrne (1984: 166).

Finally . . . evidence in support of a psychological basis for menstrually related mood disorders is currently lacking. In sum, no etiological hypothesis has been substantiated . . .

TABLE II
Proposed Etiologies and Treatments for Premenstrual Syndromes

<i>ETIOLOGIES</i>	<i>TREATMENTS</i>
<i>Ovarian Hormonal</i>	<i>Hormonal</i>
Estrogen	Progesterone
	Progestins/Oral
	Contraceptives
Progesterone	Antihormonal, Danazol
	Androgens
<i>Fluid and Electrolyte Hormonal</i>	<i>Psychotropics</i>
Prolactin	Lithium
Aldosterone	MAO Inhibitors
Renin/Angiotensin	Sedative-Hypnotics
Vasopressin	
<i>Other Hormonal</i>	<i>Other</i>
Endorphins/Enkephalins	Bromocriptine
Alpha-Melanocyte Stimulating Hormone	Pyridoxine
Glucocorticoid	Dietary Restriction
Androgen	Diuretics
Insulin	Prostaglandin precursors/
Melatonin	Inhibitors
<i>Neurotransmitter</i>	
Monoamines (5-hydroxytryptamine, Norepinephrine, Dopamine)	
Acetylcholine	
<i>Other</i>	
Endometrial Toxins	
Vitamin B ⁶ /magnesium	
Prostaglandins	

(From Rubinow and Roy-Byrne 1984: 170)

TREATMENT OF PMS

Studies to evaluate responses to various treatments are also numerous and contradictory. The most widely known regimen of progesterone (intramuscular injection or suppository) has only been the object of two controlled studies (double-blind, placebo-controlled, crossover design), and these report negative results (Sampson 1979; Taylor 1979). One study reported an improvement in mood and somatic symptoms with dydrogesterone (Taylor 1977), but in a placebo-controlled trial, although there was a 75% response rate with the drug, there was also a 53% response rate with placebo (Haspels 1981).

Following up on a presumed relationship between PMS symptoms and prolactin-induced fluid and electrolyte alterations, use of bromocriptine (a drug which can lower plasma prolactin) has been associated with mood improvement in both open and double-blind crossover trials (Benedek-Jaszmann and Hearn-Sturtevant 1976). Patients also report improvement in depression with bromocriptine (Elsner et al. 1980), but three studies show a response rate no different from that of placebo (Anderson et al. 1977; Kullander and Svanberg 1979; Ghose and Coppin 1977). These and other studies using lithium (Sletton and Gershon 1966; Tupin 1972; Fries 1969), vitamin B⁶ (Pyridoxine) (Day 1979; Kerr 1977), and diuretics (Appleby 1960; Rees 1953a) have consistently been plagued by methodological/statistical problems, or a failure to demonstrate increased efficacy over placebo (Rubinow and Roy-Byrne 1984: 167).

In short, no claims of therapeutic efficacy have, to date, been confirmed by any study other than open clinical trials and anecdotal reports. As Rubinow and Roy-Byrne summarize (1984: 168):

It would appear that the bulk of evidence in support of current popular treatments is derived from uncontrolled trials, and, as is true with studies of etiology, the lack of comparability across studies at even the most fundamental levels of population definition and symptom measurement makes the uniform demonstration of any result highly unlikely.

PMS AND PSYCHIATRIC DISORDERS

There has been some suggestion that PMS should be recognized either as a unique psychiatric disorder, or a concomitant of other recognized major psychiatric syndromes which happen to be episodic and related to the menstrual cycle. Indeed, other psychiatric syndromes (e.g., depression, bipolar affective disorder) exhibit a rhythmicity, suggesting some relationship between formal psychiatric disorders and PMS. In fact, retrospective studies which compare psychiatric diagnoses in PMS sufferers and "normal" women reveal a greater rate of psychiatric disorders (e.g., depression) and history of psychiatric care among college women who complain of PMS (Wetzel et al. 1975; Schuckit et al. 1975). Women with PMS have been also been measured as "neurotic" (Coppin 1963), but another clinician has noted both that there are a number of neurotic women who do not have PMS and that psychotherapy with women who are both neurotic and have PMS may result in improvement in the former, but not the latter (Rees 1953b).

Other studies have examined the incidence of PMS in patients with psychiatric illness. One study (Endicott et al. 1981) reports a 62% rate of

PMS among patients with major affective disorder, a rate which contrasts with rates of 7%, 15%, and 38% among groups of "normal" controls. Another study reports a 65% rate of PMS in women with affective disorder compared with a 14% rate in women with other mental disorders and 21% of "normal" controls (Kashiwagi et al. 1976). A third study, however, reports no difference in PMS symptom frequency when comparing patients with affective illness and control (Diamond et al. 1976), although the rates of "premenstrual depression" reported (65% in women with psychiatric diagnoses or 57% in "normals") is comparable to rates in the studies mentioned earlier.

These studies would indicate that, although similar and often occurring together in patients, PMS and affective psychiatric illness are not inseparable. There are, however, over two dozen specific cases in the literature describing premenstrual tension associated with other major psychiatric disorders that are felt to relate to the menstrual cycle (Williams and Weeks 1952; Endo et al. 1978). In short, there has been little examination, to date, of menstrual cycle regulation or synchronization of psychiatric problems, despite great growth of interest in the general area of biological rhythms and brain neurochemistry. The association of limbic system, electrolyte, and endocrine physiology disturbances associated with both PMS and psychiatric illness, however, is an area of potentially important future study, given the ascendancy of biological interests within psychiatry.

Future development in psychobiology notwithstanding, the relationship of PMS to other psychiatric disorders remains as elusive as an understanding of its physiological basis and treatment. Focusing on the usual biomedical investigative techniques has shed very little light on the nature of PMS. More assuredly, these investigations have not addressed the important question of why premenstrual *syndrome* (PMS) has only appeared in Western industrial cultures in the past two decades, despite the fact that premenstrual *symptoms* have been reported in diverse cultures for centuries. Whatever the outcome of Western scientific studies of the biology of PMS, the emergence of this syndrome clearly deserves to be examined culturally, and anthropology has much to offer in this regard.

PMS AS A CULTURE-BOUND SYNDROME

Unfortunately, the rapid expansion in biomedical understanding in Western culture has increased not only the number of discrete biological disease entities and created a reductionistic focusing of our attention on

the biological aspects of symptom complexes, but also has systematically obscured our view of the essential cultural components of biomedical disease definition (Ritenbaugh 1982: 348). We strive to discover the biological "reality" of PMS, for example, without examining the cultural forces which are attendant in the *process* of creating that reality. We are willing to see culture-bound syndromes in other cultures when we cannot readily understand their symptom complexes in biomedical terms. Even though there are those who strive to find congruence between bizarre symptom complexes in other cultures and Western biomedical disease entities, there has been an implication that such syndromes are "not real." Yet we unquestioningly treat our own problematic syndromes, such as PMS, as "real," striving constantly to find physiological correlates of symptoms.

Although some transcultural psychiatrists and medical anthropologists would advocate studying PMS by establishing evidence for its presence or absence in different cultures, and others would insist that culture as an etiological variable in PMS can best be studied by epidemiological correlation of symptom incidence with psychometric or sociometric indices within a given cultural context, two problems with these approaches exist. First, as previous discussion makes clear, current epidemiological studies of PMS are fatally flawed, and the prospects for adequate future studies are problematic. Second, such approaches are reductionistic, systematically focusing attention away from the depth and pervasiveness of culture in distinctively shaping illness behavior, regardless of the extent of organic involvement (Simons and Hughes 1985: 11-12).

Even epidemiologically, however, PMS presents a picture very much like other culture-bound syndromes classically discussed in anthropological literature because it does not occur universally. A thorough search of bibliographies in transcultural psychiatry and of other indexing sources reveals no mention of the term "PMS" in areas of the world other than the United States and Europe. Although there are clearly recognized perimenstrual symptoms in other cultures, there has been no study to date which has discovered an analog to PMS crossculturally; such research should be carried out, but is beyond the scope of this paper. This particular taxon appears only recently in these industrial cultures; it has only been formalized during the past two decades. PMS involves bizarre behavior which is recognized, defined, and treated as a specific syndrome only by biomedical healers in Western, industrial cultures, and can be only understood in this specific cultural context.

By accepting unquestioningly PMS as a disease entity, however, and not examining how PMS reflects core meanings and preoccupations of

Western culture, anthropologists, unwittingly and ethnocentrically, fail to apply the same standards of analysis in our own "back yard" that we demand in studies of such disease syndromes in other cultures. We should not be seduced into excluding PMS from the realm of culture-bound syndromes simply because of biomedical attempts at diagnosis and treatment. In so doing, we lose a valuable opportunity to better understand Western culture, the phenomenon of culture-bound syndromes, and the relationship between culture and disease.

Although analyses of culture-bound syndromes have been epidemiological, psychopathological, or behavioral in thrust, a symbolic analysis of PMS is compelling. Such a symbolic analysis is consistent with the hermeneutic, meaning-centered focus of the "new cross-cultural psychiatry" (Kleinman 1977). In this approach, any culture-bound syndrome can be seen as an "expression . . . of the key elements (statuses, relationships, institutions) of the society's social structure, as well as the central cultural meanings and norms that legitimate them" (Kleinman 1978: 207). Epidemiological questions are essentially tangential to such current, meaning-centered definitions of illness, in general, and of culture-bound syndromes, specifically, in medical anthropology. Such an approach demands understanding of disease in cultural context, not attributing to PMS, for example, ". . . a reality apart from that which is negotiated between those who treat it and those who suffer from it" (Swartz 1985: 726).

Further, the meaningfulness of culture-bound syndromes rests with their contrasting relations to culturally accepted standards of normal behavior. Not only can culture-bound syndromes "represent alternative structural possibilities in ritual form, [they] can develop into counterstructure that can actively introduce changes in existing social structure" (Lee 1981: 236). In short, a culture-bound syndrome can serve as a symbolic mechanism for both structural maintenance and change in a particular society and, so studied, can assist in the identification and understanding of salient cultural upheavals.

The central point upon which such a symbolic understanding of PMS as a culture-specific disorder rests is the fact that its appearance follows on the heels of a unprecedented alteration of the status and roles of women in the social structure of those cultures in which PMS is recognized. The "appearance" of PMS at this specific time in the history of Western industrial culture should not be surprising in the least, nor should the fact that the major impetus for recognition of PMS has come, not from medical professionals, but from lay persons (such as self-help or support groups). Underscored by numerous articles in the popular press, our culture has placed women in a role conflict in which they are expected to

be both productive and reproductive: to have both careers and families. In fact, the "messages" are highly ambiguous, with women placed in a cultural double-bind in which expectations for doing *either* or *both*, are equally conflict-laden ("You mean you could be happy "just" being a mother?!" or "How can you possibly work and have a family at the same time? . . . you won't do either well!").

PMS serves to answer this role conflict of productivity and generativity by simultaneously and symbolically denying the possibility of each: in menstruating, one is potentially fertile but obviously nonpregnant; in having incapacitating symptomatology one is exempted from normal work role expectations. With PMS, women can be seen as "victims" who did not "choose" to be sick. Through PMS, Western culture translates the ambiguous and conflicted status of woman into a standardized cultural idiom which makes her position "meaningful." It is a symbolic cultural "safety valve" which recognizes the need for women to simultaneously turn away from *either* alternative role demand.

This ambiguity and ambivalence about productivity and generativity is symbolically revealed in advertisements and articles about PMS remedies in popular women's magazines. A content analysis of such material in recent issues of *Glamour*, *Redbook*, *Cosmopolitan*, and *Seventeen* is noteworthy for the fact that in no case (out of twelve major advertisements) are children or men depicted; of equal importance, neither do the advertisements depict women in obvious business milieus. In fact, all advertisements depict women in ambiguous settings and/or clothing. The most common theme is athletic, with women dressed in aerobics outfits, horseback riding, etc. Some are highly ambiguous, with one woman shown talking from a phone booth (which is neither at work or at home), another sitting at either a desk or a breakfast bar (although it is impossible to discern which), and another dressed in a businesslike suit but with the jacket unbuttoned and wearing a long string of pearls (an artifact often seen in discotheques or nightclubs). Yet another popular advertisement depicts a young woman dressed conspicuously like a physician extolling the virtues of a particular PMS product.

Clearly, the symbolic status/role ambiguity seen in PMS literature is also found to an increasing degree in other representations of women in the media. Advertising for pain remedies implicate the stresses of work and family in the etiology of tension headaches; hair sprays, perfumes, and deodorants promise to last throughout the business of the day and the pleasures of the evening; frozen dinners and microwaves are associated with caricatures of working mothers. Indeed, signs of the social change involving women's roles are literally everywhere in our material culture,

but PMS, both in its phenomenology and its symbolic manifestations is a powerful focus for understanding such change.

From the point of view of social change, PMS solidifies the position of women in the changing social structure of Western industrial culture. Throughout history, women have been considered "delicate," "fragile," emotional," "unstable," or "hysterical" (from the Greek *hystera*, meaning "womb"). As such, women have been held to be incapable of assuming masculine, public roles. Heretofore, menstrual symptoms were topics largely relegated to the domain of women, who were forced to suffer these prodromal aspects of their "curse" without benefit of general cultural sanction. The recent structural alterations in which women's work roles have become central to the mode of production, however, demand a liberation from these constraints, for example, by a mechanism which can "obliterate all assumed differences between individuals" (Lee 1981: 238).

Women and men learn about PMS as they grow up in this culture, and the "reality" of PMS now permits women sufferers to be "legitimately" deviant and seek care from specialists, because once so labelled, the behavior is "understandable." PMS provides a basis for a structural realignment in sex roles by encapsulating the cultural stereotype of women, defining women as potentially irresponsible only some of the time, providing a legitimate label for a previously deviant status, and asserting that irrational thoughts and incapacitating physical symptoms relate to a medically treatable entity. By defining women as potentially "in control" of heretofore devalued constitutional characteristics, PMS "negotiates" access to power in a way which indirectly legitimates the changing status of women without directly threatening or destroying the structural *status quo*.

The discovery of PMS at this specific time in the history of Western industrial culture should not be surprising in the least, nor should the fact that major impetus for recognition of PMS has come not from medical professionals (a dominant structural element), but from lay women (an anti-structural element seeking status change). It represents a "negotiated reality" which has resulted from a process characterized by confusion, definitional difficulties, and problematic therapeutic relationships. These are said to be the very keys to seeking and finding culture-bound syndromes in Western culture (Cassidy 1982: 326).

In short, PMS can be seen as internally related to our culture, and can be *best* understood as a social and cultural phenomenon, even though there may be psychological or psychiatric determinants and consequences. It is not suggested here that premenstrual *symptoms* do not exist, but rather that the phenomenon of premenstrual *syndrome* is best studied as a social, rather than individual, reality. PMS is but one cultural mechanism

which militates against structural breakdown or disintegration; the symptoms experienced by individual women may or may not be somatized reflections of role conflict: as discussed earlier, not enough is yet known about the "psychological epidemiology" of PMS to make claims about the relationship between stress and symptomatology at the level of the individual. It is likely that symptoms relating to the menstrual cycle have always existed, may ultimately be linked more scientifically to physiology, and serve a multitude of psychological functions for individuals. Research in these areas of psychophysiology should continue, and the analysis presented here is not intended to denigrate such efforts to better understand the relationships between psychology, sociology, and symptoms.

Neither is this analysis intended to reify the concept of culture-bound syndromes. The simple fact that the term has been used elsewhere is not sufficient justification for applying it in Western cultural settings. Rather, it should be applied here as it has in other settings, because it helps us make sense of a disorder that carries central symbolic meaning in our changing, industrial society. It also helps us understand the larger social context of the interaction between patients and physicians, and helps us focus our attention away from the purely psychosomatic level.

As a culture-bound syndrome, premenstrual syndrome can serve as a symbolic barometer of status and role changes of women in modern society. It is as such a "barometer" that PMS deserves continuing study by anthropologists, because the appearance, alteration and ultimate fate of PMS in our culture should mirror quite accurately the resolution of conflicting role demands on women. PMS, then, is not as profitably studied for what it can tell us about individuals as for what it reveals about culture and the way in which "medical" problems are representations of social realities.

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