

# A Woman's CURSE

*Psychiatrists often treat women as inherently disordered. The latest candidate for female disorder, reports Denise Russell, is pre-menstrual syndrome. For some psychiatrists, PMS is the cause of everything from bank robberies to domestic violence.*

**P** sychiatry has functioned in the past to support notions that women are somehow inherently disordered. While this function continues today, its focus has changed in keeping with developments in the theorising of female criminality.

Until the 1970s at least, women were viewed as disordered as a reflection of sex-role stereotypes. A mentally healthy woman differed from the adult (male) standard of mental health by being more submissive, less independent, less adventurous, less aggressive, more excitable, more emotional and less objective. Such a description amounted to saying that there is a logically necessary link between women and disorder. A slow erosion of the sex-role stereotypes has taken place, especially with the increased participation of women in the workforce—even into traditional male domains within the workforce—and, to a lesser extent, with the rising female crime rate. As the stereotypes break down so too does the basis for conceptualising women and disorder.

In the mid 20th century the diagnosis of depression really came into vogue as the mental illness that large numbers

of women suffer from. Depression was usually thought to have a biological base, related to faulty neuro-transmitter functioning, probably with a genetic component. However, the genetic studies have come under heavy criticism, and the evidence for neuro-transmitter malfunctioning was only ever indirect. In the late 70s, studies pointed to social factors such as women's marital and employment status. For instance, married women with no employment outside the home and parenting pre-school aged children ran a much higher risk of depression than other people.

Four very large longitudinal studies—in Sweden, Canada and the US—now suggest that men are just as likely to suffer from depression as women. The researchers attribute this shift to various occupational factors such as increasing male unemployment (Sweden), expansion of women's participation in the workforce (Canada) and particularly in traditionally male-dominated areas (US). These studies support the earlier notion that depression is an artefact of socially-imposed restriction on the female role.

While there are still strong adherents to a biological factor in depression, a recent survey of biological psychiatry claims that identification of a biological abnormality may have no causal significance, and there is a growing caution in assertions relating to the biological base of depression.

## PMS — defined

Katharina Dalton, a major English theorist on PMS, claims that the term PMS covers a wide variety of symptoms which regularly recur in the same phase of each menstrual cycle followed by a symptom-free phase in each cycle. This phase may be anywhere from ovulation to four days into menstruation. She explains that the term PMS was chosen at a time when it was not realised the symptoms can occur at menstruation and ovulation. Dalton claims the term premenstrual tension covers only the psychological symptoms—depression, lethargy and irritability. PMS includes these and somatic symptoms, e.g. asthma, epilepsy and migraine. In the book, *Once a Month*, Dalton elaborates on the psychological symptoms. She says that “the image of women as fickle, changeable, moody and hard to please” and our periodic irrationality can be explained in terms of the “ebb and flow of the menstrual hormones”.

Dalton claims that the symptoms of PMS are at their worst during the four days prior to menstruation and the first four days of menstruation. She used the term ‘paramenstruum’ to cover these eight days. These days are linked with low levels of progesterone, and she regards PMS as a progesterone-deficiency disease.

Judith Bardwick supports the view that depression, irritability and hostility form part of the PMS but says they are “predictable, normal, emotional states in women”—another variant of the theme that it is normal for women to be disordered.

In a 1985 survey of the literature and clinical experience concerning PMS, Halbreich and others state that “at least 200 symptoms and complaints have been reported to occur premenstrually” and some of the symptoms are positive, for example, increased affection and sex. They call this the Increased Well-Being Syndrome. To their credit, they use this finding to distance themselves from calling PMS a disorder. They prefer to talk about premenstrual changes.

Rubinow and others in another survey in the same year claim that over 150 symptoms representing every organ system have at one time or another been attributed to PMS and that there are no symptoms which are either necessary or sufficient for the diagnosis.

They offer the following operational definition of PMS: “a cyclic disorder with symptoms that are of sufficient severity so as to interfere with some aspect of living and that occur with a consistent and predictable relationship to menstruation” but they point to the wide variability of claims regarding which time is supposed to be relevant. The catch-all nature of the definition then starts to emerge. Thus, it is not surprising that some put the incidence of PMS at 100% of women. It is strange that PMS went undetected for so long, since it is not supposed to be a product of social circumstances but rather our biology. Dalton claims that “very few of the doctors in practice today had any training in diagnosing or treating what we now know is the world’s commonest disease...”.

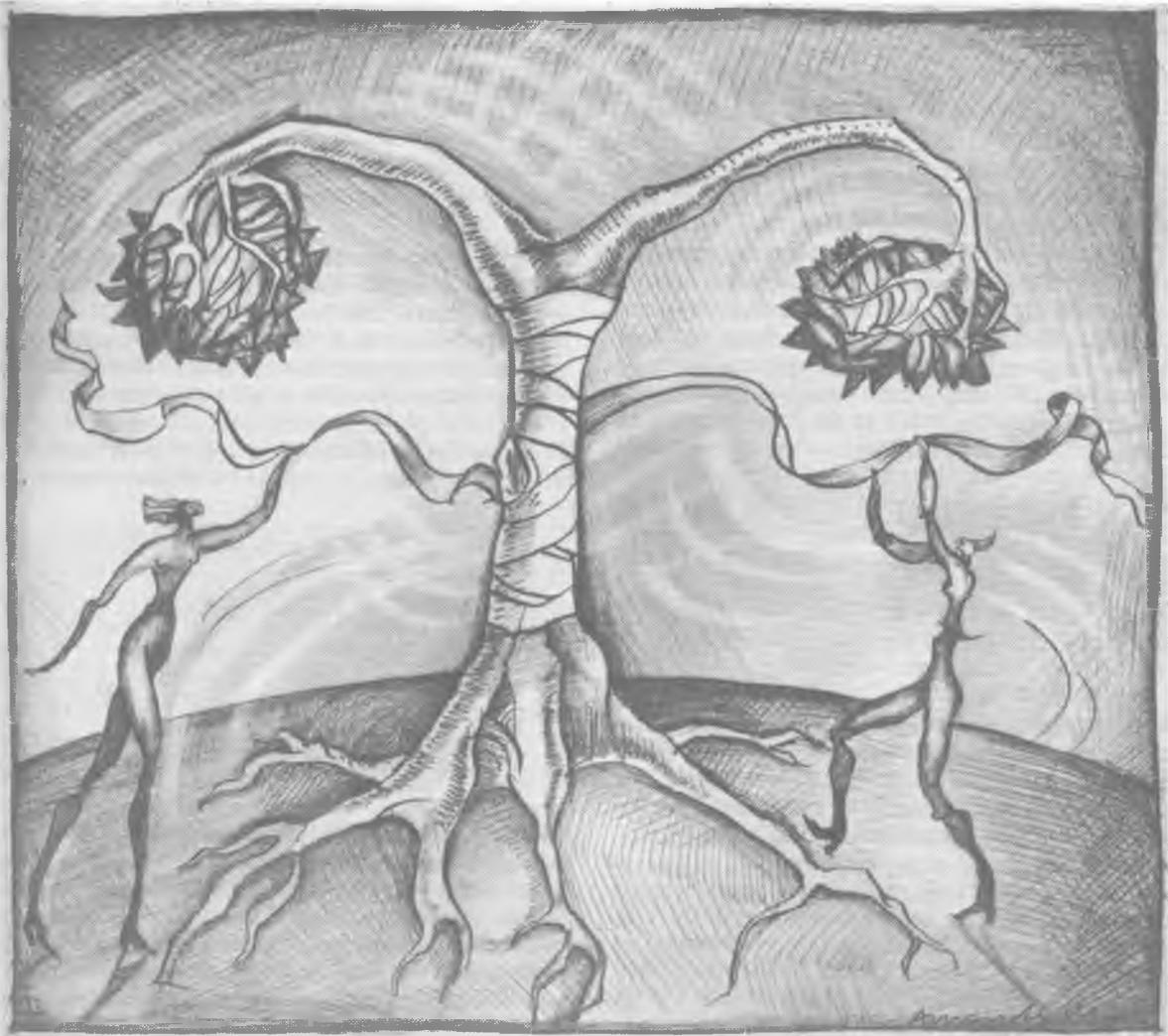
If it is the case that depression is primarily a disease that women experience and if depression is also very common, then the assumption that women are inherently disordered seems to receive some support. However, if depression is experienced almost equally by men and women and if the rates are dropping for women, then support for the assumption about women’s disorder is undermined. If, too, it is accepted that depression can be understood in relation to social factors rather than biology then the previous high rates of depression in women can be explained in terms of their occupations—almost exclusively housekeeper and child-rearer.

Some psychiatrists and doctors have now shifted their gaze to aspects of women’s normal reproductive functioning—e.g. menstruation and menopause—and are claiming that these are linked to mental disturbances and that they constitute disorders or diseases of a psycho/physical kind. This is a variant of the old theme: that it is normal for a woman to be disordered, again according to a male norm. Men are more aggressive than women, so it is disordered to be submissive. Men do not menstruate, so it is disordered to do so. An attempt is being made to provide a general understanding of women’s disorder then in terms of reproductive functioning. Depression has acted as a ‘catch-all’ diagnosis for those discontented with their lives.

Just as this diagnosis is applied to fewer women, another is announced, one that can only apply to women: the pre-menstrual syndrome (PMS). Most of the Western world accepts the American Psychiatric Association’s (APA) system of psychiatric diagnosis, and in its 1987 revised classification PMS—technically called Late Luteal Phase Dysphoric Disorder—is listed as a mental disorder. Some psychiatrists are currently writing about PMS as ‘the world’s commonest disease’, with claims that it is experienced by 80-100% of women.

Biological distortions are now more commonly used to explain women’s criminality. Since 1980 the APA has classified all criminal behaviour—whether or not it is accompanied by mental disturbance—as a psychiatric disorder (including petty theft, truancy, vagrancy). It is not surprising then that new theories of women’s crime should be linked to the rising importance of PMS (see box above).

Psychiatry provides women with opportunities to conceptualise their discontent in various ways and gives them hope for an answer. In the absence of other social forces offering solutions, it is likely that psychiatry will continue to be viewed as playing a positive role. There is complicity in the theory linking women’s crime to PMS. The use of a defence on the basis of PMS has only very recently been



Graphic: Amanda Lipson

introduced into legal actions and it is the defence lawyers who medicalise the criminality. From a broader perspective this works against women's interests since the social/political motivations for crime are overlooked. I contend that the diagnosis of PMS has been introduced to strengthen the idea that women are disordered and to specify more precisely the biological basis of women's crime.

If PMS is a widespread biological fault, why is it only now being recognised, especially as some report the incidence to be 100% of women? Is it now being recognised or is it now being invented? I want to reject both those answers and argue that the high incidence of PMS is produced by a combination of factors:

\* Some women do experience cyclical changes in mental and/or body states.

\* The subjects in PMS studies do not constitute a random sample of women. Rather, they are women seeking the help of the medical profession or being tried in criminal courts. If the former, then they may have a psychiatric problem which is mistakenly diagnosed as PMS.

It is possible that the patient will comply with this diagnosis for a variety of reasons: acceptance of expert opinion, desire to medicalise problems to avoid other means of handling them, wanting an excuse for anti-social acts and so on. Women criminals may have an additional motive to medicalise their crime in the hope of a more lenient sentence.

\* Beliefs and expectations may produce experiences of our bodily states which may differ with changing beliefs and expectations. Diane Ruble conducted studies in which she purportedly convinced one group of women that they were in their 'premenstrual' phase and found that they reported higher levels of menstrually-related pain than did those who had been told that they were in the middle of their cycle. This, coupled with the background assumption that we believe or expect the premenstrual time to be painful is taken to show that beliefs about the menstrual cycle can influence women's descriptions and experiences.

(I find the gullibility of these subjects hard to accept, but the general idea that beliefs and expectations influence experience is well supported in other areas—for instance the placebo effect. It is quite possible then that some women's experiences of PMS are produced by evolving cultural beliefs about the premenstrual time.)

## PMS and criminality

Icard, writing in 1870, claimed disorders of menstruation gave rise to kleptomania, pyromania, homicidal mania, suicidal mania, lying, etc. Otto Pollack, writing in the book, *The Criminality of Women*, in 1961 also suggests a strong link between women's crime and menstruation especially for shoplifting, arson, homicide and resistance against public officials. Dalton refers to these criminal categories and relates them to the premenstrual phase or to menstruation. She adds to the list: suicide attempts, citing a lecture given by Pollitt to the Royal Society of Medicine in 1976 where he said that the timing of suicide attempts helps to explain their failure: "Killing oneself is not easy, success requires careful planning. Women in the premenstrual phase show a marked tendency to be careless, thoughtless, unpunctual, forgetful and absentminded. This inefficiency at a time when they are more likely to try to end their lives may result in a disproportionate failure."

Dalton also relates assault to PMS: "There are those cases of assault where in a sudden fit of temper the woman throws a rolling pin at her neighbour, a typewriter at her boss, or tries to bite off a policeman's ear. There are the cases of baby-battering, husband hitting.. and so on." Theft, being drunk and disorderly and all crimes of violence are related, by Dalton, to PMS, and she claims that information from the courts and police in the UK, US and France support her view. The phenomena of 'battered husbands' seems of particular interest to her. She sympathetically reports the claims of two US researchers that there are 12 million battered husbands in the US, that it is the "most unreported crime", affecting 20% of husbands.

Judy Lever in the book *The Unrecognized Illness* adds wife battering to the crimes of violence attributed to PMS.

This occurs when the wife provokes the husband by her own violent behaviour when suffering from PMS.

In two English court cases in 1981, Dalton gave 'expert evidence' that PMS diminished the responsibility of the women killers. The judge accepted PMS as a strong mitigating factor, and the women walked out of the court with no punishment. In other cases of arson and assault where Dalton appeared as an expert witness, PMS was accepted in pleas for mitigation of sentence. PMS has been used in plea bargaining in the US and is recognised in the French legal system as temporary insanity.

In the courts, PMS has been brought in only to explain crimes of violence—and then only where the violence is out of character or atypical of stereotypical female behaviour. (A normal woman could not behave like this; she must be sick.) This suggests that the courts are adhering to male/female stereotypes that are breaking down in other areas. There is a trend to see violent criminal women as doubly disordered—by not complying with the female role and as suffering from PMS.

The apparent rise in the female crime rate has been one factor leading to the need to develop a theory of women's criminality. Yet if the changed incidence of female crime is accepted then it would be reasonable to assume that such crime must depend on some factor which has changed rather than some constant factor such as biology. It might be relevant, for example, that more opportunities have been opened up by women's changing social role for women to organise robberies. It is also worth noting that nearly all the crimes referred to by the PMS researchers involve aggression. Aggression could be taken as a protest against injustice. To medicalise it means that the injustice remains unquestioned; the woman is kept in her place.

\* Nearly all the studies on PMS have used retrospective data. Yet recent studies employing prospective and retrospective data indicate that retrospective ratings overestimate symptoms experienced or that symptoms do not turn out to have any relation to the menstrual cycle. This suggests that data on PMS are produced by a particular method of collection, and if the method was changed the reported incidence of PMS would drop significantly.

\* A spokesperson for the US National Women's Health Network stresses that a lot of PMS is 'iatrogenic'; that is, it is caused by medical treatment. It often appears for the first time after a woman has stopped taking birth-control pills, after tubal ligation or even after a hysterectomy.

\* Some researchers claim that women experiencing PMS may not actually be aware that they are doing so. According to Judith Bardwick, "one seems to see the cyclicity of

the affect response more clearly in measures which are less self-aware or conscious probably because people perceived themselves as being more consistent than they actually feel". This perspective means that a great deal of scope is given to the doctor to read the syndrome into the woman's experience and thus inflate the incidence rates.

Because of all these compounding factors in the diagnosis of PMS, we have no way yet of knowing how many women do suffer from a biological malfunction that is labelled PMS. It may, in fact, be quite rare. The popularity of the diagnosis cannot then be explained by appeal to biology, but there are ideological factors that make sense of it.

That there has been a move away from the diagnosis of depression in women and that attitudes about the mental health of women are shifting leads to a need to reconceptualise women and disorder—if you believe that women

## Causation of PMS

Many theories concerning the cause of PMS have been advanced, the three main contenders in the psychiatric/medical area being:

1. A progesterone deficiency disease. The reasoning here is as follows: cyclical changes occur in women, they are worse when progesterone is low, hence it is progesterone deficiency that causes the cyclical changes. Dalton introduced this view before accurate measurements could be made of hormone levels, but she claims support for her view in observing the effectiveness of progesterone as a cure for PMS.

Recent developments in the testing of hormone levels have not supported Dalton's hypothesis. Women with high degrees of cyclical mood change have not shown any difference in progesterone level from women with low degrees of cyclical mood change. Also a fairly consistent finding is that progesterone is no more effective than a placebo as a therapy for PMS.

2. A surge of testosterone production premenstrually: Judith Bardwick and others attempt to link PMS with fluctuations in this androgen, a perspective which fits in neatly with recent psychiatric theories about male criminality. These theories attempt to explain criminal behaviour biologically by relying on a postulated relationship between aggression and crime. Some theorists further claim that the male hormone, testosterone, affects the level of aggression. The basis given is that castration seems to have a calming effect and that males are more aggressive than females.

There are many problematic features in this approach. Not all crimes committed by men are related to aggression, and it is not the case that all males are more aggressive than all females, even though all males in the reproductive-age group produce much greater quantities of testosterone than females. Recent more accurate chemical tests have not backed the theory that testosterone production is linked to PMS.

3. Neuro-transmitter malfunctioning. Many theorists suggest that psychotropic drugs may alter the neuro-

transmitter functioning. Although this package of theory and treatment recommendations is also adopted by many, no direct evidence has been found linking PMS with neuro transmitter-malfunction nor cures for PMS with psychotropic drugs.

None of these theories concerning the cause of PMS are well enough supported to provide a convincing answer to the appropriateness of the grouping of characteristics that are supposed to be a sign of PMS.

Halbreich and others writing in the *Canadian Journal of Psychiatry* state: "An evaluation of the literature...leads us to the conclusion that at present there is no solid evidence for any of the hypothesised pathophysiological mechanisms of pre-menstrual condition."

Rubinow and Roy-Byrne state in the *American Journal of Psychiatry*: "Despite 50 years of study there is still surprisingly little known about menstrually-related mood disorders; questions of etiology and treatment are largely unanswered."

Both the major British medical journals have published editorials emphasising the doubt that exists about the scientific basis for claims made about PMS.

Comments such as these should not be taken as indications that psychiatry will drop the attempt to explain the disorder of women in terms of PMS. They would most likely be read as challenges for theoreticians to come up with more convincing causal theories. This has been a typical pattern in the relationship between papers in psychiatric journals and ideas propagated in psychiatric texts and through practitioners.

So the fact that there is no solid evidence for the cause of PMS will probably drive psychiatrists into new theoretical approaches and this theoretical activity, independent of the content of any particular theory, may have the effect of in fact bolstering ideas about the reality of PMS as a psychiatric disorder.

are disordered. A new diagnostic category is produced that will help fulfil these needs. The label sounds quite specific, disguising its catch-all nature. The weakness of the theorising used to support the notion of PMS as a diagnostic category is underplayed.

It defuses the political impact that women's crime might have had. It provides justification for women's unequal position in the workforce. Dalton asserts that "the cost to industry of menstruation is high" and then details the harmful effects in various industries in Sweden, the UK and US before recommending that employers handle these

problems by giving women time off or assigning us to less skilled jobs. Employers might be encouraged by such reasoning not to employ women at all.

The diagnosis of pre-menstrual syndrome is carrying the ideological weight which the diagnosis of depression used to bear. The full impact of this shift has not been experienced in Australia. It would be heartening if, on this issue, we didn't follow these overseas trends.

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