

# 1 Introduction

The title chosen for this thesis 'I Don't Feel Like Myself' was the statement I began to contemplate before any research questions materialized. This came up often as either an initial comment before women mentioned PMS problems or as a statement that summed up their experiences that they had come to associate with PMS. It is hard to know exactly what part of this description is problematic. Is it actually feeling different than usual or the way a woman feels about experiencing altered states? Perhaps it could be a way for women to say that this way of feeling does not rhyme well with the expectations that the societal role a woman has. This roll in society is best described by Martin in her article *Premenstrual Syndrome, Work Discipline, and Anger (1998)*. The undesired and unacceptable exhibition of behavior that the term 'anger' encompasses is at the center of the practice of 'managing menstruation'. PMS has to be managed because the consequences of not acting feminine (nurturing, caring, responsible and subdued being among these traits) must be avoided. The price is too high for women. So not feeling like one's self is a signal that a woman is in a situation she does not want to be in. In order to understand this commonly occurring experience women have, I needed to talk to women about their ideas about themselves, who they are, who they see themselves to be and how they want to portray themselves. Using a contrasting point of departure I felt answers could be found in their descriptions of lack of 'one's selfness'.

Our experiences of the world come to us through our senses. The body has come to be seen as an experiencer in the development of theories of embodiment. What happens to reality when the arena through which we experience the world goes through changes on a cyclical basis and through different phases? The field of menstruation offers an opportunity to observe how a biological system can alter experience. Through exploring women's ideas about going in and out of states of being we can gain knowledge about how this shapes cultural ideas about what it is to feel normal and what makes up the authentic self. By letting women tell of their experiences from the first person perspective and placing it in a social context, the combination resulting from this phenomenological study can contribute to the development of theory about the life world.

Previous research in the field of menstruation is lacking in many ways. Most importantly for humanistic and social science research is the missing voice of women in every day life. Studies about the body and about illness are dominated by the biomedical sphere. The process of medicalization is spreading further into areas previously not seen as medical issues. Important to this study is how medical technologies are utilized in managing everyday situations that are not clearly in the category of illness. Menstruation and the suffering reported that is connected to it is one such overlapping

theme. SSRI antidepressants and hormonal therapies in the form of oral contraception are the medical technologies which influence the way menstruation is currently contemplated.

The discrepancy between simultaneously occurring ideas of normality and deviance are at the core of interest in the proposed research question. The main objective of this thesis is to contribute knowledge about women's experiences to theories of embodiment. The normal biological cycle, representing predictability and necessity for a healthy reproductive system is seen in industrialized societies as a deviance due to interpretations of fluctuating and uncontrollable levels of hormones that affect behavior of all women. This incongruence makes a phenomenologically based social analysis of menstruation a worthy study. This especially holds true when menstruation has come to be visible primarily if not only in discourse about PMS, a sign of the process of medicalization.

By using a phenomenological approach to examine women's ideas about menstruation as well as their ideas about medical technology I hope to gain knowledge about how suffering contributes to what women see as normal and how changed ways of being in the world are incorporated into the authentic self.

# 2 Research in the field of menstruation

## 2.1 Introduction

In this survey of research the focus has been put on understanding how different approaches brought researchers to their findings and what these researchers judge to be missing in the production of knowledge in the field of menstruation. The following works have been selected because of their relevance for understanding the current views held by people in Western society about menstruation. Women's health is an arena where the construction of health and illness has gained increased attention. It has been important to focus on works that have relied on direct experiences of women, not just of their bodies and the meanings of processes therein but also of the experiences of dealing with the attitudes of the people around them. In order to understand what is culturally significant about menstruation we need to see how it figures in importance for women in different social contexts.

Social science research done in the field of menstruation is unique for two reasons. Scholars in these disciplines have realized its importance relatively recently. It is a well-known fact that most researchers have been men and contributed to the first theories on the subject from which others have used as their point of departure. The tone setting academic works I have used still comment on the lack of research in the area and warn 'fellow' researchers to avoid androcentricity and reliance on universal assumptions of the nature of men and women (Buckley & Gottlieb, 1988). Even the most recent works repeat the same statements, including wishes that specific books wouldn't have to be written if there weren't serious methodological and theoretical shortcomings due to the fact that the male perspective is still being complemented by scholarship conducted by women.

Universality and determinism are hindering production of knowledge that will encompass female perspectives and it is important that we speak of *multiple* perspectives. Individual women's points of view tend to be described as a commonly shared perspective (Buckley & Gottlieb, 1988). The repeated message is that even feminist research bases assumptions on universal ideas about women, for instance that childbirth signals what a woman is (Laws, 1990).

The second reason explaining the uniqueness of menstrual research is that despite the realization that menstruation touches on every aspect of human existence for both women and men, relatively few scholars feel totally comfortable and professionally supported in doing work focusing on the meanings of the menstrual cycle.

## **2.2. Menstruation in two Swedish historical contexts**

Certain researchers have focused on understanding the historical development of the meaning of menstruation in Swedish society which is the main contribution found in Malmberg's (1991) ethnological dissertation. Her analysis is built on two groups of empirical evidence. The first part of the research focuses on menstruation during Late Peasant Society in Sweden. Terms, expressions, norms and ritualized behavior together with the practical conditions under which women lived were gathered through written material and interviews. The second group of evidence draws upon interviews as well as on historical documents about the ideology of the Swedish reform movement as well as concurring marketing strategies in the launching of feminine hygiene products.

Malmberg uses an agent's perspective as well as a sexual perspective as instruments of analysis. The sexual perspective includes sexual identity as well as social gender, what is womanly and what is manly. The patriarchal structure of Swedish culture in these time periods make up the power structure that ultimately form ideas about menstruation and norms in behavior and practice. A review of the development of medical ideas about menstruation help to emphasize Malmberg's point about how the valuation of women stems from the medical, scientific and religious discourses describing a physical phenomenon. These traditions have also formed the norm for research strategies.

In reviewing Malmberg's dissertation (1991), I was most curious about what could be said about the development of ideas about menstruation and mental and physical suffering existing in current Swedish society. Attitudes during two consecutive historical periods contrast and Malmberg uses this comparison to show the development of attitudes towards menstruation. During Late Peasant Society the societal aims emphasized the importance of a physically able body. Signs of suffering and ill health were meant to be hidden to uphold inclusion in the norm of what was expected and desired in women. The ability to bear children, together with being able to contribute to survival through hard work were central ideas of desirable traits in a wife.

According to Malmberg, signs of changes in attitudes toward the physical and mental effects of menstruation could be observed in a number of ways during Early Industrial Society. Practical aspects, biological function, education, ritual and what was considered normal behavior were affected by the changes reported. Keeping clean and hygienic standards increased in importance which had an impact on women's behavior. Health of the reproductive system being of utmost importance, behavior that was seen as putting a woman at risk was limited. Examples include not lifting heavy things while bleeding or bathing practices that could cause chilling and subsequent infection or illness. At the same time the importance of keeping physically active was emphasized to maintain a strong and reproductively healthy body. The overt manifestation of symptoms changed from the previous time

period but not necessarily new physical experiences. In Early Industrial Society there was a marked increase in the frequency of the reporting of mental symptoms. In Malmberg's analysis the reason for this increase was the transformation of ideas of womanhood, femininity and behavior.

Changes from one historical period to the next included the break of the tradition of silence around menstruation. The increased importance of scientific knowledge in this area in Early Industrial Society helped to make blood private but menstruation public in a way that differed greatly from the time period before where blood could be seen but not spoken of. Spotting on clothing and on the ground or floor were unmentionable overt manifestations. What also contributed to this shift in ideas about menstruation was the dominating idea that menstrual blood was a physiological impurity, part of the developing medical scientific theory in the mid 1800's that defined menstrual blood as a surplus needing to be purged from the body. Menstruation from this perspective was not seen as a natural phenomenon but was included in what constitutes an illness and was treated as a periodical deviance that characterized the female sex (Malmberg, 1991).

The medical theories being developed at the beginning of the 20<sup>th</sup> century contributed to changes in how women were seen as being capable of hard work and what impact it could have on their reproductive systems. Proper rest, acknowledgement of pain, exclusion from work and physical activities in school built on the understanding that exertion, especially intellectual, was potentially harmful to the development of reproductive organs. This was especially true for women in puberty and impacted the development of the educational system in the direction where young women were offered less qualified educations.

Malmberg also writes about the social implications that influenced the expectations of how mothers should inform their daughters about menstruation. Earlier there was overt evidence of blood and girls could acquire a silent but physical knowledge of what could be expected. When that evidence disappeared with changing hygienic practices the visibility of menstruation went from blood to feminine hygiene products. This made it possible to talk about menstruation but only after menarche when the girls were considered adults after their first sighting of their own blood. I found this change in the type of silence around menstrual blood as useful in understanding current practices in modern Western society.

Other researchers have also investigated the development of health related ideas from an historical perspective. Karin Johannisson has written extensively on the subject in her books on the intellectual history of medicine. In *Kroppens tunna skal- sex essäer om kropp, historia och kultur (Translation: The Thin Shell of the Body. Six Essays on Body, History and Culture)* (1998) Johannisson shows how changes in the prevalence of certain types of illness and how they are manifested reflect changes in the

culture as a whole. An example noteworthy for the thesis topic at hand is the explanations given for mental illness in females from the 1800s through the turn of the last century. Changes in the view of the body and illness impact on individual experience when sense is being made of bodily functioning and in turn determines how behavior related to illness is described and explained in a given society.

A marked difference reported in Malmberg's work that is important for current studies on menstruation and PMS<sup>1</sup> is the emergence of the discussion of monthly bleeding in the public sphere through hygiene campaigns and marketing of new products. The acceptance of physical traces of blood on clothing in Late Peasant Society disappeared but the reference to bodily functions entered into the realm of subjects that could be discussed. The need to be able to hide menstrual blood, the signs of a working reproductive system, with the use of feminine hygiene articles, indirectly made menstruation visible. Changes in what was womanly and feminine from one time period to the next resulted in changes in practice and behavior. These changing practices affected gender power relations. The women's behavior changed due to this control but with it came the opportunity to use this control strategically by not participating in school gymnastics, heavy physical labor and exemption from participation in social situations and sexual relations.

### **2.2.1 Avoiding universal assumptions in the field of menstruation**

Recent anthropological work on menstruation has been compiled in the book *Blood Magic*, edited by two anthropologists, (Buckley and Gottlieb, 1988) themselves contributing authors. The primary objective of compiling these ten works is to show the diversity with which menstruation is represented culturally and socially. These author's works were preceded by two major theoretical assumptions used to analyze or to choose not to analyze menstruation. The first is over application of the idea of a 'menstrual taboo' accompanied by an assumption of being negatively charged. This tendency to view menstruation negatively resulted in giving the taboo interpretation a nearly universal status. The other major theoretical assumption related to a universal view of menstruation is that it is caused or accompanied by female subordination. The contribution of this work as a whole reveals the necessity to abandon this approach completely. The evidence presented from vastly differing examples of cultures, and a close look at the symbolic values of menstrual practices and beliefs within their unique cultural context, shows the importance of studying the whole to understand the specific.

What previous scholars tended to do was to isolate a bodily function, such as menstruation, subsequently ignoring the interrelatedness of its meaning. Ideas about fertility, survival, organization

---

<sup>1</sup> PMS is the commonly used abbreviation for 'premenstrual syndrome' - a group of physical and emotional symptoms that may precede a menstrual period, as fluid retention, fatigue, depression, irritability, etc. Webster's New World College Dictionary Copyright © 2010.

of work, spirituality, sexuality and roles of men and women, are examples of what play a part in various degrees depending on which culture is being looked into. Neither a micro or macro system of symbols can be understood as it is understood by the people who own these cultural experiences if elements are isolated and universalized. This is the main premise of the compilation of work in *Blood Magic* (Buckley and Gottlieb, 1988).

Menstrual customs are the starting point of all the articles in this anthology but the approach required differs depending on what has been identified as meaningful in the culture and the research question involving menstruation. It is argued that a break from tradition is necessary, avoiding general theories, universality or universal approaches. The collections of studies here have contributed to a comprehensive theoretical approach drawing on a diversity in methods.

Throughout the ten articles deriving from extensive ethnographic or historically constructed material there were a number of points I found useful to ‘think with’; first *multivalence* means that within each cultural there will be multiple meanings attached to things, experiences, practices and can be held by the same individual. Different groups within the same culture can hold opposing attitudes to things like menstruation depending on how practices and beliefs affect them as group members (Buckley & Gottlieb, 1988). The second point emphasizes that when studying a specific phenomenon like menstruation, one should identify what is culturally significant first, like the Koran and spirituality in Turkish village society. Systems of thought often reveal reasoning behind practices as well as attitudes towards them (Delaney, 1988). The third point I found useful is to have sociological focus, that economics and politics as overarching social structures will shape experiences (Buckley & Gottlieb, 1988). Lastly an effort to identify silences will reveal that there is evidence in what is not said (Skultans, 1988).

In addition to providing these tools for study pertaining to PMS, the authors of *Blood Magic* point out that it is important for Western scholars to accept that scientific knowledge is relative. There are overarching difficulties with our own ethnocentrism. The scientific explanation of menstrual discomfort plays a crucial role in the construction of PMS in Western society. Current feminist ideas about PMS are historically related to the “hormonal onslaught” explanation that has grown from the biomedical model. (Buckley & Gottlieb, 1988) Comparisons and contrasts between systematic studies of the biomedical discourse about hormones and analyses of native perceptions of behavior in the time before menstrual bleeding are example of types of study which are important in understanding PMS in Western society.

### **2.2.2 The meanings of medicine in the context of menstrual ‘illness’**

Problems stemming from the issues involving medicine and treatment in human lives are the focus of the book *Social Lives of Medicines* (Whyte, Van der Geest & Hardon, 2002). Taking a material object used to cure illness, materia medica and backtracking into origins, uses, connotative meaning and symbolism is a way to describe how this book came to be. The material covered ranges from the simple choice of a cold remedy to the globalization processes involved in the commoditization of medicine. The perspectives of many different actors in the social exchange of medicine are accounted for in the use of varying research methods and subjects.

In addition to being at the core of medical treatment, taking and giving medicine can easily be seen as a ritual where the performance carries meaning for those involved in a social transaction. The ethnographic material offers observable situations to evaluate the symbolism that medicines carry in human acts of treating illness. What people actually do, as opposed to what they are instructed to do, is one starting point to trace the lives of medicine. Mainly referred to as compliance, this also emphasizes the social interaction that takes place in the every day lives of people, in their homes among family members and in other social arenas. The authors use these arenas to gain insight into how people understand illness and health in their own culture.

### **2.2.3 Social aspects of communicating illness**

Most interesting for studies related to how menstruation is managed were the social aspects of communication in interaction between caregiver and patient. Whyte et. al. (2002) have contributed to the understanding of health issues that are out of sight for health care workers in the traditional settings of hospitals and clinics. In a study of consumers the ethnographic material raises a number of considerations, the first one being exhibition of a person’s needs when in a state of sickness. Being ill, cared for, treated and attended to, are part of human life. These needs for nurture, especially at birth, are part of what we share with the rest of the animal world but for humans these acts have meaning beyond ensuring continued existence. These acts also strengthen social bonds with others and are important in the construction of meaning within a society.

The perspective of the sick person, having the need to be cared for, was discussed in the chapter “Women in distress: medicines for control”. This article tells of women in the Netherlands going to a physician, reaching out for help to manage their daily lives, work and relationships, and more often than not leaving with a prescription for Valium or one of its cousins. The women’s need to be functional was the most often given reason for why they sought medical attention, a point stressed by the authors. One interviewee states that she was told to take it easy for a while, but only after being

prescribed medication. This might have been a clue to what she really needed; to be taken care of and acknowledged in a psychological as well as a physical sense. In focus here is the patient's experience of being sick and what receiving medicine meant in the sense that they were being taken care of. A doctor is quoted as saying:

"I always provide a prescription in liquid or tablet form, even after a session of psychotherapy. Of course, it is not strictly necessary in medical terms, but at least when they go home, they feel they have something to cling to." (Whyte et al, 2002:122)

I interpret this 'clinging' as a feeling of being cared for. The medicine, in its concrete form symbolizes the care and concern of the doctor. Many doctors were said to have felt this way, that they are transferring their concern through material things and that they felt that this is what the patient expects. The act of caring was attributed to the object, medicine or paper prescription by both patient and doctor (Whyte et al, 2002).

The role of medicine in these women's lives can be seen in a number of ways. Medicine can be the agent in a type of social control. The process of medicalization where previously non-medical problems are treated as such, takes agency away from other actors, either the women themselves or from other structures of social control.

Many symptoms discussed in the study about the Dutch women (Whyte et al, 2002) are included in the diagnosis of PMS and are today often seen as menstrually related or at least worsen in the premenstruum. (Anxiety, insomnia, sadness, mental distress) What is important to note though is that by seeking and using medication women are active agents. This role of medicine contrasts with the role medicine plays in medicalization processes which gain much more attention from social researchers.

"They (medicines) give them means to control their lives, in the absence of other possibilities for more structural change. In the ongoing interactions between distressed women and tranquilizers, it can be argued that both women and medicines have agency. The social well-being of women and the efficacy of the technologies are constantly negotiated, and mutually constitute each other." (Whyte et. al., 61)

The closing point in the article "Women in Distress" actualizes the question of how we can investigate the relationship between people and medical technological substances. Theory that can incorporate both human agency and non-human entity influence try to explain how society is produced in interactions between them. The authors point out that pharmaceutical production developing out of knowledge about culture and nature is an example of how a network of information constructs society (Whyte et.al, 2002).

#### **2.2.4. A feminist social-constructivist perspective on menstruation**

Women's attitudes and opinions develop within a culture, within families and under pressures. One pressure is the attitudes of men and the impact of patriarchal ideas. This feminist approach to research uses menstruation as a way to understand existing power structures resting on ideas about patriarchal society. An example of this type of study can be found in Sophie Law's dissertation, *Issues of Blood* (1990) examining young men's attitudes in modern British society.

Law's starting point is the interest in women's report of pain and changes in mood as being the primary concern to women regarding menstruation. Often ideas about women's inferiority have been based on women's experience of physical and mental changes during the menstrual cycle. (Laws 1990) Instead Laws asks how a normal bodily function can be painful. Can the answer be in how women are treated? She wonders if the suffering and its effects have provoked men's negative attitudes or if the experience of pain, discomfort, and suffering comes from men's attitudes towards women. Women seeking help often feel doctors don't give them the help they need. By interviewing men in her empirical data "the spotlight is turned back onto the powerful, onto these who usually decide which questions will be asked and which will not" (Laws 1990:2).

Even though Laws investigates the attitudes of menstruation held by men, she doesn't claim there is *one* positive female view of menstruation. She does say that the women's experiences vary greatly since they are molded socially. This keeps in line with the social constructionist view in general. The radical feminist view she employs means that there is no need to romanticize female physical functions for the purpose of disallowing them to be used against women. Most interesting is what Laws promises early in her book, that this social-constructionist feminist understanding may illuminate why women have widely differing experiences of menstruation.

Of utmost interest is what Laws writes about in reference to the meaning of 'premenstrual tension'. The portrayal this part of the menstrual cycle receives in mass media is one of a treatable disease. She argues that PMT (premenstrual tension) cannot be seen as a naturally occurring disease like the flu or infection. The use of the disease model is based on a scientific discovery that emphasizes negative effects by isolating the premenstrual phases from the rest of the cycle. This is a process of the construction of illness, as opposed to a subtle continuum of change (Laws, 1990).

Women are encouraged to see themselves as 'not themselves' during PMS. Laws sites Koeske and Koeske (1975, 1980) who describe this as 'bracketing out' the feelings and expressions women have during this time to be attributed to the menstrual cycle. This supposedly results in the diminishing of other factors, like relationships, living and working conditions. In medically based theoretical

perspectives on menstrual cycle research, the process that an attributional approach would have on perception of mood swings pinpoints the effect the disease model has on the understanding of women's experiences. Medical treatment would then 'free the woman from her suffering' in order to be feminine, her 'modest self'. Naturally since Laws is a feminist scholar she is interested in talking about who benefits from these ideas.

According to Laws, men understand menstruation as a marker of womanhood. Men's attitudes toward menstruation affect all women though all women do not menstruate. These ideas stem from the broad societal view of what constitutes a real woman, the ability to bear children. These gender-related beliefs are a part of a system of power relations between the sexes, according to Laws. One of the main goals of a feminist project, which I consider Laws book to be, is to look closely at the sexual-political consequences of men's ideas and behavior (Laws, 1990).

The choice to study men leads Laws into an explanation of what feminist methodology is, studying for women, not of women, and outlines the difference between liberal feminism and radical feminism, she adhering to the later. Women are oppressed and a commitment to end that oppression is a kind of social theory itself. *Issues of Blood* is not a feminist project in consciousness-raising aimed at discovering what women have in common to produce theory about women's oppression but a sociological work analyzing the influence of attitudes on the meaning of menstruation from a gender perspective.

A widely shared sociological idea in Western culture is that women's bad attitudes are responsible for period pain, and not the other way around. This can be seen as a part of the discourse blaming the victim and placing the problems associated with menstruation in women's minds. Laws' radical feminism with a social-constructionist basis assumes that oppression of women is unique and fundamental, not deriving from another social structure like class or race. These social structures exist parallel to one another but one does not explain the other.

### **2.2.5. Internalization of ideas and embodiment of stereotypes in the female body**

In research on menstruation, it is important to understand how negative stereotypes about the body develop. Internalization of ideas by an oppressed group, works like the process of internalization of attitudes towards racial features. In meetings between male plastic surgeons and female patients with Asian features, Kaw writes about how negative attitudes become internalized by a subordinate group (1993). When this reasoning is applied to menstruation, it offers an explanation for why all that is visible in society is PMS, hygienic concerns and maintenance of femininity defined by a hegemonic

patriarchy (Kissling, 2006). Negative stereotypes are partially produced by the internalization of ideas about PMS.

bell hooks in “Naked without shame: a counter-hegemonic body politic”, (1998) wants to raise the issue of how we can construct an affirming body politic within white supremacist capitalist patriarchy. In presenting a history of the domination of the black female body from colonization to the present, hooks outlines her thoughts about society, unequal living situations, inequality, domination, oppression and marginality with the discussion of shame and how it impacts on the presentation of the self.

Embodiment of stereotypes and reactions to stereotypes are central issues in the construction of shame. By looking at hooks example of a doubly stigmatized group where racism and sexism combine and result in an intensification of their oppressing effects, it is apparent how the development of shame can have impact on women’s lives. These processes have contributed to current etiquette surrounding PMS, the effects of this etiquette and women’s ideas about themselves. As Laws points out, women do not talk about their own menstruation to men with the possible exception of living partners. Women are expected not to refer or mention the subject of menstruation to men (Laws, 1990). Few women are willing to mention suffering from PMS to men other than their partners. The choice to suffer in silence or to medicate stems from ideas of shame, inferiority or risk of ridicule.

The development of a sense of shame is made more apparent when shifting focus from the ‘center to margin’, alluding to the title of hooks’ book on feminist theory (hooks, 2000). The processes hooks examines in this marginalization can be used to trace what has lead to current etiquette surrounding women’s bodies in respect to concealment, nakedness and subsequently to sexuality and gender.

“...obsessions with bodily cleanliness, exaggerated displays of modesty, repression of the erotic, denial of sexual presence and desire, all efforts to counter notions that black females were ...driven by animalistic sexual cravings which could not be controlled.” (hooks, 2000:69)

By using shame to ensure protection from being interpreted in ways dangerous to women, this particular historical analysis sheds light on why women as a group are silently coerced to hide that which is an outward, overt sign of sexual reproductive function. In hiding menstruation and diverting attention away from this biological system women try to protect themselves from this oppressive focus. By denying the body women attempt to control how they are ‘read’ by others according to hooks (1998). The presentation of self becomes an issue of power.

The body image emphasizing the virtuous hooks describes, was a way to prove that one was worthy of respect. Later in the second wave of feminism, repression of the body through purity would be

released through sexual liberation for some, particularly white middle class women. Black women in the opposing stereotypical image of the overly sexual body were already thought to be sexually liberated. The virtuous image lives on through shame to counteract this opposing stereotype. Kissling (2006) examines the issue of discreteness and secrecy in the marketing of feminine hygiene products drawing on the same argument of counteracting negative stereotypes. If no one knows about your menstruation you cannot be overtly oppressed by these stereotypes in an everyday context.

What hooks presents in these arguments is an example of feminism calling for change. The ideas about the bodies of black women reflect society's attitudes. Feminism reminds us of the domination of the white supremacist patriarchy, the hold it has on interpretation of women and their bodies and the effects it has on the lives of women. The call for a collective resistance to reclaim the images of the black female body can be paralleled with the same type of call that Laws (1990) outlines in her work on the images of menstruation in British society.

#### **2.2.6. The commercialization of menstruation**

Elizabeth Kissling is a Women's Studies and Communications professor who has written widely about menstruation. She uses this extensive knowledge to investigate the commercialization of menstruation in the past century. One of her recent works is largely an analysis of the discourse of menstruation and aims at examining cultural attitudes towards it. She does this with the help of Simone de Beauvoir's theory of woman as Other in existential feminism. *Capitalizing on the Curse* (Kissling, 2006) is the book resulting from exploration into the representations of menstruation in US mass media and consumer culture from a feminist critical perspective. The reason why the focus is on business is repeatedly linked with the economic and political implications that profit-making has on women.

Kissling begins with reviewing the changes in the past century in the lives' of women in regard to menstruation. The rest of the book's chapters cover critical surveys of the marketing of menstrual products and medicines, discourse analysis of mass media, and the influence of medical technologies on the construction of illness through the development of the diagnosis of PMDD<sup>2</sup> and trends in regulating menstruation.

---

<sup>2</sup> The exhibiting of symptoms in the premenstruum that have an adverse affect on a women's life situation is reported in 18% of women (Wyatt, Dimmock, & O'Brien 2002). The diagnosis PMD, premenstrual dysphoria which preceded PMS and PMDD only requires the prevalence of two symptoms, irritability and a depressed state during the premenstrual period. These two symptoms are reported to have a negative impact on interpersonal relations. The development of the diagnosis of PMDD and the inclusion of menstrually related problems in a manual of mental disorders uses a compilation of descriptions of symptoms divided into five categories. Category A defines the periodicity of the symptoms. Category B defines the prevalence of multiple symptoms and the inclusion of either lability, anger, anxiety or a depressed mood. Other symptoms contributing to a PMDD diagnosis can be fatigability, difficulty in concentrating, a change in appetite, insomnia, feeling overwhelmed or

Kissling, in agreement with Laws (1990) sees part of the phenomenon of premenstrual syndrome as having to do with isolating a section of time out of a cyclically occurring process. Focus is put on the days before a woman menstruates when a number of bodily changes occur. This part of the menstrual cycle has come to be the most visible representation of menstrual body experiences in modern Western civilization (Kissling, 2001).

In the article, *The Truth about Sarafem* (Caplan, 2001), the debate and development of the diagnosis of PMDD is examined. Caplan traces the steps that lead to the use of antidepressants in treating menstrually related illness. Kissling's use of similar articles, studies, hearings and advertising campaigns reveals the relationship between consumer behavior and attitudes towards women in society. The particular consumerist relationship to menstruation is how most women relate to their menstrual cycle in the United States today. This can be expected to be true of all modern societies that are emerged in a culture of consumerism. This fact makes it necessary to look at women's lives in just that way; that our organization of resources and work in a capitalistic model *is* the culture and should be studied as such. The goal of Kissling's work is to bring about change in the attitudes towards menstruation. Knowledge of the workings of commercialism and its economical, political and social impact are vital to this endeavor. Advanced gender equality lays the groundwork for women to relate to their bodies on their own terms as authentic subjects (Kissling, 2006).

### **2.2.7 The medical science perspective on menstruation and PMS**

Medical science has made a distinction between the two diagnoses related to menstruation: PMS, where physical symptoms are in focus and PMDD which deals with psychological symptoms having a negative impact on close social relations. What is important in both diagnoses is that within approximately three days after the onset of menstruation the symptoms disappear.

Women who experience suffering related to the menstrual cycle have been statistically categorized by using diagnostic criteria. PMDD, premenstrual dysphoric syndrome, is an example of a diagnosis used in this categorization related to PMS. According to self-appraisal reports, 3 to 5% of menstruating women experience PMDD (Festin & Hovellius, 2007). The criteria used to diagnose this condition are listed in DSM-IV.

---

feeling out of control and physical symptoms such as breast tenderness, swelling, headaches, joint or muscle pain, water retention commonly described as bloating or weight gain. Category C is filled if disturbance resulting from symptoms interferes with work, usual social activities or interpersonal relationships. Category D rules out the disturbance from being caused by another disorder such as depression or panic disorder. The final category, Category E is a requirement that daily self-ratings during at least two menstrual cycles have confirmed the disturbance from previous four categories. (Source: *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. rev. (Washington, D.C.: American Psychiatric Association, 1987 in Kissling, 2006).

PMDD, premenstrual dysphoric disorder is in the appendix of the DSM and is technically a research category rather than a diagnostic label (Kissling, 2006). If a code number is included in the description in the manual it can be used as a diagnosis. Such is the case for PMDD since 1994. In 2000, fluoxetine hydrochloride, commonly known as the SSRI antidepressant Prozac, was approved for the treatment of PMDD but under a new name, Sarafem®.

It is not surprising that there has been strong resistance throughout the process that has led up to the inclusion of PMDD in the DSM for all intents and purposes an applicable diagnosis. There are often concerns raised on the risk of stigmatizing all women (Kissling, 2006). Figures on the prevalence of PMDD vary in mass media and in medical periodicals (Festini & Hovelius, 2007). Proponents estimate that approximately 5% of menstruating women fit the criteria for PMDD. In the United States alone this would imply that nearly half of a million women would be mentally ill (Caplan, 1995). Opponents to the diagnosis cite statistics from menstrual cycle data done by Sally Severino (formerly on the revisionary board for the inclusion of PMDD in DSM) where anywhere from 14 to 45% of women could receive the diagnosis.

In current practices of health care of individuals in Western societies it appears to be more often the rule than the exception that we learn about a diagnosis first and relate it to our own experience of illness. The concerns are then taken to a medical practitioner where we report experience of symptoms from the first person perspective. If we know about treatments we will ask about them or expect to hear about them. The doctor knowing of treatments will present them as alternatives. The final decision to treat and medicate is the patient's as we are reminded by Lupton (1997).

## **2.3 On menstruation and medicalization**

### **2.3.1. Normality, deviance and menstruation**

The studies of normality and deviance in the social sciences are intricately related to human experience and behavior (Bryman, 2004). The realm of experience within the body is fed by information provided by the senses, a view of reality developed by Merleau-Ponty (Csordas, 2002). Behavior can be seen as communication between people and is in part the result of embodied experience. Understanding of what is normal and expected comes from the construction of meaning evolved from a shared socio-cultural context (Bourdieu in Csordas, 2002).

In current discourses on menstruation, bodily experiences are heavily reliant on narratives referring to hormonal levels. Rising and falling levels of hormones are thought by the medical practitioners and the general community to be the cause of fluctuating behavior referred to as mood swings. On the one hand, this is normal and expected. On the other hand living in a female body is seen as a deviance due to this cyclical transformation of the body exhibited in the menstrual cycle. Transformations in biological function during menarche, pregnancy, nursing and menopause have been used as explanations for why the female body is the Other (Beauvoir in Kissling, 2006).

### **2.3.2 Medicalization**

Medicalization is the process by which a previously non-medical problem is addressed by modern medicine and changes the way the problem is be dealt with. Medical solutions are proposed for areas that were not previously thought to be medical entities (Helman, 2007). Major areas that have come to be medicalized are the experiences of women and the elderly. At first the benefits of utilizing medical intervention in illness are seen positively. What is more difficult to assess are the consequences medicalization has on other areas like being included in a 'sick' category or being forced to make decisions about whether or not to medicate for a condition as is the case for Western women, menopause and the use of hormonal replacement therapy. It is required by default that women must address this question.

One major contribution developed by Foucault relevant to menstruation and illness was to use the 'Clinic' as an arena for an analysis of power. Foucault's concepts of discipline and power applied to medical encounters "provide guidelines about how patients should understand, regulate and experience their bodies." (Lupton, 1997:99).

Foucault (1984) emphasized the positive productive nature of power in the medicalization process. The strategies of disciplinary power, observation, examination, measurement and comparison are used in ways that make these normalizing practices both voluntary and coercive at the same time. Bodies are brought into view and subjected to medical practices. Lupton (1997) points out that it was in Foucault's later work (*The History of Sexuality*, 1986) that he began to speculate on the modes of the formation of personhood that he termed 'practices of the self' but that ideas about the unconscious level of an individual's action are not explored in this idea where action is seen as intentional. Her critique of the Foucauldian perspective on medicalization calls for approaches that would explore the emotional and psychodynamic dimensions of medical encounters using a phenomenological analysis of individual experience.

Premenstrual syndrome and its more severe form resulting in a diagnosis of PMDD are aspects of menstruation that focus on pathology credited to changing hormonal levels. Medical attention focused on a previously non-medical issue can be explained with help from a medical historical analysis and medical sociological studies that attempt to situate the development of medical advancement in a context that can explain its use.

A diagnosis is a medical category. What also needs to be examined in the medicalization process are how advances in medical technologies and how applying them as treatments can change the state of a human biological system. Once a change can be identified, a treatment develops. The change lays the groundwork for the unaffected and untreated original state to become a category of illness and in turn a diagnosis.

The term medicalization is misleading. The creation of medical categories in the form of diagnoses is facilitated by actors outside of medical communities. In Carl Elliot's book *Better than Well* (2003), we can follow the birth of a diagnosis through the development of psychopharmaceuticals. In Elliot's examples, the creators of antidepressants were able to widen the existing category of depression by marketing the illness. This involved the medicalization of states of being that were previously not considered medical issues. Starting with depression and a reference to David Healy's *The Antidepressant Era*, the role of pharmaceutical companies marketing tactics is presented as crucial to the creation of illness categories previously explained by individual personality and characteristics.

“Depression, they thought, was too uncommon. Therefore, when Merck started to produce amitriptyline, a tricyclic antidepressant, in the early 1960s, it realized that in order to sell the antidepressant it needed to sell depression... The strategy worked.” (Elliot, 2003:123)

Elliot gives further examples of how this same process is behind the success of Prozac® and demonstrates how the diagnosis ‘clinical depression’ has expanded to include states previously understood to be melancholy, anxiousness and alienation. Other diagnoses that have either been created or expanded in order to include the use of ‘sister’ antidepressants are panic disorder, social anxiety disorder, paraphilias, sexual compulsions, premenstrual dysphoric disorder and obsessive-compulsive disorder (Elliot, 2003).

Sarafem® is the name given to fluoxetine hydrochloride, the same psychotropic drug as Prozac® a SSRI antidepressant. It was developed specifically to be used by women suffering from PMDD.

“Sarafem” is homophonic with “*seraphim*,” the borrowed Hebrew word meaning “angel,” and targeted to *females*. Through this kind of packaging, marketing and targeting, pharmaceutical products take on changing symbolic lives, and are representing in new ways a constellation of cultural messages regarding illness.” (Greenslit, 2003:3)

Using cultural analytical perspectives combine knowledge from different fields to reveal the relationships between societal factors, issues of power and medical development. Understanding how illness is constructed in a culture, in this case PMS and PMDD, requires knowledge from multiple levels of human experience.

### **2.3.3. The development of premenstrual syndrome**

Emily Martin in her article *Premenstrual Syndrome, Work Discipline and Anger* (1998) gives an historical account of why menstruation was made visible through the development of PMS at times when the roles of women had to be identified to steer what their desired function in society should be. At times when women were needed in the work force coinciding with a lack of male workers during WWI and WWII, PMS discourse was quieted. When the reverse was true, there was a desire for women to make way for what society saw as the rightful breadwinner in the family. PMS discourse flourished. The medical/physiological model of PMS emphasizes the symptoms, suffering, physicality and requirement for medical treatment of this state. When it was first named by R.T. Frank in 1931, a direct connection made to the ovaries, emphasizing hormonal dysfunction and the debilitating effect of its occurrence (Martin, 1998).

Moving to the present, Martin's main position correlates the symptoms of PMS to the discipline required in Late Industrial Society. She lifts the question of whether race and class play a role in the exhibition or frequency of symptoms, the hypothesis being that the more discipline to which one is subjected, the more prevalent would be the occurrence of PMS. Studies up until her article had not been done focusing on this type of sociological analysis. Aside from Martin's work on PMS in society, this still holds to be true during the compilation of this thesis.

Anger is a central symptom in PMS that only affects women, Martin writes. The reasons for anger being problematic are based on the idea that the nurturing family role that is expected of women is incompatible with exhibitions of anger. A number of cultural assumptions are taken for granted, that women are responsible for the feelings and well-being of others in ways that men are not.

Uncontrollable anger must then be explained. The anger is a malfunction, hormonally related and therefore needs medical treatment. Female display of socially unacceptable anger can only be due to a medical condition. This example of a hegemonic model of explanation based on biomedicine leaves little room for a social analysis of anger. If medical explanations expand, as they have in Western society, they do so at the expense of social critique, minimizing room for negotiation. Simply put, individual bodies of women are forced to adapt to the social environment seen in the existence of multiple and conflicting social roles, responsibilities and expectations. Instead of seeing the issue as a collective one, shared by women, where anger is understandable, expected and interpreted as protest,

anger remains to be seen as a symptom leading to medical solutions and not to social change in living conditions or organization of work.

## **2.4 Research on the body, socialization and transformation**

What is the manifestation of premenstrual syndrome in the bodies of Western women saying about the social conditions of this group? This section is a survey of anthropological research on the body, socialization and transformation. I would like to inventory advantages for including research on the society in which women live and then include articles that can contribute to answering questions about normality and authenticity.

### **2.4.1. Resistance/agency**

Psychological anthropology can be used in enhancing our understanding of behaviours labelled as resistance. When it comes to illness both the intentional use of existing symptom frameworks in society and the unconscious display of illness through learned patterns of symptom communication existing in the culture are of interest. They are interdependent. This fact is very important for understanding display of illness which Seymour presents in *Resistance* (2006).

“In a context of differential power relationships, resistance refers to intentional, and hence conscious, acts of superior defiance or opposition by a subordinate individual or group of individuals against a superior individual or set of individuals.” (Seymour, 2006:319)

Resistance is overt and obvious in a way that cultural behaviors and motivation are not. Explanation, experience and interpretation of illness require anthropological methods combined with psychology. This is Seymour’s main point. Interpretative frameworks and cultural schemes together can explain how culture is internalized and how motivation works. These types of analysis rely heavily on knowledge about psychology.

G.H. deBessa has also focused on analyzing resistance but with emphasis on sociological mechanisms. In deBessa’s article we read about low-income women in Brazil who resort to sterilization in order to meet the demands society places on them in regard to motherhood. The medical alternatives available to them that can be seen as less invasive are not satisfactory since they are either difficult to manage because of practical issues, religious affiliation, personal income, dependability of treatment or issues concerning what is thought to be healthy and safe. For example, using oral contraceptives that ‘block the flow’ of menstrual blood are viewed as unhealthy. Other medical techniques such as abortion are not available due to social and political factors. The women in this study resort to a higher level of medical intervention because of the guarantee it offers to improve their expected quality of life. Here

we have an example of medicalization that is seen as highly desirable because of unequal gender relations and economic limitations in their lives and shows the interactive process of medicalization.

When looking at the extreme conditions in Brazil in comparison with given living situations in Anglo America or Europe it becomes more obvious why women choose medical answers to non-medical questions. Pragmatism is a strong justification for actions otherwise seen as invasive when it makes daily living conditions easier to manage. Where in low-income groups in Brazil this matter is often a matter of life and death, it is a less drastic question of quality of life, self-definition and relational issues for women further from the poverty line. We can see managing menstruation as an example of this. Situations where basic needs are less likely to become dire, the reasoning and justification are similar but not as easy to understand in terms of why people chose to solve problems individually, through medical procedures or technologies. Private decisions about the body are not collective but communicate collective conditions.

#### **2.4.2. The Mindful Body**

Answering basic questions when studying a phenomenon like suffering is to put focus on human experience. Why this person? Why this disease? Why this bodily symptom? Why now? Medical anthropology is about viewing culture through illness. These thoughts are laid out in Scheper-Hughes & Locke's article 'The Mindful Body' (1987), reminding us that sickness is a form of communication. By seeing the body on three different levels, the individual body-self, the social body and the body politic, Scheper-Hughes & Locke reveal the presence of both nature and culture in socio-cultural ideas about health and the body and how the relationship between the two is about power and control.

This article goes to the heart of the matter, why there is a justified motivation to see PMS as something other than a dysfunction of the biological organism. Following the growing influence through the last century of interpreting the body with the medical model, medical practitioners have begun to claim both aspects of the role of sickness; disease **and** illness. Claiming both, the medical community has come to treat ailments of the body and emotion with medical techniques.

In discussing the body politic, Scheper-Hughes & Locke build on Douglas' (1966) explanation of what happens when a community experiences itself as threatened. The social controls that regulate the boundaries of groups expand. To keep groups in their place, social controls are expressed through the regulation of bodies. Self-control and social control are intensified. Linking the body politic to the individual body, boundaries are guarded from outside threats. The individual control of what goes in and comes out of the individual body (literally or figuratively) grows in importance along with what is important to maintain the body politic. Recounting the history of PMS, Martin (1998) is able to give a

specific example of the use of social control through medical research focused on menstruation and the individual bodies of women affected by it over time. On the contradictory demands of post-industrial American society, Scheper-Hughes & Locke write about the same issues that Martin would later develop on the conflict between self-control and self-indulgence and between discipline and femininity.

Scheper-Hughes & Locke see the need to incorporate a theory of emotions to the analysis of the individual body-self, the social body and the body politic. Since emotion affects the body, medical anthropology and other work related to embodiment must include this type of analysis which would look at all three levels of 'the mindful body'.

### **2.4.3 The 'sick majority' and the overproduction of illness**

In regard to menstruation and PMS, Scheper-Hughes & Locke explain the body politic and how society controls bodies for its needs. One of these needs is the continued existence of hierarchies of social groups. The power/knowledge arguments developed by Foucault, arguments important for the three body model, are an example of less overt exertion of control that are just as effective in disciplining individual bodies. Foucault analysed the role of medicine using this explanation. Surveillance medicine with the instruments of measurements and statistics create the categories of disease. What Scheper-Hughes & Locke point out is the relatively inactive response by researchers to study the construction of a sick majority. PMS is a striking example of the use of self-reported medical statistics to create this type of sick majority targeting the entire female population. According to Kissling in *Capitalizing on the Curse* (2006), estimates of the prevalence of PMS is said to vary from 5 to 97% with more than 327 proposed treatments.

By studying the 'three bodies', we may be able to understand illness by examining the interrelated processes. Why this is important in the current era is because of the dominance of categorically using the disease model with no counter balance from other areas of research.

“Radical changes in the organization of social and public life in advanced industrial societies, including the disappearance of traditional cultural idioms for the expression of individual and collective discontent... have allowed medicine and psychiatry to assume a hegemonic role in shaping and responding to human distress.” (Scheper Hughes & Locke, 1987: 26)

Female rage is one defining symptom of PMS but can be seen as a sign of social complaint. Using a medical interpretative model blocks rage from being transformed into wrath that would be able to communicate this social dissatisfaction (Martin, 1998). Whether talking about PMS or ADD, Scheper-

Hughes & Locke see this as the ‘overproduction of illness in contemporary industrial societies, a direct result of medicalization’.

#### **2.4.4. Societal changes and metaphors of the body**

Another example of privatization of collective experience is presented by Dona Davis in “Blood and Nerves Revisited” (1997). This article describes why menopause has come to be conceptualized by a biomedical model. Changes in society in this post-industrial fishing village in Newfoundland had a direct impact on the bodies of women.

Changes are not only due to medical discourse dominance or influence of mass media but how societal structures have changed interpretations of the body. Davis first cites Martin (1992) who described how metaphors of the body have changed as the American economy has moved from an industrial to a post capitalist mode of production. She also draws on the discussions presented by Locke on the politics of state and national identity in Japan and how it is related to formerly non-existent negative views of menopause. These two works of research tie in the importance of societal, economical and political changes to shifting views about the body. Again the body politic, the social body and the individual body mirror each other (Scheper-Hughes & Locke, 1987). In Davis’ work examples are given of physical structure of buildings, how communities are planned spatially, how families organize their living arrangements, types of work done, in what sectors the work is done, the organization of work and how these factors had effects on women’s changing perceptions of the body and in particular of menopause (1997). Davis shows how changing relationships due to modernization are examples where economics and politics are placed on the body. Transferring the social into the biological is a predictable outcome in societies exhibiting a hegemonic medical discourse (Scheper-Hughes & Locke, 1987). One of Davis’ most important points is that medicalization as well as the influence of mass medial discourse cannot explain these changes alone.

Davis writes that “a series of large-scale studies have demonstrated that menopause is most remarkable for being unremarkable” (1997:5). She points out the view held by anthropologists that the relationship between the biomedical model and cultural description must have a dialectical relationship to be of any worth analytically. Biology dominates the focus of menopause research, as it does in research about menstruation, making the distribution of knowledge production uneven and analytically unsound.

Like menopause, PMS stands out in medical discourse in this ‘unremarkable’ way. Both have great impact on experiences of suffering, are treated as medical issues but mark aspects of life that have

existential depth. The answer to why this is the case requires the dialectical approach that humanistic and social science research can offer to the knowledge production of the body, experience and self.

## **2.5 Summary**

This compilation of work previously done in the field of menstruation, shows that the subject has been studied from different perspectives. A humanities and social science perspective will examine the categories created from a set of biomedical instruments and how these categories impact on social mechanisms and human interaction. What is still missing from research in the field of menstruation is the perspective of individual women. The lack of systematic study of experience in every day life is the motivation I draw on in my choice of theoretical approach. I have chosen to apply a phenomenological perspective to contribute to making the research deriving from experiences within female bodies more analytically sound.

Previous studies done on menstruation and premenstrual changes have mostly been quantitative in nature focusing on sensitivity to changes in hormonal levels, chemical imbalances, prevalence of depression and attitudes in society towards PMS and related behavior. Symptoms are divided into two groups, physical and mental. There are few qualitative studies on a woman's own understandings and experiences of the events in the body related to menstruation which focus on their meaning to her as an individual. This object study requires a systematic look into the attitudes and experiences of individuals in real life situations.

# 3 A Phenomenological perspective

In order to explore how women talk about their bodies and menstrual cycles from a personal perspective my choice to use a phenomenological perspective in this study was made to access a specific kind of knowledge about bodily experiences. The main interest of this study deals with lived experience and the material to be collected is the verbal representation of what takes place in the body.

Phenomenology is a philosophy that is concerned with how individuals make sense of the world around them. Alfred Schutz initiated a phenomenological approach in social science building on Weber's concept of *Verstehen*. The *Verstehen* approach strives to use interpretation of social action which utilizes both explanation and understanding (Bryman, 2004). These ideas belong to the epistemological school of interpretivism which grew from criticism of using the scientific model of the natural sciences to study the social world.

The world of nature as explored by the natural scientist does not 'mean' anything to molecules, atoms and electrons. But the observational field of the social scientist -social reality- has a specific meaning and relevance structure for the beings living, acting and thinking within it. By a series of common-sense constructs they have pre-selected and pre-interpreted this world which they experience as the reality of their daily lives. It is these thought objects of theirs which determine their behaviour by motivating it. The thought objects constructed by the social scientist, in order to grasp this social reality, have to be founded upon the thought objects constructed by the common-sense thinking of men [and women!], living their daily life within the social world (Schutz in Bryman, 2004:13).

The point of departure in phenomenological studies is the view of the people being studied. Embodiment is a phenomenological strand used by social scientists to use the being-in-the-world experience as a source of data. This data, identifying preconceptions based on a person's point of view have been a major contribution to the qualitative research tradition. Tracing the development of the first person perspective in this tradition reveals part of the development of using phenomenology in research concerned with the body. One example is how the anthropology of the body, inaugurated by Douglas (1973), started a move away from the body as the source of symbolism or means of expression to an awareness of the body as the locus of social practice. Another example is the work of Foucault which is part of the tradition of the textualist and representative paradigm that he shared with Levi-Strauss and Derrida. The phenomenological approach grew later starting with the works of Geertz. Schutz can be seen as the first to use this philosophical base in studies of society. Turner and Bruner in their 'anthropology of experience' and Joan and Arthur Kleinman in their 'ethnography of experience' continued to develop the phenomenological approach (Csordas, 2002). Thinkers influenced by Merleau-Ponty claim that embodiment, based on phenomenology is where culture and self are grounded. Our experience is accumulated through our senses and reality exists in the bodily experiences resulting from this accumulation.

Social science perspectives in health have strived to 'bring in the body'. What has been missing is the meaning the body carries and how it can be experienced differently at different times in life. An example where different perspectives utilize these assumptions can be found in Olin Lauritzen's study on 'ambiguous bodies' of middle-aged women (Olin Lauritzen, 2005) where she asks questions about separate bodies at specific points in time. The view point of the individual is an important part of a social science perspective like this one. Many of the assumptions the phenomenological perspective builds on are used by researchers as tools. Another example of multiple perspectives drawing on phenomenology is found in the discussion of the individual body, stemming from Scheper-Hughes & Lock's article, *The Mindful Body* (1987). An individual is seen as an embodied social being which challenges the Cartesian split often used in descriptions of human experience. These examples point out a type of thought used in many approaches in qualitative research without necessarily using it to structure study design or the empirical evidence. What specifically supports a phenomenological approach is that it enables a researcher to take the individual verbal representation of actual experience in every day living and systematically include a reflective first-third perspective in the description of perception and experience of the body simultaneously.

Drew Leder's book, *The Absent Body* (1990) is a theoretical study of embodiment from a phenomenological perspective. The idea that the absence of dysfunction makes the body disappear from consciousness is the foundation of the idea of *dys-appearance*. The body disappears when functioning properly and *dys-appears* when attention is brought to sensation in one's own body. For studies on bodily experience, this way of thinking about existence can help to gain understanding about the relationship between experiencing a body from within and what that means in everyday life. A phenomenological study on menstruation can thus shed light on how experiences take their place in consciousness not just from within but reflected from the presence, thought, attitudes and behavior of others we communicate with. The idea that the first and third perspectives of human existence are combined in an embodied knowledge is an important aspect to keep in mind when using this particular interpretive approach.

The notion of absence of conscious awareness of the body is useful in figuring out how we use our senses. We act and think through perception of our world. That is what makes up experience. What that experience means to us eventually constructs what we commonly call reality. This focus on senses, awareness, perception and experience together is part of the move to 'bring in the body' in our modern Western culture which is still under the 'sway of the Cartesian paradigm' (Leder, 1990).

Contesting Cartesianism has been a main goal of a long list of philosophers. I find it important to use a type of philosophical ontology that can help social scientists to do this as well, since it is a difficult task in itself to be aware that we still think and talk about the body as one part and the mind as

another. It is because of the far reaching social effects that Leder discusses the broader implications that phenomenological theory can have. He specifically mentions how the dualistic paradigm is the type of thinking that lead to the oppression of women and ‘other Others’ which makes Leder’s project also an ethical pursuit (Leder, 1990).

Leder’s concept of the body builds on the work of other philosophers but particularly Merleau-Ponty. It is not just a physically existing object but a medium, ‘the body-as-experencer’. This is the part that I feel is good to think with since it helps to overcome the culturally programmed way of thinking in dualistic terms. This requires an incorporation of thinking about experience in a unique way, both from within and from without. The body lived from within is what we experience first hand. But experience from others’ perceptions of me, from a third person perspective, are part of what Leder explains as lived embodiment. The external gaze is necessary. Others may be more aware of my intentions, feelings and movements that I am. The subject and object together offer a way to analyze the life world of individuals by using these ideas, from the inside of the body, from outside of it, the perspectives of both the first and third person and the physical body and the lived body combined.

In his book *The Absent Body*, Leder also addresses experiences and meanings of menstruation by moving from the surface of the body to the inside, the visceral. He connects detailed descriptions of the workings of the body as a type of groundwork to understand the importance of absences. He then deals with presence and absence in regard to his model of *dys-appearance* where our bodies seize our attention at times of dysfunction.

### **3.1 Dys-appearance and menstruation**

Not noticing the body is what we expect most of the time. That is when our state of being is described as normal in everyday terms. Leder talks about the habitual state of embodiment when the body disappears. When there is a divergence, which Leder most often exemplifies in terms of malfunction, like sickness, incapacity or pain then the body changes and *dys-appears*. The body can undergo changes described as spatio-functional divisions but also of a temporal nature as well. When sick our concept of time is altered in a way that Leder describes quite elaborately. He talks about changes, novel sensations and altered capacities, where the body is transformed. Transformations are reason to no longer take the body for granted and often are associated with negative experiences (Leder, 1990).

Of particular interest in that temporal discontinuity, described by Leder as a relatively uncommon occurrence for individuals, is what many women can consider expected and predictable ways of feeling and experiencing. Stages in development like puberty with the onset of menstruation, recurring

cyclical changes of menstruation, pregnancy, menopause as well as aging in general, fall under transformations that make up the normal functioning of a female body in different phases of life.

I believe that Leder is aware that there are problems with a model of *dys-appearance* as applied to the female body since he readily quotes Young (1984) in both her description of pregnancy and when she points out that only middle aged adult males experience health as an unchanging state. (Leder, 1990:89) Normal body functioning for women includes regular and possibly extreme bodily shifts. Leder says that women's bodies stand out as a place of transformation. He mentions that there might be problems in describing non-pathological states like menstruation with a model of *dys-appearance* since process like it are normal and necessary. At least he mentions that the notions of 'bad' or 'ill' in the prefix *dys*-shouldn't be associated with them.

The visceral is a system that is largely meant to function without notice, or as Leder describes it as 'depth disappearance' (Leder, 1990). His explanation is that when the inside of the body, the organs, are *not* silent we associate this with discomfort and illness. However, a working reproductive system in women is often very noticeable. This can reiterate why men often view the female anatomy as malfunctioning (Laws, 1990). The question is whether or not it can contribute to a phenomenology of menstruation that does not fall into a similar trap to that of a dualistic view of the body. There are problematic consequences that echo the same problems and perpetuate viewing women as deviant none the less. Still a problem is the idea that physical experiences of the body are in some way debilitating or faulting in and of themselves that even scholars on embodiment can't quite seem to free themselves from.

So how should heightened body awareness be understood according to Leder's model of *dys-appearance* in regard to menstruation? Rapid changes are associated with being problematic in this model. Leder ends this discussion of temporality with linking normal bodily changes with discomfort; morning sickness, body growth and delivery in pregnancy, puberty and the discomfort of menstrual cramps and aging and the loss of function. There clearly are other avenues to develop how *dys-appearance* can include these non-pathological states and systems.

Lastly what is interesting is how these changing states, both spatial and temporal, influence how we are able to experience our surroundings directly. All in all, Leder's work greatly contributes to ways of approaching the study of menstruation. An understanding of phenomenological theory and perception are crucial to using personal experience as a basis for perspective.

## 3.2 Finding the boundary between normal experience and illness

Phenomenology attempts to explain reality through this type of personal experience that often is associated with mental health and has been the focus of psychiatry from its start. The senses are the central experiencing tools that shape reality as we know it. My concern is with how the internal bodily sensations are interpreted in a socio-cultural context that affects how individuals view themselves. More specifically, how do women experience heightened bodily awareness, a *dys-appearance* of the body (Leder, 1990) and how is this interpreted and possibly transformed into mood? Positive moods and emotions logically should occur with the same regularity as negative ones. Why are they regarded differently? This investigation could lead to what the culture being studied uses to explain disposition and define categories of ways of being in the world that are considered deviant, harmful or signs of illness. Another question yet to be answered is how does the state of ‘unhomelikeness’ described by Svenaeus (2007) in respect to antidepressant use, respond to variations in cultural categories like gender, race and ethnicity? What do women experience socially that influences embodiment?

Fredrik Svenaeus’ article “Phenomenology Listens to Prozac; Analyzing the SSRI Revolution” (2007) uses a phenomenological analysis to study the relationship between normal feelings and illness. The answers to questions about mood, emotions and normality are found in everyday life. Svenaeus emphasizes the methodological imperatives that distinguish how disease and illness can be studied.

As outlined by Svenaeus, answers to where we draw lines between normal experience and illness are found at the life world level. There are no tests for serotonin levels in the brain which is what SSRI antidepressants are developed to influence. All medical caregivers have to go on are what phenomenology calls the lived-in-the-world experiences of people.

Advantages of a phenomenological approach in a study of menstruation and menstrually related problems are made evident by examining the criteria doctors use for the diagnosis of PMDD as presented in the previous chapter. The deciding factors for being included in this diagnostic category deal with self-reported problems that occur with an unchanging backdrop of the world women live and work in. The change in experience of that world has origins from within. Evidence of the manifestation of signs and symptoms of illness are primarily through the language of the individual. Self-evaluation and communication are the objects of these types of diagnoses and at the same time act as the building blocks of the diagnoses. It is therefore vital for humanistic and social science studies to understand how meaning is constructed through communication about the body.

Another argument for why phenomenology should be used to study menstruation is how we make the distinction between what is normal and abnormal in everyday life. What are women willing to accept and endure when we have choices available to us through medical technology? How are those choices shaped by ideas about who women see themselves as being?

Svenaesus reminds us that there are no theoretical prejudgments in a phenomenological approach (2007). The phenomena appear and are then studied as a structure of meaning. The causes are not the issue and do not matter in this type of analysis. What does matter in a phenomenological analysis is how painful feeling and disruptive moods relate to everyday life. In a study done in the Netherlands on the use of benzodiazepines among women, the main reason given for using these medications were consistently situated in their day-to-day living. These women wanted to be able to function in their roles as workers, mothers and partners (Whyte, Van der Geest & Hardon, 2006).

The process of medicalization together with an analysis of power may miss the mark of explaining the increased behavior of self-medicating for managing life situations. "...the charge of medicalization overlooks the complexities of agency and control." (Whyte, Van der Geest & Hardon, 2006). Even when using a phenomenological approach focusing on embodiment, the social environment should also be seen as embodied.

### **3.3 Summary**

At the core of the discussion in this thesis will be how a woman experiences changes in her everyday life due to a biological function, her menstrual cycle. It is inadequate for a social science study to limit the questioning to exhibition of symptoms of a diagnosis. The point of going further into experience, understanding and meaning is to tap into embodied knowledge. A tendency to think that physical evidence is more real is a dominating view existing in society that blocks the ability to find explanations for complex issues like illness. The view of Western medical communities 'assumes that biological concerns are more basic, 'real', clinically significant, and interesting than psychological and sociocultural issues.' (Kleinman et.al. in Helman, 2007). To utilize what we know about perception and reality in the life world in areas concerning health the methodological approach required will continue the questioning to include individual interpretation of experience at the very least.

The division between health and illness is a volatile one. The quantification of measurements strives to create categories that determine what is normal in a biomedical sense. This is one culturally shared way of describing one's way of being in the world which is dominant. But if you continue to explore issues of embodiment the division between states of health is not clear cut. The arena of health is in

the body which is experienced individually and communicated in a collective. As Shultz is quoted earlier it is the social scientists' duty to use the thought objects of everyday living to grasp social reality.

The choice of perspective for this study situated in the domain of everyday life focused on the view of the people being studied is a phenomenological one. In addition to balancing the effects of overrepresentation and over application of positivistic approaches in areas not reachable by its limitations to quantitative evidence, a phenomenological approach will include answers to questions that have implications for all fields of health research. It is a contribution in itself to focus study on what women experience, and include the female body, in studies of health. This is one part of the advantage of producing knowledge based on the assumption that the body and the self are not separate but combined in the phenomenological standpoint that experience is invariably embodied.

# 4 Objectives and Method

## 4.1 Objectives

What kind of knowledge can be gained by studying women's experiences related to their menstrual cycles and menstrually related suffering? Knowledge about how the body shapes reality lies in stories like the ones presented by women who detect changes and feel altered states at different points in time in a menstrual cycle. Changing states in the body influence and alter existence. Both the experiences from without and within are experienced through the body. A woman compares her experiences with herself, her own personal register of varying experience. This takes place in the cultural context where she also compares her experiences with other women's bodies resulting in the construction of meaning. There is a type of knowledge about authenticity that is unique for women who menstruate and feel affected by it physically, mentally and emotionally. How do women incorporate their different ways of being in one person? How do they uphold their authentic selves with differing experiences in a rapidly changing cycle?

The main objective of this thesis is to contribute to a deeper understanding of the women's experiences in regard to menstrually related suffering. More specifically, how can these experiences be understood in relation to notions of normality and authenticity?

Three questions to be answered in order to reach the main objective are:

- How do the women express their experiences of menstruation?
- How do the women understand changing embodied experiences related to the menstrual cycle?
- How do the women express ideas of menstruation and menstrually related suffering as a part of themselves?

In order to understand current practices of applying medical technologies in the form of antidepressants and hormones in a context unique to the experience of women, it is necessary to explore ideas, experiences and meanings about menstruation. The motivation for the use of medicine in managing premenstrual conditions is just as important if not more so as the resulting changes women experience from this use.

My motivation for using an open-ended, thematic interview is that it is necessary to understand what the physical and mental signs of the different parts of the menstrual cycle mean to the woman who

experiences them. By asking questions about different ways of being in her body and feeling changes in her mood I would be able to draw conclusions about how the relatively fast progression from one state to another influences how she experiences the world around her. The subject of menstruation in the society being studied is heavily denoted with discourse on PMS. It is the most visible representation of menstruation in Western society and makes the subject of menstruation also a subject of suffering. The way women incorporate this type of predictable and reoccurring suffering into what is normal in society, normal for women and normal for them is at the core of the research question. The question of authenticity and what women can ascribe as a part of themselves or a way of feeling or not feeling like themselves can only be answered with first hand accounts of what it is like to live a life inside that woman's body.

## **4.2 Choice of methodological approach**

In order to gain knowledge about this subject I have chosen to speak with women about their individual experiences of their bodies, moods and sensations connected to the reproductive system and regularity of cyclical change. I wanted to pay particular attention to two things: when women feel like themselves, what I term as 'one's selfness' as opposed to when they feel affected and what they see as normal in reference to this sense of authenticity. The intent of this investigation is to lead to answering questions about how new medical technologies are used in negotiating experiences in the life world. Both the use of hormonal therapies in the form of contraception and the use of SSRI antidepressants come into focus and require an interpretive method focusing on embodied experience found in a phenomenological approach. With this introduction I have outlined the development of my ideas around methodological choices in order to study normality, authenticity and menstruation in the life world.

## **4.3 Study design**

This project was constructed using a phenomenological approach to examine the life world of women as outlined in the previous chapter. The type of knowledge needed to answer questions about how experience is understood is found using theories about embodiment, reality and existence. Focus is put on exploring embodied experiences, the women's personal perspectives on menstruation and her ideas about her own experiences in every day social contexts. Questions were specifically designed pertaining to how women experience their surroundings differently depending on physical and mental changes and as well as the use of medical technology in the form of antidepressants or hormonal therapies. How these two altering processes affect being in the world, the one menstrually related and the other with origins in medical technological development is the main focus of the study and the goal is to produce knowledge about embodiment through this qualitative research method.

### **4.3.1 Recruitment**

In order to recruit subjects a call for interview subjects began in the fall of 2008. A written survey was sent out electronically to acquaintances and colleagues and to students connected to the Master in Health, Body and Culture Program at Stockholm University (Appendix 2). This was done to expand my informal background knowledge on the subject of medications used for treating PMS symptoms. Secondly, a letter was distributed in Swedish and in English on the campus of Stockholm University, posted on bulletin boards in places of employment through personal contacts and via email to interested parties in Sweden and the USA (Appendixes 1 and 3). A choice was made to only include material from live interviews in the scope of this thesis. All of the women who responded to the search for subjects had recurring problems they associated with their menstrual cycle and had experienced suffering in respect to menstruation. Ten women from the Stockholm area were chosen for the study and contacted by email and telephone to arrange a one-hour long interview.

It was never the intention to recruit a statistically representative group based on criteria such as income, education level, class, ethnicity, functionality or sexuality. The deciding factors for including informants in the study were determined primarily by experience of menstruation and secondarily by experience of medical technologies related to menstruation.

### 4.3.2 The informants

The interview subjects were asked to choose a name I would use for them in the written texts in this thesis when given a letter in alphabetical order. For example A was the first interview etc. The women's real names are only recorded in my field notes.

**Table 1. Informants' names, occupations, marital status and number of children**

Alias, age	Occupation	Marital Status	Children
Anna, 27	Degree in social science	Living with her partner	None
Betty, 51	Communications consultant	Single	Three: ages 14, 12 and 10
Cecilia, 40	Medical doctor	Single	One: age 5
Doris, 40	Psychologist	Living separately but involved w/partner	None
Eva, 27	University student	Living with her partner, engaged	One: age 11 months
Fredrika, 37	Technical IT manager	Living with her partner	One: age 1 and half Pregnant
Greta, 39	Physical therapist	Married	One: age 7
Hanna, 34	Administrator	Living with her partner	Three: ages 8, 8 and 5.
Isabel, 23	Student in higher education	Single	None
Jenny, 33	University student	Living with her partner	None

All of the interviews were conducted in Swedish with the exception of Betty's interview which was in English. Betty is originally from the United States and is the only non-Swedish informant.

### 4.3.3 The interviewing process

In the spring of 2009, I interviewed the 10 women for approximately one to one and half hours. The interviews were conducted in different places depending on the woman's preference. Three interviews

took place in homes and the remainder took place in a university or school setting. These open-ended interviews were thematic following a line of questioning that enabled me to ask questions in different ways to access the woman's own understanding of her experiences related to the research question. Digital recordings of the interviews were made and then transcribed. The written transcriptions are the empirical data on which this study is based. The research questions focused on in this thesis are answered based on the transcription of these interviews.

I began the interviews by presenting a one-page form to the interviewee to list negative and positive experiences related to menstruation and use of medication as well as biographical information for organizational purposes (Appendix 4). This was done for two reasons. I wanted to assure that their contact information was correct and for organizational purposes have basic information about negative and positive experiences listed as well as names of medicines or treatments that they had tried for menstrually related problems. Secondly, it enabled a structuring of the interview for the initial questioning as well as time to work out practical digital recording conditions. The form the women were given also reiterated the focus of the study and was meant to help the interviewee to be prepared for the line of questioning I would be pursuing. After presenting this information together with a verbal reminder about what this interview material would be used for, the women gave their informed consent. Confidentiality and anonymity were explicitly guaranteed at this point in the interview, as the nature of the subject to be dealt with would concern intimate and private issues.

I felt it important for the nature of the study to allow the interview to accommodate the women's needs to elaborate on what they felt was most important about their experiences. Most of the questions were intended to help the woman being interviewed to feel able to retell her experiences in a way that was most comfortable for her and suited her preferences when revealing sensitive information (Appendix 5). Since the subject is intimate in nature in a number of ways I used different interviewing techniques depending on the individual. It happened often that I returned to the same question after we had talked through the basic focus of the interview, mainly ideas about normality, 'one's selfness' and experiences in the body. This was meant to direct the narrative to how she experienced different ways of being in different phases of the menstrual cycle. Comments on normality and authenticity came early and were focused on when these subjects were brought up during the interview.

The phenomenon of bodily changes and altered states is difficult to articulate since many workings of the body are taken for granted. To be able to elaborate on such issues, sharing thoughts on intimate subjects require that the interviewer can be identified with and trusted. This exchange which is the study object is a product resulting from the interaction between the interviewer and the interviewee. Answering questions that are often considered to be in the category of 'things you just don't talk about' puts demands on both parts in the interview situation. The women in the study were pressed to

be able to articulate subtle and not readily definable occurrences. Their specific and unique experiences became the most revealing information that came out of the interviews. Coming from social backgrounds where higher educational levels and social patterns of discussing menstruation are common made their task of expressing these ideas easier. There is no statement being made that these are average experiences that women share. Rather, that in order to study a difficulty defined area, the extreme examples enable a collection of experiences that in turn will be able to increase our ability to ask the right questions in a manor that will access knowledge more readily about individual experiences and understandings about the body in a life world context.

To structure these thematic, open-ended interviews I focused on the following questions generated by my objectives. What are women's understandings of their own menstrual cycle? How do ideas about what is normal influence experience? How is 'one's selfness' constructed? How do women make their contrasting experiences a part of who they are? A strategic choice to focus on antidepressant use in menstrually related suffering was the starting point of my study and contributed to the organization of questioning during the interviews. The first part of the interviews were focused mainly on menstruation and towards the end of the interviews, medication and treatment for menstrual problems was explored.

#### 4.3.4 Transcription

I have chosen to present the excerpts from interviews in a revised form. The transcribed data were made using the following transcription conventions:

-	interrupted word
,	short pause with no intonation of conclusion
.	intonation of conclusion followed by a pause
#	unintelligible,
(?)	inconclusive transcription
<i>italics</i>	marked speech either by volume of utterance or emphasis
<b>*word*</b>	utterance accompanied by laughter
(laughter)	laughter without speech or other non-verbal sounds
<b><u>underlined</u></b>	simultaneous speech
<b>(Liz: "mm")</b>	voice of interviewer
<b>[comment]</b>	comment on transcription

(Fewer transcription markers were used in quotes included in the thesis.)

Due to the nature of the study, I have chosen to present detailed quotes from the interviews because it enables one to understand how women described their experiences and to be able to follow their reasoning. I have also chosen to translate the Swedish quotes to English and to present both versions. The authentic quotes give the reader access to the original versions which are useful when articulation of experience is the empirical data.

#### **4.4 The role of researcher and ethical aspects**

The material from the interviews with these ten women is a product resulting from communication between a researcher and willing participants. The women were guaranteed confidentiality and had given their informed consent to be interviewed. Due to the personal nature of the subject it was important for these women to feel at ease when answering questions which emphasizes the significance that sharing similar experiences or coming from a similar background enables a particular type of exchange. Being female, having similar frames of reference, being close in age, having an interest in women's health etc all contributed to what happened in the interview situation. The choice to utilize this influence to obtain information that could answer the research question was a conscious choice. To not recognize the influence the researcher has would give be false representation.

It was important for me to clarify the purpose of the study for the women who volunteered. I wanted them to know that I alone would have access to the digitally recorded interviews and that their names would never be used in computer file information. The transcripts from the interviews would only be shown to my advisor in the case that it would be requested. I made it clear that I would possibly use the material from the interviews in future projects on the subject. The women were asked if they were willing to be contacted again and guaranteed that they would remain anonymous. Their experiences over time could prove to be of interest and I reinforced the point that any participation in the future was voluntary and could be discontinued at any time.

#### **4.5 Analysis of the material**

The transcribed interviews were analyzed according to three areas: how and what women talked about in regard to menstruation; what women thought to be normal and deviant; and ideas about if these experiences made up a part of who they are. First the most typical types of responses and ideas on each subject were identified or described. Then the variations of the subject or experiences that stood out in a way that contributed to answering the research question due to how they differed from experiences reported by women in the group. Finally an analysis was done on the findings recapitulating on the theoretical ideas useful to the study.

In the analysis of the material an effort has been made to systematically organize the everyday experiences of women into themes in three areas. The answers to the questions used for interviewing were organized into three parts in the processing stage. The analysis of the material began when I sought out key words i.e. 'body', 'changed', 'feel like myself', 'part of myself', 'normal' and 'forget'. Sometimes a collection of words to describe an experience or behavior was compiled i.e. mental illness terms women used to describe PMS. The three parts that were initially used to structure the findings of the study were headed 'Menstruation', 'Normality' and 'Authenticity'. Each section was constructed thematically first according to the original objectives and resulting questions followed by questions to highlight points of interest revealed by the interview material:

1. Menstruation- What are women's understandings of their own menstrual cycle? How do the physical and mental signs in the menstrual cycle influence how women experience their bodies? What particular events are discussed? (Bleeding, ovulation, the premenstruum, PMS)
2. Normality- How do notions about normality influence experience? How do women define their experiences in terms of what is normal? What evidence is there of trying to fit fluctuating way of being in the world with their ideas about what is normal? Does normal existence include being even, consistent, unaffected and undetectable?
3. Authenticity- How is authenticity constructed? How do women make their contrasting experiences a part of who they are? Here the focus is on the concept of 'one's selfness' and narratives of acceptance or incorporation of a negative state into what is normal for one's self. How do ideas about not feeling like one's self and ideas about showing true feelings or exhibiting extreme behavior influence what women define as 'one's selfness'?

Excerpts from the interviews were organized into subgroups following the questions in each part before the writing process began. The first chapter sets the stage and introduces the field of menstruation as a focus of study. It is organized in a way that presents characteristic experiences of the subject in question. This is then followed by comparative and divergent experiences to be able to include the variation of the material in the findings. The second chapter on normality is organized similarly where frequently occurring ideas are presented first and then experiences that are exceptional or extreme. The final chapter of findings on authenticity is organized more thematically where the most significant experiences related to 'one's selfness' figure as subheadings. The previous two chapters on menstruation and normality lead up to the last chapter where an attempt is made to discuss women's understanding of authenticity including experiences of menstruation, the body and notions of normality.

What women believe to be normal in regard to their experiences of their own menstrual cycle was a question that combined ideas about the symbolic value of menstruation reflected in society with her personal interpretation of signs in her body. How normality is shaped based on what can be expected due to cyclicity and personal history was a central idea to understand what was problematic to a woman. Ideas about suffering determining what is normal were necessary to ask since suffering due to a healthy and functioning biological system was assumed to be an anomalous category.

The questions about menstruation and normality laid the ground work for asking when a woman feels most like herself. The way a woman motivated her answers was expected to reveal what was significant in her experience. Incorporating ideas about what is normal into what a woman feels defines her authentic self lead to questioning about when she would consider using a type of coping strategy. When are women willing to alter their authentic feelings, moods and behavior, was the synthesis of the previous line of questioning. How the affected state was contemplated as authentic was returned to when discussing different strategies and their advantages and disadvantages.

# 5. Understandings and experiences of the menstrual cycle

## 5.1 Introduction

How do the women express their experiences of menstruation? Even though menstruation is a normal process it is not an experience shared by all people, by all females or continuously throughout a lifetime by an individual. Initially, I would like to present some common ground shared by the women who volunteered to be interviewed. I will use categories containing pieces of the women's stories that typified most interviews, then some variations in experience with common denominators and finally examples of oppositional experiences. It is important to keep in mind that I sought out women who had experienced suffering in respect to menstruation. The focus of the answers in the initial phase of the women's stories often met the expectations of the interview situation to address suffering and negative aspects. As the interviews proceeded, the general ideas women held about menstruation in a broader context were revealed as well.

There were a number of areas about the menstrual cycle that were described similarly by the women I interviewed. Quite clearly and not surprisingly the periods of time chosen to speak about first and most were the times when they felt the worst. 'PMS' and 'premenstrual' were frequently used to define this time period. As the interviews progressed each woman was able to give some type of menstrual narrative that continued by stating how many days the menstrual cycle was, whether it was regular or irregular and often ended up backing up to the first day of bleeding to continue the description. Usually this first day of bleeding marked the end of the part of the cycle these women viewed as problematic. There was very little emphasis put on flow of blood or the physical experiences during bleeding **unless** compared to the time prior to bleeding. In the cases it was talked about, bleeding always represented a very positive experience for the women who presented it emphasizing the contrast. A description of the change of symptoms from the mental to the physical took up most of the women's focus when talking about the onset of bleeding.

The length of the bleeding period was seldom emphasized. What was significant was which day the woman could expect to feel *affected* mentally, how long this could last and which day she could expect to feel *unaffected* mentally. This was the start of what some described as the good days or high energy days as opposed to entering the phase that would bring the most negative experiences of the

menstrual cycle. Often women would say that they didn't feel like themselves or that at a certain point they felt like themselves again.

## 5.2 Recurring patterns in experiences of menstruation

One common experience was to recognize physical signs in passing from one phase to another of the menstrual cycle. Ovulation was a marked subject for women who experienced physical signs at that time. The day of ovulation for some involved very sharp pain in the lower abdomen. Ovulation was an indicator that made the women realize they were in a new phase in their cycle, the phase that would bring with it negative experiences. Besides discomfort there were other physical bodily changes that reinforced the phase change, often acting as physical indicators of mental changes that were on the way. Most women indicated that if they had detected ovulation, they became aware that they were in the second half of the cycle, the one they are most aware of because of feeling changed in some way. The mental signs or changes in mood came after the physical ones for many of the women interviewed. Aside from the description of the sharp pain of ovulation the changes going into the premenstrual phase were gradual and would culminate either right before bleeding or two to three days before. The onset of the bleeding phase was the most overtly marked for women. Often it was described with words like *relief* and involved experiences of realization or being able to relax. It was not uncommon for a woman to tell about how the muscular pain of abdominal cramps and lower back took over from the mental state that they described so negatively.

It was quite clear that most of the emphasis was put on the time a woman could pinpoint as when she felt the absolute worst. Each woman reported this by the number of days before she started to bleed quite often described as 'the week before' and often more specifically 'x to x +1 days before'. There was always some type of variation for each woman regardless of whether or not she reported a regular or irregular cycle. Notes on calendars about when they expected their periods were often used and spoken of in these interviews. This usually came up when women spoke of their suspicions of behaving differently because they felt irritated or felt listless and without energy, all negative experiences. When women felt changed, they sought out a way of trying to figure out why things were different, commonly accompanied by 'oh that's why...' exclamations when they realized they were in the premenstrual phase. An exception to this is the changes women felt around ovulation and having more interest in sex in general which, if mentioned, was accompanied by positive remarks (Hanna, Cecilia and Doris).

### **5.2.1 A life story of menstruation**

Other parts of the narratives on the menstrual cycle reported what menstruation was like when they first started to have periods. These descriptions started with thinking back about menarche, the experiences they had then as pre-teenagers or teenagers which were dominantly described as physical symptoms. When it came to PMS these women did not report having it or remember having it when they first started to menstruate. Some reflected on the fact that this stage in life was one of huge bodily change and was rather volatile or stormy because of changes associated with puberty. Often the choice to use contraceptive pills was discussed and how they were able to see changes in their symptoms when the pills were used or when they stopped taking them. Choices made to stop using oral contraception were motivated roughly in three ways; because of suspicions that they felt bad when using them (mood), they had uneasy feelings about using them for a long period of time when they weren't needed for contraception or when confronted with possible health side effects like blood clots.

The life-story nature of these descriptions often lead to reports of increased difficulty with PMS and symptoms that are associated with it. When the use of oral contraceptives was discontinued women noticed how problems increased but seldom directly linked their growing problems with their change in regime of birth control. Rather a comment that symptoms worsened with age was included in these narratives. 'It just gets worse and worse as I get older'. Relationships with partners throughout their lives where the partner's role in identifying symptoms or inability to be supportive or understanding were tightly connected to the mental affectedness women experienced in connection to the premenstrual phase and were highlighted in these life stories.

Nearly every interview had parts touching on lack of memory or lack of recognition of having suffered similarly due to what they interpreted as menstrually related. Even though there were signs, notes in calendars, regular patterns or physical indicators that preempted the symptoms that affected mood, the onset of bleeding was often an experience of realization and a wondering about how they could forget their experiences from month to month. Many women spoke of how they were hardly able to remember what it felt like during the time period before they started to bleed. This way of being affected could take a woman through a very depressed period to the point of hopelessness, meaninglessness and indifference to life itself and within a short period of time not be able to recognize themselves in that experience. The memory that it happened was still there but the memory of feeling that way was absent, especially if it involved contemplations of suicide. Being able to incorporate feelings into one's true self that can't be remembered in such a short period of time on a highly reoccurring basis poses questions of how individuals resolve this experience.

### 5.2.2 Organizing time based on embodied events

The most common way that women organized their talk about menstruation in these interviews were centered around the cyclic nature of it, gradual change in entering the premenstruum as opposed to sudden change when it ends with bleeding, organizing time from where the problematic begins, having highs and lows, being affected by not remembering what it was like and contrasts in experience. Time and descriptions of varying ways of experiencing life were organized around good days and bad days which divided up a recurring pattern of around four weeks. Even in exceptional situations when periods were too frequent, problematic or irregular there was a focus on cyclicity. Time was divided into two halves. If ovulation was detectable then it was the marker of when the bad half was starting. In one informant's case, Doris', this was so evident that she reflected on how her conceptualization of the menstrual cycle was so focused on this period from ovulation and through the bleeding period that she didn't really 'count' the good days as being part of the menstrual cycle at all.

In discussing how they knew they were experiencing changes in how they felt mentally and physically I asked for signs or details that made them aware of changes. Aside from the very distinct pain that some women experienced at the time of ovulation, the change from good days to bad days was a gradual one. Each woman could describe a gradual entrance into a time they experienced as problematic, a time that was identified as a way of suffering. They left this state in a much different way than they entered it. Each woman interviewed attested to the experience of quickly experiencing another way of being when bleeding started. Even though mental affectedness was switched out with physical pain and women could very much feel affected (cramps, heavy bleeding, an urge to rest, wanting to withdraw from interaction, seeking warmth, lying down), the change in mood was so great that this physical way of being changed was not emphasized.

#### *Starting in the middle*

Once women elaborated on the process of going in and out of different ways of being that were connected to menstrual events they offered information on how frequently this occurred. I understood this way of talking about menstruation as 'starting in the middle' with their narratives. After the problematic events were described, women would back up to the 'beginning' with day 1, the first day of bleeding, sometimes mentioning how long they would bleed or not mentioning it at all. It was much more important to report when they felt like themselves again even though they were still bleeding. Women would talk of energy levels being high, feeling level or balanced and used positive descriptions of how they experienced their lives. For example, Jenny described her ability to move about and when she was interested in the physical activities she usually enjoyed. At these times the

body was talked about when it was being utilized as opposed to when it was experiencing changes from within. Jenny was one of the two women who divided the month into two almost equal parts. The contrast was mainly expressed in how she was able to move and the physical space she moved in.

Jenny: I go around, I feel satisfied with my looks, with my body, by mobility, it is easy to jump up on my bike and ride off to the store and put on my jeans and look in the mirror and... no but it's not too bad... until all my clothes feel lumpy, I don't feel as mobile... Almost like something, that from, I feel like a big whale, (laugh) who just, I wade around, from running with light step, my steps are heavy, like treading through, I see it like a fog, and like I wrote down too, I start sweating around my neck. Instead of sitting on the subway, leafing through a magazine or through a book, I just sit there and stare and feel like, uh, in other people's way and in the way for myself.

Jenny: Jag går runt, jag känner mig nöjd med mitt utseende, med min kropp, rörlighet, det är lätt att hoppa på cykeln och cykla iväg till affär och ta på jeansen och titta sig i spegel och ... nej men det är inte så dåligt... till att alla kläder som känns knöliga, jag känner mig inte lika mobil... Nästan som nåt, att från jag känner mig som en stor val, (skratt), som bara, jag vadar, från att springa på lätta steg så ah, det är tunga steg, som att forcera en stor, jag ser det som en dimma, och alltså som jag skrev också, jag börjar svettas kring nacken. Att istället för att sitta på tunnelbanan, bläddra i en tidning och titta på en bok, jag sitter bara och glor och känner mig, ah, ivägen för andra och för mig själv.

#### *Division of time depending on affectedness*

So if a timeline could be used to understand how women spoke of menstruation it was not the one spoken of in medical settings or the one they wrote down in calendars with number 1 marking the first day of bleeding and the number of days describing the length of the cycle, like 28 or so. The division of time was clearly the day or days they felt different acting as the symbolic day 1 for these women. In my letter seeking interview participants I stated that the study would focus on menstrual suffering. The women who answered or showed a willingness to participate had already identified themselves with menstruation as problematic in some aspect as this division of time exemplified.

For some women, irritation was the word used to describe sensations or feelings that set in as early as the days directly after ovulation. The word *irritation* in this sense was commonly followed by a reflection that there was nothing different from the day before, no cause for irritation or that things that were tolerable before this phase were now disproportionate sources of irritation. Here is Eva's experience:

Eva: In my case it is often one to two weeks before I get my period is when I have these problems. Most of the time it starts with irritation, trying to find something to argue about, I get irritated, I go around and just find things that are irritating, mostly my husband, (laughter). He is usually the one who gets caught in the line of fire. And then the closer I get to getting my period the lower I get, things are tougher, everything becomes difficult, sometimes I almost can't get myself out of bed it feels like. It can get that bad but it isn't always that way.

It is different from month to month. There really isn't anything to be irritated about, you know, everything is fine. It can be when things are cozy, at home in the evening just relaxing and I'm still sitting there and am irritated. Like, what is this? Usually otherwise when you're irritated you have a good reason for why these feelings develop. It can also be when I am standing there doing the dishes and you start slamming the dishes around because you're angry for no good reason really.

Eva: För mig är det ofta en till två veckor innan mens så får jag de här besvärerna. Oftast så börjar det med irritation, konfliktsökande, irriterad, jag går runt och stör mig på saker, oftast min man, (skratt) det är han som hamnar i skottlinjen. Och sen så blir det ju närmare mens kommer desto mer nedstämd, det blir tyngre, trög rott allting, ibland kan jag nästan inte ta upp mig ur sängen känns det som. Det kan bli så illa men det är inte alltid så.

Det skiljer sig från månad till månad. Det finns egentligen ingenting att vara irriterad över, allting är liksom bra, det kan var mysigt, en mysig kväll och jag sitter där ändå och är irriterad, vad är det här liksom, för att annars när man är irriterad har man en klar anledning för varför de här känslorna väcks. Det kan också vara när man står och diskar och så smäller man extra hårt med porslinet för att man är arg över ingenting egentligen.

Eva's story, like most stories provided by the women I spoke with, attempted to connect their bodily experiences with their mental state at the time they felt bad.

Eva: It can be like this bloating feeling comes, you get irritated, I don't get really bloated, I get this feeling in my body that something is about to start up. So it is connected, surely in some way. That's probably why exercise relieves it maybe but I feel irritation. I feel it in my body. I feel on the verge of exploding. It's like menstrual cramps and things like that I have no problems with. I feel it when it comes, I'm not bothered by it at all.

Eva: Det kan liksom vara att den här svullnaden kommer på, man blir irriterad, jag blir inte jättesvullen, jag känner i kroppen att nånting är på gång liksom. Så att det hänger ihop säkert lite grann. Det är säkert därför motion lindrar, då kanske men jag känner irritation. Jag känner det i kroppen. Jag känner mig explosiv. Alltså mensvärk och sånt där har inte jag besvärats av. Jag känner av när det kommer jag tycker inte att det är jobbigt alls.

Eva was able to connect her mood to a bodily event. The change in her body occurred at the same time but the feeling of being 'on the verge of exploding' is an example of a metaphor used to describe irritation.

#### *Differences of changes within the affected state*

Details added to their stories elicited through questions or spontaneously contributed could describe certain days as worse than other *within* this problematic half of the menstrual cycle. Here it was common to speak of highs and lows as opposed to good and bad days. Lows for some women started

at ovulation and got better (Hanna). Lows here were physical, painful, or a change in feeling. Some physical symptoms of course lasted longer. Mood followed a falling and rising curve for some with the lowest point around  $x$  or  $x+1$  days before bleeding. The absolute low point was a subject returned to often during the interview. The variations in when negative experiences started or how long they lasted vary but each woman could talk about the worst days. For some the curve would turn up and things wouldn't be described as quite so bad the day before bleeding for instance in Greta's and Hanna's experience. Also typical for these women was the fact that experiences varied from month to month but never so much that they would be completely out of the good and bad division or the high and low of the curve that was described.

### **5.2.3 Recognizing affectedness**

Greta described her irritating responses to others as a clue to being in this state. Interaction with other people for Hanna, unexpected reactions to situations for Doris, unwillingness to participate in daily activities for Eva and Jenny could act as clues for these women who didn't have a clear physical sign like pain, swelling or bloating. Symptoms like these might be experienced by these women other months but not always. Some never emphasized having physical reminders. When women didn't recognize themselves, or understand their response to things as in Fredrika's case, calendar notes would be checked to verify why they might feel differently, to rule out that something outside of them changed. Fredrika needed to know why something that wasn't a problem at all yesterday was insurmountable the next. Doris sought reassurance about how she questioned herself and her capabilities by repeating to herself that 'Look, this is why this is happening, take it easy'.

There were other reminders that lead to detection. Women talked about their partners who were reported to know when the woman would ovulate. Some partners pointed out when women would overreact when discussing a daily subject, become angry or mean or become conflict-seeking. Interaction with other people and the consequences that expressions of emotion had on others were experiences that were mentioned often but not gone into in great detail. Most of the focus of the interview questions on menstruation returned to experiences that the women themselves felt as opposed to how they made others feel. When discussing antidepressant use, more focus was put on the impact their behavior had on others.

### **5.2.4 Contrasts of experience- highlighting the onset**

Narratives women used in describing menstruation began when the bad days or problems would start or were pre-empted by entering a phase that they connected with the half of the month they associated

with it, like ovulation. In second place in emphasis in these narratives would be what I call 'highlighting the onset'. Descriptions of what it felt like to start bleeding, not physically but what it symbolized to the individual, came relatively early in each woman's interview. It was contrasted by the problems that came first in their stories. Very rarely was it necessary to probe for information about leaving the bad days. It came spontaneously after descriptions of PMS and in very positive ways. Here is an overview of the core messages women had to say about the onset of bleeding.

Feelings of relief, realization and happiness were associated with the menstrual cycle's first day of bleeding. The transition from one state to another during this phase of the menstrual cycle was said to take only hours from the first sign of bleeding. This quick exit contrasted the gradual entrance into the negative states associated with the time after ovulation leading up to the worst days of the premenstrual phase.

In the very first minute of her interview Anna put it like this:

Anna: Menstruation is a positive thing. That's what releases all that's negative. In the past it was really like night and day, finally getting my period was a confirmation that it wasn't me, I wasn't that I was becoming depressed, then it came, it felt good. Really a feeling of release.

Anna: Mensen är positiv. Det är det som förlöser allt negativt. Förut var det verkligen som natt och dag, det var när jag väl fick mensen att det var en bekräftelse att det inte var jag att jag inte höll på att bli deprimerad utan att... sen kom det, vad skönt. Verkligen en förlösande känsla.

This point Anna makes about menstruation being positive because of the relief or reassurance it symbolized was a theme that would be reiterated by each woman interviewed in varying degrees. Eva expressed herself strongly about the onset of bleeding as well when she refers to it as a sort of liberation and how she needs to see the blood to be able to take it in.

Eva: I realize now after having talked about it that it's like this, this irritation that builds up everything and the looking for conflict and then towards the end that heavy feeling and then depressed and anxiety filled mood, and then when I start to bleed everything is let go and it feels great. It is like being freed, it feels great. Yes, exactly, it is all connected, like I usually don't feel it flowing, so it's when I go to the bathroom and see, then I see and it's like it has let go at some point before, that it is first when I see it that I can take it in. It's gone in some way so it isn't like I feel completely, like it isn't sudden like 'pow' and like that. More like that it is linked with that I see that it has started and then it gradually decreases. It's within a couple of hours that it is undone. It think it takes a couple of hours then I feel much better.

Eva: Jag inser nu att när jag talat att så här är det att det är irritationen som bygger upp allting och konfliktsökande och sen på slutet den där tyngden och liksom nedstämd och ångestfyllda sinnestämningen, och sen när jag då börjar blöda så släpper allting och då känns det jättebra. Det blir som en befrielse, det känns jättebra. Jo precis, det hänger ihop ja alltså jag brukar inte känna alltid att det rinner, så det är när jag går på toaletten så ser jag, då ser jag och alltså det har släppt nån gång där innan, att det är första när jag ser det att jag kan ta in det. Att det är borta på nåt sätt så det är inte liksom att jag känner helt, det är inte plötsligt att pang, och så utan att det är i samband med att jag ser att det kommit att det successivt trappas ner, det är inom ett lopp av nån timme där som det är fri. Det tar några timmar tycker jag så känner jag mig mycket bättre.

Interesting here is the transformation that takes place with the visible sign of blood signaling the end of what Eva describes as something that had a hold of her: ‘everything is let go’ and ‘it has let go’. If it has a hold of her or if something inside of her has let go and has released the blood is harder to discern but the metaphor communicates a type of feeling or sensation for the listener.

Doris was asked to describe what it felt like to go in and out of ways of feeling and in particular what it was like at the end of her premenstrual phase.

Doris: Oh, it is wonderful! It is a hallelujah moment, I go around and really want to start to bleed # not sure either if that is really, if that is a good strategy to go and wait for it and anticipate something, that increases the stress hormones to go and occupy yourself with it, avoidance, control, mess around with it instead of just, it’ll come when it comes. To be able to rest a little, trust myself, my body will take care of this, I don’t need to go in and manipulate, come on, come on, and then go and try to feel if something is happening all the time. If you focus on something it makes it worse in a way and just aaaah, if it starts it starts instead of just, but when it finally starts and I start bleeding then I become calm. I can feel how # my body relaxes and my mind and become happier, calmer, regardless of the pain because the physical pain is, nowadays I have Naproxen and I take Omega 3. It isn’t at all as bad, I mean it hurts but it isn’t that part that is the problem. I get, it’s like it was last Monday, last week (heavy sigh) **finally** and I am fascinated that it is like this every month.

Doris: Åh det är så skönt! Det är en halleluja moment, jag går och längtar efter att få börja blöda # inte heller om det är egentligen om det är en bra strategi att gå och vänta på nåt och vara beredd på nånting ökar också stresshormonerna så, att liksom hålla på med nånting, undvika, kontrollera, greja med det istället för att bara, det kommer när det kommer att kunna vila lite förtrösta mig, kroppen sköter det här jag behöver inte gå in och manipulera # kom kom gå och känna efter hela tiden för det man fokusera på blir på ett sätt värre att bara åh kommer den så kommer den istället för att bara men när det väl kommer och jag börja blöda då blir jag lugn jag känner hur jag # slappnar av i kroppen och i psyket och blir gladare, lugnare, trots smärtan för den fysiska smärtan är nu för tiden jag har Naproxen och jag äter omega 3 den är inte alls nånting som är jobbigt alltså det gör ont men det är inte det som är det jobbiga, jag blir det var som i måndags då förra veckan (djup suck) **äntligen** och så blir jag fascinerad över att det är så här varje månad.

Doris explained ideas about how anticipating and stressing worsened her premenstrual experience.

The stress hormones she describes have a strong force on her body and in her view increase with this type of behavior of waiting and wanting her period to start.

The contrast of being in one state and quickly experiencing another was very significant for Anna who emphasized in what way menstruation is positive. It is the onset that gives back her energy and resolves everything that she was experiencing during PMS. Since PMS is viewed as a disturbance by her the bleeding represents returning to a naturally positive state. Another reason why the onset of bleeding was so positive was that it was evidence that the problem was not her, it was not a depression or something that was permanent, it was just PMS and not a personality dysfunction.

Anna: Really a feeling of release, PMS penetrates the personality and how you are as a person. That’s why I feel such a feeling of release from starting to menstruate, it wasn’t me, it was PMS.

Anna: Verkligen en förlösande känsla, PMS går jättemycket in på personlighetsdrag och hur man är personligen. Det är därför jag känner det förlösande känsla av mens, det var inte jag, det var PMS.

She even came back to the subject a number of times and described the switch or transfer from PMS to the bleeding phase as fantastic and that this is something that she would not want to be without. The contrast is what makes the good days great. She had earlier expressed that she sees the contrast in experience as a part of who she is and feels sorry for others who don't experience what she described.

Even more striking is what Anna says about how starting her period reunites her back into one part making her whole again. She starts by saying that when she feels good she is in her body. She is here and now, she feels a heightened existence, she *is*.

Anna: Yes, I feel better then and that is also why I feel better when I get my period because then I know that my entire body becomes whole again. Somewhere here, in the middle, right by my ribcage, there, right between my ribs and then, but also I feel almost a little like when I have these depressed periods, then it's a little like I go outside of my body, because I feel that when I feel good I am in my body. I am here, I am now, I **am**, but when I am depressed, there are so many thoughts, everything is up here (points to her head) my relationship with others, what I am like myself, thoughts you know, that I in some way forget my body. I think that it is, that maybe it is good to work out or do yoga when you have PMS, that when you work out and are more in your body and that is what makes you feel good. Yes, I feel better because it is also why I feel better right before I get my period because then, I don't know, it's like your whole body becomes one.

Anna: Ja, jag känner mig bättre då och det är därför att jag känner mig bättre när jag får mens för att då vet jag att jag blir hel igen. 'Någonstans här mitt i, precis vid revbenen, är det så, precis mellan revbenen och sen, men alltså jag känner nästan lite så här, när jag har deperioderna, då är det liksom lite att jag går utanför min kropp, för att jag känner att när jag mår bra så är jag i min kropp, jag är här, jag är nu, jag **är**, men när jag är deprimerad, så blir det liksom mycket tankeverksamhet, allt blir här uppe, (pekar på sitt huvud) min relation till andra, hur jag själv är, alltså tankar, att jag på något sätt glömmer bort min kropp. Jag tänker att det är, att det kanske är bra att träna eller göra yoga när man har PMS, att man tränar och är mer i sin kropp och det är det man mår bra av. Ja, jag mår bättre för att det är också därför att jag mår bättre precis när jag får mensen för att då, jag vet inte det är liksom, hela kroppen blir en helhet.

When depressive feelings overcome her she forgets about her body and there is hardly any room for anything else. She goes out of her body. The body is forgotten. She ponders on this and mentions that she thinks that is why physical activity like yoga during the time she experiences PMS brings the individual back into her body, makes her more aware of her body resulting in feeling a lot better as opposed to when her feelings were blocking this connectedness to body.

### 5.2.5 Relief in realization

The way women spoke of menstruation in respect to the experience of the onset of bleeding was described in a highly positive way in all of the interviews. Relief in realization was the dominating feeling women spent time talking about. Sometimes the nature of the interview or conversing style of the woman being interviewed would present an encompassing register of the different feelings she could experience and what it meant to her at one point in the interview. Others would return to the subject a number of times, reflecting on the positive feelings in new ways depending on questions or

lines of thought. Regardless of style or situation the positive experiences contrasted the suffering and in some cases took up as much answering time as the negative experiences.

This type of relief women talked about often was described in a quick return to normalization in mood. Realization was represented by the biological process of bleeding. When they spoke of the biological they often used words like normal, expected, understandable, and hormonal in their accounts of relief in realization about their adverse experiences during the premenstrual time.

### **5.2.6 Aging and PMS**

Women's experience of worsening symptoms or feeling more affected by hormonal changes due to age was not a subject I intended to ask questions about. Ideas about PMS getting worse and worse with age were often offered after women talked about their PMS experiences in this life history style. Often women offered their own analysis or referred to conversations with friends that it is their experience that PMS worsens with age. Jenny and Betty also talk about that now that they have gained experience with different hormones or antidepressants they can see patterns and understand their earlier behavior when they were teenagers, in their early 20's or ten years ago when they were taking an antidepressant. Although women talked about these experiences in different areas interrelatedly, there were still comments about PMS as a separate subject, without being related to other events, as getting worse and worse with age. This thought was repeated in a similar way by many of the women interviewed. It was not uncommon that it was isolated from their own narrative about PMS. A sense of summing up the subject accompanied this statement. That PMS gets worse and worse with age as an idea was easily identified as a common idea held by people in society in general.

Hanna offered her own analysis, as did Doris, about why PMS worsens. They offered ideas about society, demands and stress combined with increased responsibility at work and in the family. Connections to stress and the affect it has on well being, especially during the premenstrual phase were common in these interviews but there still remained an understanding that a worsening PMS experience was somehow related to aging.

## **5.3 Variations in experience of menstruation**

The uniqueness of each woman's life laid the background which made women's experiences different. Similar reports of symptoms and changes described above were embedded in stories that women told differently. Emphasis made by the individual and importance to events were the factors that revealed

the connections of interest in this study. The variation in emphasis on different events made women aware of their bodies in differing ways.

### 5.3.1 Reproductive health, life events and PMS

Isabel, Betty and Cecilia were the best examples of when women intertwined their stories about management of menstruation with their management of reproduction. Birth control pills, surgically inserted long acting contraceptives or hormonal IUDs were mentioned early since I asked about medicines on a form that I used before the interview started. (Appendix 4)

When I asked the question about when they started to notice their experiences of PMS women paused and recollected. This was often the time they went back in time, not monthly when describing different ways of being or experiencing in terms of good or bad or high or low. This question almost always initiated a line of thought that combined, menarche, the symptoms they remembered as adolescents, their first experiences of using birth control, when they stopped using it or switched it, why they stopped using it, if they were involved in intimate relationships, their first meetings with midwives or gynecologists, side effects they felt using oral or inserted contraceptives, pregnancies or childbirth. Irregular periods or frequency or periods if the cycles were short were significant since it made it difficult to know when they could expect to feel differently or affected. The women interviewed often used a narrative style that combined experiences of reproductive health and experiences of PMS in order to trace back to when PMS became a problem for them. It coincides with when they talked about reproductive events.

Anna: Before, now when I take the pill I don't bleed as much but I bled a lot before, it was like really like, it was nice to see when it started to come but when I bled a lot it felt even better, so the more I bled the better it felt, it is really hard to explain. Now there is just a little bit. Before it was like, I was depressed and then I got my period and then everything flowed and it felt fantastic, now things are more even but sure, I can miss it that I bled a lot.

Anna: Förut, nu när jag äter p piller blöder jag inte lika mycket men jag blödde mycket förut, det var liksom verkligen så här, det var lite fint att se när det började komma men när det kom jättemycket då kändes det ännu mera skönt, så ju mer det kom ju bättre det kändes, det är jättesvårt att förklara. Nu blir det bara lite grann. Förut var det liksom, jag var deprimerad och så kom mensen och då flöde allt och det kändes fantastisk, nu är det lite mer jämnt, men visst, det kan jag sakna, att det kommer mycket.

Here Anna compares how the flow of blood changed when she started using oral contraceptives. For Anna the contrast of feeling so much better when she started to bleed is tightly connected to bleeding. Since there is less blood, the contrast is less and positive experience lessens as well.

Throughout her interview, Betty talks about menstruation almost exclusively in terms of PMS. After having gone through difficult life experiences and trying to understand her reactions she comes to the realization that PMS affects her in a cyclical way and starts to seek help for it. (The interview was conducted in English.)

Betty: And that of course came up that I had these swings and I was supposed to keep a diary, What provoked me? What made me angry? Why did I scream? This was back in 2000 when I first had this great therapist. I had just gotten laid of by Ericsson and also was in the middle of trying to get a divorce. It was a pretty crazy period, 2000, 2001. When did I get divorced? It took me three years for god's sake, four years to get out of there. I was miserable for ten years.

So I remember talking about it then so like I said in my 40's I realized I was having this (PMS). And it was always when we looked at the calendar and the diary it was usually right around the PMS time that I would go up and down and that is when I went to him and said I was having problems.

I hated it. I knew it was coming. I always looked at the calendar. That's probably when I was anxious, there is the anxiety, knowing that it was coming. And I thought, oh, I am going to start this and I'm going to be angry and going to be listless and I'm going to be out of control. That's the word, I always feel like, if I could describe all of those symptoms and put them in one, I always felt out of control. I couldn't stop myself saying things. I couldn't stop my shaking and no one could understand that and they just thought I was wacko.

In her description, Betty talks about life events when trying to backtrack to when she first started to realize she had problems related to menstruation. Stressful circumstances were recorded in a diary, finding a pattern in what precluded her outbursts. After having discovered the pattern knowing that the premenstrual time was coming became a part of the suffering. Betty ends with how no one understood how debilitating her problems were to her.

### **5.3.2 Relationships contributing to how women felt affected emotionally by PMS**

Relationships often came up in women's stories. In Cecilia's and Jenny's cases, the way they treated their partners and the affect it had on them increased these women's premenstrual suffering. Greta pointed out how the people closest to her, her husband and son would be the ones to feel the effects of her irritated state. Anna also talked about her boyfriend and his ability to accept her different ways of acting and also mentioned how her parents and siblings wanted to help her to not feel quite so low during PMS. She mentioned it being difficult for her to see that they were worried about her.

Hanna talked about how frustrating it was to be accused of being premenstrually affected when she argued strongly on a subject. Betty talked about not wanting to bother to tell her partner why she was feeling bad because of the potential for being belittled by comments about PMS. Feelings of not being taken seriously because of previously having had problems with PMS were a source of resentment for the majority of the women I talked to. Frustration with being misunderstood both when affected and not affected by PMS added to the suffering when PMS really was a problem. Women were very selective in bringing attention to suffering from PMS because of this.

The strongest motivators to want to change the way they acted when they were experiencing premenstrual changes were associated with children. Fredrika discussed her willingness to try antidepressants when her children got older and would be able to notice changes in her. Hanna decided to go to the doctor to get medication that would help her when she had PMS. Her motivation for this was if she would be alone with her children for a weekend she wanted it to be more pleasant for her children to spend time with her. Betty also talked about her relationships with her children and if she raised her voice they could ask her if she had taken her medicine or not. This was a humorous way for Betty to show that her behavior and motivation to change it were interrelated with her children.

### **5.3.3 Locating experience in the body**

In the interviews I wanted to ask questions about women's embodied experiences in everyday living. The differences in sensations, signs or symptoms during the menstrual cycle both physical and mental were the focus of these body questions. I wanted to know where in the body they felt differently. I asked questions about going in and going out of different ways of feeling. The first part of the interviews focused on ideas about menstruation, the menstrual cycle and their experiences. In the latter part of the interviews I asked questions about medicines, treatments or strategies they used and how the experience of going in and out of ways of feeling was affected by that treatment, particularly if they used antidepressants.

The talk about the body was unique for each woman. They spoke of feeling changed but how they felt changed or what mattered to them was talked about with great variation. Isabel talked about her physical symptoms very positively since it represented a healthy bodily function for her. It happened in a number of interviews that the questions I posed about the body were understood to be asking for symptoms that are commonly experienced while bleeding like cramps, back ache and wanting to lie down and curl up.

Others like Cecilia could come up with nothing that was positive and went into great detail about the pain she used to experience. Paradoxically, it was difficult for her to locate experiences of PMS in her body right away. For Hanna the fact that she feels marked as biological by society in comparison to men who aren't thought to be affected by their biology as much was very disturbing especially since she experienced so many symptoms for long periods of time. Hanna was able to describe her experiences of change in breast size and tenderness and marked differences in how her clothes felt on her body. She was able to locate irritation and sensitivity to sound around her head, ears and shoulders. She described herself as a piece of porcelain that was poorly glued together, on the verge of shattering.

Anna on the other hand was much more intrigued by how she could become so unaware of her body when she was affected mentally during PMS. Her experiences in her body were very significant to her and she thought a great deal about these experiences regardless of menstrual phase. She felt a sense of being reunited into a whole temporarily when she practiced yoga during the premenstruum and contemplated her ability to relate to others when she felt the least connected to her body. In my interview with Greta talking about how she experienced irritation, she was able to describe it as beginning in her feet and moving upward through her body, culminating in her head and coming out in a verbal expression of irritation.

Doris, Cecilia, Eva and Anna focused on the abdomen similarly to how Anna put it:

Anna: I don't have that many symptoms, no painful cramps in my stomach and things like that. Many of my feelings are in my stomach in some way, positive and negative, I don't know, it is some type of feeling in my stomach, if I'm nervous it can settle in my stomach.

Anna: Jag har inte så många symptom, inga smärtsamma kramper och sånt. Många av mina känslor sitter i magen på nåt sätt, positiva och negativa. Jag vet inte, det är nån känsla i magen. Om jag är nervös kan det sitta i magen.

This clump like feeling or a knot that grew tight in the midsection, lead some women to compare it with other feelings which settle in the same place. When comparing premenstrual experiences with other states like anxiety there were descriptions of intensity on a scale, irritation was something that could pass, while anxiety would not let go as Cecilia described. Still, it was difficult for some women to talk about mood and body. The interview with Betty leads instead, to a use of her body to show how she experienced mood. She drew a graph in the air with her hand about how she felt, showing peaks and valleys in a recurring pattern. She used her body to show how she felt rather than describe sensation.

### 5.3.4 Variations in the body feeling different all over

The subject that the entire body was changed in some all encompassing way often came up but it came up in ways that emphasized different issues related to the body. When it came to locating experience through the body it was easiest to elicit experiences that were in every day situations. Fredrika used the word *ämlig*, (feeble/uncomfortable) to describe feeling uncomfortable in a general way. She said she would get up in the morning, shower and put on her clothes and feel completely unkempt and unclean like she hadn't showered at all. She mentioned how clothes didn't feel right on her and how she couldn't understand this since it was a work day like any other and nothing had changed but this feeling.

Doris mentioned feeling sweaty and always needing a shower. Jenny experienced this unfresh, unshowered feeling and said that it felt better to do physical work were she was expected to get sweaty when she was feeling like this.

Feeling warmer was easier to relate to the unshowered feeling but the general description of not feeling like themselves in their bodies was problematic when trying to pinpoint a change. Jenny said she would put on the very same clothes the next day and feel completely wrong and uncomfortable. The clothes simply didn't fit. I asked about if they felt like they had gained weight or retained water but neither Fredrika nor Jenny were able to identify what happened to them with this symptom. (Bloating is one of society's commonly associated symptoms of PMS. None of the women emphasized this bodily change the way it is emphasized in popular literature or medical contexts which I found very surprising when analyzing this section of material on overall bodily change.) They hadn't even thought about the reason why their clothes felt strange and didn't seem to fit their bodies. Cecilia felt much warmer and unshowered and summed it up by simply saying she felt completely unlike herself, nowhere close to 'normal'.

Jenny continued to talk about body dissatisfaction during PMS. She was generally satisfied with her body and its size and form. During PMS she felt like she had to do something to make herself happier with her body like buy something new to wear. Since she was in this state she described as feeling uncomfortable in her body, trying on clothes in stores was a definite way to reinforce this uncomfortable feeling. She said she often tried on clothes during this time and was confounded about why she insisted on putting herself through it month after month, especially when she was feeling this general body dissatisfaction to begin with. She offered an explanation that she was possibly trying to find some relief from feeling so unhappy.

A few women did experience increased dissatisfaction with their weight and felt bad about what they ate in a more negative way connected to how they felt about their bodies in general. The uncomfortable feeling described best was a very general, overall feeling that often reminded women of what they should do to increase their wellbeing in general. Part of the problem was that this was the time they felt the least motivated and capable of actually doing that for themselves like eating right, getting enough sleep and exercising for example.

Variation in experience was revealed when women talked about their bodies in respect to what was important to them. If feeling energetic was important then the loss of energy was focused on. If body image was a problem otherwise it became an even bigger problem during PMS. Weight became an even bigger issue during PMS causing another type of negative focus on the problem. If the mental suffering was intense then the bodily symptoms that eventually took over were described very positively.

During most interviews women mentioned that they didn't experience the same physical symptoms each and every month and if they did experience them regularly they weren't as intense or disturbing on the same level. 'It wasn't always like this' was an idea that often came up. The feelings or signs in the body don't always coincide with changes in emotion and mood. Sometimes, like in Jenny's case, the worried, uneasiness in her mood brings on depressive feelings. Often connections to other quality of life factors like lack of money, a comfortable living space, security, a satisfactory job situation, relationships etc were identified as increasing the problems they had with PMS.

This set of examples of variation in the experience of menstruation can be divided into two areas. One shows how reproductive events played in a woman's life including intimate relationships. The other mirrored what was symbolically important to women on an individual level. The process of how what is significant in an individual's life can influence the perception of the senses is present in both instances.

## **5.4 Examples of extreme experiences of menstruation**

Two things I would like to mention that were not talked about often but are important for being different are the extent to how women felt changed mentally and what it meant to them to feel so completely different within such a short period of time. These subjects focus on the fear of being mentally ill and having a total lack of perspective while feeling so bad resulting in not being able to identify the affected state as menstrually related.

### **5.4.1 Suicidal thoughts**

In two cases, the women's suffering that they relate to the menstrual cycle was so serious that they felt forced to do something about it so they wouldn't lose the willingness to live. Jenny described it as a loss to want to continue living if it was going to go on like this for half of every month. Later in her interview she says she will do whatever it takes to avoid these experiences and had started to consider her options. Even though she had negative experiences with hormones when using birth control pills she contemplated both using antidepressants or birth control pills on a schedule that would eliminate her menstrual cycle altogether. It was so important to not feel hopeless and without will to live not because she was afraid she would take her life but that the feelings of meaninglessness for such long periods of time and so frequently was just too much to take.

In Fredrika's interview she returned to the subject of mental illness three times. First her own experiences that included the fear that she would do something irreversible like killing herself and how unthinkable that was to subject her children to that. Then she described a close relative's mental illness and how antidepressants could make her recognizable again as she once had been to her family. The third time she mentioned mental illness was when she talked about being skeptical to medicine, antidepressants in particular, because of what they could do and what they are designed for again mentioning her relative.

### **5.4.2 The loss of perspective**

Two accounts stand out when it comes to perspective issues. These women contemplated the act of realization, 'oh that's the problem' that many women said they experienced once it had passed, once bleeding had started or after an unpleasant incident in interacting with others situated closely in time with the onset of bleeding. The difference in two cases is how they described being incapable of seeing outside of themselves or seeing outside of their experiences.

This loss of perspective in time and loss of being connected to events outside of one's own thoughts in the premenstruum was surprising and disturbing to the women who described it this way. Fredrika talked about her memory. She would remember that certain details were enormous problems just a day ago or that she was so affected that she didn't want to live but the feeling, having the experience, was blocked by mood. Rationally she could remember it but when she was in it, she was not able to remember that this happened the very month before, that she felt like this just a matter of weeks ago. Even when she had support around her and explanations for what was going on. When in that state of

being, that she identified as the absolutely most problematic and in her opinion a threat to her own life, she was incapable of recognizing it as having happened to her previously.

Fredrika: It feels like my life gets taken over, it gets switched out with something else these three days maybe. The whole, whole uh, it's like the ability to relate to my surroundings, it's like I am suddenly unbelievably handicapped that I can't handle input. I can't interpret, it gets unbelievably strange. It is like life gets so difficult without anything around me having changed in the least. Everything around me is exactly the same so I have the same conditions but I have no ability to handle it. I can't, I don't have it in me any longer to be the way I usually am and enjoy what I normally enjoy. Nothing that is good can break through this darkness and remind me that it is actually still there and everything is the way it should be...

Yes, life is good and I can and the sick thing too is that I only realize that "but I am going to get my period, that's it". That's what is up, it is like ghosts in my head (figments of the imagination), I can let it go, I don't have to get myself wound up in it, it is enough to just look in my calendar. You have to, that is an ability as well, to take it in, it isn't the end of the world...

No, it is about realizing that that is what is happening then it's easy. Then I can laugh that I had been so down. It is like "okay, how can I forget it?" Every time I forget it. Then you are out of it, that's enough.

Fredrika: Det känns som mitt liv tas över, alltså det byts ut mot nånting annat under de här tre dagarna kanske. Hela, hela uh, alltså förmågan att förhålla mig till min omvärld, det är som att jag plötsligen blir otroligt handikappad att jag kan inte hantera intryck. Jag kan inte tolka, det blir otroligt konstigt. Det är som att livet blir otroligt svårt utan att det har ändrats sig det minsta runt omkring. Allting runt omkring mig är exakt det samma så jag har exakt samma förutsättning men jag har ingen förmåga att hantera det. Jag kan inte, jag har det inte i mig längre att vara som jag brukar vara och njuta av det man normalt njuter av. Ingenting som är bra kan bryta igenom det här mörkret och påminna mig om att det faktiskt är kvar och allting är som det ska var...

Ja, livet leker och jag kan och det som är så sjukt också är att jag bara kommer på att, 'men jag ska ha mens, det är det'. Det är det som är på gång, det är som spökar i huvudet på mig, jag kan släppa den, jag behöver inte snurra ner mig i rötan, det räcker ju med att man faktiskt tittar på kalendern. Man får, det är också en förmåga att se det, att ta in det, det är inte "the end of the world..."

Nej det handlar om att inse att det är det som händer så blir det enkelt. Då kan jag skratta att jag har varit så nere. Det är som 'aha hur kan jag glömma det?' Varje gång glömmet jag det. Så är man ut ur det, det räcker.

Fredrika's experience is very similar to most of the women interviewed but differs in how even the outside explanations of why she feels changed offered by others cannot alleviate the mentally suffering she describes.

Fredrika: That's all there is to it but sometimes it isn't enough if I am in a dark enough place then I don't get to that point where I can see it. I can look at myself from without and see it that it is because I am going to get my period and then maybe it has to go so far that I actually start to bleed to be able to realize that and then it becomes something else. Then the physical takes over too it hurts and you worry about that instead then you are definitely out of it- it passes. Yes, it is a mystery to me. It feels like it is a huge lack of control. It should with all logical resources... I have everything there. It says it on paper, I have someone to tell me or talk me through it kind of. I have been through it a hundred times, a hundred thousand times but still I don't get it. I don't have the ability to lift myself out of it. Some outside force has to be applied...

Liz: This mood that you get... you seem very transformed from one day to another that if you are lucky you realize it and if you are unlucky it is a changed way of experiencing the world, that is my interpretation of what you are saying-

Fredrika: Yes, that is exactly how it is. It is completely, it is just awful I think, yes, it is clear that I like to be in control of my reality, know how to handle it, know what I need to worry about... if two tablets are enough to avoid this feeling. It would be terrible. Think if you would take your life on account of something like this... that you shouldn't have to feel like this. It would be terrible and as I said to be able to avoid making life for others around me more difficult and especially children, I feel.

Fredrika: Det är inte mer än så men ibland räcker det inte om jag är tillräckligt mörkt i sinnet så tar jag mig inte till den punkten att jag kan se det. Jag kan titta på mig själv utifrån och se det att det är för att mensen kommer och då kanske det måste gå så långt att jag faktiskt börjar blöda för att inse att och då blir det ett annat. Då tar det fysiska över också det gör ont och man bekymrar sig över det istället då är man definitivt ur- det går över. Ja det är ett mysterium för mig. Det känns som det är en otrolig brist på kontroll. Det borde med alla logiska medel... Jag har ju allting där. Det står på papper, jag har någon att berätta för mig att eller prata mig ur det liksom. Jag har varit med om det hundra gånger, hundratusentals gånger ännu gör inte jag det. Jag har inte förmågan att lyfta mig ur det. Det måste till något yttre påverkan...

Liz: Den här stämningen som du får då... du verkar väldigt förändrad från en dag till annan att om du har tur då upptäcker du det och har du inte tur då är det en förändrad sätt att uppleva världen, det är min tolkning av det du säger-

Fredrika: Ja det är precis så det är. Det är rent, det är otäckt rent ut tycker jag, ja, det är klart jag tycker om att ha kontroll över min verklighet, vet hur man ska hantera den, veta vad man behöver bekymra sig över... räcker det med två tabletter för att jag ska slippa känna. Det vore förfärligt. Tänk om man skulle ta sitt liv på grund utav nåt sånt här ... att man inte borde behöva känna sig liksom. Det skulle vara förfärligt och så som sagt för att kunna undvika att göra livet för min omgivning svårare och speciellt barn då, känner jag.

Fredrika's description of how she was unable to take in the changes in her mood as a part of her menstrual cycle is the clearest example of how memory can be altered by a woman's mental state. She says that she has multiple strategies to aid her in remembering; notes, calendars, a partner who can remind her and talk her through it and the previous experience of having been through the same thing 'a hundred thousand times' but it doesn't help. This way of experiencing the world is so completely different from what she deems normal for herself because of not being able to remember or identify this state when she is in it and then when she is out of it, not understanding how she can feel so changed.

Doris commented on what makes this way of being in the premenstruum different from other mental states that people go in and out of and can't really see how affected they are. The difference is how often it happens, the regularity with which it happens and the short length of time that passes. She went so far as to say that one of the main parts of PMS is the very fact that 'there is no perspective in PMS; you don't see it until afterwards'. The transformation takes place within a day in these cases.

Some women said that the worst of their suffering abates a day or two before bleeding but their perspective is still affected. Once the bleeding starts then the lack of perspective experience is gone, save from having been in it and results in what was mentioned in numerous interviews as “How could I have forgotten again? How is that possible?”

This perspective issue, that perspective can be lost or blocked in a woman’s premenstrual phase, is larger than just trying to remember to look in a calendar or have a partner remind her that this is what is happening. A woman can be so affected that she can’t take it in. When asked about how she felt physically when experiencing PMS, Cecilia contemplated the fact that her ‘body memory’ or lack of one made it so hard to talk about what she had experienced earlier. After 26 years of menstruation she didn’t feel able to come up with how it had felt.

Greta said that if her physical symptoms are clear enough and coincide with her irritation then her understanding of why she loses her temper is much easier to detect. This seems to be a key point in the nature of PMS, that mental affectedness can occur without bodily symptoms and then mood or feelings and behavior aren’t anchored together and contribute to this experience of a lack of perspective.

## **5.5 Summary**

The women who answered or showed a willingness to participate had already identified themselves with menstruation as problematic in some aspect. What was talked about began with suffering and negative descriptions and was followed by the women’s thoughts about their experiences. The subject of menstruation was talked about, cyclically, in relation to reproductive history, situated in relationships with others. Looking back in their menstrual lives and life history events was the stage for sharing their experiences. Contrasts played a large roll in describing different ways of being in the world as in their descriptions of good and bad days and highs and lows in mood. The cyclic nature and pattern of reoccurrence was a significant part of women’s stories when reflecting on their perspective and self-evaluation of behavior. Dominating ideas that were expressed had to do with feeling so changed each month and at the same time not being able to recognize the cause and that women were only able to attribute these changes to their menstrual cycle in retrospect.

# 6 Understandings of normality

## 6.1 Introduction

How do the women understand changing embodied experiences related to the menstrual cycle? The word ‘normal’ is used by the women to mean different things. In general, normal is positive as in when women feel normal they mean they feel good, healthy or energetic. Descriptions of problems, troubles or symptoms have their point of departure in what is normal, an absence of awareness of the body. In comparisons of different ways of feeling, there is a need for a normal state to express extremes in either negative or positive directions. Often when talking about menstrually related suffering, the way these women typically describe what is normal then means ‘average’ or a statistically conceptualized norm. The group of women I spoke with could create a type of normal experience out of suffering if they had contact with other women who experienced the same thing or experts who had dealt with it before. So the idea of exploring normality in respect to suffering is complex and can best be understood by avoiding to ‘boil down’ ideas of what normal means. Rather, a discussion of individual experiences in real life contexts has a clear advantage in gaining an understanding of how a woman incorporates a changing embodiment into her view of herself based on her own ideas of normality.

The ideas of what is normal influence a woman’s suffering. Boundaries are crossed when a woman decides to manipulate a normal bodily function to alleviate suffering. These two observations center on ideas about what women understand to be normal in several areas: what is normal for the individual, what is normal for women in general and what is normal in society?

### 6.1.1 Reproductive capacity as a point of departure

There was no doubt that menstruation was a sign of good health and in itself a prerequisite for belonging to the norm of healthy, fertile women. Having a normal menstrual cycle was important to all of the women even when ideas were shared about what it would be like to not have it, to avoid the nuisance and problems women associated with it. This quote sums up ideas expressed by most of the women interviewed that the presences of menstruation is necessary to uphold an idea of being healthy and that the absence of menstruation is clearly the opposite.

Hanna: I would be very bothered if it did not work if my period didn't come like it should I would really be concerned, that I would. It is like, yes it is a sign of a partly healthy body, in any way there is something there that works anyway. A sign of health, that's what it is. It is positive.

Hanna: Jag skulle bli väldigt störd om inte det fungera om inte mensen kom som det skulle så skulle jag verkligen fundera, det skulle jag. Det är liksom, ja det är ett tecken på en delvis frisk \* (kropp) i alla fall det är nånting där som i alla fall fungera. Friskhetstecken, det är det. Det är positivt.

A lot of the ideas about normality in the field of menstruation have to do with reproductive health. A process in the body that negatively affects the way a woman feels, like with experiencing frequent or heavy periods, can be seen as normal if it has a purpose that is valued. Whether or not a woman is willing to alter, change or treat a condition depends on how it is connected to the whole body.

In this quote from Fredrika's interview she talks about limits to what can be manipulated, number of days of a normal cycle, being in an abnormal state and what justifies using medicine.

Fredrika: You can manipulate your body. I can think that if it doesn't affect the rest but it feels like my body is a whole. It has its cycles and then you could go into what is what, what the world and all the heavy metals have done to my cycle and my life but it still feels that there is a point if you can test where the limits go if... a 21 day cycle is an abnormal condition then you maybe can, then I am fully prepared to use some type of help, medicines or hormones to normalize it towards something more normal. No, if it is just something my body does, produce eggs with this interval and it is meant that this is supposed to happen. If I am not ovulating between each period then I would like to stop this unnecessary bleeding that is just something that my body has come up with on its own but if I am actually ovulating this often then it is something. I would naturally want to know why I ovulate so often, that the normal population doesn't (ovulate) this often but it feels like it is a, it is a whole (the body)...

Fredrika: Man kan manipulera sin kropp. Jag kan tänka mig att om man kan om det inte påverkar resten men det känns som att min kropp är en helhet. Den har sina cykler sen kan man inte fördjupa sig i vad som är vad, vad världen och alla tungmetaller har gjort med min cykel och mitt liv men det känns ändå att det är nån poäng om man kan undersöka var gränserna går om ...21 dagars cykel är ett onormalt tillstånd då kan man kanske, då är jag fullt beredda att använda hjälpmedel, mediciner eller hormoner för att få den tillrätta igen till någonting mer normalt... Nej utan om det bara är så att min kropp trycker ur sig äggen med det här intervallet och det är meningen att man har det. Har jag nu inte ägglossning mellan varje då skulle jag vilja stoppa den här onödiga blödningen som bara är nånting som min kropp hittar på själv men har jag faktiskt ägglossning så ofta då är det ju nånting. Jag skulle naturligtvis vilja veta varför jag har ägglossning så ofta, som normalpopulationen inte har det så ofta men det känns som att det är nån det är en helhet (kroppen)...

Understanding what is normal in connection to the menstrual cycle for Fredrika is tightly connected to utility. Her frequent periods could be a part of her body that she can tolerate only if she has some type of assurance that her body is actually ovulating. Ovulation, the production of eggs as she puts it, is part of the reproductive system. It is a highly meaningful event that normalizes what Fredrika otherwise sees as not adhering to the norm or the 'normal population', in the form of her frequently recurring periods. On the other hand if a test would show that she isn't ovulating but still has frequent periods she would like to do something about it to change it. Seeing her body as a whole is a way for

Fredrika to understand that its processes are connected. If they are not connected then it is not part of the whole and then can be altered with the help of medicine, but only then.

In my interview with Betty there is an example of how menstrual experiences were divided into categories of negative and positive with positive experiences defined solely as her having reproductive capacity resulting in the birth of her three children. This was what defined normal in respect to menstruation per se.

The ability to become pregnant is a strong representation of normality for women which a quote from Isabel's interview is an example of.

Isabel: I'm pregnant! I'm pregnant! It wasn't just that, that there was a child in the picture, I also felt like I was healthy. And it, I still am able to have children, in my case it was, okay, I could have gone to the doctor and had myself checked but... I was like, in general, I don't know it was just a real balancing act, that whole time period when I had my period without hormones and had unprotected sex, I think it was some type of deep # inside me that I wanted to test myself. Test myself and see if I still worked kind of.

Isabel: Jag är gravid! Jag är gravid! Det var inte bara det där, att det var ett barn med i bilden, jag kände också att jag är frisk så. Och det, jag har fortfarande möjlighet att bli med barn, med mig så var det, okej, jag kunde ha gått till läkaren och kollat upp mig men... Jag var liksom överhuvudtaget, jag vet inte det var bara en riktig balansgång, hela den där perioden då jag hade mens utan några hormoner och hade oskyddat sex, jag tror att det var nån slags djup # inom mig att jag ville testa mig själv. Testa mig själv och se om jag fungerar liksom.

The experience of becoming pregnant was described as an intensely relieving event since she had previously had a lot of problems with contraception. It was apparent that this function has such a strong normalizing effect on a woman's thoughts about her bodily experience and can put the monthly reoccurring suffering of PMS in a permanent secondary concern if women can connect it to reproduction strongly enough.

### **6.1.2 Suffering as a sign of what is normal**

In daily conversation there is a mix of talking about different subjects at the same time, specifically what is normal for a woman menstrually speaking and what feels normal emotionally speaking. Even on the individual level these two processes are often in opposition. The biological process where normal is used to talk about health, in particular reproductive health and the other process encompassing disposition, mood and personality, a psychological process where normal encompasses socially favorable traits are the two areas that are in opposition. I identify this opposition as causing a unique type of suffering, suffering as a sign of health. This was a reoccurring way that the women I spoke with talked about what was normal in regard to menstruation. The most revealing parts of the

interviewing process were when women tried to combine their ideas about normality in these two opposing areas on an individual level.

Mixing uses of the word 'normal' in every day speech occurred in each interview. Here is a typical example of how different subjects as well as different uses of the word normal were discussed in understanding what was normal. Betty talks about how she thinks about PMS and what is normal for her and whether it is due to heredity or environment.

Betty: I understood that it is part of my body, yes it is normal. It has to do with my body. Hormones are normal.

I forgot to tell you I thought it was normal like when I grew up in a family, like I said my father has been clinically depressed, he used to have these outbursts all the time, up and down and my sisters had them. Seeing them all of a sudden go crazy and flip over chairs, worse than I ever was, well this is a normal thing, and again they were not on antidepressants then. So I truly believe that there is something that we all are missing. Something you said just reminded me... It's normal in my family anyway.

Liz: Okay, normal in your family and where something is missing, and whatever that is that is missing is what you need to feel like yourself?

Betty: Let me just say since I've had this as long as I've had my period and at least experienced it the last 20 years. This is the best I've felt in 20 years. (using antidepressants) Ever. I can control myself, still having my periods, it doesn't matter, I don't care when they come, I don't have to look at the calendar like, oh my PMS is going to come and all the anxiety about that is gone.

Liz: When you say "the best I've felt in 20 years" and that there is something missing in your family, oh you mean the chemical imbalance (said in unison)

Betty: They have this type of behavior that I have I find that strange, is that a learned behavior or is it chemical?

Liz: When you take the antidepressants and feel more, you feel better? And when you don't have them, how-

Betty: I feel the old way. I feel I am not in control; I am erratic, mood changes, angry, frustrated yeah. I am normally a positive person and happy.

Liz: Tell me more about how you feel normally.

Betty: The normal Betty is mixed up. I try to be a positive person. I had an upbringing where everything was negative, and part of the therapy I am going to is to get over thinking that way and every time I start to think that way I have to mentally to think change it now. I also took this took great therapy called what is it called when you are being there. Mindfulness. So I think together with the mindfulness course and this forgiveness course of what I have been through and this medicine has physically helped me, I am in a really good place.

Liz: Something you said right now, the mindfulness, the forgiveness, being able to change your thinking, these are the things going on right now, these do a lot for you.

Betty: Yes.

Liz: When you mention the antidepressants, you said I get the help I need physically, something like that-

Betty: I still think it is chemical thing, I really do.

Liz: Which makes perfect sense from the way you have been describing your experience. It is like ok, it makes something possible physically that wasn't possible before.

Betty: Absolutely. Like I said without therapy I don't think I would be in such a good place. Physically I might be but I might not react in a good way like I react now. I think the two work good together. Not saying I am very good at it, at least it is there, I know what I need to do, I don't always do it.

Since Betty describes herself as ‘normally a positive person’ when she doesn’t have PMS the antidepressants enable her to feel like herself at the times she usually experiences premenstrual problems. Quite simply Betty feels more normal when she is on antidepressants. Her reasoning leads back to her family, either as an inherited chemical make-up or an environment that fostered a certain behavior but eventually is determined as a ‘physical’ deficiency. Regardless of the origin Betty is convinced that she feels more like herself when using the antidepressants. She feels better, more stable and in control. Positive descriptions are used and she identifies with being a positive person. Her problems with PMS have always been a part of her menstrual experience, 20 years as she says. Now the antidepressants stabilize her behavior and she feels good. Good for Betty is normal. But normal is also used to describe what is normal for her personally, what is normal for her family and what is normal hormonally.

### 6.1.3 The ways women talk about what is normal

Women used a variety of ways to talk about normality. *Problem based descriptions* were very common. *Listing* symptoms and describing changes lead into what was normal for them individually. Stories about not realizing what was going on in their way of reacting was often a way to describe the lack of a normal way of feeling. *Descriptions of physical and mental changes* were changes away from what they identified as a normal state. *Comparisons* were made between different times during a menstrual cycle, the first half of which was the normal half. Another type of comparison was the one made to other women’s experiences. If other women felt what one woman had felt it provided reassurance as to what is normal or normally expected. It relieved part of the suffering as well. This type of measurement of normality, a comparative one, enabled a number of the women interviewed to tolerate their condition.

Betty: I think I might have a higher, I don’t know, I really can’t compare, I don’t know if other women, like you said we don’t talk about it, but I don’t know of any other woman who experiences it like I do but that doesn’t mean they don’t. It is normal for me; I don’t know if it is normal comparatively, I have never asked anyone actually, I have never spoken to anyone, except my therapist. Yeah therapists, doctors-

Liz: Do they give you the impression that “I know what we can do”?

Betty: Yeah, I felt the impression that it was a normal thing.

A way to identify what is normal was talked about mostly when women discussed normality and menstrual life in relation with others. Exchanges with partners, children, friends at work and in meetings with therapists, doctors or midwives formed what women understood to be normal. The importance of having friends to talk to was emphasized in a number of interviews because it reassured those women that they were normal and since they were normal they were going to be OK and could

accept it. Having a partner that was able to tell a woman that he saw a pattern in her behavior and could remind her that she had felt this way before was a common experience. (All the women interviewed were heterosexual.) The *reoccurrence* of symptoms in a cyclical pattern of adverse experiences became a sign of normality for them. “This is what is normal for me since it has happened many times before.”

#### 6.1.4 PMS representing the norm

Ideas about the normality of PMS were an extension of the ideas surrounding menstruation as a sign of health. The term PMS and menstruation were used similarly and interchangeably. For this group PMS was the most visible part of the menstrual cycle in these women’s interviews.

Doris: When I was in the laundry room I realized that when we talked about the menstruation cycle and PMS I only focus on PMS and the bleeding and not on the whole cycle. For me it is like menstruation is like PMS and bleeding like the other, then, I have no clue about, I only focus on the part that is difficult like and then when the relief comes it was interesting how you like, it came to me what you define as a menstruation cycle. Exactly, that was it. Like half of the menstruation cycle you are normal and the other half you are like \*crazy\* (laughter).

Doris: När jag var i tvättstugan kom jag på att när vi pratar om menscykeln och PMS då fokuserar jag bara på PMS och blödningen och inte hela menscykeln. För mig är liksom det här med mens det är liksom PMS och blödning som om att det andra, då, det har jag ingen koll på utan bara fokus på det som är blir jobbigt liksom och sen när lättningen kommer det var intressant hur man liksom, jag kom på det vad man definierar som en menscykel. Exakt det var det ah. Som om halva menscykeln är normalt och den andra halvan är man \*crazy\* (skratt).

PMS symptoms which women reported could sometimes be described as extreme in how they experienced them but the symptoms themselves were seen as normal, much like how menstruation is normal. This extreme experience was pointed out to be the deviance. Since it was abnormally extreme in some way for the individual, women were able to motivate their attempts to try to do something about it regardless of how normal the actual process is. This can be seen in contrast to how some of the women saw medication as not being normal when it was used to change a normal state or function like menstruation. Therein lays the conflict for the majority of the women I spoke with, that the symbolic value of fertility is what menstruation represents and to manipulate it was somehow dangerous or involved risk.

Medication requires some type of condition that needs a remedy. Part of the problem in identifying the need to medicate lies in the inability to categorize PMS as an illness; a digression from a normal state of health.

Greta talks about PMS not being a state of sickness.

Greta: It's like PMS is not a symptom of illness... it is not a sickness so sometimes you can make it into that anyway and it is understandable that for those who have really, really severe PMDD symptoms it borders being an illness. I am split on how to view that how you should see PMS. Of course we want to help women who have problems and difficulties but at the same time not emphasize that women during half of their lives basically at least half of the menstrual cycle would be less dependable or worse drivers or something to that effect so you don't want to make it into an illness.

Greta: Alltså PMS är inte ett sjukligt symtom... det är inte en sjukdom så ibland kan man få det till att det är det i alla fall och det är klart att för dem som har riktigt, riktigt svår PMDD symtom så är det väl gränsen till sjukdom. Jag är lite kluven till det där hur man ska se på PMS. Vi vill ju självklart hjälpa kvinnor som har problem och jobbigt men samtidigt inte framhäva att kvinnor under halva ens liv i princip åtminstone halva menstruationscykel skulle vara mindre pålitlig eller sämre bilförare eller något i den stilen så att man vill ju inte heller få det till att bli en sjukdom.

PMDD, as outlined earlier, is the diagnosis developed to identify women with severe symptoms related to the premenstruum with the recommended treatment of SSRI antidepressants. Greta describes this state as on the verge of being a sickness and sees it as a dilemma that problems related to menstruation are classified as abnormal. This idea conflicts with the ambition to help women who suffer.

#### **6.1.5 Hormone talk; what is natural is normal**

What types of subjects come up when women talked about what was normal? The theme that was touched upon the most in discussions of normality and the menstrual experience was hormones. Hormones were used to explain what was normal and in the ways hormones were mentioned they were never questioned to be abnormal in themselves. Hormones were rather an extension of the idea of a natural and normal bodily process. Hormones were the part of the biological process that women accepted as what caused the differences in how they felt. There were experiences described as being 'showered by hormones' or 'evening out of levels of...' or getting used to 'hormone levels' but the hormones themselves were neutral.

When talking about PMS, Cecilia's description of what causes this syndrome was the clearest account of how the women I spoke with think about hormones. This quote expresses the general ideas that each woman made reference to in the interviews.

Cecilia: I believe that it is a hormonal disorder or a disturbance, yes, I believe that we are quite steered by our hormones and some more so than others. I can draw parallels to when I tried to take the pill once and became completely wacko, it was not working out, I cried one second and laughed the next and didn't recognize myself and became totally unstable. I believe then that it was the effects of estrogen that it became so, so that an imbalance in hormones, it affects you but how it affects you that is hard to know. We don't know really it is really hard to measure or understand you know, the body what with certain levels and then they are increased it becomes a type of imbalance in the system and then there is a connection to serotonin and how **it** works and it is really strange because really estrogen, hormones shouldn't have any connection (to signal substances in the brain).

I think that the menstrual cycle is, that it is normal to have swings, that you have that it goes, that it is in different phases. I think like it is very apparent when it comes to other parts like sex drive and such. It is also steered, we are in the end biological beings so there is some type so I can't see it as **abnormal** but then I can think that even if it isn't **abnormal** and you have a lot of problems with it why shouldn't you do something about it if you can? That's how I feel.

Cecilia: Jag anser att det är en hormonrubbing eller rubbning ja jag anser att vi är väldigt styrd av våra hormoner och visa mer än andra. Jag kan dra paralleller till när jag försökt äta p- piller en gång i tiden och blev helt kukoo det gick inte jag grät i ena sekunden och skratt i andra och kände inte igen mig själv och blev total labil. Och då tror jag att östrogenpåverkan att det blev så så att en obalans i hormoner det påverkar liksom men hur det påverkar det är svårt att veta. Vi vet det inte riktigt det är väldigt svårt att mäta eller förstår alltså kroppen är vad med visa nivåer och sen så höjs dem det blir en slags obalans i system och sen finns det koppling till serotoninet och hur **den** fungerar och det är också jättekonstigt för att egentligen så borde inte östrogen, hormoner har någon koppling (till signalsubstanser i hjärnan).

Jag tror att menscykeln är det är ju normalt att man har svängningar att man har att det går liksom att man det går # att det är olika faser. Alltså jag tycker att det är väldigt tydligt när det gäller andra bitar som sexlust och så. Det är också styrt, vi är ju ändå biologiska varelser så det finns nån slags så jag kan inte tycka att det är **onormalt** men sen kan jag tycka att även om det inte är **onormalt** så att man har mycket besvär av det varför ska man inte göra något åt det om det går? Så kan jag tycka.

Part of the dilemma of deciding to treat PMS is the fact that many women see it as normal to experience it. Treating or medicating is what you do to abnormal and unhealthy states and PMS is categorized as neither by these women.

Identifying problems as hormonally related offered a type of relief for most women when they realized that there was a pattern to how they felt. Even within a cycle, when bleeding started, there was relief in realization when women identified symptoms or behavior as being caused by hormones. Hormones represented a normal process that had an explanation.

Important to mention when women spoke of hormones is that another type of suffering tied to normality had to do with not allowing a normal biological process to run its course. It was described as suffering since we tried to change a normal process either by manipulating, ignoring or not accepting that feeling bad physically or mentally was normal. Cecilia expresses this:

Cecilia:(about antidepressants) I would say that it depends on how you feel how bad it is if it would help you to manage your daily life and that without them you couldn't cope then I think it is completely justified to take them but then it has become a little like that everyone has **depression light** and should take SSRI and that I believe really is not good even if I am an advocate... But you have to, you have to work with why it gets like that too. You can't just ignore your feelings. You maybe should realize and understand that it is a reaction that is taking place too. It depends on, I don't know how much you can do for PMS really. You can in any case think about if it would be reasonable that it is OK to feel bad some days but it isn't really like that. There's a problem but that isn't just the case for PMS. That goes for colds that goes for like everything. That demands that are put on the individual that you should be 100% on top at all times that doesn't work.

Cecilia: (om antidepressiva) Jag skulle säga att det beror på hur man mår hur illa det är om det skulle hjälpa en att klara av vardagen och att man utan dem inte kan klara sig då tycker jag att det är helt korrekt att ta dem men sen har det blivit lite grann att alla är liksom **depression light** och ska äta SSRI och det tror jag egentligen inte är nån bra även om jag kan förespråka...Men man måste ju man måste jobba med varför det blir så också. Man kan inte bara trycka ner känslorna. Man kanske ska inse och förstå att det är en reaktion som händer också. Det beror på, jag vet inte hur mycket man kan göra åt PMS egentligen. Man kan i alla fall fundera på om det inte vore rimligt att det är OK att må dåligt några dagar och så är det inte riktigt. Där är ett problem men det gäller inte bara PMS. Det gäller även förkyllning det gäller ju allt liksom. Att kraven som ställs på individen är att den ska vara 100 % på hela tiden och det går inte.

The acceptance of what was talked about as fluctuating hormones or non-acceptance of them were the topic each woman was able to say something about. Clearly this group of women experienced conflict with norms of society that disenabled them to accept and allow these changes. Frustration in trying to accept their situation since it was seen as a normal process with normal causes is a way women used 'normal' in talking about their suffering.

Doris reflected on the fact that what she sees as a normal process of changing levels of hormones influences an individual's ability to handle pre-existing problems.

Doris: When PMS comes I become incapable of handling the fundamental problem, the fundamental problem gets worse, more unmanageable and I imagine that that worry about the fundamental problem disturbs PMS too, so that, it is like I am under stress so that I can't start to bleed and then I experience PMS as being prolonged and extracted and painful. I see it like levels of hormones in the body stress hormones versus I don't know these PMS hormones and how they and how it pulses through your body and if the stress hormones are too high then your body won't let go so that it can start to bleed. Instead I just bob around in this pool of PMS in a way. It is hard to break it.

The levels of hormones weaken the functions of the self.

Doris: När PMSen kommer blir jag oförmögen att hantera grundproblemet, grundproblemet blir värre, mer ohanterligt och jag föreställer mig att den oron för grundproblemet stör PMSen också så att, det är som att jag är i stress så att jag inte kan börja blöda och då blir min upplevelse att PMSen blir förlängd och utdragen och smärtsam. Jag ser det som hormonhalter i kroppen stresshormoner kontra vad vet jag det här PMS hormonerna och hur de och hur det pulserar i kroppen och om stresshormonerna är för höga då släpper inte kroppen till så att jag kan börja blöda. Utan då ligger jag kvar och guppar i det här PMS-gyttret på nåt sätt. Det är svårt att bryta det.

Hormonhalter försvagar ens jag-funktionerna.

Doris' quote is an example of where talk about hormones, hormone levels, PMS-hormones or stress hormones, is seen to combine with underlying issues resulting in the problems associated with PMS. PMS is seen to amplify these issues making them unmanageable. Doris' view can be interpreted as if it is the combination that creates abnormality.

'Hormone talk' included a wide range of experiences. Much like how women talked about the body, with lots of variation but focusing on similar events, women spoke of hormones. These included taking birth control pills, feeling changed by birth control pills, what causes PMS, what lies behind feeling different, what they are willing to change when it comes to hormones, dangers with hormones, antidepressants instead of hormones, normal hormones, accepting hormones and hormonal effects getting worse and worse with age.

Descriptions and metaphors of being overtaken, engulfed, showered or covered by hormones was a common way for women to describe how they felt. That there was an experience of feeling like something came from without or outside of them even though they all talked about hormones as being something from within the body was evident. This sensation in the body that affected how they felt mentally was one of the discrepancies I think contribute to not recognizing one's self. Hormones being *natural* are from within but the embodied experience was that this feeling came from somewhere else. Here is an example of how Doris visualized effects of hormones on the body.

Doris: It's like all of me is showered with hormones. It is so hard it is like, is a fish aware that it is swimming in water feeling \*so\* it gets so totally it gets so totally (consumed). And at the same time I say, I think I, no, I don't want to go outside of these hormones, it is this, no it is a part of life. It is easy to sit here and say now when it is over because that thought never comes to me, when I have PMS "Do I want to be without this?" To like not reflect when it is at its worst.

Doris: Det är som att hela jag är nerduschad av hormoner. Det är så svårt det är som, är fisken medveten att den simmar i vatten, känslan, \*så\* det blir så totalt det blir så totalt. Och samtidigt så säger jag ju så tänker jag nej, jag vill inte gå utanför de här hormonerna, det är ju det här, nej det är här är en del av livet. Det är lätt att sitta här och säga nu när det är över för den tanken kommer inte ens till mig, när jag har PMS "Vill jag var utan det här?" Att liksom reflektera inte så, när det är som värst.

First Doris describes the hormones as being showered on her, then a likeness to swimming in water. She situates herself inside the hormones not really wishing to be outside of them. Finally when inside them she is incapable of thinking the thought that this is a part of her or her life. Hormones represent both the normal and the abnormal. The effects of naturally fluctuating hormonal levels are potentially overwhelming which categorizes them as having abnormal effects. Nevertheless hormones strongly represent the natural. Similar ideas about the authentic play a large role in ideas about normality and will be returned to later in the next section.

## 6.2 Normality and manipulation

Manipulation was a subject mentioned time after time when birth control pills or other hormonal treatments were used. Manipulation was a word used to talk about changing a part of the experience of menstruation and was often used with a negative connotation, implying that it was not a good thing to manipulate.

Liz: Do you think that it is normal?

Anna: Well, yes, I can think that. You mean with hormones that you get like this? I like, I kept away from the pill for a long time, I didn't want to take a bunch of strange stuff that is in them but then I felt that in quotations, that **the normal** wasn't manageable for me, I thought I have to do something.

Liz: So you believe that it is normal to feel like this but that it wasn't sustainable?

Anna: No, (exactly).

Liz: Tycker du att det är normalt?

Anna: Alltså, ja, det kan jag väl tycka. Du menar med hormonerna att man blir så här? Jag alltså, jag höll mig ifrån p-piller väldigt länge, jag ville inte stoppa i mig konstigheter i den, men sen jag kände att inom citationstecken, att **det normala** inte blev hanterbar för mig, tyckte jag att jag måste göra någonting

Liz: Så du tycker att det är normalt att känna sig så, men det var inte hållbart?

Anna: Nej, (just det).

Throughout these interviews the unwillingness to change their experiences of PMS with hormonal treatments like birth control pills was brought up in ways that conveyed the message that this is a system women felt should seldom be tampered with. When discussing the tediousness of menstrually related problems I would sometimes ask if they had ever considered using birth control to improve the way they felt during PMS. This questioning could come up after the woman mentioned not having as much trouble with PMS when they were on the pill. I would mention that a birth control pill regime (Seasonale®) increasing in use in the USA resulted in just four menstrual bleeding periods throughout a year (Kissling, 2006).

Liz: To just bleed four times a year, do you think that would be something you could do?

Greta: Absolutely not because like I say it is still me and in addition to that I believe that you shouldn't manipulate with like with, yeah not with anything but absolutely not with the menstrual cycle because you don't know what kinds of consequences it will have. The same thing with the pill that I have been very skeptical to it and not used it very much because I think that is a way of manipulating the body as well.

Liz: Att bara blöda fyra gånger per år, skulle du tycka att det vore något?

Greta: Absolut inte för som jag säger det är fortfarande jag och dessutom så tror jag att alla att man ska inte manipulera med liksom med ja inte med något men absolut inte med menstruationscykeln för man vet ju inte vad det får för andra konsekvenser. Samma sak tycker jag med p-piller att jag har varit väldigt skeptisk till det och inte använt det särskilt mycket för att jag tycker också att det är ett sätt att manipulera med kroppen.

As seen in this quote, this information about a product that could reduce the number of monthly bleedings was either responded to in surprise or disagreement, saying it wasn't natural, or that it wasn't a smart idea at all to manipulate the menstrual cycle that way. Only one woman, Jenny, returned to the subject and said she was going to have to do something and that she just might want to try something like that.

Jenny: It gets to be that I feel that it is healthy to have your period. I am, as I mentioned, prepared to re-evaluate. The ideas that I am raised with in what our culture believes, it is healthy, you should have your period and you know that a lot have PMS so that it is completely normal but it is still not normal that you should have to feel so bad and I am contradicting myself in everything I say at the same time I would hesitate to take for example a pill that caused me not to menstruate. It is like it would feel strange to not have it so it would be not healthy but at the same time like I say I could do anything to not have these problems so it is kind of hard to answer.

Jenny: Det blir ju att jag känner att det är friskt att få sin menstruation. Jag är ju som sagt beredd att omvärdera. Det jag är uppfostrad i liksom vad vår kultur tycker, det är friskt, man ska ha sin menstruation och vet att det är många som har PMS så det är också helt normalt men det är ändå inte normalt att man ska behöva må så dåligt och jag blir motsägelsefull i allt jag säger samtidigt skulle jag tveka till att äta t ex p-piller som gjorde att jag inte hade menstruation. Alltså det skulle kännas konstigt att inte ha den så skulle inte det var friskt men samtidigt som jag säger att jag kan göra vad som helst för att slippa de här besvären så det är svårt att svara liksom.

Jenny actualizes a cultural idea about menstruation and how this translates into what is considered normal. In the same utterance, normal is used to describe the lack of bad feelings. In essence this quote summarizes the root problem for the women I interviewed. How can feeling so bad for so long be a part of being healthy?

The bleeding experienced while on oral contraceptives is not a 'true menstrual bleeding'. Ovulation does not occur. The change in hormone content of the pills during one week causes the bleeding period. The symbolism of the bleeding period still represents a functioning reproductive system mimicking a menstrual cycle where ovulation is not suppressed. This was another manifestation of the symbolism of the bleeding period. It represents a functioning reproductive system including the presence of blood on a monthly basis which is an overt sign of fertility. Asking the question about Seasonale® and reducing the number of bleeding periods to only four per year showed how strongly normality is associated with the menstrual cycle. Women's health is represented by the overt sign of bleeding even if it is medically constructed with hormones. This questioning lead very specifically to an area that women felt was normal, natural and healthy. Manipulating the reproductive system in this way made women think of much worse problems than PMS; infertility, problems in family planning or hormonal imbalances of a more serious nature. Since these women had problems with a condition they associated with changing levels of hormones, any potential problems with hormones, real or imagined, should definitely be avoided.

### 6.3 Normality with antidepressants

It became clearer after a number of interviews that SSRI antidepressants were thought to pose fewer potential problems in the area of reproductive health than the problems women connected to hormones. The choice to use antidepressants was often tied together with what was normal and what was not. Antidepressants were spoken about in changing the extreme experiences, the mental suffering related to menstruation. SSRI's were not seen as a manipulation of the menstrual cycle, therefore not changing something that is normal and healthy. Since the menstrual cycle in itself represents a normal function for these women, this is what I found to be the reason for why antidepressants could be seen as preferable to hormonal therapies. There is also the fact that taking antidepressants for menstrually related mental symptoms was limited to two weeks, two days or whenever the woman felt the need to take one during the menstrual cycle to alleviate symptoms. Birth control pills were taken every day and many women saw this as negative, 'too high a price to pay' or 'bandaging your whole body if you cut your finger'. This was yet an additional way of saying that manipulating an entire system or the entire cycle that was functioning normally to avoid the temporary suffering that PMS represented was questionable.

Fredrika: I had been on the pill off and on for 20 years anyway then I stopped somewhere there at the end of when I was 28, 29 years old. Then I stopped taking the pill because I didn't need it, it fit my life situation and my, I wasn't afraid to use condoms anymore either, it was like also a maturity thing, so it worked to stop taking the pill because it felt like something like one of those things that you maybe shouldn't take them. You don't have to take them unnecessarily, if you don't need them for some specific reason. But when you take the pill you have a cycle that is very smooth and controlled in a lot of ways. Possibly there were skin problems and such but it is hard to say if it came from the pills but it wasn't bad enough that I experienced it as problematic. So, so it was, I don't remember my period as painful really when I took the pill. It was just just something that needed to leave the body. Yes, it felt weird to take hormones to avoid the problems even if it maybe was just that that was needed to alleviate them.

Fredrika: Jag hade ätit p-piller till och från under i alla fall 20 års åldern sen slutade jag nästans där i slutet av 28 29 år gammal. Så slutade jag äta p-piller för jag behövde det ju inte, det passade både ihop med mitt privatliv, och mitt, jag var inte rädd för att använda kondomer heller längre, det var liksom också en sån där bra mognadsdetalj, så då funkade det att sluta med p-piller för det kändes som en sån grej att man kanske inte ska äta dem. Man måste inte hålla på att knapra de in onödan, om man inte direkt behöver de av nån anledning. Men när man äter p-piller så har man en cykel som är väldigt behaglig och kontrollerad på många sätt. Möjligtvis att man fick lite så här hudproblem och så där men det är jättesvårt att säga om det kom från det att det var p-piller men det var inte tillräckligt för att jag skulle uppleva det som problematiskt. Så, så det var, minns inte mensens som smärtsam riktigt när jag åt p-piller. Det var bara nåt som skulle ut ur kroppen. Ja det kändes tokigt att stoppa i sig hormoner för att undvika besvären även om det kanske var det som skulle kunna behövas för att få bukt med dem.

Again the use of hormones was seen as unnecessary and undesirable if it wasn't used to avoid pregnancy even if it helped the problems associated with PMS. Fredrika later spoke about taking

antidepressants for the days she felt the absolute worst. The physical act of taking medication daily or just the days when absolutely necessary made a big difference in what was seen as normal. A daily regime of medication could be a constant reminder of an unpleasant and problematic abnormal state. Cecilia, in her interview, compared antidepressant use to using pain killers and what it did to alleviate or change sensation of feelings. Fredrika used a similar rationalization. If you just take medicine the days you need it you can minimize the ‘unnaturalness’ of taking medication for a healthy state.

### 6.3.1 The category of ‘normalizing’

Of course when talking about antidepressants in general there were comments revealing skepticism, unwillingness and fear of something we know so little about. None of the women interviewed used any type of description of antidepressants use as normal. Rather that it was a strategy to ‘normalize’ an affected state of being. When it came to experiences of these substances being able to dampen feelings or eliminate actions that weren’t normal, they were included in this ‘normalizing’ category. The onset of bleeding was the clearest example a ‘normalizing’ event. Talking and rationalizing with other women who had similar experiences with menstrual problems were ‘normalizing’ acts. Something that could normalize a non-normal experience especially in a social context was viewed as positive in this regard. Cecilia talks about the normalizing that can be obtained by using medication and how this is necessary since individuals experience things quite differently.

Cecilia: I think that it is great that # if you have bad problems, that it doesn’t work, that the possibility to take a tablet absolutely. That it isn’t a reason to deny it because it is another problem, this societal problem isn’t something everyone experiences. I don’t even think that different individuals can have the same problems. Not everyone experiences them as problems.

Cecilia: Jag tycker att det är jättebra att # har man så stor besvär att det inte fungerar, att möjlighet att ta en tablett jag tycker absolut. Att det är ingen orsak till att förneka det för sen är det ett annat problem det här samhällsproblem det är inte alla som upplever. Jag tror inte ens att olika individer kan ha exakt samma besvär. Det är inte alla som upplever dem som besvär.

Another strategy included in the normalizing category was physical activity. Exercise made women feel better during the premenstrual phases. They could temporarily return to feeling more like themselves, more connected with their bodies or less irritated and angry. Each of these descriptions could stabilize or normalize the way a woman felt in a PMS affected state. Discussing the ‘going in and out’ of different ways of being first due to the menstrual cycle and then within this larger cycle going in and out of different ways of being with help from antidepressants or other mood altering therapies offered the most revealing exchanges in these interviews when talking about what women saw as normal ways of being in the world.

### 6.3.2 Normal to feel different vs. normal is feeling good

Ideas about what is normal were often represented by equalizing normal to feeling good. This set of ideas conflicted with the interviewed women's existing knowledge that feeling differently during the month was quite normal and expected. It was often mentioned that it was a part of life to feel happy and sad. Regardless of these attitudes about human existence in general, this monthly version of this volatile experience was hard to accept on a personal and social level. There was a general thesis of knowing you can't feel great all the time but still want to. Pinpointing the problem of this dilemma offers a philosophical explanation for why this isn't possible. You can't have positive feelings without experiencing negative ones.

Feeling different during a course of time was understood to be a normal way of experiencing life and has value in itself for Anna.

Anna: It doesn't feel sick and it doesn't feel abnormal but, it feels more or less manageable. It feels... I don't know at the same time it feels human to change like this. I feel sorry for those who don't have these peaks either. It would be interesting to compare with guys who don't have PMS. I can feel that my boyfriend can have it sometimes. These emotional ups and downs. Not each month but like. They might have another cycle. It just feels human to go up and down. I felt like I was forced to deal with it in some way. It was affecting my everyday life. And things I was going to do. And it, the outcome of it like. It was like I become a much worse driver when I have PMS. I get nervous and a little scared. Scared of wrecks. I don't know.

Anna: Det känns inte sjukt och det känns inte onormalt men, känns mer eller mindre hanterbart. Det känns... jag vet inte samtidigt det känns mänskligt att växla så. Jag tycker synd om de som inte får de här topparna heller. Det skulle vara intressant att jämföra med killar som inte har PMS. Jag kan känna att min kille kan ha det ibland. De här känslomässiga ups and downs. Inte varje månad men liksom. De kanske har en annan cykel. Så det känns bara mänskligt att gå upp och ner. Jag kände att jag var tvungen att hantera det på något sätt. Det påverkade mitt vardagliga liv. Och saker jag skulle göra. Och det, the outcome of it typ. Det var som jag blir en mycket sämre bilförare när jag har PMS. Jag blir nervös och lite rädd. Rädd för krockar. Jag vet inte.

For Anna the contrast in experience was important to be able to feel her best. She didn't want the emotional changes to disappear completely and spoke nostalgically about the time before she used birth control pills to handle the negative states she experienced. Anna, who felt very depressed periodically due to her period, had to address the problem, well knowing what she had given up.

In talking about feeling different being normal, there was often a conflict with how the word 'normal' was used to mean how the woman felt her best. The desired way of feeling was normal. Feeling less-than-well was normal. Again a conflict arises when these ideas are juxtaposed. Jenny talks about both 'normals'. She also includes acting normal (outward representation), statistically normal, and a normal life, meaning unaffected.

Jenny: I don't know. I wish that it were not normal. And when I talk to my female friends about this then it feels like half of my friends can relate to it but half of them can't relate at all. There are... there are many who are in the same situation and it is a consolation, so I think it is pretty, like you can say it is normal, but I don't want to say it is normal because it makes me so mad that you have to put up with it.

Liz: I understand. And when you have it, when you are in it, does it feel normal then?

Jenny. **No.** It does not feel normal. But since, despite the fact that I am so mad at, especially one friend I usually talk to, "like is it supposed to be like this?!" Then I can try to motivate myself to act normally, except, like exactly but to take care of what needs taking care of, not like, break down and try to live normally even though I don't feel like it. Just simply grin and bear it. Pretend like it isn't happening. As best you can.

Jenny: Jag vet inte. Jag önskar att det inte var normalt. Och när jag pratar med mina kvinnliga vänner, om det här då känns det som hälften av mina väninnor kan känna igen sig fast hälften kan inte alls känna igen sig. Det finns... de är många som är i samma situation och det är ju en tröst, så att jag tror att det är ganska, alltså man ska säga att det är normalt, fast, ja vill inte säga att det är normalt för att jag blir så förbannad över att man ska behöva ha det på det sättet.

Liz: Jag förstår. Och när du har det, när du är in i det, känns det normal då?

Jenny: **Nej.** Då känns det inte normalt. Men eftersom, trots att jag är så förbannad på att, speciellt en kompis brukar jag pratar med, "men ska det var så här?!" Då kan jag försöka tagga mig själv till att försöka bete mig normalt, fast just det men att, sköta det jag ska sköta, inte liksom, bryta ihop o försöka leva ett normalt liv, fast man egentligen inte har lust. Bitar ihop helt enkelt. Låtsas inte om. I den mån man klarar av det.

Accepting that she feels different or less well on a regular basis was what some women tried to do on an individual level getting support by talking with others. They often felt that accepting these adverse changes was impossible on a social level which was described in experiences living with others. Feeling 100% capable, energetic and efficient were referred to by most women as an expectation and part of their suffering was rooted to this expectation. That it is unrealistic to always **be** in any one state was agreed upon by all the women interviewed. Regardless of this consensus the interviewed women could state it as a fact that this positive and productive way of being is expected and is one of the norms of modern society. This is what Eva had to say when asked about the need to feel efficient and productive.

Eva: I can feel that way, absolutely. It has penalties, the things that accompany PMS. I feel inhibited by it, very inhibited and it feels that, it is hard to explain, that um, now I have these problems. Now I have to take it easy, and I might not be up to getting together with people, have meetings booked, and I have to meet these people, it affects things, PMS affects these other things that I have to do. It results in that I feel bad about myself, I feel worse because I can't handle this during this time.

Eva: Det kan jag känna absolut. Alltså det har påföljder, det som kommer med PMS. Jag känner mig hämmad av det, väldigt hämmad och det känns att det, det är jobbigt att förklara, att ah, nu har jag de här problemen. Nu måste jag ta det lugnt, och jag kanske inte orkar träffas, har inbokade möten, och så måste jag träffa de här personerna, det går ut över, PMSen går ut över de här grejerna som jag ska göra. Det resulterar i att jag känner mig lite dålig, jag känner mig sämre för att jag inte klara av det här under den här perioden.

To feel limited, bad and incapable of coping are products of the expectation to be able to function well at all times. Again, the conflicting ideas of what is normal contribute to the suffering associated with menstruation.

### 6.3.3 Effects of verbal expressions about PMS: ‘You have your period, don’t you?’

When talking with others who have had similar experiences, women felt better. On a smaller intimate group level there is an acceptance of this feeling different due to a normal bodily function. Nearly every woman mentioned the ‘Are you on the rag or what?’ or ‘You have your period, don’t you?’ phrase. It was used to express a widely held idea about how society viewed their problem of being affected by the menstrual cycle. This represented the normal response to their suffering if they were to exhibit extreme behavior. This response increased the suffering and caused a number of women to be very selective in whom they spoke with about their problems. Attempts to counteract this silencing were made by seeking support from other women or in intimate relationships.

Eva: I feel a lot of sympathy for those who have PMS. I feel really, it makes me happy to hear that people have it because then I feel normal or what should I say, at the same time I think that it is too bad that people talk about it like “oh, do you have PMS or what?” It is like a type of, I don’t know, as if it is a public, public concern in some way that allows you to talk about it and people have opinions about it and people think that it means this people don’t really know very much. It can be pretty tough and it is something you laugh about like I can laugh about it but at the same time it is really difficult.

Eva: Jag känner en väldigt stor förståelse för dem som har PMS. Jag känner verkligen, jag blir nästan glad när jag hör att människor har det för då känner jag mig normal eller vad ska jag säga, samtidigt så tycker jag att det är lite synd att man pratar om det som ”ah, har du PMS?” Det är som liksom som en slags, jag vet inte som om det är en allmän, allmän angelägenhet på nåt sätt som man kan prata om, och man tycker saker och man tror att det innebära det här och folk vet inte speciellt mycket. Och det kan vara så pass tufft, och det är något man skrattar åt alltså att jag kan skratta åt det men samtidigt är det jättejobbigt.

It was a common experience among the women interviewed that when menstruation is mentioned in every day speech; it almost always refers to PMS. Eva’s account exemplifies how there is a normalizing effect of hearing about others who experience PMS. But most often references to PMS are meant to tease, provoke or joke about this experience. This type of discourse had an adverse impact on the women interviewed. Women want to avoid being associated with menstrual suffering. Instead of feeling like they are experiencing a normal state they feel misunderstood or belittled which causes feelings of exclusion and isolation. This experience was reported by each woman I spoke with and more or less made them feel included in a category of people with problems that cannot be mentioned publicly.

Relating the common experience of indignation that colored how women spoke about these derogatory phrases, with the interview material seen as a whole, is way to summarizing why understandings and experiences of normality are important to explore. It was not only an isolated, irritating or offensive remark women spoke of. This particular practice made women feel categorized as not being normal for the moment as well as not being normal in general since they had a menstruation cycle that caused it. It also singled them out, defining them as different or revealing something about them. It showed them that they were not in control of how they portrayed themselves. They were unmasked. These comments were a way of communicating to an individual woman that she was outside of a normal way of behaving, behavior that only women exhibited.

Secrecy, being discrete, secret coding of calendars, shame in asking for pads or tampons, not openly talking about your period, a subject surrounded by 'taboo'. This is a list of the ways that women mentioned how the subject of menstruation and PMS were kept hidden. This need for discretion made the experience of suffering from PMS deviant in itself, regardless of how many women experienced it.

## **6.4 Summary**

Normality isn't only constructed from the interaction a woman has with others around her. Ideas about what is normal are constructed on multiple levels simultaneously, from within the body, in comparison to one's own experiences and in comparisons to other groups. These other groups can be those who suffer and those who don't, those who understand and those who uphold the voice of the majority. In regard to menstruation ideas about what is normal were most tightly connected to what was normal in regard to reproduction. Ideas about normal in regard to society and desirable feelings were marked by ambiguity. The ideas women expressed about hormones were tightly connected to ideas about what is natural, especially in reference to the authentic. Now a survey of what these women had to say about authenticity can be explored to answer questions of how a woman makes opposing experiences part of her authentic self.

# 7 Experiences of ‘one’s selfness’

## 7.1 Introduction

In chapter five and six we have seen how women express their experiences of menstruation and how the women understand these changing embodied experiences to be related to the menstrual cycle. The questions now are what these experiences mean to the women and how they interpret them as authentic events. How do the women express ideas of menstruation and menstrually related suffering as a part of themselves?

Two ideas conceptualizing the self were prominent throughout the material. The first idea was often phrased as ‘not feeling like one’s self’ and covered a range of states but most often meant feeling worse than normal. The other idea expressed by these women concerned a reconciliatory thought process. ‘This is a part of who I am.’ If the woman didn’t have this, behave in this way, or feel these changes then who would she be, was a philosophical question that was actualized over and over through individual interviews. The major part of the premenstrual suffering discussed in the data collected in this study dealt with emotion and mood. Women offered numerous accounts where they readily connected their feelings to their personality and who they **really** see themselves to be.

Doris: Well, I think that it is a part of me, that I want to learn to handle better. That is the way I think of it, it is a part of me. Like I think that we are born with different predispositions around different physiological processes and temperament then ah it is with how quick we are in our feelings or how easily we are influenced by them and I think that I want to learn to be better. I haven’t had this type of difficult PMS before in life now it is showing up since I haven’t been aware of it, that is the way it might be too so I think that this a little new for me still I should actually say. It isn’t like I have been aware that I have had problematic PMS through the years I have taken the pill for god knows how many years. Then I didn’t have PMS, in this way...

Doris: Alltså jag tänker att det är en del av mig, som jag vill lära mig att bli bättre på att hantera. Så tänker jag om det, det är en del av mig. Alltså jag tänker att vi föds olika med olika predisposition kring olika fysiologiska processer och temperament då ah det är med hur snabb vi är i känslorna eller hur lättare vi bli påverkade av det och jag tänker att jag vill lära mig blir bättre. Jag har inte haft såna här jobbig PMS tidigare i livet nu kommer det eftersom jag inte varit medveten om det så kan det också vara um så jag tycker att det här är lite nytt för mig fortfarande ska jag faktiska säga. Det är inte så att jag varit medveten om att jag har haft jobbigt PMS genom åren jag har ätit p-piller i en herrens massa år. Då hade jag inte PMS, på det här sättet...

Doris ends by commenting that she had been on oral contraceptives for long periods and how not taking them caused the difference in her experience now. Hormones and antidepressants were both subjects I asked women to comment on for this reason; how they can cause changes in experiencing every day life.

In chapter five I wrote about how women talked about menstruation. In the sixth chapter ideas about normality were explored by looking at how women understood what is normal for them and normal for women as a group. Here I would like to discuss how feeling changed mentally and physically impact on what determines when a woman feels like herself.

## 7.2 Strategies in the construction of self

In these ten interviews, the emotional suffering these women associated with menstruation appears to have two parts. The first has to do with the experience of actually feeling negatively changed. To cyclically feel bad, irritated, angry, listless or depressed is a part of life women described in terms of suffering. In these women's opinions there was little tolerance from others and from themselves for the behavior in which these feelings were exhibited. This intolerance was often expressed as being a product of the demands of society. The other side of the suffering had to do with accepting that they belong to a group of people who have emotional problems. The stigma that mental illness carries is what women seem to be indirectly referring to.

Each woman deals with her periodic and regularly occurring suffering by either distancing herself from it, keeping silent about it or trying to forget about it most of the time. This creates what I started out by stating; the experience of not feeling like one's self. Below, this general description is seen in examples of being surprised nearly each month that this change in their way of being in the world takes place. Some women describe their experience as being two different people in one. Another way to distance one's self from identifying with this type of suffering is using words in descriptions of PMS that are usually reserved for descriptions of mental illness. In these interviews it was also common to state that 'this is part of who I am' in a definite or defensive tone signaling that there was lack of acceptance of these qualities found in menstrual experience, by others or by themselves. This reasoning often lead a woman to expressing a wish that she be more accepting and tolerant of this part of herself.

Jenny: You forget because, I don't know, you want to repress that person in yourself maybe.

Jenny : Man glömmer bort för att, jag vet inte, man ville förtränga den personen hos sig själv kanske.

One common idea that materialized in the interview situation was that all of the women had reconciliation difficulties with feeling and acting so differently particularly during some time between ovulation and the onset of bleeding. The quote above was one way to explain why it might be so common to forget what it felt like to experience one's surroundings so differently as I will discuss in regard to memory and perspective. The changes women felt were described negatively save for the

fact that these changes were associated with the ability to bare children which was highly regarded and valued on both an individual basis and how women saw this as a valued part of life. Since the changes were negative it made sense to Jenny that one would like to repress this type of memory. This possible tendency, together with the negative attitude towards the changes a woman experience both contribute to why it would be hard to include this way of feeling in the premenstruum as part of the authentic self.

### **7.2.1 'One's selfness'**

When trying to pinpoint different ways of experiencing the world in regard to menstruation the phrase 'I just don't feel like myself' recurs as a theme in each woman's interview. It would come up together with descriptions of the part of the menstrual cycle that was problematic for the woman. The declaration of a lack of 'one's selfness' during this time was a way women expressed when they felt affected or when they did not feel normal.

There was a great deal of ambiguity surrounding these experiences of going in and out of different ways of being in the world. Physical and mental changes were the signs women could talk about to get closer to their understanding of what was happening when the transformation from 'one's selfness' to 'non-one's selfness' occurred. There were two arenas to focus on, the one related to the menstrual cycle and the other related to coping strategies like antidepressant use or use of hormonal therapies like birth control. I attempted to look at the two continuums of transformation together, the first from 'one's selfness' to 'non-one's selfness' and the other from non-affected to affected by therapy strategies situated within the 'one's selfness' continuum.

The consequences of exhibiting deviant behavior, of loosing control, is a way some women saw as a loss of normal functioning and definitely a 'non-one's selfness' experience. This loss of control through symptoms like irritability, anger and impulsiveness were what had to be balanced with the willingness to manipulate a normal biological event. This was a recurring theme for women who had to weigh the consequences of using medication with the consequences of what that medication could do to their general health or feeling of what was natural. In particular, hormones in the form of birth control could alleviate PMS but disrupt the menstrual cycle bringing with it problems in reproduction or other potential hormonal side effects. Antidepressants changed a person's ability to experience true emotions, true being understood as natural or authentic. A number of women saw this as masking or subduing a person's personality.

Ideas about manipulation were often mentioned in regard to antidepressants. Often women contemplated the changes they felt and how the suffering was possibly increased simply by the fact

that we as women did not accept feeling changed. Attempts at changing this altered state were seen as negative manipulation by some of the women I spoke to. Also the messages from society about performance and productivity were seen as a cause to this increased suffering and unacceptance. Doris put it this way:

Doris: I don't really think that you should go in and manipulate something, (with antidepressants) on the contrary I think if you let it be the way it is, be tired, listless, without energy and rest and withdraw and not feel like you have to excel and be good and happy then it wouldn't involve additional feelings of suffering on top of that. I feel that thoughts add suffering that doesn't need to be there if you just accept "Now this is what things look like one week out of the month. Now I need to do things in this way." Oh, it's okay.

The pain is there and the feeling of vulnerability is there but if you only saw it for what it was. I think it is normal, really when I sit and talk with you about it on this intellectual level then I think it is normal. When I am in the middle of it I feel "I'm not myself, this is not good, I can't put up with this" ah, and then it doesn't feel like it is me or that it is normal because I don't allow myself to be that way.

Doris: Jag tänker egentligen inte att man ska gå in och manipulera nånting, (med antidepressiva) tvärtom jag tänker om man låter det vara som det är, vara trött, håglös, energilös och vila och gå undan lite och inte behöva topprestera och vara duktig och glad då skulle det inte bli såna jobbiga ytterliga känslor av lidande på det. Jag tänker att tankarna lägger till ett lidande som inte behöver finnas där om man bara acceptera "Nu ser det ut så här en vecka i månaden. Då behöver jag göra på det här sättet" Usch, det är okej.

Smärtan finns där och hudlöshetskänslan finns där men om man bara såg det för vad det var. Jag tycker att det är normalt, egentligen när jag sitter och pratar med dig på den här interjektuella nivån så tycker jag att det är normalt. När jag är mitt upp i det jag känner att "jag är inte mig själv, det här är inte bra, jag orkar inte med det här" ah, och då känns det inte som det är jag eller att det är normalt för att jag inte tillåter mig att vara så.

Even though Doris is well aware of the added suffering that not accepting a situation brings, when she is in it, in an altered state that is isolated from other states then she is incapable of taking her own advice. It is important to listen to the message here, that the suffering is described as two-fold. Even if a woman would accept feeling poorly from this part of her menstrual cycle, she still feels changed. Exploring the difficulties of accepting these changes as a part of the self seem to be the first step that has to be taken to go further into understanding differing lived experiences that make up a cycle of embodiment.

Greta also discussed manipulation and questioned who we as women were trying to change for. She brought up both antidepressants similar to how Doris discussed it but also birth control as a strategy for changing experience to which she was negatively inclined.

### 7.2.2 Negative feelings as part of the self

After having explored what women saw as normal it became clear that the dilemma of not feeling like herself was centered on expectations of feeling good all the time. Since a woman had not done

anything differently herself and that the conditions under which she lived were relatively constant the change can be seen as having internal origins located in the body. External and internal origins of change are thought of differently. The experience of things and situations around her feeling so differently from the day, days or week before was often one of utter consternation. In addition to this difficulty to take in this type of change was that it happened every month. Women mentioned that logically it was not a new experience to feel changed or different at times. This is where the idea of lost perspective came in for the women I interviewed. ‘How can I forget?’, ‘Why don’t I see it coming?’ and often the question ‘Why can’t I accept it?’ Not being able to incorporate these types of experiences due to internal change into their lives was a subject a number of women talked about.

Here is what Hanna had to say:

Hanna: Yes, and but when I don’t have it, when everything levels out, I can’t really see myself kind of, that that is also me. I can’t relate to being so incredibly irritated. It is like it just (snap) disappears. I can reason like this, if I like don’t go into myself and feel that I...can’t bring back this **irritation** again, or it’s like... it just doesn’t affect me. It is strange but (laugh) I feel like this kind of... That’s exactly it. I can’t remember what it is like to be in this condition.

Hanna: Ja, och men när jag inte har det, när allting planar ut, så kan jag inte liksom se mig själv, att det där är också jag. Jag kan liksom inte relatera till att vara så himla irriterad. Det är som att det bara (knäpp) försvinner. Jag kan liksom resonera så här, om jag liksom inte gå in i mig själv och känna att jag... kan inte få fram den här **irritationen** igen, eller att det är som att... det verkligen bara rinner av mig. Det är märkligt men (skratt) ungefär så här känner jag... precis så kan man säga. Jag kan inte minnas hur det är att vara i det här tillståndet.

The descriptions women used for when they felt the most changed mentally hold a part of the explanation of why this happens as I have previously discussed in the chapter on menstruation. It was not the focus of my questioning or central to this thesis’ initial questions but the return to talking about the unacceptance of society of a woman exhibiting irritation and anger, being changed, feeling changed or acting differently made it important. For example to feel irritated was not surprising to the woman when she knew she was close to getting her period. Most of the women interviewed talked about things like irritation or anger as being a part of a natural, biological process and see it connected to the most essential system in a woman’s body. Problems arise when this system’s accompanying changes in mood are not accepted as allowable feelings and the behavior in which these feelings result in every day living. This contradiction can explain why a number of the women said that they simply couldn’t accept not having control of how they acted.

Eva: Well I felt, I always feel that when I come out of PMS it feels like I can look at myself and say "God what am I doing?" like "Who is that?" I can't recognize myself as the person I really am or what can you say, it feels as if it is a whole other part of me that takes up a very large space. It is in anyway a large part of me. The antidepressants dampen that thing.

Liz: That part?

Eva: Yes that part, absolutely, it doesn't feel like I can steer it. That is what is so strange. Otherwise I can choose a little how I want to be, how I present myself kind of but at that time it doesn't feel like I have control. So it is just that. Which is the hard part.

Eva: Alltså jag kände, jag känner ju alltid när jag kommer ur PMS så känns det som jag kan titta på mig själv och "Gud vad håller jag på med"? "Vem är det där?" liksom, jag kan inte känna igen mig själv som den jag är egentligen eller vad man ska säga, det känns som att det är en helt annan del av mig som får ändå ta en sån väldigt stor plats. Det blir ändå en stor del av mig. Och de antidepressiva dämpar den grejen.

Liz: Den delen?

Eva: Ja den delen, absolut, det känns inte som jag kan styra det. Det är det som är så konstigt. För att annars kan jag ju välja lite som jag ska var, hur jag framställer mig själv liksom men i det läget så känns det inte som jag har nån kontroll. Så det är ju det som är det jobbiga.

Eva first starts out the way many women described the point in time when they had left the state they felt the least like themselves. She includes it as a part of herself though, as opposed to saying it is another person or an exhibition of mental illness as some women expressed it. Her main concern is about control of behavior and outward representation which were brought up time and again throughout her interview. Often it seemed as if the difficult part of incorporating adverse experiences into one's self had more to do with what women were able to regulate or present outside of themselves than actually feeling a negative change in mood. On the one hand symptoms or changes were accepted as natural, normal and part of being a woman who menstruated. On the other hand these changes were not a part of herself that she wished to be outwardly exhibited. This was seen to create the added suffering brought up by Doris when she talked about not feeling normal because she doesn't allow herself to feel like that. Not wanting to show how she felt was questioned by the individual as not being true to herself. It is problematic to include experiences viewed negatively by society into the individual realm of personality. 'One's selfness' is partially produced by the internalization of values the source of which lies between people, outside of the individual, where the meeting with others in the culture occurs. The conflict described in menstrual suffering arises between personal experience and desirability of characteristics and levels of emotional expression existing in society.

Greta elaborates on the theme of what is actually authentic when it comes to feeling differently throughout the menstrual cycle. What is different here though it that Greta believes that it could very well be this time, the time that most women describe as not feeling like themselves, that allows the most authentic representation of feelings and mood.

Greta: It maybe is just that if you let more of yourself surface a bit more maybe you are really holding back too much during the other part of the cycle so that which is, everything is me so to speak, it is just that maybe it just becomes even more **apparent** during these weeks. You can see it in that way too. It maybe would be good if it came out a bit more evenly...so that I don't feel like myself. That I become another person. That I become someone, like someone I don't recognize in myself. It is still me really.

Greta: Det kanske bara är att om man lever ut lite mer av sig själv just det kanske är så att man egentligen håller tillbaka för mycket under den andra delen av cykeln så vad som är, allting är ju mig själv så att säga, det är bara att det kanske blir ännu mer **tydligt** under de veckorna. Man kan ju se det på det sättet också. Det kanske vore bra om det kom ut lite mer jämt... så att jag känner inte mig att jag blir en annan person att jag blir nån liksom nån jag inte känner igen i mig själv. Det är då ändå jag liksom.

Greta could be trying to reconcile with this part of her life experience by describing it this way.

Answers to why it is problematic to incorporate such differing ways of being in the world into the authentic self, as Greta puts it, 'someone I don't recognize in myself' will come from interdisciplinary scholarship including contemplations like Greta's. Nevertheless, she touches on an area that could be examined further by comparing societies. The reasons for 'holding back' one's exhibition of emotion, even in what women in Western society define as the good days or normal half of the cycle are an area of study that needs a comparative approach. These women's experiences of the authentic can't be separated from constructions of society and can only be understood in the societal context where they occur.

### **7.3 Variations in descriptions, mental illness as a distancing strategy**

In trying to describe the changes in how they felt, women used a variety of different diagnostic terms and descriptions; ADHD, hyperactivity, manic-depressive, bipolar, depressed, multiple personalities, feeling changed, chemically imbalanced, having a Dr. Jekyll and Mr. Hyde experience, wacko, cuckoo, crazy, insane and suicidal. These discussions centering around authenticity and normality often took the turn of describing drastically changed ways of being with the strongest words we share in our culture for not being normal.

Variation in experiences related to authenticity was marked by how drastically the emotions affected a woman's thinking about her life situation.

Fredrika: I am normally rather easy-going, a light-hearted person but when this storm of hormones sets in or whatever it was that happened to your body, I get so unbelievably, so unbelievably in a dark place in my mind. It is exactly how I imagine a depression must feel like for a person who suffers from that, that you can't see ahead in life, you can't see anything. Yeah daily life around me becomes like not the same, it fades, my existence becomes unbelievably narrow. Completely, well the worst worst that has ever happened is that I started to consider to kill myself. It becomes so unreal, it ends all that is normal in life, that I can't even consider to go on living. It it scared me so much.

Fredrika: Jag är normalt ganska lättsam, en lättsinnig människa men när den här hormonstormen sätter in eller vad det var som hände med kroppen, så blir jag så otroligt så otroligt svart i sinnet. Det är precis som jag föreställer mig en depression måste kännas för en människa som drabbas av det, att det går inte att tänka framåt i livet det går inte att se nånting Ja, ja vardagen runt mig blir liksom inte samma den bleknar, min tillvaro blir otroligt trång. Rent alltså det värsta värsta som någonsin hänt är att jag börjar fundera på att ta livet av mig. det blir så otroligt det tar så slut på allting som är normalt i livet, att jag inte kan tänka mig att fortsätta det. Det det skrämde mig jättemycket.

It is not surprising that thoughts of suicide are frightening and depict a clear dilemma of how experiences cannot be unified with one's standpoint of one's selfness. This variation in experience which Fredrika's account represents can be seen as a boundary between what is allowable by an individual to include in who she is and what is seen as mental illness. This distinction in extremes facilitates the willingness to use medication.

From the interview material as a whole it is noteworthy that the women who emphasized the fact that they were normally very positive and outgoing were the women who had the most extreme experiences of PMS. Either women who have an extroverted personality suffer more from having depressive feelings or extroversion is a trait that is accompanied by a broader register of emotion. It was often a reflection of mine that this study would benefit greatly from a psychological anthropological approach similar to the one called for by Scheper-Hughes and Locke in the development of a "theory of emotion" (1987:21) and by Seymour in her analysis of resistance (2006).

Another area besides the association made to mental illness that leads to the decision to take medication is when relationships are affected, especially the mother-child relationship. Here the incorporation of unwanted behavior may be accepted by the woman but since children lack the ability to understand the behavior and the belief that it can harm the child to expose them to it is motivation enough for the women I spoke with who used antidepressants for menstrually related problems. The choice to medicate has less to do with authenticity and suicidal thoughts and more to do with interpersonal relationships and the well-being of others.

### 7.3.1 Variations in thoughts about the self and suicidal thoughts

Cecilia relays a part of her life history and had this to say about how changed she had felt having had suicidal thoughts on a regular basis. (Cecilia did not use antidepressants for PMS.)

Cecilia: It is hard to answer if I weren't this type, then I wouldn't be who I am. I medicate (with antidepressants) when I treat an emergency situation (depression). I have had acute pain and such but I, I have always had a huge amount of PMS problems when I look in a rear view mirror so to speak with suicidal thoughts you know really **planned** how you go about taking your **life**, more in a practical aspect and that is pretty pathological to come so far down in the suicidal ladder when you start to think like that but I have never viewed it as pathological rather I have just seen it as okay, this is the way it is then but when you, I have never thought of treating it actively where I would seek help for it. (PMS)

Liz: "I am this person who has these feelings or thoughts and that is who I am."

Cecilia: Yes, but then there gets to be so many disturbances that you can't carry on with your regular business, that I can see as a part of me, it is the same line of thought as saying that sure, I am a depressive type, that's the way things are with me but if you get depressed and you're not going to do anything about it, I don't think that's good.

Cecilia: Det är svårt att svara på om man inte var en sån, då skulle man inte vara den man är. Jag behandlar (med antidepressiva) när jag kan behandla i akutsitsen (depression). Jag har haft akutmärutor och så men jag, jag har haft ju alltid haft jättemycket PMS besvär så när man tittar i backspegeln liksom med självmordstankar liksom riktigt **planerat** hur man ska ta **livet** av sig så, ja mer praktiskt så här och det är ju ganska patologiskt att komma så långt ner i självmordsstegen när man börjar tänka så men jag har aldrig sett det som patologiskt utan jag har bara sett det som okej, så är det och sen så men när man kommer, jag har aldrig kommit på att jag skulle behandla det aktivt att jag skulle söka för det. (PMS)

Liz: "Jag är den personen som har såna här känslor eller tankar och det är den jag är."

Cecilia: Ja, men då blir det liksom så mycket störningar att du inte kan bedriva din vanliga verksamhet, det kan jag tycka är en del av mig, det är samma bransch som att säga att visst jag är en depressiv typ, så är det med mig men om man blir deprimerad och inte ska göra något åt det, det tycker inte jag är bra.

It is perhaps easier to accept these types of feelings of wanting to end one's life if the contrast during different phases of the menstrual cycle is less great. Being a 'depressive type' of person to begin with as Cecilia describes herself, would give the individual opportunity to recognize these characteristics as authentic parts of one's self and not so different from other life experiences she has had. If a woman, like Fredrika, can't identify with these feelings or recall having similar thoughts at any other time then it would make it more difficult to accept it as a part of who she is. The contrast in experience might be a way for women to divide up their experiences into two parts and lead to a way of talking about one's self as two different people. Jenny's frustration with having to put up with this suffering, especially losing the willingness to live, leads her into this type of reasoning.

Jenny: Yes. I think it is more like I am going crazy but it is even more like I get scared because I lose my will to live, more a fear for, "No, I really do want to jump over this bridge." If it is really bad, where it goes so far that my will to live is gone, there is no meaning in living when things are like this. To have suicidal thoughts. And then I can mmm... And then I can get scared...

It is nice to know that it is connected to menstruation, that it is not me who is going crazy, that it isn't me who doesn't have the will to live. That it is this other person who feels like this when she has her period...

Jenny: Yes but it gets to be that your body and your head don't hang together really then either yet you still have to live your life, go to school or work so your head says like, don't get out of bed, stay in bed, you don't have to go anywhere but my body goes anyway. It is like you have two voices in your head which can make you feel just a little bit crazy.

Jenny: Ja. Jag tror att det mer är att jag håller på bli tokig fast det är nästan mer att jag blir rädd för att jag tappar livsglädjen, mer en rädsla för, "Nej jag vill ju verkligen hoppa över den här bron". Om det är riktigt illa, går så långt att livsglädjen är borta, det är ingen mening att leva när man har det så här. Att ha självmordstankar. Och då kan jag mmm... Och då kan jag bli rädd...

Fast det känns ju skönt att veta att det är kopplat till menstruationen, att det är inte jag som håller på att bli knäpp, att det är inte jag som inte har en, har livsglädje. Att det är den här andra personen som känner så när hon har mens...

Jenny: Ja men för det blir som att kroppen och huvudet hänger inte riktigt ihop då heller än att man måste ändå sköta sitt liv, gå till skolan eller jobba så huvudet säger så där, ligg kvar i sängen, ligg kvar i sängen du behöver inte gå någonstans men min kropp går ju ändå. Det är ju så att man har två röster i huvudet vilket kan gör att man känner sig lätt galen.

Jenny uses two types of inclusive strategy. One is where she divides up her experience into the experience of two different people and in the other she describes hearing two different voices. The two parts are still part of her but they are so contrasting or painful that she has to separate them to cope with them. The division of a woman's 'one's selfness' may be what many of the women felt to be so difficult to include in their authentic image of themselves that they had to use terms of mental illness to describe them.

## 7.4 Experiences with antidepressants and ideas about what is authentic experience

The discussion of the motivation to manipulate changed states of existence revealed a great deal about the attitudes these women had towards antidepressants. I asked women specifically about their experiences with SSRI, the type of antidepressant developed and marketed for treating menstrually related symptoms among many other conditions, the most common of which is clinical depression. The marketing of SSRI for women with severe PMS symptoms targets the feelings women described earlier about losing control.

Women's thinking about their menstrual suffering had very much to do with emotion. I thought it to be important to ask women about their attitudes towards antidepressants since their use has grown exponentially in the past two decades. SSRI antidepressants make available a way for women to

damper the affects of a self-reported altered state. This is the cyclical going in and out of ways of being in the world in focus in this study. The most familiar way of being in the world is what the woman sees as her normal way of feeling and going into another way of being is when she feels different either mentally, physically or both. With this embodied changing process as a back drop another going in and out of ways of being that affects mood can be obtained by using a mind altering substance.

The women I spoke with who had used antidepressants to change how they felt during the premenstruum went through a process where they first identified their going in and out of ways of being in the world and then explored options to manage this type of change. I wanted to know more about what it felt to feel these changes but also what women feel about being able to make choices about how they experienced premenstrual suffering.

Below Betty told about how she felt at the beginning of her use of antidepressants.

Betty: I'd say 10 years ago when it (premenstrual problems) started after the kids were born.

Liz: And you started to notice things that just were not acceptable and you saw a pattern to this.

Betty: Yes.

Liz: And somewhere someone said try these instead of the birth control, try these, they are an antidepressant that you only take half of the time, like half of the month, can you remember what experiences you had with antidepressants before you started to take them.

Betty: I think they were just starting to get accepted more and I always, I am not a medicine person, I will try and not take something as long as I can. When I have this chest infection, it took me a week before I finally went in there. I was dying, don't give me antibiotics until you do a test, don't just write it out. He took a blood test, he said you are very sick and I say OK!! just don't like to take medicines. I am apprehensive. And I thought this (being given a prescription for antidepressants) is going to give me a thing on my record, health record, Socialstyrelsen, if I get, Försäkringskassan, insurance, how will that look if they get hold of my record. It was a stigma. But I was desperate at this point and I say ok. You know I made it a point to say "My gynecologist gave me this for my menstruation". I made that a point, I didn't go to a therapist. So it wasn't for depression. I told them to write that too actually.

Liz: Who?

Betty: The doctor told them to write that for my menstruation. Yes that was a big thing for me. Didn't want to have that stigma or whatever it was.

Betty begins by telling me how she is normally apprehensive to medication in general. Here she mentions antibiotics as an example. There are also ideas about the stigma associated with mental illness and how this could be used against her in the future by authorities. Other parts of the interview

imply that this has to do with custody of children and future employers. The intent of this account by Betty was to describe how motivated she felt to do something about her suffering, that she was willing to risk all of these things.

In this next excerpt, Cecilia explains how her experience with taking antidepressants taught her to value her authentic feelings and who she truly is. As mentioned earlier she did not take antidepressants for PMS. Her ideas are representative though of how a number of the women felt about antidepressants in general. This type of discourse shapes attitudes and influences decisions about using this medicine. It is understood by all of the women interviewed to be a process of altering the mind.

Liz: ... do you feel that some feelings or personality traits are suppressed or are taken away?

Cecilia: No, yeah. I think I feel it afterwards, last time I took them but right now I don't feel it, a little like I feel, I want to be, I **am** this explosive person who has a lot of feelings. It is a part of my personality. In the beginning it felt like "oh why didn't I take these from the time I was 14 and always taken that medicine, how great that would be." I would have been much better off wouldn't have to get so angry. The longer I stayed on antidepressants I got a type of insight that you, I don't want to be numb and not have these feelings because it is such a large part of me. I thought more positively towards myself and my personality, that I felt that now I have experienced this, now I know what it is like... but I wouldn't choose it, I would rather choose to be how I am and that is maybe difficult for both me and the people around me but it is okay actually.

Liz: ... känner du att några känslor eller personlighetsdrag inte kommer fram eller plockas bort?

Cecilia: Nej, ja. Det tror jag att jag känner det i efterhand, förra gången jag åt men just nu känner jag inte det, lite så att jag känner, jag vill ju vara, jag **är** ju den här explosiva människan som har mycket känslor. Det är ju en del av min personlighet. I början så kändes det som att "åh varför åt inte jag det här från när jag var 14 år och jämt hade ätit den medicinen, va bra det skulle var." Jag skulle ha klarat mig bättre skulle inte behöva bli så arg. Ju längre tid jag åt (antidepressiva) fick jag någon slags insikt om att man, att jag vill inte var avtrubbad och inte ha de här känslorna för att det är en sån stor del av mig. Jag blev mer positivinställd till mig själv och min personlighet, att jag kände att jag nu har jag upplevt det här, nu vet jag hur det är ... men jag skulle inte välja det utan jag väljer att vara som jag är och det är kanske jobbigt för både mig själv och min omgivning men det är okej faktiskt.

Cecilia's explanation of how her feelings are a part of her, touch on an important part of the subject of 'one's selfness'. Even her explosive part is a part of her personality regardless of what problems it may cause for her and others. A number of women revealed this thought pattern of reconciling not feeling like themselves with wanting to own their emotional experiences.

It becomes clearer why antidepressants are seen to be a more attractive alternative for women who want to alleviate this emotional part of premenstrual suffering. One reason is that it changes the behavior or outward representation of the altered state a woman experiences during PMS. Cecilia describes this here:

Cecilia: No but there are many who describe this by saying they feel numbed in contact, they feel disconnected from emotional reactions so then a part of your personality disappears if you don't react to your feelings in the same way. That you more take note, okay, now I am angry, now I am sad, now I am happy but nothing **happens**. Can say it like now I don't feel the feeling but you know that's it. It is sort of like when you leg hurts so you take a painkiller. If you take a stronger painkiller then you know that my leg hurts but don't feel the pain anymore, you can still say that your leg hurts but the feeling isn't there, nothing happens.

I don't get angry, I don't stand there and yell, because it doesn't keep up kind of. I have blocked a type of reaction to the feeling. Mmm It is the reaction that is blocked.

Cecilia: Nej men det är flera som beskriver det här med att de känner sig avflackade i kontakten de känner sig som avflackade i känslomässiga reaktioner så att då är en del av personligheten som försvinner om man inte reagera på känslor på samma sätt. Att man mer notera okej nu blir ja arg, nu är jag ledsen nu är jag glad men det **händer** ingenting. Kan säga det liksom nu känner jag inte känslan fast du vet att det är den. Det är ungefär som när man har ont i benet så tar man en värktablett. Om man tar en starkare värktablett då vet man att jag har ont i benen men känner inte att det gör ont längre, man kan fortfarande säga att det gör ont i benet men känslan finns inte kvar, "nothing happens".

Jag blir inte arg, jag står inte och skriker, för det hänger inte med liksom. Jag har blockerat någon form av reaktion på känslan. mmm Det är väl reaktionen som är blockerad.

Cecilia's description of the use of these SSRI antidepressants offers the individual control over what others see, a point Nettleton and Watson include in *The Body in Everyday Life* (1998). The outward representation of the self can be steered with new discoveries. The boundaries of the body change in an age of medical technological advancement. The effects of not feeling like one's self can then be hidden which would eliminate the added suffering these women talked about when their anger, frustration or irritation is taken out on the people closest to them.

Cecilia uses a comparison with how the body has sensations that we block with painkillers to how feelings are blocked by antidepressants. The pain in the leg is still there and the feeling of anger is still there but they are blocked resulting in a different type of behavior than their anger usually results in. This understanding of how antidepressants work and the reports women give on how it makes them feel and affects their behavior can be contrasted with how women talk about hormones. Most of the women made the connection that they experienced less PMS when on oral contraceptives. However the discussion of considering it as a medicine to deal with symptoms related to the premenstruum was very limited. If it was mentioned in dealing with PMS, it was considered too invasive. Concerns ranged from having damaging effects on their hormonal balance or on hormonal systems, ability to have children and numerous health issues including blood clots and cancer.

To still have feelings but to block the outward reactions of them that can impact others negatively is an experience shared by the other women who had used SSRI medication for premenstrual complaints. The primary feelings which are described as blocked are different though. One of the main problems

associated with suffering from severe PMS in this research material is how it affects relationships with others resulting from feelings of irritation to aggressive behavior.

#### 7.4.1 Ideas about the natural and the artificial in authentic experience

Ideas about what is natural and what is artificial are ideas that are closely connected to authenticity and an individual's personality and emotions. The use of antidepressants enables individuals to make choices for themselves in how they feel and what they feel. In the interviews I did not pose the alternatives of using SSRI antidepressants and hormonal therapy against each other. The attitudes towards each choice of treatment were still readily comparable and women generally saw the antidepressant alternative as less problematic. I attribute this tendency to be related to how ideas about the natural, hormones and hormonal processes are generally talked about in society.

Doris: Take the pill all the time. That feels completely unnatural to me. Completely unnatural. I even have difficulty considering SSRI even though I feel it has been terribly hard these past months. I have felt half-suicidal. Now I am exaggerating, no but like "My god what is the meaning of life?" and I can handle anything and da da da da da and I wanted, I feel extremely doubtful towards SSRI.

...how hard, I think, it is so complex because we live in an artificial way... just push some artificial SSRI in there instead of going out into nature and going out for a walk, move around, eat blueberries (laugh) and oatmeal maybe too might help so it maybe has already fucked up our chemistry... Because it is hard to separate from each other. The artificial in SSRI but the artificial way in how we live how it influences the natural processes on cell level, it is that too. It is easy that you, I can easily condemn SSRI. I don't think that our way of living is that fantastic.

Doris: Äta p-piller hela hela tiden. Det känns helt onaturligt för mig. Helt onaturligt. Jag har tom svårt att tänka mig SSRI även fast jag tyckt att det har varit vidrigt jobbigt de sista månaderna. Har känt mig halvsuicidal. Nu överdriver jag, nämen så "herregud vad är mening med livet?" och jag klarar inte att hantera nånting och da da da da da och jag ville, känner mig extremt tveksamt till SSRI.

... vad svårt, tänker jag, det är så komplext för vi lever på ett artificiellt sätt ... då trycker man till lite artificiell SSRI istället för ut i naturen ut och går, röra sig, äta blåbär (skratt) och havregryn kanske också skulle hjälpa så det kanske redan har fuckat upp våran kemi... För att det är svårt att skilja ut ifrån varandra. Det artificiella i SSRI men det artificiella i hur vi lever hur det påverkar det naturliga processer på cell nivå, det är ju det också. Det är ju lätt att man liksom, jag har lätt att fördöma SSRI. Jag tycker inte att det är så himla bra med sättet vi lever på.

This quote from Doris' interview shows how ideas of the natural are connected to the reproductive system in her initial statement about taking the pill all the time to avoid problems with PMS. Further down she goes into the discussion of SSRI's and the reasons for being doubtful towards them which are not as tied up in the naturalness of reproduction. Her discussion of artificiality though, builds on a likeness to her first thought about what is natural but it is referred to as the cell level. Manipulating the body, fertility and being about to have children are very concrete. The results of using hormones that inhibit ovulation and pregnancy are closely connected to the physicality of reproduction. The

antidepressant manipulation if much less tangible, ‘on cell level’, as Doris says and has varying effects. It is not mentioned specifically but can be understood to mean that antidepressant use is different for different people and situations and that it is less long-lasting with a limited effect on the rest of the body. When it comes to treating menstrually related suffering or manipulating it as it is often thought of by the women I spoke with, the emphasis is on difficulty in managing everyday life. Here it is worth emphasizing that only one of the women, Jenny, wished to eliminate the cause of the suffering in focus of this study, the menstrual cycle itself. Even in this woman’s case it was after lengthy discussion. A discussion of how women go about managing life, manipulation and what is authentic will be returned to further down.

Greta strongly connects aspects of being a woman to the authentic self. For her menstruation represents womanliness, fertility and youth. It would not be off target to assume many women share this conception. Ideas about personality and what is natural and what is authentic are intertwined ideas that have a complex relationship with ideas about womanliness.

Greta: ... at the same time it is true that it (reproduction) is a part of your personality and I think that that it is something you might almost not **miss** but it would be saddening then when you don’t, when in a way when your period disappears and you know that you can’t have children anymore and that then that it anyway has, it still has a positive part too. That you know that you are still at a fertile age so to speak (laugh) and so and I can start to feel that now. Now I am soon 40 and soon I can’t like I still only have one child and I am trying to have another you know and then you can start to feel that it is going to be sad to not have this anymore. It is still in a way still positively associated,

Liz: With fertility?

Greta: Yes, exactly.

Liz: Youth?

Greta: Yes that you maybe also associate with womanliness in a way so, so now when you start to get close to 40 you can almost experience some, ah, sorrow that it is soon going to be over so it is not only negatively associated.

Greta: ... samtidigt så är det sant att det (reproduktion) är ju en del av ens personlighet och jag tror att att det är nånting man kanske nästan skulle inte **sakna** men det skulle vara en sorg sen när man inte när man på nåt sätt när mens en försvinner o man vet att man inte längre kan få barn och att så att det har ju ändå, det har ju ändå en positiv del också. Att man vet att man fortfarande är i fertil ålder så att säga (skratt) och så och det kan jag börja känna nu. Nu är jag snart 40 och kan snart inte liksom jag har fortfarande bara ett barn och jag försöker skaffa ett till liksom och då kan man börja känna att det kommer blir sorgligt att inte ha det här längre. Det är ju ändå på nåt sätt är det ändå positivt förknippat med-

Liz: Med fertilitet?

Greta: Ja, precis.

Liz: Ungdom?

Greta: Ja som man kanske också förknippa med kvinnlighet på nåt sätt så, så nu när man börjar närmar sig 40 så så kan man nästan få nån, ah, sorg att det snart kommer att vara slut så det inte bara negativt förknippat.

Age, life situation, wanting to have children now or in the future, affect how a woman sees her suffering or interprets the manifestation of symptoms. If you do not plan on having children then the

whole process would have much fewer positively associated qualities which could very well increase the suffering if you have no 'use' for it. But even women who do not want to reproduce see that menstruation is a sign of health. The difference is in how it is valued. The complex relationship between what is seen as natural and how it is connected to personality and authenticity affects the meaningfulness of the experience of suffering.

The experience that complaints and problems connected to menstruation like PMS increase with age, are connected to these life events. This is an additional aspect to the 'PMS worsens with age' conception. There are other implications aside from what stems from discontinued oral contraceptive use, having or not having the number of children you wish to have, added responsibility of caring for others and less time to care for one's self. These are lines of thought about ageing and changing identity that affect embodiment and ultimately the life world of women.

Taking hormones for birth control masks the changing experiences a woman could have in her menstrual cycle. Having covered them up for so long and then revealing them again could be what is happening for many of these women. Instead of recognizing the cyclical changes in their bodies and emotions it can be interpreted as new experiences. It is highly likely that this regime women submit themselves to contributes to the impression of a worsening condition of menstrually related suffering.

### 7.4.2 Managing life and the body with antidepressants

When talking about menstruation and medication, Jenny discusses her experiences with oral contraception, mental health and PMS:

Liz: When did you start taking the pill?

Jenny: About when I was 15, one year later. I took them relatively regularly until I was 25. And that is also something I am pretty angry about that it is so easy, even though I am in favor of safe sex that it is prescribed so generously. And now one talks about how it can affect your body. You know, a 15 year old, I didn't question it in any way. I had a few problems with depression. Now afterwards it was the pill that made me, that made it so that I was in a certain way or just being a teenager and also anyway, no. Then when I felt that no, it was when I started talking to friends who had stopped taking the pill, because I wasn't alone in this situation, there were a lot of others. Eh and they said that they felt good because they had quit. Then I quit too. It was like I got my body back in a way. After having stopped taking the pill but before I had PMS. So I got my body back but I started to feel, it is hard to describe, but I recognized my body at the same time that I started to get PMS. Then it feels like it has been like the last five years that it has just gotten worse and worse and worse. If it has anything to do with age, I don't know.

Liz: När började du äta p-piller?

Jenny: Ungefär när jag var 15, ett år senare. Då åt jag relativt regelbundet tills jag var 25. Och det är också någonting som jag är ganska arg på att det är så lätt, fast jag är för säker sex, att det är ändå skrivs ut lättvindigt. Och ingen pratar om hur det kan påverka kroppen. Alltså en 15 åringen, jag ifrågasatte det inte på något sätt. Jag hade lite problem med depressionen. Nu efterhand var det p-pillren som gjorde mig, som gjorde att jag var på ett visst sätt eller bara tonåren och, också i alla fall, nej. Sen när jag kände att nej, det var när jag började prata med vänner som hade slutat att äta p piller, för att jag var ju inte ensam i situation, det var många. Eh och de sade att de mådde så bra för att de hade slutat. Då slutade jag med det. Då var det som att jag fick tillbaks min kropp på ett sätt. Efter att jag hade slutat med p piller fast innan hade jag inte PMS. Så att jag fick tillbaks min kropp men jag börja känna, det är svårt att beskriva, men att jag kände igen min kropp samtidigt som jag började få PMS. Sen känns det som att det har vart typ de senaste fem åren har det bara blivit värre och värre och värre. Om det har med ålder att göra, det vet jag inte.

Jenny went through her menstrual history thinking about what were authentic experiences in relation to the birth control pills she had taken so long. What is interesting is what Jenny says about getting her body back when she stopped taking hormones. This is another way that the naturalness of the body and the menstrual cycle surfaced in an interview. Many women Jenny knew felt better when they stopped taking oral contraceptives. The paradoxical part for Jenny is that at the same time that she feels she gets her body back she starts to have problems with PMS.

Jenny had used antidepressants but had not tried them for her current problems with PMS. She didn't understand how antidepressants could work for just half of the month as SSRI's are commonly intended to be taken for premenstrual symptoms. She had used it for depression and saw herself as a whole. When the same medicine is supposed to be used when she only felt this way half of the time she doubted that it could work this way. PMS wasn't the same as what it was like to be in a depression. She was also confused by the extended time it took for antidepressants to start to work and

how it was important to faze them out slowly as well. How did this make sense with just taking them when you felt periodically affected by PMS? How could they work immediately in one case and not the other? (Jenny was the one woman who showed interest in using birth control hormones on an extended schedule like Seasonale®.)

In Eva's case she had also had prior experience with antidepressants. She was able to describe the physical side effects of the SSRI medication she took but was ambivalent towards them. Using SSRI's for premenstrual problems removed the irritability but her biggest complaint was the limited range of emotion she experienced from slightly glad to apathetic. She said she was relieved to not feel the effects of PMS when she took them but started to consider alternatives to the medication after a couple of months. Eva would rather try getting more rest and taking better care of herself as an alternative to medication. However, she concluded by saying she would definitely take them again even though her partner said he would prefer her to be irritated and angry instead of the drastic change he saw in her when she took antidepressants.

Hanna had a pragmatic approach to using SSRI antidepressants. She described her experience as being in such a bad mood for a two week period each month. Hanna had no prior experience with antidepressants and before having children had not had trouble with PMS early. After being prescribed medicine she described as 'mood enhancing' and reading about how other women used it anywhere from one to two days to two weeks, she decided to take it when she knew she was going to need it during a certain period. An example of this was if she would be alone to take care of her children for the weekend and how she wanted to make it easier for them to be with her. When asked about how they made her feel she said she didn't feel like anything was very fun and that she wasn't angered by anything. All the extremes were erased from her emotional register. Feeling cut off was the disturbing part for Hanna. She now knows what to expect when she takes them during the time she feels affected by her menstrual cycle and weighs the pros and cons of using them with how she wants to feel around the people she will be with.

Betty feels that the antidepressant regime she follows for premenstrually related problems makes all the difference in her life quality. She saw no reason for trying to manage in any other way because of the change for the better she experienced and the experience her family members had with antidepressants. Her interpretation is that something is missing chemically that she needs to be who she is, a trait she shares with her family. For Betty the altered state of PMS is not a part of who she is as it was described by some of the other women who wanted to reconcile with this fact. She does not see herself as altered by antidepressants either but rather reinstated to her normal way of being. Quite simply Betty sees that she can manage life much better being who she really is with this help. Where other's interpret this type of antidepressant use as enhancing (Elliott, 2003), some individuals 'who

live the use' see it quite differently; either as a return to one's original personality or a medical compensation for lack of balance in brain chemistry.

## 7.5 Summary

Ambivalence is the word to describe the way women related to the lack of 'one's selfness' during the premenstruum. What most women expressed needing differed depending on the focus of the exchange in the interview. Sometimes women focused on needing a way to change their mood like when having lost the will to live. At other times what was needed was a way to alter their behavior when discussing relationships or interaction with others. A wish to change her personal values was emphasized when a woman wanted to be more accepting of herself and what was happening to her. When looking at the bigger picture so to speak, women wanted a change in society in the form of being taken seriously as well as calling for tolerance and understanding of their suffering much like the discourse about pregnancy goes. Alternatives were considered and weighed according to how they could address the problem but also how these interventions with medical technology could affect their general health. Ideas about the authentic self, 'one's selfness', were used as a determiner for what was acceptable to alter. Antidepressants were understood to be able to alter the already altered state of PMS. This lead women to contemplate if menstrually related suffering was a part of who they were or if it wasn't.

The connections between a biological process, societal values, interpersonal relationships and goals of well-being make a woman's interpretation of her experiences dependant on interrelating factors. Experience of suffering due to what women see as a natural and healthy process has multiple and contradictory meanings for a woman. What is authentic becomes uncertain to her due to conceptions about the natural, the artificial and manipulation. Determining which strategy to pursue to uphold 'one's selfness' depends on the resulting manifestation of her experience in the life world.

# 8. Discussion

## 8.1 How do women experience menstruation and menstrually related suffering?

In order to contribute to a deeper understanding of women's experiences in regard to menstrually related suffering questions have been posed about how these particular experiences are understood in relation to notions of normality and authenticity. To reach the main objective of this thesis the women were first asked to express their experiences of menstruation. Then focus was directed towards the understandings of their changing embodied experiences related to the menstrual cycle. The final stage in this work combined the answers to these questions with how the women expressed ideas of menstruation and menstrually related suffering as a part of themselves.

### 8.1.1 An exploration of bodily experiences

What has been attempted in this master thesis is a phenomenological exploration of the experiences inside of the body as signs of health, not dysfunction and what role these experiences play in the construction of a person's identity. When Lupton (1997) emphasizes the meaning of experience that can be studied using a phenomenological approach she is critiquing the Foucauldian idea of a 'docile body' where it can be interpreted that the body is static or unchanging in its medical encounters. Lupton reminds us that a patient is never docile in responding to medical advice. The women I spoke with about menstruation were able to offer descriptions that lead one to see the body as where meaning was created. Lupton quotes Chris Shilling who says that:

"It is necessary to allow for lived experience, for the *phenomenology* of the body. Bodies may be surrounded by and perceived through discourses, but that are *irreducible* to discourse. The body needs to be grasped as an actual material phenomenon which is both affected by and *affects* knowledge and society." (Shilling in Lupton, 1997:103).

This creating of meaning is a type of knowledge that is not graspable without methods developed to explore embodiment. It was often not an easy task to ask questions in this way and answers have to be analyzed with an interpretation model that builds on this specific type of phenomenologically focused exchange between the interviewer and the interviewee. A woman's knowledge about menstruation is experiential. The value of what menstruation represents is determined by what it means to her on an individual basis. It has been helpful to think with Foucauldian notions of surveillance and disciplined bodies in analyzing what women have to say, mostly because these theoretical tools explain ideas which we share about what was normal in reference to experience in the societal context these women

exist in. This was a type of starting point so to speak, to pinpoint experiences that diverted from what was thought to be normal.

When I first asked the women in this study to describe how they felt when they said they had PMS, I hear (as we have seen in chapters 5, 6 and 7) about negative experiences of mood centering on irritation and anger. Often there were reports about not being able to cope with the trials that come up in day to day living. Symptoms having to do with changes in how the body feels, can be clues to why a woman feels less well emotionally. When I asked about the explanation for why this happens there is a highly common response that it is caused by changing hormone levels. When I took the time to ask what these events mean to the woman, and where in the body she feels the physical and mental change, I was presented with a great deal of information about human experience. When the women traced going in and out of phases, and were given the opportunity to explain what it feels like and what it means to them, their answers contribute to a more general knowledge about how humans put together information from the senses. In the next sections I will discuss how these women's descriptions can be seen in the light of self-awareness of events in the body and with boundaries between the self and outward representation.

When I asked these ten women about their experiences of menstruation I first heard about when they felt the worst which included physical changes but focused primarily on feeling less than well mentally and how that affected them emotionally. I understand these descriptions as a way of organizing time in many ways, between good and bad days, high or low energy periods and 'starting in the middle' since the latter half of the menstrual cycle contained these adverse experiences when problems started. Events like ovulation, gradual physical changes leading up to menstruation, detection of unwarranted irritation, being in subdued and listless states and the onset of bleeding organized women's experiences of their existence when they were able to connect them to the menstrual cycle. Often this had to be done in retrospect because there were explanations from most women that they were not able to detect a menstrual explanation until they had left the most affected time period. This is perplexing to women. The influence on memory was a subject women wanted to make sense of. Discussion of what was normal began in this sense-making. What was determined to be normal by each woman was individual and helped explain what she meant when she said she did not feel like herself or was not feeling how she normally does and wants to feel.

These were the initial findings that once presented offered an opportunity to ask the questions that centered on 'one's selfness'. What was real emotion to her? What were authentic experiences? What was a part of her? Ideas about unrealistic demands of society, non-acceptance from themselves and others of not feeling well, coping with suffering to be able to meet expectations, being misunderstood by partners, being made fun of or not taken seriously when affected and especially feeling out of

control were themes that women focused on. Discussions of utilizing different types of medical technology revealed women's ideas about their bodies which relied heavily on hormonal explanatory models. Localizing the origin of their complaints also influenced how they felt their problems could be dealt with but always in an everyday context like if they need to use birth control or not. If some medical solution had to be chosen antidepressants were found to be a preferable alternative to hormonal therapies since the outward representation of their altered state was what caused their suffering. These stories situated understandings and experiences of menstrually related suffering in social contexts. After these ideas had materialized in interviews I suggest that a woman was more able to reunite experiences throughout the menstrual cycle into a whole. I see this as one example of how women could very well have experiences that they described as not feeling like themselves but that they did, since they were menstrually related, see as a part of themselves because they were a part of her experience as a woman. I will return to these answers I found in the next section.

My intentions have been to give more room to the bodily knowledge of a woman which is often in opposition to how Western culture sees medical knowledge to be; uncontested, universal and objective. Biological reductionism needs to be counterbalanced since the tendency to over-interpret in a society dominated by biomedical discourse hinders scholarship aimed at explaining and understanding experience. This female experience is also in opposition to the dominating structure of the male experience, a patriarchal force that also holds an often uncontested position. The challenge we are faced with is how individual experience from groups forced to relate to the center from a marginal position can be used as a basis of social science evidence (hooks, 2000).

### **8.1.2 The organization of time**

Focus on menstrual problems contributes to isolating negative experiences and makes them stand out and emphasizes them. This was evident in the way these women tended to organize time that pinpoints negative experiences that last for short periods comparatively. This way of emphasizing only one part of a cycle is communicating that it is a culturally significant event. (Buckley and Gottlieb, 1988)

When these ten women had a chance to talk about what happens to them during different phases, the cycle was reunited or consolidated instead of being isolated into one bad phase that stuck out. The exchange in the interview often shifted to talking more holistically about the body, their lives and the social positioning of menstruation. I found that the way of thinking about time influenced thinking about a woman's experiences. Ideas about the problem of not allowing one's self to feel different or bad came into focus. The woman being interviewed could begin to question her own thinking about where the problem was, in her own body or in society. I see this as an indication that organization of time can influence how meaning is constructed in the meeting between the individual, society and culture.

It is important to note that women organized time differently than the medically constructed phases of the menstrual cycle. Even though much emphasis was put on PMS as a pinpointed interval resulting from the phases of a cycle, an experiential division of time was created by each individual depending primarily on what the woman experienced from within. The changing phases of an organism were important only if they were useful to a woman as indications of coming changes or awareness of changes serving as explanations for altered feelings.

Because of this organization of time and because of the rapidly occurring change from a negative state to a 'normalized' state, the onset of bleeding was emphasized on many accounts. This event is seldom talked about in every day situations but was quite significant in our discussions together. It was often described as a relief and very positively associated. I see this as being due to how bleeding signaled an end to a type of suffering but also because it is an outward representation of a healthily functioning reproductive cycle. This also supports previous researchers' conclusions to PMS being the most visible part of menstruation in society (Kissling, 2006). It cannot be said that PMS is the most significant part and this is an important distinction. What is not talked about in daily conversation, like menstrual bleeding, can occupy the thoughts of women in a way not yet clearly understood.

### **8.1.3 The social origin of accounts of suffering**

The individual's bodily experiences are interpreted against the back-drop of socially shared understandings of the normal body. According to Foucault, part of the historical transformation towards new forms of governance through strategies that women 'do' to themselves, self-surveillance or behavior is connected to public health as a form of governance (Howson, 1998). The idea of normality is the base upon which clinical standards of health are built and this type of talk about health permeates daily conversation women have about their bodies. It was useful to contemplate a number of ideas related to the thesis question about what the expression 'I don't feel like myself' meant in the context in which it materialized. There is the creation of new diagnoses, self-surveillance as an internalized form of applied power and the new sick majority in terms of normality which include all women by default. These are examples of areas that have been thought about with Foucauldian inspired ideas about normality.

Normality was often seen by the women I spoke with as health, and that to not be normal was to be sick. What was considered normal or how the majority of people feel most of the time was what women used in order to be able to communicate their experiences in a menstrual context. Silence around menstruation and related sensations contributed towards the level of deviance women saw their own experiences to hold. All women in Western society, especially fertile women who experience

menstrually related changes, are confronted with regularly occupying a category that is not described as normal. Ideas about what the majorital experience is, builds on what is seen and talked about in every day contexts.

Commonly occurring statements like ‘I don’t feel like myself’, ‘It gets worse and worse as you get older’, and ‘You have your period don’t you?’ are examples of verbal expressions that we can generalize about because of the social origins they share. After exploring the reasoning behind these expressions with individuals important information about what these expressions mean in a given social context materialize. Stories about extreme affectedness, like severe depressive states or suicidal thought stemming from menstrually related suffering cannot be generalized in the same way. The discoveries made through unique experiences can be useful though when the meanings of those experiences to the individual are discussed. Then the focus is on how an individual conveys thoughts about bodily sensation, events that involve the senses in a way that examines the situation in an every day setting. What is difficult to grasp in human thought because of the taken for grantedness of bodily living can be pinpointed more easily with listening to extreme experiences and applying those findings to less severe manifestations of illness or suffering. Generalizing these types of experiences should be done to find out what questions we should be asking as opposed to assuming that the answers lie in the experience itself.

## **8.2 Health, normality and the *dys-appearing* female body**

Using the concept of *dys-appearance*, Leder (1990) explains how bodily self-awareness influences experience in reference to temporal and spatial functioning of the body. The body can no longer be taken for granted because of the changes it goes through. When the body changes where one experiences new sensations he describes it as a ‘temporal discontinuity’ when the body is altered. There is a “heightened attention to the physical” (1990:89) during the time of menstruation. Leder agrees with Young (1984) when she says that health is an unchanging state only for men who are neither young nor old. This motivates the necessity to focus on female embodiment.

This phenomenological point of departure in the analysis of being aware of the body builds on the ideas that there is discomfort or pain which communicates a negative experience to the individual. For these women who were describing suffering related to menstruation, the *dys-appearance* model requires additional concepts that would focus on the complex relationship between bodily sensation, mood and cyclical change intersectioned with internalized societal interpretation of signs in the body. A step in this direction would be to complement the meticulously worked out ideas of Leder based on

the lived body concept utilized by Merleau-Ponty (1945) among others. In her recent article “A phenomenological analysis of bodily self-awareness in the experience of pain and pleasure: on dys-appearance and eu-appearance” (2010), Kristin Zeiler explores what happens to the subject when the body appears as something positive. Where dys-appearance refers to different kinds of self-awareness focusing on forms of pain or discomfort, Zeiler suggests that the body can *eu-appear* (eu derived from Greek meaning good or well) as something positive and exemplifies this with descriptions of physical exercise, sexual pleasure and wanted pregnancy.

*Eu-appearance* is applicable in many ways to the experience of menstruation as described by these ten women. I have found that the detectable inner workings of the reproductive system in females are seen as positive, are highly-valued and are essential to the idea of being in good health. Even in cases of discomfort this is so. Here we have an example of the body appearing as *well* due to signs that are often described in negative terms like discomfort. I see the description as a societal phenomenon that goes through a transformation at a point of intersection when it is outwardly represented which I will return to.

*Eu-appearance* (Zeiler, 2010) is most helpful in this study to explore what these women told me about the specific event of the onset of bleeding. Positive physical signs of a functioning menstrual cycle include pain or discomfort, like at the time of ovulation, with sharp abdominal pain and breast tenderness or in the premenstruum with headaches and lower back pain. The dominating interpretation of this pain is that the body is well although the socially audible message is that one is ill, experiencing a type of suffering. The body *dys-appears* and *eu-appears* simultaneously. In the event of the onset of bleeding this happens as well but there is an added element that goes further than the *dys/eu-appearance* of the body. The immense relief and reassurance, that the menstrual cycle has, in a woman’s view, actually influenced her mood is significant (and largely unexplored). When a woman’s body *eu-appears* in this way the explanation again lies in the point of intersection where her body meets society. Social psychological mechanisms determine how eu-static the experience is, to use another notion explored by Zeiler (2010). I am referring particularly to how the onset of bleeding was described as such a positive experience that the general description of pleasure is not unthinkable. The time period preceding this bodily event determines this level of *eu-appearance* very much like the way Zeiler makes the following point:

“...lack of social support can result in a deepened experience of dys-appearance. When my body and world become painful, I need to develop strategies to handle everyday activities. If these strategies involve others helping me, and if I feel rejected by these others, my experience of dys-appearance can become even more complete than otherwise. In this sense, the intersubjective dimension of the situation in which my body dys-appears can aggravate or soften dys-appearance.” (Zeiler, 2010:6)

What happens in processes of self-awareness is socially situated. The importance of being in control of outward representation influences *dys/eu-appearance* as well which brings me to my next point.

## 8.3 Control of outward representation

### 8.3.1 Strategies to uphold outward representations

I have found that there are strategies of hiding experience, a strategy to keep experience private and concealed. The motivation for this found in the stories told by the women I interviewed, is to maintain status, avoid categorization or avoid being belittled. I summarize these experiences as an avoidance of being oppressed. The women's accounts in this study support the position that it is important to keep things silent around PMS to maintain control, to avoid the medical gaze, an unbeneficial focusing of their bodies erasing their agency. I see concealment as a way of upholding agency in encounters with a medicalized society. Descriptions of strategies to keep menstruation out of sight in the form of drugs to hide the behavior or secrecy to limit information about the body were abundant in these interviews. A medical intervention (ironically) helps a woman to avoid being seen as 'sick'. This is what I think is happening when women report being frustrated with the comments they receive about their behavior in the forms of 'Who is pms-ing?', a categorization of inherent illness because they are female. Medicalization is therefore not a one-way street leading to constructing illness. In the case of the use of SSRI antidepressants a woman is able to utilize a medical technology as an agent who controls the outward representation of herself.

Negative experiences with feeling poorly from menstruation are understood by these women to be partially due to societal values which women do not feel they can influence. In reference to *dys/eu-appearance*, I see factors which lie outside the individual experience of the body as potential intensifiers of embodiment. Much of the issue of PMS is about control for women. They want to be in control of their outward representation of themselves to avoid repercussions they may experience in social encounters.

The expression 'I don't feel like myself' is a way to express inability to uphold a false outward representation as well as being a distancing strategy as if saying 'It's PMS. It isn't me.' The problems of including PMS experiences in who one is, is related to societal roles and gender-connected desirability of qualities. In the views of the women I spoke with, womanliness is positive. Menstruation is positive. Fertility and youth are positive. Women do not want to eliminate these bodily experiences. Women express the wish to eliminate the negative experience they encounter from others. Losing control over how one feels and letting it show carries with it associations to a long list

of negatively charged attributes (Martin, 1992); a reaction to which can be summed up in an expression I have found in current mass media 'It's not PMS. It's YOU.'

### 8.3.2 Surfacing and intersection

The interviews with women who had experience using antidepressants made it clear that the knowledge of the availability of medication like antidepressants influenced the ideas some women had about their situation. This means that even indirect experience of antidepressants had implications. It is important to mention that I expected to be able to find clearer examples where antidepressants were used. Only three women actually had used SSRI medication for PMS related problems (Eva, Betty and Hanna). The other three had experiences using similar medications but during a longer time period and for other reasons (Cecilia, Jenny and Isabel). The four women who had no personal experience using SSRI's had close relations to women who did (Fredrika) or extended knowledge due to their occupations or studies (Doris, Greta, and Anna).

Antidepressant use for premenstrual complaints does have an effect. The women who used them were able to describe these changes and explained how they were helped by them. An important finding that needs to be explored further is that knowing how an antidepressant works in this type of situation is also important to women *even when she doesn't take them* and affects the way she thinks about what is happening to her. There are many indications from these interviews showing that women see antidepressant use in a more positive light for treating menstrual problems especially when compared to using hormonal therapies. The rationalizing for this was repeated in many instances and centered on how women saw reproductive health as vital and should not be tampered with.

Being able to use antidepressants is another opportunity to limit being associated to socially disadvantageous traits. I see this as a highly pragmatic view of this type of medication. It can solve a problem. The worry about stigma with using antidepressants is minimal since these women had this practical approach. Again this medicine was only used when they described themselves as not feeling like themselves so any possible stigma had not been felt to be applicable to them as individuals since what was happening 'wasn't me' or had origins relating to the biological process of menstruation. It would be fair to assume that the worry of being stigmatized by using antidepressants is in a sense proportionate to how closely the woman using them can distinguish her mental experiences as being menstrually altered.

A number of processes can be discerned in the motivation these women gave for choosing not to use hormonal therapy to change how they feel temporarily during a menstrual cycle: The unwillingness to medicate, the upholding of the 'natural', and ideas about risk in disrupting hormonal balance. Each

idea a woman holds contributes to how she experiences her body reiterating Lupton's argument about how an individual's body is not docile since lived experience affects knowledge construction (1997).

The group of women I interviewed fit the profile for the women targeted for the marketing of products like Seasonale®, the hormonal contraceptive used on an extended cycle basis allowing a limited number of bleedings per year. Suppressing the menstrual cycle in this way was not utilized by any of the women or seen as an alternative by them with the exception of one woman who was still mostly doubtful. Women did not want to manipulate the visceral workings of the reproductive system. This was clearly not the problem for these women and supports the conclusion that the problems reported by these women happened when the surfacing of behavior interfered with control of their outward representation. Depressive and listless feelings could be withstood. The issue was how emotions influenced what happened *outside* the body in interaction with others, in sight of others.

There is a relationship between embodied experience and portrayal of embodied experience that needs to be examined when women so decidedly attribute problems to *surfacing*. A woman is saying 'This menstrual cycle is positive to me because it is an integral part of who I am' and at the same time she is saying 'This menstrual cycle is negative to me because of ideas in society.' This two-fold understanding can be examined by looking at the point of intersection. What happens when you apply medical technology like antidepressants or a medicine that is mood altering? It is directed at this point of *intersection*. What changes in boundaries of the body take place? (Nettleton & Watson, 1998)

Although other strategies to minimize suffering related to the menstrual cycle were discussed, treatment was talked about in a way influenced by biomedical discourse and distinguished from coping as such. The two different groups of medical technology, hormonal treatment and mood altering substances, can serve as physical symbols of the experiences that can be summarized from these women's interviews. The one treatment that would inhibit fertility is unacceptable. It isn't even considered an option because this is not what women see as the problem. The antidepressant solution is seen as acceptable and is the one some women brought up spontaneously even though they had no personal experience with it. SSRI treatments address the point of intersection, the point where emotions are transformed into behavior. A woman is highly motivated by her position in society to want to be in control of her individual point of intersection. Where some may explain this practice of using antidepressants as a type of self-enhancement (Elliot, 2003), I see it as a way women use it more as an avoidance strategy to soften the impact of sexual oppression.

When having a choice not to menstruate, interest is very low. The suffering connected to a sign of health is positive but was only overtly expressed in that way when women individually referred to events like bleeding or ovulating. After connecting ideas in lengthy discussions, the strongest

determiner of what was normal and in turn most valuable was having a menstrual cycle that could result in giving birth. The second most important use of the notion of normal was controlling one's behavior towards others. A dilemma was found in the suffering connected to a healthy function. All of the women felt that problems with menstruation, especially PMS, are not taken seriously. Women want to distance themselves from menstruation for this reason.

## **8.4 Re-evaluating authenticity- the importance of feeling like one's self**

A process where women re-evaluate the meaning of the changes they go through occurs when women think about what antidepressants do when they take them for PMS. Even changes for the worse in emotion are indirectly related to the positive category of a woman's fertility. Being able to feel authentic emotion is valued differently when a woman has been able to change it with antidepressants. A choice has to be made if it is more important to feel or be authentic or if it is more important to be in control of how she wants to portray herself. This self portrayal is directly connected to relationships with others. A woman thinks about 'one's selfness' differently after having had the experience of being cut off from one's true emotional state. This was talked about as something that could make you feel uneasy, lose contact with one's surroundings or see one's self not reacting in a usual way. In general women expressed not wanting to be cut off from emotion where feelings could be dampened or blocked even if they took antidepressants to control their reactions during the premenstruum. Nevertheless, in order to not sink into a temporary depressive state, have experiences compared to being mentally ill or have suicidal thoughts were seen as motivating factors to use antidepressants for PMS. Women wished to uphold the ideas they had about themselves and in the end it was how she was able to interact with others in balance with who she was as a woman that would determine what strategies she would use to do this.

How does the loss of perspective due to this affected state described as PMS influence what a woman includes in a part of who she is? Changes in the way memory functions when in an altered state contribute to the inability to unite these experiences into 'one's selfness'. Bodily signs that are detected communicate to an individual that one is in a certain phase. This can help. Some women do not have physical signs or reminders that are felt in the body. For most of the women I spoke with reactions from others to their behavior was the first indication that they were not 'like themselves'. When a woman experiences a depressed state the effect of mood change obstructs the ability to recognize what is happening. The mood itself as an indicator is not easily recognizable. Going through menstrual phases is not isolated from every day events. Some of the women said that when the negative mood changes into a positive mood it could be recognized as a part of the menstrual cycle.

The feeling of 'how can I forget this every time' is the clue to why making these experiences a part of who they are, is problematic. It appears difficult to include what happens to women in severe situations, suicidal thought being the best example, into authentic experiences. They can't be recognized. They are unpleasant, frightening or symbolically related to mental illness. They are preferably forgotten and women avoid dwelling on them. These adverse experiences are then isolated in time and can explain why women feel they can't keep track of when and why it happens to them.

Recognizing a pattern of behavior which results in negative experience or demeaning treatment by others is difficult. Who wants to keep reminding one's self of shortcomings, mistakes, bad feelings, guilt, and inadequacy, inferiority, being associated with being irritated, angry, depressed or listless as these women have reported? The inability to remember that 'this has happened to me before', can also be seen as a strategy to limit the impact of these negative experiences. As mentioned above the precluding thought of soon to be going through PMS is a type of suffering in itself. Another way of limiting negative experiences is also achieved by expressing 'I don't feel like myself'. The phenomenon, of cyclically being altered for the worse, is then removed from the self. It is outside of whom one is. Being influenced by 'nature' at the cost of status in society is distanced from an individual by expressing that those experiences are not normal for me.

## **8.5 Closing statement**

Time and resources allocated to a master thesis are the main factors limiting the scope of the study. I made choices to interview a group of women individual only once rather than interview fewer women on numerous occasions. One of the major limitations of this study is due to the fact that only one interview was conducted. In the beginning stages of planning this thesis I had considered interviewing women at different times during their menstrual cycle. A comparison of interview material elicited during the time a woman felt the worst and when she felt most like herself was the intention. Another time-consuming and costly effort would have been to include women from two different cultures that would have included experiences focused on attitudes, availability and use of antidepressants.

Other factors that limit this study are the way the participants were recruited. Either women would interested in participating or acquaintances referred me to women they knew who would be interested. The group of women is homogenous in many ways. They had a similar socioeconomic background, all of the women were heterosexual and involved either in an intimate relationship or had dependent children at home. Age, educational background and ethnicity were similar as well. There are many areas that could improve this study by including variation, types of illness related to low vs. high income (fibromyalgia vs. depression), age, where younger women may not have detected a pattern to

their changing ways of being in the world either due to limited time they have experienced menstruation, use of birth control or interpersonal relations that allow for more flexibility, being able to chose to be alone when not feeling well. It is clear to me that I am compiling findings that are based on this group of women and that these findings would look different if other groups of women were chosen using specific criteria.

The interview material that I accumulated however does say something about women's experiences of menstrual suffering. These women were able to elaborate on bodily experiences. They are unique, insightful women trained in thinking about the body, reflecting on the body and have spoken with others, in small groups, about bodies. It could mean they are able to put into words that which is more difficult to express for others. It could also mean that events in the body are interpreted differently depending on what is significant for that group. The idea of multivalence (Buckley & Gottlieb, 1988) explains variation in socially held ideas in groups and between groups. Answering the question of, if what is important in society determines the impact of suffering, can only be found in comparing the understandings of meaning held by women who differ in views, ambitions, in what they feel gives status or what portrayals of the self they wish to uphold. I would very much like to see more studies using a phenomenological perspective together with a psycholinguistic approach to examine the workings of language of different groups on bodily experiences and understanding.

New questions have arisen from sharing in these women's stories. My questions for this thesis began with how women express their experiences of menstruation and how they are understood. Continuing with exploring how women were able to make contrasting experiences a part of who they are, I found that the answers women gave were imbedded in how they saw themselves as individuals in relationships and as women making up the members of groups in society. I was confronted continuously with the question of why society holds values that contribute to intolerance of exhibiting bodily events, verbally and physically. The transformation of suffering is impacted by societal values and I feel we are obligated to find out more about how this works. There are many hypotheses as to why study objects focusing on the female experience are not undertaken but it is difficult to avoid being political when finding a remedy for the solution. Rather it is quite necessary to take measures to avoid a systematically constructed inequality that leads to lacking results in research. Using a phenomenological perspective in this study has lead to insight built on individuals' experiences and views of reality. The challenge is to find ways for the scholarship in humanistic and social science research to combine a phenomenological perspective with social analysis to answer questions with the experience of the body in focus.

# References

- Bryman, A. (2004). *Social Research Methods*. New York: Oxford University Press.
- Buckley, T & Alma Gottlieb (1988). *Blood Magic, The Anthropology of Menstruation*. Berkeley: University of California Press.
- Caplan, P. (1995). *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*. Reading, MA: Addison-Wesley.
- Caplan, P. (2001). *Premenstrual Mental Illness: The Truth about Sarafem*. Network News 26, May/June.
- Csordas, T. (2002). *Body, Meaning, Healing*. New York: Palgrave Macmillan.
- Davis, D.L. (1997). Blood and Nerves Revisited: Menopause and the Privatization of the Body in a Newfoundland Post-industrial Fishery. *Medical Anthropology Quarterly*, 11 (1): 3-20.
- deBessa, G.H. (2006). Medicalization, Reproductive Agency, and the Desire for Surgical Sterilization among Low-income Women in Urban Brazil. *Medical Anthropology*, 25:221-263.
- Delaney, C. (1988). "Mortal Flow: Menstruation in Turkish Village Society". (pp. 75-93). In T. Buckley & A. Gottlieb (ed.) *Blood Magic. The Anthropology of Menstruation*. Berkeley: University of California Press.
- Douglas, M (1966). *Purity and Danger*. London: Routledge.
- Elliot, C. (2003). *Better than Well; American Medicine Meets the American Dream*. New York: W.W. Norton & Company.
- Foucault, M. (1984a). "Truth and Power", in P. Rainbow (ed.) *The Foucault Reader*. New York: Pantheon.
- Giele, J.Z. & Elder Jr, G.H. (1998) *Methods of Life Course Research: Qualitative and Quantitative Approaches*. London: Sage.

- Helman, C. (2007) *Culture, Health and Illness*. New York: Oxford University Press.
- hooks, b. (1998). Naked without Shame: Counter-Hegemonic Body Politic. (pp. 65-74). In Ella Shoat (ed.) *Talking Visions*. New York: MIT Press.
- hooks, b. (2000). *Feminsit Theory; From Margin to Center*. London. Pluto Press.
- Howson, A. (1998). "Embodied obligation. The Female Body and Health Surveillance". In Sara Nettleton & Jonathan Watson (ed.) *The Body in Everyday Life*. London: Routledge.
- Jeppsson Grassman, E. & Hydén, L (2005) *Kropp, livslopp och åldrande. Några samhällsvetenskapliga perspektiv*. Lund: Studentlitteratur.
- Johannisson, K. (2001) *Kroppens tunna skal: sex essäer om kropp, historia och kultur*. Stockholm. Nordstedt.
- Kaw, E. (1993). "Medicalization of Racial Features: Asian American Women and Cosmetic Surgery." *Medical Anthropology Quarterly*, vol.7(1):74-89.
- Kissling, E. (2006). *Capitalizing on the Curse; the Business of Menstruation*. Boulder: Lynne Reiner Publishers.
- Krag Jacobsen, J. 1993. *Intervju. Konsten att lyssna och fråga*. Lund: Studentlitteratur.
- Laws, S. (1990). *Issues of Blood*. London: The Macmillan Press LTD.
- Leder, D. (1990). *The Absent Body*. Chicago: The University of Chicago Press.
- Lupton, D. (1997). "Foucault and the Medicalisation Critique". (pp. 94-110). In A. Petersen & R. Bunton. *Foucault, Health and Medicine*. New York: Routledge.
- Lock, M. (1993). *Encounters with Aging; Mythologies of Menopause in Japan and North America*. Berkley: University of California Press.
- Malmberg, D. (1991). *Skammens Röda Blomma? Menstruationen och den menstruerande kvinnan i svensk tradition*. Uppsala: Master Tryck.

Martin, E. (1992). *The Women in the Body: A Cultural Analysis of Reproduction*. Boston, MA: Beacon Press.

Martin, E. (1998). Premenstrual Syndrome, Work Discipline, and Anger (pp. 221-241). In Rose Weitz (ed). *The Politics of Women's Bodies. Sexuality, Appearance and Behavior*. Oxford: Oxford University Press.

McLaughlin, J. (2003). *Feminist Social and Political Theory; Contemporary Debates and Dialogues*. New York: Palgrave Macmillan.

Merleau-Ponty, M. (1945). *Phenomenology of perception*. London and New York. Routledge.

Nettleton, S. & Watson, J. (1998). *The Body in Everyday Life*. London: Routledge.

Olin Lauritzen, S. & Hydén L. (2007). *Medical Technologies and the Life World. The social construction of normality*. London: Routledge.

Olin Laruitzen, S. (2005). "The Contradictory Body of the Middle-aged Woman" (Translated from: "Den medelålders kvinnans motsägelsefulla kropp") (pp.125-142). In E. Jeppsson Grassman & L. Hydén *Kropp, livslopp och åldrande. Några samhällsvetenskapliga perspektiv*. Lund: Studentlitteratur.

Petersen, A. & Bunton, R. (2006) *Foucault, Health and Medicine*. London: Routledge.

Scheper-Hughes, N. & Locke, M. (1987). *The Mindful Body*. Medical Anthropology Quarterly. New Series. Volume 1, No. 1 (March 1987):6-41.

Skultans, Vieda. (1988). "Menstrual Symbolism in South Wales." (pp. 137-160) In T. Buckley & A. Gottlieb (ed.) *Blood Magic. The Anthropology of Menstruation*. Berkeley: University of California Press.

Seymour, S. (2006). Resistance. *Anthropological Theory* 2006 (6): 303-321.

Spradley, J.P. (1979). *The Ethnographic Interview*. Belmont: Wadsworth Group/Thomson Learning.

Svenaesus, F. (2007) "Phenomenology listens to Prozac; Analyzing the SSRI revolution". (pp. 164-183). In S. Olin Lauritzen & L. Hydén (ed.) *Medical Technologies and the Life World: The Social Construction of Normality*. London: Routledge.

Whyte, S., Van der Geest, S. & Hardon, A. (2006) *Social Lives of Medicines*. Cambridge: Cambridge University Press.

Whyte, S., Van der Geest, S. & Hardon, A. (2002). "Women in Distress: Medicines for Control." (pp. 50-62). In S. Whyte, S. Van der Geest & A, Hardon. *Social Lives of Medicines*. Cambridge: Cambridge University Press.

Young, Iris. "Pregnant Embodiment: Subjectivity and Alienation." *The Journal of Medicine and Philosophy* 9 (1984): 45-92.

Zane, K. (1998). Reflections on a Yellow Eye: Asian I (\Eye/)Cons and Cosmetic Surgery (pp. 161-192). In Ella Shoat (ed.) *Talking Visions*. New York: MIT Press.

Zeiler, K. (2010). "A Phenomenological Analysis of Bodily Self-awareness in the Experience of Pain and Pleasure: on Dys-appearance and Eu-appearance." *Med Health Care and Philos.* (On-line publication)

Internet sources:

Festin, K. & Hovellius, B. (2007). *Premenstruellt dysforiskt syndrom- dold sjukdom eller säljande idé? Klinik och vetenskap*. [Internet] <http://www.lakartidningen.se/engine.php?articleId=7334>. [Accessed 28 April 2008]

Foucault, M. (1969) *The Archaeology of Knowledge*. [Internet] <http://www.marxists.org/reference/subject/philosophy/works/fr/foucault.htm> [Accessed on 4 December 2008]

Greenslit, N. (2003). Vital politics. Program in Science, Technology and Society. MIT. [Internet] <http://www.lse.ac.uk/collections/BIOS/pdf/NateGreenslit.pdf>. [Accessed 3 December 2008]

Psychopharmaceuticals [Internet] <http://www.online-medical-dictionary.org/Psychopharmaceuticals.asp?q=Psychopharmaceuticals> [Accessed on 4 December 2008]

Wyatt, Dimmock, & O'Brien. (2002). "Selective Serotonin Reuptake Inhibitors for Premenstrual Syndrome." *Cochrane Database Syst Rev*. 2009;(2):CD001396. [Internet] <http://www.ncbi.nlm.nih.gov/pubmed/12519554> [Accessed on 10 May 2010].