UNDERSTANDING AS COPING:
A GROUNDED THEORY OF WOMEN'S EXPERIENCES OF PREMENSTRUAL CHANGES

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Abstract

Previous psychological research into premenstrual changes has tended to operate from a biomedical perspective and employ a positivist (or scientific) approach. The present study utilises a qualitative approach, the grounded theory method, as a means of collecting and analysing data. Ten women were interviewed using a semi-structured interview guide approach. These women were asked questions centred around four areas; (1) What sorts of premenstrual changes do you experience?, (2) In what ways do you think your life is influenced by these changes?, (3) How do you cope with and manage these changes?, and (4) What changes would you like to see that would help you and/or other women cope with these changes? The interviews were transcribed verbatim and analysed using grounded theory techniques. A grounded theory of the women's premenstrual experiences - experiential learning and perceived control - is presented and the implications of this theory for future research and as a therapeutic tool are outlined.

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Preface

The idea that women experience various physical, emotional and behaviour changes during their menstrual cycle has evolved over time. This evolution has been reflected by the upsurge in interest in the possible changes women experience just before menstruation. Terms used to describe these changes - premenstrual tension (PMT) (Frank, 1931), premenstrual syndrome (PMS) (Dalton, 1977) and, more recently, Late Luteal Phase Dysphoric Disorder (LLPDD) (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, third edition revised, 1987) - reflect this interest and also point to the dominance of the biomedical model as a way of conceptualising and studying these changes. Only since the 1970's have other perspectives (such as sociological and feminist research) emerged to challenge this view. Ways in which menstrual related changes have been conceptualised and studied are gender specific and applicable to all women. It is therefore important that these ways are examined and understood as they have far reaching implications.

In the present study women's experiences of changes just before menstruation (premenstrual changes) are explored using a qualitative approach to data collection and analysis. Specifically, ten women were interviewed about their premenstrual experiences. These interviews were transcribed and analyzed using the grounded theory approach.

Ways in which premenstrual changes have been conceptualised and studied are presented in Chapter One. This chapter highlights the dominance of the biomedical perspective and the use of quantitative methods, and outlines various criticisms of this view. Ecological and social psychological perspectives are presented as more recent ways of conceptualising premenstrual changes.

The implications various trends in the literature have had on the present study are discussed in Chapter Two and Three. Chapter Two offers a rationale for studying premenstrual changes qualitatively. In Chapter Three the reasons for using the grounded theory approach to collect and analyze data are presented. The various data analysis

procedures associated with this approach and used in the present study, are outlined. The method of data collection is discussed in Chapter Four.

The findings of the study are presented in Chapters Five and Six. Chapter Five offers an outline of the various premenstrual changes the women talked about. A grounded theory of the women's premenstrual experiences is discussed in Chapter Six.

Finally, in Chapter Seven, conclusions about the present study are made and implications for this research suggested.

CHAPTER ONE

Ways of Conceptualising Premenstrual Changes

Popular Literature

During 1980-81, two women had their murder charges reduced to manslaughter after using PMS as a defense. Since this time there has been an upsurge in media interest on PMS and PMT. Three content analyses (Chrisler & Levy, 1990; Parlee, 1987; Rittenhouse, 1991) have examined the way the media have portrayed PMT/PMS.

Chrisler and Levy (1990) conducted an analysis of 78 PMS articles in popular magazines which appeared between 1980 and 1987. Their findings indicate that the articles were confusing and negative in tone. The types of symptoms reported were also vague (such as "getting weird"), confusing and contradictory (for example, "poor concentration" and "good concentration"). The focus of the articles tended to be on the biological etiology and treatment of PMS, an 'illness' it was assumed most women suffered from. Finally, there appeared little distinction between 'normal' premenstrual changes and more severe changes that could be considered a 'syndrome'. In conclusion, Chrisler and Levy recommended a more balanced tone and point of view from those writing articles in the popular press.

In a content analysis of published discourse on PMS between 1931 and 1987, Rittenhouse (1991) reviewed 48 articles from popular magazines. She discovered that the definition and treatment of PMS in these articles was usually discussed within a medical paradigm. Furthermore, the articles tended to reflect the ambiguities and contradictions characterised by medical literature in the area. In the articles published before 1980, premenstrual women were problematised and portrayed negatively (for example, being called "Once-a-month witches"). It was also taken for granted that most women 'suffered' from PMS. In contrast to Chrisler and Levy (1990), Rittenhouse stated that after the early 1980's the popular press began to avoid exclusively negative

portrayals, and premenstrual changes themselves, not women, were problematised.

Parlee (1987) conducted an in depth, sociological analysis by tracking media coverage of PMS and menstruation from 1977 to 1987. She stated that the focus of the coverage tended to be on negative symptoms and moods, undesirable and 'antisocial' behaviour and the identification of biological causes and treatments. Limited space, time pressures, news orientation, news worthiness and the editing process, combined with the complex inter-relationship between journalism, science and the wider social system was said to have contributed to this portrayal.

From these studies it is clear there exists a consistent image of what PMS/PMT is, and what the premenstrual woman is like, in the popular literature. Coverage of PMS/PMT has tended to be negative in tone, vague and contradictory. Furthermore, such literature has been characterised by adherence to the biomedical paradigm. The pervasive use of the biomedical model to conceptualise premenstrual changes in the medical, psychological and popular literature has had various implications for research, and for women in general. These implications are discussed in the following section.

The Biomedical Model

In general the biomedical approach involves isolating biological phenomena and connecting them to somatic, psychological and behaviourial 'symptoms' (and vice versa). Disease is viewed as any deviation from 'normal' functioning (Bell, 1987; Halbriech & Endicott, 1985; Scambler & Scambler, 1993). Those adopting a biomedical approach tend to view menstruation as a biological event under the control of the central nervous system. Female ovarian hormones, oestrogen and progesterone, have been implicated in physical and psychological changes associated with the menstrual cycle. This 28 day cycle has been separated into the follicular phase (from menses through to ovulation) and the luteal phase (from ovulation through to the following menses). For a more in depth review on the biology of menstruation see Asso, (1983) and Halbriech and Endicott (1985).

The late luteal phase has also been identified as the premenstrual phase. After Frank coined the term Premenstrual Tension (PMT) in the early 1930's, the physical, psychological and behaviourial changes many women were noted to experience during the late luteal phase were attributed to alterations in hormonal levels, particularly the ovarian hormones. Subsequently, a variety of biological hypotheses have been put forward to explain premenstrual changes: an excess of oestrogen; progesterone deficiency; altered oestrogen and progesterone ratio; prolactin excess; changed insulin metabolism leading to reactive hyperglycaemia; fluid and electrolyte imbalances; vitamin deficiencies (such as vitamin B6); neurotransmitter regulation and the mediating roles played by dopamine, serotonin and norepinephrine; endogenous opiates; prostoglandin excess; melatonin excess and caffeine excess. For more detailed summaries on biological hypotheses see Gallant and Hamilton (1988), McFarlane and Williams (1990) and Rubinow and Roy-Byrne (1984). Such alterations in hormonal and biochemical levels have been linked to various premenstrual changes in physiological functioning, mood and behaviour (Gitlin & Pasnau, 1989; McFarlane & Williams, 1990).

There has been much debate in the medical and psychological literature as to whether PMS/PMT is a gynaecological disorder or a psychological disorder. Many of those arguing from a psychological perspective (for example, Endicott, Nee, Cohen & Halbriech, 1986; McMillan & Pihl, 1987; Rubinow, Roy-Byrne, Hoban, Grover, Stambler & Post, 1986) emphasise the premenstrual occurrence or exacerbation of affective symptoms. Although not all studies are consistent, research in this area has indicated a higher rate of moderate to severe PMS in women with affective illness as well as higher rates of affective illness in women with PMS (Gitlin & Pasnau, 1989). The inclusion in the appendix of the DSM III-R (1987) of the diagnosis Late Luteal Phase Dysphoric Disorder (LLPDD) is a more recent attempt to systematise procedures for documenting disturbances in mood. It's inclusion heralded a new era in the study of the link between biological factors and psychological 'disorders'. See Gallant and Hamilton (1988), Kutchins and Kirk (1989) and Blumenthal and Nadelson (1988) for more detailed discussions on the implications of the inclusion of LLPDD in the DSM III-R.

In some respects, the labelling of premenstrual changes as PMS or PMT has had positive implications for women. Medical research and interest has resulted in the recognition and legitimization of premenstrual experiences which were previously discounted or ignored by the medical profession (Asso, 1983; Reissman, 1983). In some instances, changes associated with the menstrual cycle were erroneously linked to physical and psychological disorders such as major depression and hysteria. As such, the development of the biomedical model and it's popularization via the media has meant that the cyclic nature of women's lives has been acknowledged. Dalton (1977), a major proponent of the biomedical approach, insists that relief and treatment of symptoms is available through progesterone therapy. Other treatment approaches such as nutritional and exercise programmes and hormonal and biochemical therapies are made possible with continued scientific research. See Halbriech and Endicott (1985) for a more detailed discussion on the biomedical treatment of PMS.

However, there have been a number of criticisms levelled at the biomedical perspective, it's foundations in science and it's approach to research in the area. Specifically, these challenges have come from those adhering to psychological, sociological and feminist perspectives.

Conceptual And Methodological Critiques of Biomedical Research

Biomedical orientated research in this area has tended to involve a hypothetical-deductive approach. This research has been criticised on conceptual and methodological grounds.

Researchers critical of many of these studies (for example, Gitlin & Pasnau, 1989; Koeske, 1983; Rubinow & Roy-Byrne, 1984) have argued that there has been no accepted and satisfactory definition of PMS/PMT and that these terms are vague and have many referents.

They mention similar problems with the definition, identification and measurement of

premenstrual 'symptoms'. Gitlin and Pasnau (1989) argue that up to 150 symptoms have been identified but that there is little consensus on how best to rate or quantify them. It is suggested that in many studies the issues of symptom severity and change in symptoms across the menstrual cycle are not addressed, not measured or the measurement scales that are used are insensitive (Koeske, 1983; Parlee, 1974; Rubinow & Roy-Byrne, 1984). Parlee (1974) has criticised some instruments (for example, the Moos Menstrual Distress Questionnaire) on the basis that women respond to items according to stereotypes and expectations about menstruation rather than simply their own menstrual changes.

There has also been criticism of the small sample sizes and atypical populations being studied (such as clinical populations and oral contraceptive users). Some researchers (Gallant & Hamilton, 1988; Rubinow & Roy-Byrne, 1984) argue that claims about the generalizability and validity of findings based on these studies may therefore be unfounded or premature.

Many biomedical researchers have favoured the use of retrospective accounts in gathering information about premenstrual symptoms. A number of studies (for example, Gallant & Hamilton 1988; McFarland, Ross & DeCourville, 1989), have shown biases of recall on menstrual symptoms whereby women report more negative changes retrospectively than they do prospectively. Even prospective, longitudinal studies have shown flaws, such as the subjects attributing their symptoms to stress and social expectations. As such, societal and personal beliefs and expectations act as confounding variables in many of these studies.

Feminist and Sociological Critiques of the Biomedical Model

Koeske (1983), in a detailed critique of the biomedical model states that it is characterised by a set of "unexamined assumptions about women, the cycle and the conduct of research" (p. 1). Those operating from a feminist ideology challenge the view that science is value free and attempt to find connections between biomedical

'facts' and the social, economic and political position women hold in western society (Koeske, 1983; Laws, 1983; Reissman, 1983).

Many feminist and sociological researchers (for example, Bell, 1987; Golub, 1985; Koeske, 1983; Laws, 1983; Laws, Hay & Eagan, 1985; Reissman, 1983; Scambler & Scambler, 1993) have identified a number of assumptions underlying the biomedical model and it's scientific approach to the study of menstruation and premenstrual changes. Central to these criticisms is the concept of medicalisation.

Medicalisation is the process by which physical, psychological and behaviourial changes are given medical meaning (Bell, 1987; Reissman, 1983). Feminist researchers have claimed that terms used to describe premenstrual changes, such as 'syndrome', 'disorder' and 'symptomatology' imply a pathological condition that render women in need of medical attention. This has been intensified by a stereotypical negative bias in the medical and psychological literature regarding symptom identification, to the virtual exclusion of possible positive changes such as increased activity and heightened sexuality (Logue & Moos, 1988). It has been argued that, rather than conceptualising premenstrual changes as a normal part of the menstrual cycle, they have been 'abnormalised'. Reissman (1983) argues that by defining the premenstrual woman as 'ill' or 'abnormal', medical professionals and institutions are able to increase their control over women's lives by being the primary vehicle for treatment. Feminist researchers in particular emphasise that there are far reaching negative implications of labelling PMS/PMT for women.

It is thought that this process reinforces traditional stereotypes about the influence of biology on women's lives - that much of the way women (as opposed to men) behave is biologically determined and that women are passive recipients of cyclical hormonal changes. Bell (1987) states that this leaves women's position in society open for question: Can women handle stressful situations at a particular time of the month? Can they make responsible decisions and judgements? Are they likely to act violently, and if so, are their children safe? Thus the capabilities of <u>all</u> women are questioned.

Related to the above argument, the process of medicalisation is said to reflect, maintain and perpetuate the structure of a sexist society. Laws (1983) argues that 'illness' is socially defined and therefore political. She states that medical knowledge and science reflect the social norms of the dominant culture (the patriarchal structure) and that scientific and medical 'neutrality' and 'objectivity' are myths. It may be argued that medicine and science are used as tools of oppression and control. The changes many women experience before their periods is taken as evidence of their inherent weakness, inferiority and 'abnormality' and is used to justify discrimination in the home, the work force and the legal system. Furthermore, both Laws (1983) and Scambler and Scambler (1993) argue that medicalisation is used to divide and separate women into 'good' and 'bad', and the 'good' and 'bad' within themselves. This, many feminist researchers claim, renders women impotent and thus less likely to challenge the patriarchal structure and authority.

It is argued that the process of medicalisation and the definition of premenstrual changes as biologically determined, removes women from their sociocultural context. The biomedical model has been further criticised for being ahistoric, unduly reductionistic and simplistic (for example, Koeske, 1983; Scambler & Scambler, 1993). Typically, studies adhering to the biomedical model have been criticised for neglecting sociocultural issues in women's premenstrual experiences and for focusing solely on context free biological variables. It is argued that, by not addressing context and the interaction of variables at all levels, the model fails to recognise the complexity of women's experiences. As a result, there exists the assumption that these 'problems' are individual and private and should be solved individually (such as through hormonal therapies). Change to the individual is therefore favoured over change to the environment. Some feminist researchers (for example, Koeske, 1983; Laws, 1983) have claimed that this is another example of how medical institutions and professionals gain greater control over women's lives.

Finally, it is argued that the process of medicalisation encourages women to deny responsibility for changes in their mood and behaviour before their periods (Laws, 1983; Scambler & Scambler, 1993). Adherence to the biomedical model also makes it easier

for others to invalidate and ignore women's experiences at this time, to discount and trivialise their anger and discontent as 'that time of the month'. Other social and environmental reasons regarding why women are unhappy are therefore less likely to be explored.

Ecological Research: Beyond Reaction

From the mid to late 1980's, researchers operating from an ecological perspective (in particular, sociological, feminist and anthropological researchers) became less reactive to medical and popular literature and developed research of their own. As Koeske (1983) states,

> *"Acknowledgement of the biological influence in women's lives is not, per se, inconsistent with feminism. It is biomedicine's tacit assumptions about the meaning and elemental nature of biological factors which must be challenged."* (p. 2)

Other researchers echoed these concerns and emphasised that it was not their contention that there existed an organised male medical conspiracy against women (for example, Delaney, Lupton & Toth, 1988; Scambler & Scambler, 1993). Research in this area began to move in two directions.

Firstly, there were attempts to 'recontextualise' premenstrual changes and the concept of PMS. It was argued that PMS was an issue primarily because of the change in the status and roles of women in the 1980's. Johnson (1987) viewed PMS as a western culture specific disorder, best understood as a sociocultural phenomenon despite biological determinants and consequences. He claimed that PMS, as a medical entity, reflected social realities associated with the special status of women in our culture. As evidence, he documented the emergence of PMS (in it's popularized form) soon after major changes in women's roles in the 1960's and 1970's. King (1989) also recognised a cultural basis to PMS. He compared PMS to the nineteenth century disorder

Neurasthenia, a nervous 'disease' typically diagnosed in women. Cultural values and views of the time were considered to be the major contributors to the establishment of both these medical 'disorders'. Similarly, Martin (1987) saw PMS as intimately linked to culture specific values. For her, PMS was "ultimately related to different constructions of time and the human capacities of men and women" (cited in Rittenhouse, 1991, p. 418).

Secondly, and more recently, Scambler and Scambler (1993) discussed the social construction of menstruation (and PMS) as a pathological process and the relationship of this construction to gender stereotypes in western society. They investigated how women's perspectives of menstruation have diverged from medical perspectives and have focused on women's experiences of menstruation and their attitudes and beliefs about this process.

However, there has been little research into women's perceptions and experiences of premenstrual changes in particular, and the research that does exist uses a hypothetical-deductive approach.

Social Psychological Literature

Whilst psychological literature addressing premenstrual changes has been predominantly biomedical in orientation, research has emerged that focuses on cognitive and social factors. This literature, rather than viewing woman as passive recipients of physiological changes, sees them as active participants in their own menstrual and premenstrual experiences. Specifically, research in this area has focused on the way in which sociocultural stereotypes and beliefs about menstruation, and the socialization process, have influenced women's experiences. This literature is briefly reviewed and the emergence of a new perspective of the menstrual cycle, the biopsychosocial model, is discussed.

Continued biomedical research has revealed that physiological factors alone are

insufficient in explaining variation in menstrual and premenstrual experiences. Furthermore, it has been a consistent finding that, despite women continually reporting cyclic changes in mood, negative affect is not associated with menstrual cycle phase (for example, Brooks, Ruble & Clarke, 1977; McFarland, Ross & DeCourville, 1989). This has led many researchers to look towards intervening factors and variables to explain women's menstrual cycle experiences.

A number of researchers (Aubuchon & Calhoun, 1985; Chrisler, 1988; Olasov & Jackson, 1987) found that women who were informed that the study in question was on the menstrual cycle reported significantly more negative menstrual and premenstrual symptoms than women who were not informed. Importantly, it was discovered that women with negative expectations about the impact of the menstrual cycle experienced more menstrual and premenstrual distress (Aubuchon & Calhoun, 1985).

What led women to have such negative expectations about the impact of the menstrual cycle? Brooks-Gunn and Ruble (1982) and Brooks, Ruble and Clark (1977) state that there are clear societal beliefs regarding menstruation - that women are expected to experience more severe symptoms in their premenstrual phase and that the most severe symptoms will be negative affect, water retention and pain.

The effect this negative sociocultural stereotype has on women's attitudes, beliefs and expectations about the impact of the menstrual cycle, has been explored by a number of researchers. Social learning and the socialization process have been seen as important links, whereby negative information is imparted through the family, other social networks and the media (Brooks-Gunn & Ruble, 1986; Chrisler, 1988; Koeske & Koeske, 1975).

It has been found that symptoms reported retrospectively are consistent with this stereotype and that retrospective reporting actually increases the likelihood of negative self reports of menstrual cycle symptoms. In an innovative study, McFarland, Ross and DeCourville (1989) examined the relationship between the theory's women hold about menstruation, and memory biases. Specifically, they discovered that the more women

believed in menstrual distress (the stereotypical conception) the more exaggerated, in recall, was the negativity of their symptoms. In short, their recollections were biased to coincide with this theory.

The role of sociocultural beliefs and expectations has also been evident in studies looking at gender role identity and menstrual and premenstrual distress. Aubuchon and Calhoun (1985) found that women with more traditional attitudes towards the female role experienced more premenstrual distress and menstrual discomfort. Chrisler (1988) went further by linking femininity with menstrual and premenstrual distress. She found that women adhering to 'feminine' and 'androgynous' sex roles complained more about symptoms and found menstruation more bothersome than those adhering to a 'masculine' sex role or no sex role.

Psychological research applying attribution theory to the study of the menstrual cycle also points to the importance of socially learned connotations. Koeske and Koeske (1975) were the first to outline a possible attribution chain or pattern connecting physical and emotional symptoms to self attributions. They discovered that biological theories were important in explaining negative, but not positive, mood during the premenstrum. These theories appeared unimportant when explaining postmenstrual moods. Brooks-Gunn and Ruble (1986) noted a tendency for subjects to attribute negative symptoms occurring premenstrually to menstrual cycle causes, while attributing positive feelings to other factors. Moreover, negative feelings at other times were attributed to external causes. More recently, Bains and Slade (1988) found that negative moods occurring premenstrually were invariably attributed to physical and health factors and positive moods were attributed to environmental events and personal lifestyle. The pervasiveness of the biomedical model and it's influence on social belief systems about the impact of the menstrual cycle on women's lives may be of key importance when explaining this attributional pattern.

Recently, psychological researchers (for example, Jarvis & McCabe, 1991; Logue & Moos, 1988) have argued for a biopsychosocial approach to the study of the menstrual cycle. They claim that sociocultural stereotypes, individual interpretations, beliefs and

expectations and biological events, all interact to produce each women's unique menstrual and premenstrual experience.

Summary of the Literature

It is evident that social and historical events have had a major impact on the way premenstrual changes have been conceptualised and studied. The large majority of studies in this area appear to have been done from a positivist perspective using quantitative research methods. Furthermore, most of these studies adhere to the biomedical view. The role of the media (particularly the popular press) in the spread and acceptance of the biomedical view, should not be underestimated.

It was not until the early 1980's that the ecological view, fuelled mainly by feminist and sociological research, emerged to challenge the biomedical view and establish itself as a major way of conceptualising menstruation and premenstrual changes. The general consensus of those operating from this perspective was that the biomedical view had many negative, far reaching implications for women.

Recently, social psychologists in particular have responded to this trend by addressing issues of context, the interaction of variables and the role of women as active participants in their own premenstrual experiences.

The implications of these trends for the present study are discussed in the following chapter.

CHAPTER TWO

Studying Premenstrual Changes Qualitatively

The following discussion will illustrate how the preceding literature review has led to using qualitative methods to study premenstrual changes. In order to 'set the scene' for this discussion, the predominant paradigm in psychology, the positivist view, and it's application to premenstrual changes, will be examined. It doing so, the researcher will be outlining her own epistemological stance.

Positivism in the Social Sciences

Psychology has been characterised by a positivist approach to research (Guba, 1990; Lincoln & Guba, 1985; Mishler, 1979, 1986; Stiles, 1990). Psychological research on premenstrual changes has reflected this trend. Mishler (1979) describes positivism as the view that the methodology developed in the natural sciences is applicable to the study of social events and processes. Many critics of this view (for example, Guba, 1990; Lincoln & Guba, 1985; Morgan & Smircich, 1980; Stiles, 1990) have identified a number underlying, interconnected assumptions relating specifically to questions of ontology, human nature, epistemology and methodology.

It has been argued that those adhering to the positivist view believe that there exists a single reality, independent of the observers interests (Guba, 1990). This reality is seen as concrete and 'knowable'. Context free, universal laws, expressed in cause-effect relationships are said to underlie all human behaviour. Human beings are viewed as the products of the external environment to which they are exposed. Their responses are similarly viewed as lawful, that is, predictable and determinate.

Related to these ontological assumptions, knowledge (as opposed to opinion) is seen to be contained only in statements linked to descriptions of direct observations

(Polkinghorne, 1984, cited in Stiles, 1990). These observations are seen as facts (or certain knowledge). Those adhering to the positivist view see subject and object as separate. The completely detached, objective observer is held in high regard. Thus, excluding the researchers biases is believed to be both possible and desirable within the positivist paradigm.

With regards to methodology, those adhering to the positivist view tend to adopt a interventionist or scientific approach to research. Good research is that in which the item under inquiry is rendered completely context free. Researchers utilize various methods to control multiple variables and strip the phenomenon under inquiry of its context. The ultimate aim is to produce a hypothetico-deductive system using the formal structure of mathematics as the methodological ideal (Mishler, 1979; Stiles, 1990).

Positivism and Premenstrual Changes

From the review of the literature on premenstrual changes, it is clear that the large majority of studies are grounded in the positivist perspective. Furthermore, although there have been criticisms regarding methodological and conceptual issues, few researchers have asked basic questions concerning whether or not premenstrual changes are best studied from a positivist view using quantitative methods. It is argued that it is not only suitable but imperative to view and study premenstrual changes qualitatively.

The issue of context is of key importance when addressing positivist assumptions. Those critical of this view (for example, Guba, 1990; Lincoln & Guba, 1985; Stiles, 1990) have argued against both the desirability and the possibility of studying context free social phenomena.

It is argued that one cannot understand human behaviour without understanding the contextual framework in which it occurs. This brings to light the crucial issue of meaning. Mishler (1979) suggests that there is a paradox regarding the importance of meaning in context. He states that there exists a common sense understanding of

meaning as context dependent - we rely on the context of our everyday lives in order to understand our own and others behaviour and speech. However, he says that positivist research methods in the social sciences have viewed context as 'contaminating' research findings, rather than being a research resource. This is revealed in the previous chapter whereby the majority of the medical and psychological studies have neglected the issue of meaning in context. More recent sociological and social psychological literature, however, has shown that context is extremely important with regards to premenstrual experiences. For example, the adherence to negative social stereotypes of menstruation has been shown to adversely effect women's premenstrual experiences (for example, McFarlane, Ross & DeCourville, 1989). Also, the biopsychosocial model highlights the importance of context and the interaction of variables at all levels (Jarvis & McCabe, 1991; Logue & Moos, 1988).

It has been suggested that it is impossible for anything to be context independent. For example, it can be argued that premenstrual changes will always be embedded in a cultural, social and historical context and that this can never be 'stripped' away. Even in an experimental situation women bring with them socially learned expectations and attitudes about the menstrual cycle. A number of studies have shown that such attitudes and expectations influence findings (for example, Bains & Slade, 1988; Chrisler, 1988; Logue & Moos, 1988).

This issue of context makes the search for general laws problematic because their essential feature is that they are context independent and thus universal. Stiles (1990) states that a feature of positivist psychology is that it has discovered very few universal laws such as those found in the natural sciences.

This brings into question whether there actually exists an external and knowable reality, whether there is a 'truth' separate from individual experience. It is argued that such a truth is illusory as it can only be assessed within some point of view (for example, Lincoln & Guba, 1985). Rather, 'reality' is relative and, as such, multiple, shifting and socially and experientially based. 'Facts' themselves are a matter of interpretation and therefore value bound. For example, many researchers studying premenstrual changes

have viewed them from a scientific and medical perspective. It has been found (mainly by those operating from a ecological view) that certain unquestioned assumptions and beliefs are associated with these perspectives. The possibility and the desirability of the totally objective and neutral observer can be seen as obsolete as interpretations always derive from an individualistic contextualised framework.

It can be further argued that research findings are the product of the inquiry process rather than observed facts (Guba, 1990). Both the inquirer and the phenomena under inquiry can be seen as interlocked in a process of mutual understanding. Feminist researchers in particular have argued that the emphasis on detachment and objectivity reflects and perpetuates hierarchical social relationships and power differences between the researcher and subjects (Acker, Barry & Esseveld, 1983; Lather, 1988). Furthermore, research methods that advocate such detachment exploit and disempower women. This is particularly pertinent to the study of premenstrual changes as they are gender specific. Rather, it is argued that if 'knowledge' is viewed as the product of an inquiry process involving mutual understanding, the research activity itself can be both educative and emancipatory for women.

Finally, sociological and social psychological research on premenstrual changes have portrayed women as active participants in their own premenstrual experiences. This is contrary to the positivist view of human beings as passive 'products' of the external environment. Research (for example, Bains and Slade, 1988) looking into attributions and attitudes for example, show women as constructors of their own premenstrual experience.

From this discussion it is evident that research into premenstrual changes needs to be; context sensitive, creative and fruitful for theory development, emancipatory and empowering, sensitive to the personal nature of premenstrual experiences, focused on meaning and internal processes, sensitive to the researchers own experiences and insight, and flexible.

Characteristics of Qualitative Inquiry

Qualitative inquiry has been described as;

> *"Any kind of research that produces findings not arrived at by means of statistical procedures or any other means of quantification."* (Strauss & Corbin, 1990, pp 17).

However, qualitative research can be seen as much more than simply not quantitative research. Given the existence of a diversity of methods of qualitative data collection and analysis, qualitative research is best seen as an approach rather than a set of techniques. A number of common themes or characteristics to this approach have been identified (Glaser & Strauss, 1967; Lincoln & Guba, 1985; Marshall & Rossman, 1989; Miles & Huberman, 1984; Morgan & Smircich, 1980; Stiles, 1990).

Qualitative research is naturalistic. The researcher enters the natural setting and 'lives' experiences and events as they unfold naturally. Qualitative inquiry therefore tends to be non-manipulative, non-controlling and non-obtrusive (Patton, 1990). This means the researcher is less likely to impose his or her world view on the participants or adversely effect them through unnecessary intrusion or manipulation. As such, qualitative inquiry is more likely to be sensitive and empowering to the research participants.

Qualitative inquiry is also inductive. Open ended research questions allow the researcher to discover important questions and relationships rather than simply test them. The descriptive and exploratory nature of qualitative inquiry means findings are more likely to be unexpected. Non-qualitative research has tended to be deductive. This may have prevented the discovery of new ideas because findings always come out as directed (i.e. the hypothesis is either supported or not supported). The need for theory development and new directions in the area of premenstrual changes may therefore be fulfilled by the use of qualitative methods.

Qualitative inquiry uses linguistic data. Data is not reduced to numbers but is

summarised verbally, often using quotations. Inquiry is done in depth and participants experiences are captured in their full verbal complexity. This aspect of qualitative research is particularly fitting to the study of premenstrual changes as, traditionally, premenstrual experiences have been reduced and simplified into numbers.

Qualitative inquiry also allows the researcher to get 'inside' and explore participants inner perspectives. In this sense, this approach deals with how people give meaning to their experiences. Traditionally, research on premenstrual changes has taken an 'outsiders' view and the issue of meaning has been neglected. However, sociological and social psychological research suggests that inner perspectives are crucial to a woman's actual experience of her premenstrual changes. Qualitative inquiry is more likely to allow the researcher access to these inner perspectives.

In contrast to non qualitative inquiry, qualitative research focuses on process rather than just outcomes or products. As outlined in the previous chapter, the process of how women make sense of their premenstrual changes has been a neglected area in the premenstrual literature. Most studies have focused on 'symptoms' - the outcomes of biological changes during the premenstrum. A qualitative approach may therefore provide a new avenue of inquiry.

Qualitative inquiry tends to be holistic. The participants experience is looked at as an interactive whole as opposed to simply parts or sections. Qualitative inquiry therefore acknowledges non linear causality and the interaction of variables at all levels. It has already been suggested in the sociological and social psychological literature that various factors interact to produce a woman's unique premenstrual experience. The biopsychosocial model (e.g. Jarvis & McCabe, 1991) is an example of this. Qualitative research methods are more likely to allow this interaction to be explored in more depth and without constraints.

Qualitative inquiry is also inherently context sensitive. Data is both interpreted and reported contextually. In the previous chapter it was recognised that context is of paramount importance to women's premenstrual experiences. Qualitative methods allow

the researcher to explore the importance of context more thoroughly.

The researcher is the key instrument in any qualitative inquiry. His or her personal experience and insight are important, both in terms of understanding the phenomena under study and in terms of being a valuable source of information. The researchers own experiences are therefore recognised as a valuable resource.

Unique to qualitative inquiry is the special relationship between the researcher and the research participant. This relationship is characterised by close contact, reciprocity and empathy. Research findings are the result of this relationship whereby understanding is only gained through empathy and negotiation. Qualitative inquiry is therefore more likely to be egalitarian, empowering and emancipatory. The researcher gives back to the participants rather than simply taking from them.

Qualitative inquiry tends to be reflexive. The researcher is continuously reflecting on his or her own values and expectations and determining how these may influence the research findings and the research relationship. In previous literature on premenstrual changes, many researchers failed to acknowledge or address their own assumptions. This resulted in the subsequent findings being biased and value laden. Qualitative inquiry in this sense, is more responsible and corrective.

Finally, qualitative research is flexible. It evolves and changes as the understanding of the phenomena under inquiry progress and change. Qualitative researchers reserve the right to modify aspects of their research as it proceeds. As such, they can more easily adjust to changing circumstances and pursue fruitful lines of inquiry with the aim of improving their understanding of the phenomena.

An outline of the Present Study

This study uses a qualitative approach. The problem statement and guiding questions of this study are centred around exploring the meanings women give to their

premenstrual changes. The interest is on how women define these changes and make sense of them. There are four guiding questions, or areas of interest,

1. What premenstrual changes does each woman experience?
2. How is each woman's life influenced or effected by these changes?
3. How does each woman cope with and manage these changes?
4. What changes would each woman like to see that would help her cope with these changes?

Ten women were interviewed using an interview guide approach based on the four questions mentioned above. The method of data collection and analysis chosen was the grounded theory approach outlined by Strauss and Corbin (1990).

Emancipatory Research

Practical steps have been taken to ensure this study is both emancipatory and educative for women. This is because only women experience premenstrual changes and, as previously outlined, traditional research methods in the area have tended to disempower women by reducing and 'abnormalising' their experiences.

Qualitative research - the grounded theory approach in particular - can be viewed as inherently empowering for women. For example, qualitative inquiry takes place in the natural setting and is more likely to be non-controlling and non-manipulative. Because theory is allowed to emerge naturally during the research process, the researcher's reality is not imposed on the participants. The in built reflexivity of the grounded theory approach also means the researcher's own biases and assumptions are less likely to adversely influence the research findings.

The ideas and principles outlined by Acker, Barry and Esseveld (1983), De Vault (1990) and Lather (1986, 1988) reflect feminist efforts to create emancipatory research designs. Lather (1988) emphasises the need for the research process to be seen as "a change

enhancing, reciprocally educative encounter." (pp 517)

Efforts were made to incorporate these principles into the methodology by enhancing reciprocity and negotiation between the researcher and the participants with the aim of dialectical theory building, and producing knowledge that could be used by the women (that is, knowledge that is 'user friendly'). In this study the researcher asked the participants questions afterwards inquiring as to their feelings about the content and the process of the interview. She also sent the transcribed interviews back to the participants so that they could read through them and add or change anything they wished.

CHAPTER THREE

The Grounded Theory Approach: Rationale and Data Analysis Procedures

A Rationale for Using the Grounded Theory Approach

In this study, data collection and analysis are interwoven using the grounded theory approach. Strauss and Corbin (1990) outline this approach as,

> *"A qualitative research method that uses a set of procedures to develop an inductively grounded theory about a phenomenon."* (pp 24)

The grounded theory approach involves both a number of assumptions about the nature of social research and a set of practical procedures for analyzing qualitative data.

The founders of this approach (Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990) see the distinction between quantitative and qualitative research methods as primarily concerned with verification versus generation. It is argued that quantitative methods are reductionistic and focus purely on the verification of theory. Given the ubiquity of quantitative methods, generation (the development of theory) is viewed as a neglected area in social research.

This crucial concern for generation is heightened by the belief that social phenomena are complex and inter-related. Strauss and Corbin (1990) express the need for conceptually dense, inductive theory based on the qualitative analysis of data. As such, the grounded theory approach attempts to provide a systematic and developed method of qualitative analysis, the primary goal of which is generative research.

A theory is 'grounded' if it is derived directly from the data rather than deduced from logical assumptions (Glaser & Strauss, 1967). Such a theory is therefore intimately

connected with and faithful to the area from which it has emerged. Rather than simply being the end product of research, theory is seen as a process. A grounded theory is always changing and developing during the life of the research.

In the grounded theory approach the researcher is profoundly involved in the research process. He or she both interacts with participants and contributes to the research findings. As such, successful research is dependant on the skills and sensitivities of the researcher (Strauss & Corbin, 1990). A key concept in the grounded theory approach, **theoretical sensitivity**, relates to the researchers ability to give meaning to the data, empathise with the participants and separate the pertinent from that which is not. Such sensitivity is said to come from the personal and professional experience of the researcher and the research process itself (Strauss & Corbin, 1990).

The grounded theory approach seems especially applicable to the study of premenstrual changes for a number of reasons.

Sociological and social psychological research in particular has shown that a variety of factors, contextual and individual, interact to produce a woman's unique premenstrual experience. The grounded theory approach is both context sensitive and concerned with inner perspectives. Because the developing theory will be inductive and conceptually dense, the complexity of premenstrual changes will be acknowledged.

The grounded theory approach has an in built reflexivity. Through being theoretically sensitive, the researcher is continuously exploring and freeing herself or himself of unrecognised assumptions and biases. This increases his or her ability to understand the phenomena under inquiry. It will also mean the researchers experiences and insight will be utilized.

Finally, the grounded theory approach places emphasis on inductive and creative theory development and is a novel way of studying premenstrual changes. Findings are therefore likely to be unexpected.

The Process of Data Analysis: The Grounded Theory Approach

Associated with the grounded theory approach are a set of explicit coding and analytic procedures. In the present study, the coding of data began during data collection and was continuous and progressive. The grounded theory approach to data analysis has been called the constant comparative method (Glaser & Struass, 1967). This is because during analysis the researcher continuously asks questions about the data and makes comparisons between what is found.

Specifically, in this study each transcript went through three ongoing and interwoven stages of analysis (or coding phases). During the **open coding** stage, the researcher broke down, conceptualised and categorised the data. This involved going through each transcript, paragraph by paragraph, line by line, in order to identify concepts and categories. **Concepts** are defined as "conceptual labels placed on discrete happenings, events, and other instances of phenomena" (Struass & Corbin, 1990, pp 61). Two such concepts in this study are "stomach cramps" and "migraine". **Categories** and subcategories are a classification of concepts. Categories are 'discovered' when the researcher compares and asks questions about the concepts that have been found. For example, the concepts mentioned above belong to the subcategory "pain related changes" which in turn belongs to the category "premenstrual changes". Categories are also defined in terms of their properties and dimensions. **Properties** are attributes or characteristics pertaining to a category. For example, a property of the category "premenstrual changes" is duration - how long the changes last. **Dimensions** refer to the location of a property along a continuum. Using the property 'duration', it's dimensions in this case would range from minutes to weeks.

During the **axial coding** stage, the researcher put the data back together in new ways by making connections and identifying relationships between the categories, subcategories, their properties and dimensions. An example of axial coding in this study would be identifying the connection between premenstrual changes and coping strategies. In this case the researcher makes note of how certain premenstrual changes (for example, 'irritability') are influenced by certain strategies the women carried out

(for example, taking time out).

Finally, during the process of **selective coding**, the researcher selected a core category and related it to the other categories, further defining and developing the emerging theory. For example, the core category 'perceived control' can be related to all the other categories and subcategories in this study. In the selective coding phase the emphasis is on the integration of the grounded theory.

It is emphasised that during analysis these three coding processes occurred simultaneously. For example, whilst the researcher was identifying concepts and the categories they belonged to (open coding), she was also exploring the relationships between these categories (axial and selective coding).

Along with the three coding procedures were two **adjunctive procedures**; memo's and diagrams.

Memo's refer to written records of the products of the analysis process. Memo's assist the researcher in keeping track of the development of the emergent theory. There are three different forms of memo's. **Code notes** refer to memo's written about the content of the three types of coding, that is, notes made about conceptual labels, categories, properties and dimensions, and indications of the relationships between these phenomena. **Theoretical notes** refer to memo's that focus on the emergent theory. For example, the researcher made written note of potentially relevant categories, relationships and processes. Finally, **operational notes** are memo's that offer directions to the researcher. For example, in this study the researcher made notes about sampling, particular questions to ask in future interviews and specific leads to follow in analysis.

There was a format for writing memo's. Each memo was dated and reference made to the document it was taken from. The memo was then given a heading which related to the concepts or categories it pertained to (for example, Interview 2. pp 7, 2/3/94 Premenstrual changes - Pain related changes). Memo's were also be made from other memo's and summarised.

Diagrams refer to drawings made throughout the analysis process and, like memo's, assist the researcher in keeping record of the emergent theory. Diagrams were made of the relationships between concepts, categories, properties and dimensions.

Both memo's and diagrams evolved as analysis progressed. In the open coding phase, memo's tended to be quite sparse and awkward as the researcher was just 'starting out'. In the axial, and (later) selective coding phases memo's and diagrams became more complex and conceptual as the researcher became more theoretically sensitive. Few diagrams were drawn in the earlier phases of analysis. However, later on diagrams became a useful way of presenting and thinking about relationships and processes.

CHAPTER FOUR

Method

The Participants

Boundaries for the selection of participants was broad, the only criterion being that the participants were women who menstruated. Ten caucasian women participated in the study. They were volunteers and were selected in one of three ways. Five of the participants responded to posters designed and distributed by the researcher. These posters were placed around Massey University. The posters indicated the nature of the study, who the researcher was (for example, her name, background and training) and what was required of the research participants (for example, the procedure with regards to interviews and the rights of the research participants). Three of the participants heard about the study through word-of-mouth and approached the researcher expressing their interest. Finally, two of the participants were known to the researcher and were asked directly if they were interested in taking part. Of the Ten participants, four were undergraduate students, two were postgraduate students, one was a part time secretary, and three worked full time in the social work and mental health area.

The two sampling procedures utilized by the researcher were quite different and their use points to the evolution of the research over time. **Representative sampling** refers to selecting a variety of participants with as wide a range of experiences as possible. In this study, the researcher attempted to achieve this by having a broad criterion for selection. The goal was to initially interview a variety of women (for example, students and working women) who experienced a wide range and intensity of premenstrual experiences (for example, those who experienced few negative premenstrual changes and those who experience many negative premenstrual changes).

However, the analytical procedure used in this study (the grounded theory approach) directed the sampling process after the first few initial interviews. Following this, the

selection of participants adhered to the concept of **theoretical sampling** outlined by Glaser and Strauss (1967) and Strauss and Corbin (1990). It was necessary, for the development of the grounded theory, that sampling become more purposeful. As the initial interviews were analyzed and fruitful lines of inquiry were identified, the researcher chose to interview women who mentioned experiencing more noticeable premenstrual changes. In this way, the researcher was able to follow-up and build on what were considered to be important lines of inquiry (the beginnings of the grounded theory) in the earlier interviews and substantiate them in later interviews.

Ethics

The researcher attempted to insure that the study was ethically sound. At the beginning of each interview the participant was given two hand outs. The first was an information sheet which the participant was asked to read (see Appendix A). This sheet contained information about the nature of the study, the researchers background, the requirements of the participant, assurances of confidentiality and an outline of the participant's rights.

These rights included the right to ask questions or refuse to answer questions, the right to change or add to the interview at anytime, the right to terminate the interview at any time and the right to withdraw from the study at any time. The second sheet was a consent form which the participants were asked to read and sign after they had read the information sheet (see Appendix B). Before the participant was interviewed, the researcher verbally went over the participants rights and emphasised confidentiality. This involved telling the participant that, in the transcript, a pseudonym would be used and any identifying information would be omitted. At the end of the interview the researcher asked the participant to choose a pseudonym.

Data Collection

The Data Collection Method

The researcher utilized a semi-structured interview guide approach to data collection. In this approach, the researcher has various topics or subject areas that he or she wants to explore. A list or guide is prepared for the interview to ensure that information about certain areas or topics is obtained from all the participants (Patton, 1990). In the present study the initial interview guide corresponded to the four broad areas of interest outlined in the previous chapter. Within each of these areas, sample open ended questions were identified (see Appendix C). However, given the nature of the analytic procedure used in this study (the grounded theory approach) this interview guide evolved as the research progressed. Similar to the concept of theoretical sampling, the questions asked of the participants became more purposeful and specific as fruitful lines of enquiry began to emerge (see Appendix D).

In each of the ten interviews, the researcher began with the open question "What sorts of premenstrual changes do you experience?". Open questions and prompts were used to encourage the participant to talk in depth about their experiences (for example, "Can you tell me more about that?"). Closed questions and probes were used to elicit more specific information within an area. At times, the interviewer self disclosed her own experiences in order to establish rapport with the participant and/or to elicit more meaningful information. The structure and format of the interview remained flexible throughout. At the end of each interview the researcher asked each participant if there was anything she wanted to add or change with regards to the interview.

Rationale for Using the Semi-Structured Interview Guide Approach

There are inherent benefits of using the interview guide as a data collection technique for this study.

The interview in general allows access to the inner perspectives of the participants. This is especially pertinent to the present study because phenomena that cannot be directly observed (ie. thoughts, feelings and interpretations) have been identified as important in women's experiences of their premenstrual changes. Social and ecological research in the area (for example, Jarvis & McCabe, 1991; Scambler & Scambler, 1993) suggest that not only are premenstrual experiences highly personal, they tend to be internal.

The interview allows the researcher to obtain large amounts of contextual data quickly (Marshall & Rossman, 1989). It also allows for the discovery of complex interconnections and relationships among phenomena. This, and the fact the interview allows flexibility in the formation of hypotheses, means that the interview is beneficial for theory development. Because the interview involves face-to-face encounters with the participants in a relaxed and non-structured setting, it is likely to invoke trust and facilitate co-operation and negotiation between the researcher and the participant.

The interview guide approach also has it's inherent benefits. It is efficient. The researcher has already decided how best to use the limited time available in the interview situation by identifying important areas of interest. This basic structure allows the researcher to keep the participants answers within certain boundaries, making interviewing across a number of people more systematic and comprehensive. Because similar information will be obtained from all the participants, trends and themes, as well as individual responses, can be easily explored.

This approach also maintains a certain flexibility. Both the researcher and the participant are not constrained by specific questions. The researcher is able to build up a rapport with the participant and word questions spontaneously. This is likely to heighten both empathy and understanding. The researcher is also free to follow emerging themes or lines of inquiry during the interview. This approach to data collection is therefore particularly suited to any study utilizing a grounded theory approach. The researcher is free to change the focus of questions as the interview proceeds. This flexibility ensures that themes and patterns linked to the emergent theory can be pursued both during the interview and in later interviews with other participants.

The Data Collection Process

Initial Contact

Initial contact with the participants was made either via the telephone or in person. The participant was given a brief verbal description of the study and the procedure involved. For example, they were told that the study was about premenstrual changes, that they would be interviewed for between a half an hour to an hour, and that this interview would be taped and transcribed. If the participant expressed continued interest in being involved in the study a suitable day, time and venue for an interview was arranged. Interview venues varied according to the participants preference and existing constraints (such as work limits and transport difficulties). The majority of the interviews were conducted in the Psychology Department at Massey University. Three interviews were carried out at the participants place of work. When contacted, the participants were also given a brief outline of the four major areas to be covered in the interview. The researcher hoped that, by allowing the participants time to think about their premenstrual experiences in this way, more thoughtful and detailed information would arise during the interview.

The Interview

Before the interview, the researcher gave the participant an information sheet to read and a consent form to sign (as outlined in the Ethics section). The researcher then spent some time making sure that the participant was fully informed about the research and was keen to take part. Time was also spent establishing rapport with the participant and making her feel relaxed and comfortable in the interview setting (such as offering them coffee). When the researcher had obtained written consent from the participant and was certain that she was fully informed about the study, the tape recorder was turned on. The interviews ranged from between 30 minutes and one hour and 15 minutes.

After the interview the researcher inquired about how the participant felt and what she

had thought of the interview process. If the participant desired, the content of the interview was discussed. A pseudonym was decided upon and the participant was told that their transcribed interview would be sent to her to be read over and corrected. Once the participant had left, the researcher jotted down general impressions of the interview and other important issues that might be lost in the transcription process.

The Transcribing Process

The interviews were transcribed verbatim. Any identifying details of the participants were omitted. The transcripts were then read over by the researcher and sent to the participants. With the transcript went a letter thanking the participant and explaining what they were required to do (see Appendix E). In the letter each participant was asked to read through the transcript and to add to or alter anything they felt necessary. They were then asked to send the transcript back to the researcher. A stamped addressed envelope was provided. Three of the participants made changes to their transcripts.

CHAPTER FIVE

Premenstrual Changes

Premenstrual changes refer to any change in the self or body noted by the women to occur premenstrually. These changes, although numerous, showed certain commonalities across the women and could be grouped into types (or subcategories). These types were physical changes, emotional changes, psychological changes, behaviour changes, interpersonal changes, appetite changes and changes in sexual interest.

These types of changes varied according to four different properties and their dimensions. The four properties were occurrence, duration, frequency and intensity. The time in the menstrual cycle the women identified their premenstrual changes as starting was referred to as their **occurrence**. The premenstrual changes occurred anytime between ovulation and the day before menstruation. How long the women noted their premenstrual changes lasting was referred to as their **duration**. The duration of these changes ranged from minutes to weeks. The women also talked about the **frequency** of their premenstrual changes. The frequency of these changes ranged from infrequent (rarely) to frequent (often). Finally, the **intensity** of the premenstrual changes referred to how severe the women said the changes were. The intensity of these changes ranged from high to low.

What follows is an outline of the types of premenstrual changes the women said they experienced. Quotes will elucidate their various properties and dimensions.

Physical Changes

When the women talked about premenstrual changes they often spoke of changes to their body and it's functioning. These were termed physical changes. All of the women said they experienced some form of physical change before menstruation. There were

various kinds of physical changes.

All of the women said they experienced **pain** premenstrually. This pain took various forms including headaches, migraines, abdominal pains, aching joints, aching muscles and tender breasts. Alice talks about the occurrence and duration of her premenstrual discomfort;

> *"Usually I get a reasonable amount of pain with ovulation. That's sort of the start of discomfort in the cycle."*

And Kate;

> *"Oh, sometimes I get pains too but that's often at the very end of my premenstrual time."*

Many of the women said they experienced changes associated with **digestion**. These changes included nausea, diarrhoea, constipation and flatulence. Alice talks about the frequency and intensity of feeling nauseous;

> *"Not every month, but some months I feel a bit nauseous."*

Many of the women said they experienced changes to their **skin condition**, such as acne, oily skin, oily hair, dry skin and blotchy skin. Mary discusses the frequency and occurrence of her premenstrual skin changes;

> *"I notice my skin changes. Usually I get more pimples around that time ... sort of before my period comes around."*

Elizabeth also talks about this;

> *"Not recently but sometimes I get acne ..."*

Almost all of the women said they noted a change in their **body weight and/or size** premenstrually. These changes included weight gain, general body swelling and swelling of the breasts and abdomen. Sarah discusses the intensity and occurrence of these changes;

> *"...and really bloated and heavy, stuff like that. So I feel pretty rotten the day before."*

Some of the women interviewed reported premenstrual **temperature** changes. These took the form of a general temperature increase and hot flushes. Elizabeth talks about the occurrence of her temperature changes;

> *"I get quite hot, my temperature rises...like the day before sort of thing."*

Margaret expresses the intensity of temperature changes before her period;

> *"I kind of get hot. I get a flush which is awful. It feels like my eyes are burning. It gets quite hot."*

Some of the women reported feeling **light headed and dizzy** premenstrually.

All of the women expressed having a general feeling of **physical tension** premenstrually. Some of this tension was located in specific parts of the body, notably the shoulders and neck muscles. Some of the women mentioned experiencing shakes and tremors along with this tension. Emma enunciates the intensity of this feeling;

> *"Tension. And it's tension that I can't release, particularly around the neck and shoulders. At other times I can release it but at that time it won't go away."*

Most of the women interviewed said they experienced changes in their **energy levels**. However, this varied. The majority said they felt less energetic at this time. Words used to describe this included lethargy, fatigue and tiredness. A few of the women said

that they had times when they felt more energetic premenstrually then at other times. Some said that their energy levels fluctuated during this time. Mary explains;

> *"It's funny because I can alternate between feeling really tired and feeling really energetic... physically tired but probably emotionally more energetic. But then it can sometimes be physically energetic too. So I can exert myself and the next day I'll be tired. I'm not clear on that one."*

Emotional Changes

All of the women said they experienced changes in their moods and feelings premenstrually. They all reported having **depressed mood** at some stage before their periods. Words used to describe this feeling included "low", "down", "sad" and "black". Alice expresses this general feeling;

> *"Mostly feeling really depressed and everything looking really black."*

All of the women also expressed feeling **irritable** premenstrually. Words used to describe this feeling included "shitty", "ratty" and "grumpy". As Kate explains;

> *"... and I get ratty especially closer to my period."*

Margaret also talks about the frequency and intensity of this feeling;

> *"I get quite tense and quite shitty ... yeah, quite shitty. And it's not every month to the same degree. Sometimes it's more. Some months it will be more than shitty. Really, really like murderous almost. And other months it won't be quite that bad."*

Another common feeling was **emotional sensitivity**. The women said they sometimes felt "easily upset" and "over emotional" premenstrually. Kate expresses this;

"Sometimes I get really, I don't know what you call it, but I cry for absolutely no reason and for what seems like such a small thing, that I wouldn't usually cry for."

Natasha talks about the occurrence of this feeling;

"... the week before my period I find that I am very easily upset and someone can say something that normally I would just query, whereas then I would actually start to cry."

Some of the women also described feeling **anxious** before their periods. Sarah expresses the intensity of this feeling;

"... you're anxious and things get out of proportion and you think "Ohhh!". You feel like it's going to go on forever."

The majority of women described feeling **'flat'** and **'listless'** just before their period.

Psychological Changes

The women talked about changes to the process and content of their thought premenstrually. These changes were intimately related to the other changes occurring at this time, particularly emotional changes. All the women reported having **negative thoughts** and **worries** during this phase. Alice talks about the content of some of her worries;

" ... or I'll start worrying about other things that normally I might keep under control but which get blown out of proportion. For example, I'll start worrying about my weight."

These thoughts and worries were often connected to feelings of sadness, anxiety and **low**

esteem. As Sarah explains;

> *"Just things like achievement. Yeah. I just feel that I'm basically ... useless. And wanting to do something about it but feeling that I can't."*

Margaret also voices feelings of low self esteem occurring at this time;

> *"I start to feel like I'm not good enough, like I'm failing, that I'm not coping with things and I give myself a hard time. I start to doubt my abilities and my judgement about things."*

The majority of women said they found it more **difficult to concentrate** at this time, especially with regards to their work. Natasha talks about this;

> *"My concentration tends to drift a bit ... I really can't sit for too long. I tend to drift off and think of other wondrous things. For a day or two my concentration and memory is not that good."*

Many of the women also said they noticed that they were more **forgetful** during this time. They also noted a **change in motivation** premenstrually, most saying that they felt less motivated premenstrually, a few saying that they felt more motivated. Finally, some of the women said that their **decision making** was 'out' at this time. Angela explains;

> *"... sometimes that you don't make the right choices ... it just seems to sort of twist it a bit. It's the decision made to approach it in that way rather than approach it in a more acceptable kind of way."*

Behaviour Changes

Behaviour changes refer to the changes in non-purposeful behaviour and activity occurring premenstrually. These changes were intimately related to the psychological and emotional changes the women talked about. Almost all of the women said they were more **clumsy** premenstrually than at other times. As Elizabeth sates;

> *"Well, I knock things over quite regularly. I just feel that I'm not all there. I feel I'm a big marshmallow. I do I drop things. I'm clumsy ..."*

Many also said they tended to act more **impulsively**. Vicki explains;

> *"I had a time when I actually gave notice while I had PMT and then I thought "Oh no!. I've done it now. I'll have to move out"."*

A few of the women said that they were more **creative** premenstrually. As Angela states;

> *"I quite often feel really creative... but don't have anything in place to provide an outlet."*

Interpersonal Changes

The women talked about changes in their relationships with others occurring at this time. The major interpersonal change noted involved **sociability**. Many of the women said that they felt **more distant** from other people and/or **lacked interest** in social contact at this time. Vicki expresses this general feeling;

> *"I feel sometimes I can't be bothered with them. If they say something that irritates me slightly I just think "I can't be bothered". Quite often I'll be more likely to sit by myself or stay in my room."*

Mary also talks about this;

> *"I feel as if I'm more distant, more cut off. But that's when I'm really in it."*

Two women said that they felt **more dependent** on the company of others at this time. Kate explains;

> *"But when I'm premenstrual I get really dependant on people ... but I just feel really bad when I'm by myself, worse than if I'm with other people."*

The majority of the women expressed that, although they felt more distant from others, they still wanted to be around them but not interact with them in any depth. This was termed **superficial interaction**. Emma enunciates this feeling;

> *"I like to know people are there but I don't want to be involved particularly."*

Associated with this, most of the women said that they were **less communicative** premenstrually. All of the women said that they felt **less tolerant** of others at this time and were generally **less patient** with them. Alice talks about these feelings;

> *"I can feel less tolerant and I get easily irritated by people. I'm not very patient although I try to keep that under control."*

Changes in Sexual Interest

Some of the women said they experienced changes in their desire or interest in sex. All of these women said they felt **less sexual interest** just before their periods. Alice and Emma discuss the occurrence and duration of this change;

> *"And then after ovulation, towards the build to my period, my sexual interest drops."*

"Well, my sexual cycle follows my menstrual cycle. Usually straight after my period I feel most sexual, up to ovulation. After ovulation, there's a steady decline, till just before my period when I just don't want to be touched. I just don't want anybody near me, especially sexually."

Appetite Changes

Appetite changes refer to changes in the desire for and consumption of food. All of the women said they had some sort of **food craving** during this phase. Most said that they craved **sweet things** (chocolate being the most common) although cravings for **salty** and **fatty foods** were also mentioned. The majority of women also said that they generally felt **hungrier** premenstrually then at other times and noticed an **increase in the desire to eat**. Alice talks about her general change in appetite premenstrually;

"I usually want to eat more. I do think I generally get hungrier and crave things like chocolate in particular."

Sarah discusses craving for different foods during her premenstrual time;

"Well, two days, three days before ... I get chocolate cravings and then that will last for about two days. Then, the day before my period, the last thing I want is chocolate, I want salt. Salty food like chips and sausage rolls. And then I get my period."

In the following chapter the focus is on process - the way in which the women thought about and managed the premenstrual changes just described. Therefore, although not discussed directly, the experience of these changes is implicitly stated as the reason for this process. These changes alter (in their intensity, duration, frequency and occurrence) as a result of this process.

CHAPTER SIX

Experiential Learning and Perceived Control: A Grounded Theory

In this chapter a grounded theory of the women's premenstrual experience of change is presented. The emphasis is on process and the development of theoretical links. The premenstrual changes outlined previously fit into this model in that they are the reason the women engaged in this process.

This model views women as active and purposeful 'investigators' into and 'shapers' of their own premenstrual experiences. A simplified process model is presented overleaf.

This model (figure 1.) postulates that the women's experiences of **negative premenstrual changes** are associated with the feeling that they lack control over their feelings and behaviour before their period. This is a negative experience for the women. As a consequence, they actively seek to establish (or re-establish) control via the understanding of their premenstrual changes and the application of coping strategies based on this understanding. This understanding is termed **premenstrual knowledge**.

Premenstrual knowledge is acquired by the women through the **monitoring** of their premenstrual changes and the **gathering of information** about these changes from other sources. Premenstrual knowledge allows the women to **predict** their premenstrual changes. Prediction (and thus premenstrual knowledge) promotes the perception of control. It also enables the women to **adopt theories and explanations** about their premenstrual changes and to base **coping strategies** on these explanations.

This process is termed **experiential learning**. The women learn, through experience, to manage their negative premenstrual changes. The outcome of this process is **perceived control** over these changes. The perception of control is a positive experience for the women. In order to examine this model in more depth, how the

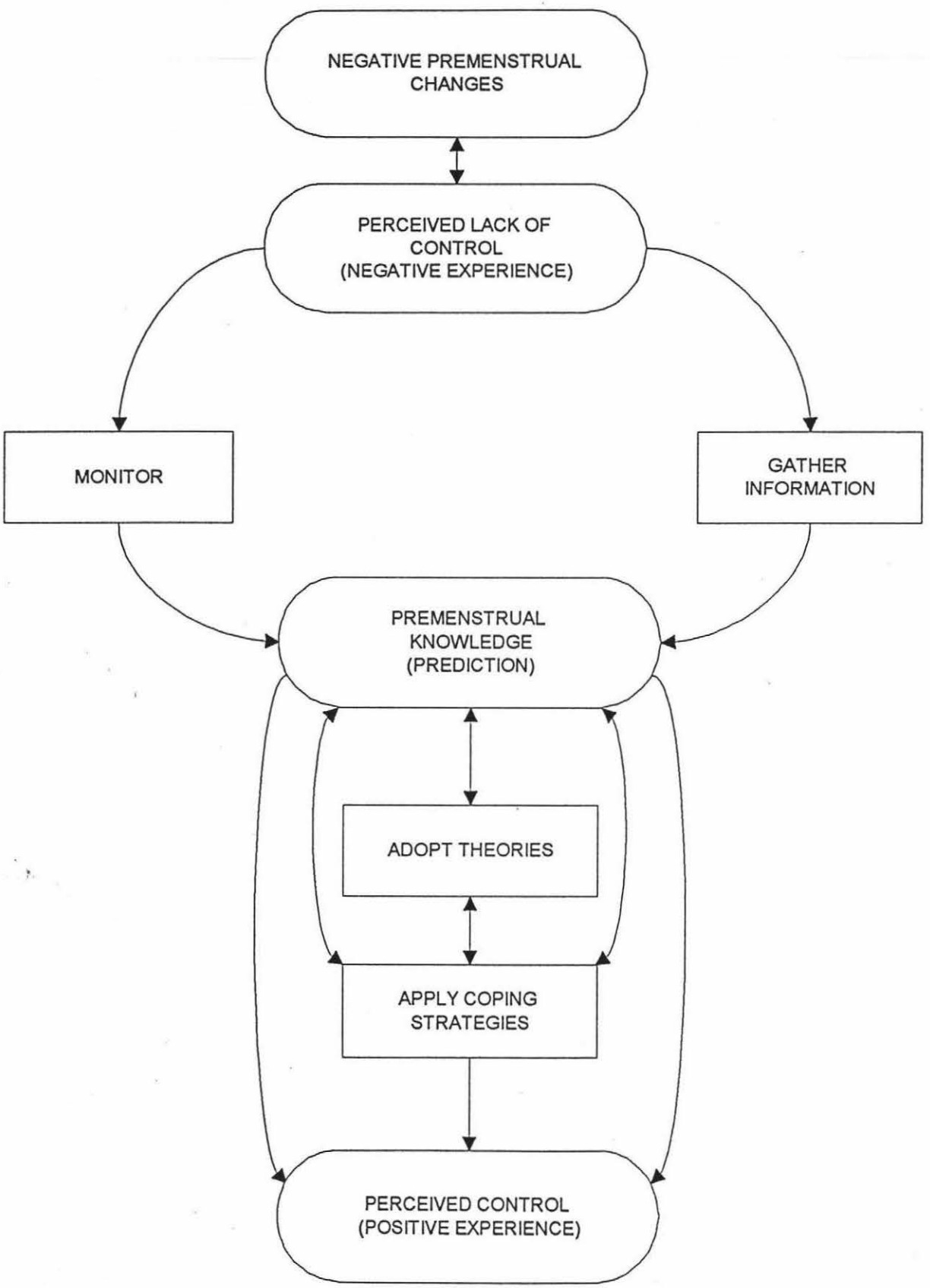

Figure 1. Experiential Learning and Perceived Control: A Process Model

women define 'control' will be outlined. The concept of experiential learning and how this is linked with the perception of control, will then be discussed. Following this, three broad areas will be presented; negative premenstrual changes and perceived lack of control, gaining control through understanding and using premenstrual knowledge to instigate change.

What is Perceived Control?

Perceived Control is the core category of the theoretical model. It is important, therefore, to define this concept in terms of how it is talked about by the women (as opposed to the already familiar meaning of the word 'control').

In it's broadest meaning, 'perceived control' refers to a sense of personal agency. For example, when talking about the perception of a lack of control over their premenstrual changes, the women said things like "I can't help it", "It just happens" and "I can't stop it". As Elizabeth and Kate explain;

> *"I can't do anything about it to stop it and I can't do anything to speed up the process (and) I can't do anything to change."* Elizabeth.

> *"I just can't help it. Then I just start insulting myself and I can't stop."* Kate.

Similarly, when the women talked about the perception of being in control of their premenstrual changes they said things like "I can control it better" and "I can manage it better". Often this perception of control was implicitly stated. The women talked about 'not being in control' as a negative experience and 'being in control' as a positive experience.

The concept of 'perceived control' can be seen as a continuum. Some of the women were near one end of the continuum (perceived lack of control), some of the women were near the other end of the continuum (perceived control) and most were somewhere

in between, in the process of establishing a sense of control. The sense of being 'in control' is seen by the women as desirable. All the women worked towards establishing this.

This concept of control was not static and depended on how far through the 'learning process' the women were. This is addressed in the following section.

Experiential Learning and Perceived Control

It became apparent that, for many of the women, the perception of a lack of control was associated with 'not knowing' and 'not being aware' of their premenstrual changes. As some of the women explain;

> *"It just happens and I don't know why I'm crying."* Elizabeth.

> *"When you don't know what it is or you forget (that you're) anxious and things get out of proportion and you think "Ohhh!" You feel like it's going to go on forever."* Sarah.

> *"Well, if I'm not aware of it, if it catches me out, then I feel negative."* Mary.

Similarly, the perception of control was connected to feeling that they "knew" and "were aware" of their premenstrual changes. Mary and Elizabeth talk about this;

> *"If I am aware of it I think "This is the time and it's OK, it will pass" and I'm kind of more objective to it."* Mary.

> *"I think I feel better now that I know what's been happening and I think I can control things a bit better than when I was younger. I feel I've got more control over what's happening even though I can't do it, I can't control certain things of it. But I feel that I know what's happening and I know why and it doesn't bother*

me as much as when I was younger, when I didn't know about it to much." Elizabeth.

This process of coming to know about premenstrual changes and thus gaining a sense of control over these changes has been termed experiential learning. It is to this process that we now turn.

Negative Premenstrual Experiences and Perceived Lack of Control

Two important issues emerged when considering the women's experience of their premenstrual changes. Firstly, all the women interviewed express that, in general, the premenstrual changes they experienced were negative (that is, unpleasant). As Margaret states;

"Everything is negative. If there was to be anything positive then it would have to be that this is part of being a woman which actually makes me want to spew."

Elizabeth also expresses this general negative feeling;

"And it's a nuisance, a real nuisance that won't go away."

Secondly, this negative experience was associated, for the majority of the women, with the perception that they lacked control over changes occurring premenstrually. Kate clearly enunciates this feeling;

"It totally out of your control. You have no control over it whatsoever. Even if people believe it (exists) they don't often think that it's out of your control."

It became clear that this feeling of not being in control was, in many cases, the negative

premenstrual experience. Again, Kate highlights this;

> *"Well, I get really bitchy and I just say awful things to people and I don't mean it I just do and I can't help it and it's really quite awful."*

When asked how things might be different if she didn't experience any premenstrual changes, Elizabeth explains;

> *"I wouldn't have so many ups and downs. I might be a bit more of a controlled person in my emotions. I might not behave so dramatically."*

Natasha also expresses this feeling;

> *"But in my mind I knew there was no reason for me to be upset but I couldn't stop the feeling."*

The inter-relationship between perceived lack of control and negative premenstrual experiences was underpinned by a feeling that these changes were 'novel' and the reasons for them 'unknown'. When talking about her negative premenstrual experiences, Margaret states;

> *"Because it always seems to be out of the ordinary for me. And for me it's not normal."*

Alice also talks about this;

> *"Or I'll start worrying about things that normally I might keep under control but which get blown out of proportion."*

And later;

> *"I used to worry before because it seemed strange behaviour to me, to start crying*

for no reason."

As is illustrated by these quotes, the women felt that these changes were negative, that they did not understand them (there seemed to be "no reason" for them) and that, subsequently, they had no control over them. The next section looks at how the women set about to establish a sense of being in control of these changes by learning about them.

Gaining Control Through Understanding: Monitoring, Information Gathering and Premenstrual Knowledge

There are two major ways in which the women set about establishing an understanding of their premenstrual changes; monitoring and gathering information.

Monitoring refers to the way in which the women 'kept watch' of their premenstrual changes. This process was done by the self and was about the self. Monitoring was implicit in the interviews with all the women. Some of the women talk about this process;

"Well, I've been observing this for quite a long time." Mary.

"Actually, I've noticed it's got worse." Margaret.

"I've got to the stage now where I know, just because of they way I feel, that I'm going to get my period, just by what I want to eat." Sarah.

There were two phases of monitoring. The first phase involved the 'noticing' of what was previously outlined in the previous chapter as premenstrual changes, their properties and dimensions. For the women, the result of this phase of monitoring was a general 'awareness' of their premenstrual changes. The women who were more aware of their changes had more to talk about and their interviews tended to be longer.

The second phase of monitoring followed on and related to the first. It referred to the way in which the women became aware of associations and connections between their premenstrual changes and other factors, such as physical (for example, illness), social (for example, work schedules) and psychological (for example, self esteem). The women often talk about this phase of monitoring as 'learning'. As the women state;

> *"So I've learnt that because I want to do well, I'm not going to do my best work at that time."* Alice.

> *"So I'm really learning. It's a matter of making myself because it doesn't make my self esteem as good. I'm just becoming aware that it's not doing me any good."* Sarah.

> *"After feeding Rebbecca and noticing it really clearly and (becoming more) aware... I noticed it more. I'm more aware of it now."* Angela.

> *"I've only been aware of it in the last year and I've been on the pill for three years. I've written a diary... When I look back to that I go back every four weeks and think "My god! Did I do that then!". So there's a pattern that's been there for years."* Vicki.

Gathering information was another way in which the women gained an understanding of their premenstrual changes. This involved the women 'gathering' information from other sources including family members, women friends, doctors and books. Although this process is termed 'gathering', it also involves social learning, communications with others and reading. Information gathering differed from monitoring in that the women did not just focus on their own changes, but on premenstrual changes in general. As such, the women gained an understanding of the 'knowledge' that existed about premenstrual changes and how their own changes fit into this.

Both monitoring and information gathering occurred in tandem and were ongoing processes. For the women, these processes resulted in an understanding and awareness

of their premenstrual changes and of the existing information about these changes - what has been termed 'premenstrual knowledge'. The women had differing levels of premenstrual knowledge. For example, some of the women said that they had only just made the association between certain phases of their menstrual cycle and changes in their own behaviour. As Margaret explains;

> *"I have been this month because last month I had a really bad day and a couple of days later I got my period. And it wasn't really until later in the day that I really realised. It's taken me ages to work this out, that I was suffering from PMT. I didn't click at all for ages."*

Other women seemed to have more knowledge about their premenstrual changes.

An important consequence of this premenstrual knowledge was that the women were able to predict their premenstrual changes. For example, many of the women said that they 'knew' when a certain change would occur, it's duration and it's severity.

Premenstrual knowledge and the ability to predict premenstrual changes every month gave women the sense of being in control. It also enabled many of them to 'take control' of their premenstrual changes.

Using Premenstrual Knowledge to Instigate Change: Adopting Theories and Applying Coping Strategies

The process by which the women sought to gain a sense of control over their premenstrual changes did not stop at becoming 'aware' of them. As will be described, the women sought to 'take control', that is, actively decrease their negative premenstrual changes. The women achieved this through adopting theories about their premenstrual changes and basing coping strategies on these theories.

Adopting Theories

As was discussed earlier, the experience of negative premenstrual changes was associated with the perception of not being in control. Furthermore, the women relate this feeling of not being in control to 'not knowing' and having 'no reason' for these changes. Through the processes of monitoring and gathering information the women gained an awareness and knowledge about their premenstrual changes. With the benefit of premenstrual knowledge, the women were able to search for reasons (or 'theories') to explain their changes. Alice talks about this;

> *"Well, it was a relief in a way, that I knew ... but there was a reason for it and it was good to find a reason. I used to worry before because it seemed like strange behaviour to me, to start crying for no reason."*

As illustrated by this quote, having a reason for the changes was a positive experience for the women and (as will become more apparent) led to increased feelings of control.

As an example, a number of the women, whilst reading about menstruation (gathering information), found out that premenstrual changes had been attributed to fluctuations in female hormones. These women then noticed (monitored) that when they were on the contraceptive pill their premenstrual changes were more (or less) severe than when they were not on it. Some of these women also checked (gathered information) with their female friends and family members to see whether they had similar experiences. As a result, these women 'adopted' the theory that their negative premenstrual changes were due to fluctuating hormone levels during their menstrual cycle.

Through monitoring and gathering information, the women became engaged in a continued and interwoven process of 'finding leads', 'checking' and 'looking for supporting evidence' in an effort to find reasons for their premenstrual changes.

There were seven different theories the women chose to adopt. All of the women adopted more than one theory and some women adopted all seven.

Perhaps the most common theories the women used to explain their premenstrual changes were physiological. This is not surprising considering biomedical explanations dominate current 'knowledge' about premenstrual changes. The most popular physiological theory was the **hormonal** theory. All but one women adopted this theory. As some of the women explain;

> *"When I was on the pill it wasn't so bad. So that way I support the theory that it's endocrinological or hormonal."* Kate.

> *"It's something to do with fluctuating hormones..."* Angela.

> *"During the rest of the month I can cope with the stress because of all the other hormones in my body, but when they go away I just can't cruise around."* Emma.

> *"But I do feel better now that I realise it could be due to hormonal changes because I've noticed a difference when I've been on the contraceptive pill and when I havn't. So that tends to make me think that it's something to do with hormonal changes."* Natasha.

> *"I guess it's a hormonal balance type thing. I was talking to someone with diabetes the other and they say they're like that a lot of the time."* Vicki.

A couple of the women supported the theory that their premenstrual changes are partly due to the **aging process**. As Emma states;

> *"But I think that's part of the aging process too because you get more inflexible. The aging process adds to the physical changes."*

The majority of women agreed that **diet** played a role in 'causing' their negative premenstrual changes. For example, the women talked about caffeine excess, salt excess, fat excess and mineral and vitamin deficiencies as contributing to some of these changes. For example;

"And I've read about getting magnesium out of the foods ... I think it's got something to do with what's in the chocolate, like magnesium and other things." Sarah.

"And I read somewhere about diet and how much caffeine you eat and chocolate bars and how much fat intake you have and things like that." Elizabeth.

Some of the women also give **lack of exercise** as a reason for their premenstrual changes.

Many of the women indicated that **stress and tension** played an important role in their negative premenstrual changes. Often, they saw the positive impact of relaxation as 'supporting evidence' for this theory. As Vicki and Elizabeth explain;

"I think it varies depending on how happy I am at the time and how many pressures you've got on you, like assignments." Vicki.

"So it's probably got something to do with ... generally whether I'm going through a stressful period, tests coming up and things like that." Elizabeth.

Many of the women adopted what have been called **'psychodynamic'** theories for their premenstrual changes. One such explanation suggests that premenstrual changes are symbolic of personal (often subconscious) issues that are not being dealt with consciously. As some of the women explain;

"Quite often my glands swell up (premenstrually) ... I think my glands are an indicator. I've just made this connection that if my glands swell up it often means that there is something that I'm not dealing with." Emma.

"Because I realise that the negativity (during my premenstrual time) could be saying something about what I've got repressed, then it's positive because it's showing me that something needs to be looked at." Mary.

"It's a chance for the negativity I might not have been aware of to be expressed or show it's face. Like I really believe that if I didn't have stuff underneath that needed to be resolved then it probably wouldn't manifest in such negativity." Mary

Another related 'psychodynamic' theory some of the women adopted, was the explanation that suggests premenstrual changes (notably interpersonal and emotional changes) were the expression of the woman's 'true self'. Sarah talks about this;

"It (premenstrual changes) enabled me to do something that I'd been wanting to do but just didn't have the guts to do."

"Like the assertiveness and also getting things out. I find that it's a good way to get things out if they're bothering you. You can deal with things, get things out."

Another theory about premenstrual changes adopted by some of the women was what has been termed the **'nature'** theory. This explanation refers to the belief that the menstrual cycle is synonymous with the cycles of nature. For example;

"I now enjoy more the fact that my life is part of a cycle, it's not the same, there are phases." Mary.

"The different times of your cycle which ... there are seasons as well and it's all part of nature." Mary.

"That's one way of being philosophical about it, to think that it's like winter, autumn, summer and spring. Otherwise I'd spend the rest of my life thinking "God, oh god!"" Emma.

Finally, some of the women indicated that their premenstrual changes could be explained in terms of being inherited. This is termed the **'familial'** explanation. As Sarah and Alice state;

"I had two sisters who suffered lots of pain and used to have to take to their beds. Well, they're older than me and I actually expected that's what it was going to be like ..." Alice.

"It (the pill) would make it worse for me, I think, because my sister .. usually if it's someone in the family you tend to be alike ... she gets PMT as well." Sarah.

Many of the women had a kind of **'combination'** of theories to explain their premenstrual changes. Elizabeth illustrates this;

"Most certainly hormones. Yeah. Maybe I've got a high sensitivity to my hormones ... and I've read somewhere about diet, how much caffeine you eat and chocolate bars and how much fat intake you have. There are lots of books I've read that have so many different opinions... A combination of things. So it's probably something to do with my hormones and my diet and exercise and generally whether I'm going through a stressful period ... that makes it worse. So if I can control my diet and my exercise routines and the amount of work I do before tests and things like that, I'm doing alright."

Here Elizabeth talks about the connection between the theories she adopted about her premenstrual changes and the ways she attempted to cope with these changes. This leads on to the following section.

Coping Strategies

All of the women carried out goal orientated and intentional measures based on their premenstrual knowledge and the theories just described. These measures have been termed **coping strategies**.

The women talked about employing two types of coping strategies; reactive strategies and preventative strategies. **Reactive strategies** were short term, intentional strategies the women said they used at the time their premenstrual changes occurred.

Preventative strategies were long term strategies the women said they carried out in order to prevent future negative premenstrual changes.

Time out was one such reactive strategy. This strategy had two parts. The first referred to the way the women said they intentionally removed themselves and withdrew from certain situations. The second referred to how the women, after removing themselves, chose to carry out certain chosen, pleasurable activities. These activities included going for a walk, resting, taking a bath and talking to a friend. Alice describes how she takes time out:

> *" ... just go away for a week and read and walk and perhaps be pampered and have nice music and have total relaxation ... could also mean doing exercise, if you wanted. Just to be away from all the normal stresses. Time out from every body."*

Vicki also talks about how she takes time out;

> *"I just go into my room. Sometimes I skip university and go home early and put some music on and just sit in the lounge by myself."*

Another reactive strategy that most of the women said they used was **warning others**. This strategy involved the woman verbally telling others that her premenstrual time was due and that this meant she might behave in certain way. Similar to this strategy was **explanation offering**. Many of the women would, just before or during their premenstrual changes, offer explanations to others about why they were behaving in a particular way. These explanations included telling people they were tired, sick and premenstrual. As Alice and Emma explain;

> *"And if I'm ever feeling particularly down or grumpy I often say so. I say "I feel really grumpy today and I think my period is due tomorrow." "* Alice

> *"Well, I tell people that's where I at."* Emma

Seeking support was another reactive strategy that many of the women talked about using. This sometimes involved just being in the company of others. At other times it involved sharing premenstrual experiences, most often with other women. Mary talks about this;

"So I usually try and talk to her (close friend) to get out of it."

The women also said they undertook various strategies to prevent the occurrence of future negative premenstrual changes. These strategies could be grouped into those that were self help and those that involved external help. **Self help** strategies were those that the women themselves were responsible for. **External help** strategies were those that involved the help of external agencies.

The women talked about engaging in a variety of preventative self help strategies. These included **taking vitamins** such as vitamin B, B6 and C and taking **non-prescription medications**, such as ponstan and naprogesic. Alice and Mary talk about using some of these strategies;

"I've tended to take B complex and B6 and I'm not sure whether that's helped or not." Alice

"Well, I take evening primrose oil and I've started taking dolomite ... calcium, I don't know if that is for that. And some other herb ... it's called FCS 2." Mary

Many of the women also said they **altered their diet**. The most common diet changes were reductions in caffeine and salt intake and an increase in iron intake. Mary discusses how she altered her diet in an effort to manage her premenstrual changes;

"And eat ... make sure I get proper meals, because my blood sugar goes down. If I don't eat well (during my premenstrual time) what I notice is ... sometimes my energy drops."

Many of the women talked about **altering their exercise routines**. This often meant going for a jog or a walk and/or doing relaxation exercises such as yoga or stretches. Again, Mary explains;

> *"I make sure I get enough rest and I practice my Tai Chi. I make sure that I do that and ... make sure that I get enough exercise."*

The majority of the women said they **structured their lives** to some extent as a way of preventing future negative premenstrual changes. This structuring involved planning ahead what they would do and when they would do it in terms of their premenstrual time. This would sometimes (and with some women) just involve work related activities, but at other times, total life style changes. Alice explains;

> *"I make sure that I do it (work) when I have the energy and I'm feeling good about myself. I really use that time well."*

Finally, some of the women said they engaged in a sort of **self analysis** as a way of preventing future negative premenstrual changes. These women felt that if they dealt with and had less personal stress and worries, their premenstrual experiences would be less negative and severe. As Mary states;

> *"... and the more I get in touch with myself, the easier it is to handle."*

The women also carried out preventative external help strategies. Many of the women said they received **medical help.** This took the form of visits to the doctor, taking prescription medication such as valium and the contraceptive pill, having hormone treatment and, in one case, having surgery. Some of the women also said they had **physiotherapy** and received **homeopathic treatment** to try and reduce their negative premenstrual experiences.

Applying Coping Strategies

The women who had more knowledge about their premenstrual changes and who had adopted more theories to 'account' for these changes, also talked about employing a greater variety of coping strategies. One way of examining the connection between premenstrual knowledge and coping is to compare how the women who seemed to have less knowledge about their premenstrual changes, and those who seemed to have more knowledge about these changes, talked about coping.

Natasha, Mary and Sarah discuss how learning (that is, premenstrual knowledge) helped them cope with their negative premenstrual changes;

> *"Because a couple of years it keeps on happening at the same time. Something has got to be there. Once you have finally worked that out you can sort of deal with it and go outside or whatever."* Natasha.

> *"It's learning how to deal with it."* Sarah.

> *"I've seen that when I'm really busy and really stressed out that it has repercussions ... (I'm) allowing myself more rest and care and stuff. But I've had to learn that."* Mary.

Emma, on the other hand, describes how knowing more about her premenstrual changes would benefit coping with these changes;

> *"If I could predict it I could make sure I didn't have a stressful day."*

And later;

> *"If I could, I'd plan what to work on, in those days. But I can't. I can't know when I'm going to be premenstrual."*

However, it is emphasised that there was a reciprocal, 'feedback' relationship between premenstrual knowledge (particularly adopting theories) and coping strategies. Through

monitoring, the women would evaluate the 'success' or 'failure' of a certain coping strategy. This, in turn, would give them extra information or knowledge about their premenstrual changes and would support or disconfirm previously adopted theories. A (simplified) example is that a woman may take the contraceptive pill, note no improvement in her negative premenstrual changes and conclude that it is not hormonal fluctuations that account for these changes. Natasha elaborates;

> *"I've noticed a difference when I've been on the contraceptive pill and when I havn't, so that tends to make me think there is something, the hormonal changes."*

Similarly, Mary's adherence to a more psychodynamic theory is reinforced by noting the benefits of becoming self aware;

> *"I've noticed that the more I get in touch with myself the easier it (premenstrual changes) is to handle."*

Certain types of coping strategies were associated with certain types of theories or explanations about why the changes occurred. For example, the use of the contraceptive pill and prescription medications were often associated with a hormonal explanation (as Natasha talked about above).

The explanation that premenstrual changes are related to stress and tension tended to be associated with structuring (for example, of work schedules) and time out (for example, resting). Mary and Sarah discuss this;

> *"Probably that's when we're meant to rest and not be so, exerting ourselves. And if you have a really busy job that's when you become really stressed. Whereas, I know if I'm studying and it's exams or something, I know that's when I have to make sure I get lots of rest because otherwise I can't function as well."* Mary.

> *"I do look ahead now so I can try and do a bit more study before."* Sarah.

The theory that premenstrual changes were (at least partly) due to a lack of exercise was identified with alterations in exercise routines. Similarly, the diet related explanations the women adopted (for example, caffeine excess, vitamin deficiencies) were always associated with alterations in food intake. As Alice explains;

> *"I started cutting down on caffeine dramatically. I read somewhere that it did help ... I have a coffee substitute (and) I think that's helped."*

The psychodynamic theories are also associated with particular coping strategies. One of these strategies was self analysis. For example;

> *"Whereas now I think probably the way I live my life is better because I deal with conflicts as they come up so there's not as much left over (at premenstrual time)."* Mary

Another strategy used was seeking support (for example, sharing premenstrual experiences). Mary illustrates this;

> *"I think "I wish I could do something about it". But that's when I might talk to someone and if I say how I'm feeling that usually breaks it."*

Perceived Control: A Positive Experience

Premenstrual knowledge, the subsequent theories the women adopted about why they experienced their premenstrual changes and the coping strategies they carried out led to the perception of control. This perception was a positive experience for the women. Natasha talks about how she feels better about her premenstrual changes;

> *"But I do feel better now that I realise it could be due to hormonal changes. because a couple of years and it just keeps happening at the same time, something has got to be there. Once you've finally worked that out then you*

can sort of deal with it and go outside for an hour or so or whatever."
Natasha

Elizabeth discusses how 'knowing' about her premenstrual changes has made her feel more 'in control' and, subsequently, more positive about her premenstrual changes;

"I think I feel better now that I know what's happening and I think I can control things a little bit better than when I was younger. I feel I've got more control over what's happening ... But I feel I know what's coming and I know what's happening and I know why and it doesn't bother me as much as when I was younger, when I didn't know about it so much."

CHAPTER SEVEN

Conclusions

General Summary and Conclusions

The premenstrual stories and the grounded theory that emerged from these stories suggest certain things about the nature of the women's premenstrual experiences.

This research is consistent with a move away from focusing on causation (why the women experience premenstrual changes) to process (the way in which women experience these changes). It is argued that the focus on process is 'user friendly' and empowering in that it enables women to look at ways they can participate in changing their own premenstrual experiences.

Generally the women talked about their premenstrual changes as being a unpleasant experience. Very few positive changes were mentioned. However, although the changes themselves tended to be seen as a negative experience, the process of learning about and managing these changes was talked about positively. It was noted that the women who were further through this process felt less negative about their premenstrual changes.

The findings reveal the women's premenstrual experiences as contextually bound. For example, the women's perceptions of their premenstrual changes depended on their past experience of such changes, their current life circumstances, how they were feeling, and others attitudes towards them. Their experiences could not be extracted from their social, historical, cultural, interpersonal, biological and psychological contexts. These contexts were inter-related and interwoven. The biopsychosocial model (Jarvis & McCabe 1991; Logue & Moos, 1988) is therefore applicable to these findings. This model suggests that sociocultural stereotypes, individual interpretations and biological events all interact to produce a woman's premenstrual experience.

The importance of context suggests a number of things about the nature of the research findings. Those participating in the study shared certain perspectives - they were all women from a similar social, cultural and historical background. Their premenstrual experiences, therefore, must be seen as embedded in, and a product of, these shared contexts. The findings - for example monitoring, the search for explanations, the need to feel 'in control' - may be common to all women's experiences. However, further research is needed to explore and substantiate this.

The findings suggest a link between mind and body. The grounded theory highlights the importance of psychological factors , for example, the women's perceptions of control and their interpretations of their premenstrual changes, as 'intervening'. This view is optimistic and empowering for women. It indicates that what the women thought (and subsequently did) made a difference and that premenstrual changes were not fixed or "beyond control" but open to change.

Furthermore, the research findings recognise the women as active participants. As outlined previously, the women were 'investigators' into, and 'shapers' of their own premenstrual experiences. For example, they were able to directly influence their premenstrual changes through coping strategies and indirectly through the theories they used to explain these changes. This active and purposeful participation was a crucial part of each woman's overall premenstrual experience. The women actively sought to reduce their negative changes by learning about them and feeling in control of them. Their 'actions' often meant that their experience of these changes was altered, for example from a negative to a more positive experience.

These findings are contrary to the traditional biomedical approach outlined in Chapter One. This model has tended to view women as passive recipients of discreet biological events and has been the predominant way of conceptualising premenstrual changes over the last 50 years. As such, it is part of the 'shared perspectives' the women had with regards to their premenstrual experiences. The impact of the biomedical model on women's perception of their premenstrual changes must therefore be considered. Biomedical 'theories' were the predominant explanations the women used to explain

these changes. As the previously indicated, these explanations were important to each women's overall premenstrual experience. It is possible that biomedical explanations decrease feelings of personal agency (the perception of control) by focusing on causation, by not encouraging understanding or active participation and by taking sole responsibility for the 'treatment' of premenstrual changes. There is a need for future research to focus on the impact of the biomedical perspective on women's experiences of premenstrual changes in particular and on peoples experiences of various physical based changes in general. Further research focusing on the implications of other models (for example, the 'feminist' model, the 'psychological' model) is also needed.

Without denouncing the influence of biology, the findings acknowledge the women's capacity to manage and cope with their premenstrual changes. By recognising the women as active participants the findings challenge the stereotypical view of women as 'slaves to their biology'. This offers support to feminist and ecological literature in the area which has largely been critical of the increased medicalisation of women's lives and the assumption that women's behaviour is largely biologically determined. It also offers support to social psychological literature which has focused on the role of psychological processes and which has tended to view women as involved in the creation of their own experiences.

Experiential Learning and Perceived Control: Wider Implications

The level of abstraction of this grounded theory means that it has much wider therapeutic implications.

This theory can aid in assisting women to have less negative premenstrual experiences by reducing the number and severity of changes and by enhancing feelings of control. As mentioned in the previous section the theory is 'user friendly'. Because the theoretical model is grounded in the women's experiences it may be more accessible to other women. The information presented in the previous chapter may be used by

women on a 'self help' basis. The suggestions of various explanations and coping strategies may be of benefit to women experiencing similar changes. The majority of these strategies do not require medical intervention and cost nothing.

Furthermore, this theory suggests that by monitoring these changes (for example noting when the changes occur and how long they last) and gathering information about them (for example, talking to others and reading) women can become more knowledgeable about their changes, predict them, think of different ways to manage them and subsequently feel more in control of them.

This theory suggests to those working with women who experience negative premenstrual changes that they focus on education and on encouraging active participation and involvement. Women (especially young women) should be encouraged to explore a variety of explanations for the changes they experience and to 'test out' a variety of coping strategies. The theory indicates that the process of learning about and managing these changes is related to experience (that is, time based). Thus, it suggests the earlier women start this process the sooner they will feel more in control of these changes and less negative about them.

This grounded theory may also have therapeutic value for women experiencing other gender-specific life changes such as pregnancy and menopause. It may be the case that women are unaware of certain changes and thus feel they don't have much control over them. The theory suggests that women are likely to have less negative experiences (and feel more in control) if they know what's happening and can actively participate. This means those working with women in managing these life changes may have to take the role of 'educator' and 'supporter'. It may also mean that those operating from a traditional biomedical perspective need to relinquish some of their 'control' over women's bodies in order to give some of this responsibility back to women.

This grounded theory may also have therapeutic value for people experiencing physical illness. The theory stresses the importance of the mind-body link and suggests to those experiencing physical illness that they can play an active part in reducing their negative

experiences. Those suffering from asthma and diabetes, for example, could be encouraged to find out about their condition, become knowledgeable about the appropriate medical procedures, monitor their own behaviour over time and find out what makes their condition better or worse. Also, taking more responsibility for managing their illness - for example, administering their own medication, planning their own diet and exercise schedules - is likely to enhance feelings of self agency and decrease feelings of helplessness.

This theory may also be applied to the treatment or certain psychological problems, notably depression and anxiety. People experiencing these conditions may believe they have no control over their moods and thoughts and subsequently feel helpless to change. The theory suggests that, as therapist or counsellor, feelings of personal agency can be enhanced by educating the client about their condition, allowing them to explore alternative explanations and actively involving them in the assessment and treatment process. For example, the client could monitor their feelings, thoughts and behaviour, could read about their condition and take responsibility for treatment inside and outside of the sessions. Nelson-Jones (1984) has recommended personal responsibility and 'self therapy' as therapeutic goals. Furthermore, previous research and clinical practice (for example, Epston & White, 1992) has explored the therapeutic benefits of using alternative explanations (or 'knowledges') with dysfunctional families, that is, introducing families to new ways of looking at their 'problems'. This grounded theory supports these approaches and recognises the benefits of strategies (for example, cognitive- behavioral methods) that encourage people to learn about and actively participate in their own treatment.

Limitations of the Research

The limitations of this study centre around the framework from which the research was done and the size and composition of the sample.

This study was done from a particular framework - the grounded theory approach -

which meant that the research was intensive and the findings conceptual and 'dense'. Following the grounded theory approach, the findings were based on the researchers own interpretations of the data. The researcher came from a certain context (she was a pakeha/european women from a specific socioeconomic group). It is likely that another researcher could have come up with similar interpretations and findings. It is also conceivable that a male or someone from a different culture may have interpreted the data in a different, and equally legitimate, way. Those utilizing these findings must therefore be sensitive to the framework from which they have come and the researchers individualistic contextualised perspective.

Necessarily, the sample size for this study was small. The participants were volunteers, came from a particular cultural/ethnic (pakeha/european) and socioeconomic (educated 'middle class') group and their exact ages were not specified. Caution must therefore be taken when applying these findings to wider populations, notably different cultures and women in general.

The findings of this study did not embody the full complexity of women's premenstrual experiences. Future research in the area is needed to further explore this complexity.

Suggestions for Future Research

This grounded theory has implications for research in many areas.

Future research is needed in the area of premenstrual changes. Studies replicating this research are required to validate these findings. Future research could involve larger groups of women. Studies could also explore premenstrual experiences in different groups of women, for example Maori women, Pacific Island women, single women and unemployed women. Given the importance of experience and context, some studies could also compare the experiences of groups of women, for example single versus married women, younger women versus older women. Mens perceptions of women's premenstrual changes is another area for future research.

Specific aspects of the grounded theory could be the focus of future research. For example, studies could explore in more depth the different explanations women have for their premenstrual changes and the different types of coping strategies they use. Research could also focus on the function specific theories serve (for example, whether some theories were more 'useful' then others) and the benefits of particular coping strategies.

Future research could also focus on applying these findings to other areas, particularly exploring the possibility of this theory as a therapeutic tool. The theory could be applied to research on coping (for example, in the social psychology and health psychology areas), the treatment of medical and psychological 'illness', women's issues and the study of life changes specific to women.

Both qualitative and quantitative research is needed. Qualitative approaches allow the researcher to explore the influence of context and the interaction of factors at all levels. These approaches are also more likely to allow access to inner perspectives, identified to be of paramount importance to any study exploring peoples experience of phenomena. Quantitative research is required to validate and 'test out' the findings with larger populations.

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APPENDIX A.

PREMENSTRUAL EXPERIENCES

Information Sheet

*** Who is the researcher?**

My name is Julie Carvell. I am currently completing a Master of Arts degree in psychology and this study will constitute my Masters thesis. I am also training to become a clinical psychologist and am involved in the psychology department's clinical psychology programme.

*** What is this study all about?**

This study is about women's premenstrual experiences. My major aim, as researcher, is to gain an understanding of how the women I talk to make sense of their premenstrual changes and what these changes mean to them. Four broad and inter-related areas will be covered:

- what sorts of premenstrual changes do women experience?
- in what ways do these changes influence and effect women's lives?
- how do women cope with and manage these changes?
- What changes would women like to see that would help them cope with these changes?

*** What would I have to do as a participant in this study?**

Each participant will be interviewed once by me. These interviews will last approximately one hour, will be centred around the four broad areas mentioned above and will be tape recorded. Later, these interviews will be transcribed and each participant will have the opportunity to read their interview and change or add to it as they wish. All participants will receive a summary of the research findings at the conclusion of the study.

*** What are my rights as a research participant?**

As a participant in this study you have certain rights. These are:

- the right to ask further questions about the study at any time.
- the right to refuse to answer questions at any time.
- the right to withdraw from the study at any time.
- the right to provide information on the understanding that it is confidential.

If you are interested in taking part in this study an interview will be arranged. If you have any further questions about this study I can be contacted at home:

Julie Carvell ph. _____

APPENDIX B.

PREMENSTRUAL EXPERIENCES

Consent Form

I have read the information sheet and have had the details of the study explained to me. All questions concerning the study have been answered to my satisfaction and I understand I can continue to ask questions during the research.

I also understand that I can decline to answer any particular questions in the study and that I can withdraw at any stage. I agree to provide information to the researcher on the understanding that it is completely confidential.

I agree to participate in the study under the conditions outlined in the information sheet.

Signed:.....

Name:

.....

Date:.....

Researcher:

.....

APPENDIX C.

INTERVIEW SCHEDULE 1.

*** What sorts of changes do you experience before your period?**

Physical changes?
Emotional/mood changes?
Self esteem changes?
Changes in the way you feel about others?
Positive changes?
Variation in changes?

*** How would you say these changes influence your life?**

Relationships with others?
Work?
Health?
General quality of life?

*** How do you cope with and manage these changes?**

Use of medications?
Other ways?

*** What do you think could be changed to help you cope with these changes?**

Changes to the environment (working, living etc.)?
Lifestyle changes?

Other changes?

Is there anything you would like to add to or clarify before we finish?

APPENDIX D

INTERVIEW SCHEDULE 2.

*** What sorts of changes do you experience before your period?**

Physical changes?
Emotional/mood changes?
Changes in behaviour?
Changes in self esteem/body esteem?
Sexual changes?
Appetite changes?
Changes in feelings towards others?
Positive changes?
Variations in the changes? i.e. month to month, day to day, within each day.

*** How would you say these changes influence your life?**

Relationships with others? e.g. partner, spouse, friends, workmates, men vs women.
Work? eg. university work, work quality and quantity.
Health?
Life in general? i.e. how would might you life be different if you didn't experience these changes?
What explanation(s) do you give for these changes?

*** How do you cope with and manage these changes?**

In what way do you prepare yourself for these changes? e.g. time out, avoid certain things, seek support.

In what ways do you try and prevent these changes from happening? e.g. medication, the pill, diet, exercise, vitamins etc.

How important are other people in helping you cope with these changes?

*** What do you think could be changed to help you cope with these changes?**

Changes to other people? e.g. attitudes

Wider social changes? i.e. political, health professions.

Changes to the environment? e.g. work environment, living environment etc.

*** Is there anything you would like to add or clarify before we finish?**

APPENDIX E.

Model Letter to Research Participants

---------- Road
Palmerston North
ph. -------
Date ------

Dear -------

Thank you for participating in my study on women's premenstrual experiences.

I have enclosed a transcript of your interview and would like you to just read through it and change, add to or clarify anything you think is necessary. This is so the transcript captures your views and opinions as accurately as possible. I have also enclosed a stamped, addressed envelope so that you can send the altered transcript back to me.

Thank you again.

Yours sincerely

Julie Carvell