THE EFFECTS OF PREMENSTRUAL SYNDROME ON JOB PERFORMANCE

by
Linda Wescott Hayes

A Master's Research Project in Partial Fulfillment
of the Requirements for the Degree
Master of Arts

OTTAWA UNIVERSITY
September, 1989

THE EFFECTS OF PREMENSTRUAL SYNDROME ON JOB PERFORMANCE

BY

Linda Wescott Hayes

has been approved

September, 1989

APPROVED:

_____ Chairperson

_____

Supervisory Committee

ACCEPTED:

_____

Director of Graduate Studies

ABSTRACT

Research literature and current books were reviewed concerning the effects of a women's premenstrual symptoms and the effect of these symptoms on her job performance. The target group that was studied included 70 women in the field of education. A three part attitudinal survey was given with collected data analyzed and compared. The results were remarkable in several significant ways: Seventy-three percent of the educators surveyed felt their job was definitely affected by their menstrual cycle. Most tried to control these symptoms through medication and exercise, but the use of alcohol, diet and withdrawal were also used. Most of the educators surveyed indicated a desire for more information about P.M.S. and possible ways that their symptoms could be controlled. The data and research indicate that the P.M.S. phenomena is real and needs to be seriously addressed by the medical community and employers of America.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

INTRODUCTION

More and more women are entering the work force each year. In fact, women are projected to account for 64 percent of the work force growth through the 1990's. Women are now 44.5 percent of the work force and will be 47.3 percent of the work force by the year 2000 (Bureau of Labor Statistics, 1986).

It is also well known that there has always been a very large percentage of women in public education. It would also be safe to say that since the time formal education began, the majority of women in education have had monthly menstrual periods. Having been in education for 17 years and dealt with many other co-workers' monthly menace besides my own, I began to observe that "that time of month" affected not only their attitudes about their jobs but also how they performed their jobs. Unfortunately, these were only personal observations and were not proven.

The questions that haunted me were: are these observations valid and could anything be done about it? Needless to say, when the opportunity came to follow through with research on the subject of women and how their monthly menstrual cycles affected their job, I rose to the occasion with enthusiasm.

Background of the Problem

Working in the media center of an elementary school gives me the opportunity to deal with the majority of the school's staff members on a daily basis. Ninety-five percent of those 68 staff members are women. After 17 years in education, I came to understand that many of them had two distinct personalities that I would have to work with each day. One personality would be amiable, cooperative and pleasant to be around. The other personality, depending on whom I was dealing with, would be uncooperative, easily irritated, sullen, explosive, argumentive and downright despicable.

Statement of the Problem

The problem became one of training myself to become atuned to which personality I would be servicing that day. This was mostly done by keen observation, noting body language, facial expressions and over-heard conversations with other co-workers. The added stress this put on doing my job could be overwhelming at times. On paper I was dealing with about 60 women co-workers, but in reality, I was dealing with 120 personalities.

All of us were aware of what caused these split personalities; our monthly menstrual cycles were sending our hormone levels to exasperating highs and lows. We would even joke about systems of dealing with these cycles. One such system was called "The Red Dot Days". On days that we felt especially vunerable to distress, we could wear a red dot on our clothes. This would let everyone know that contact should be avoided as much as possible, and it would also act as a check to the menstrual sufferer to think before she overreacted to situations.

Yellow dots would signify "approach with caution, and that the woman needed some "Tender, Loving Care" from fellow co-workers. Obviously, if we went as far as to problem-solve the situation, even in jest, the enigma was a concern for many of us, and we looked at those very few who did not feel it to be a problem as the true "chosen ones".

Purpose of the Study

It became clear to me that menstrual cycles weren't just affecting women on the job, but also every other person (man, woman and child) that they came in contact with during the work day. The people supervising all of these double personalities had an especially tricky job to do, since part of their responsibility was to enhance work productivity among employees. Being in the situation I was in, I felt a real empathy for those

supervisors across the country. If it could be shown that most jobs of women were adversely affected by their menstrual cycles, then maybe the problem could be dealt with effectively.

As it stands now, the problem is ignored, laughed at, or seen as a personal weakness by the woman who exhibits problems with her period. I can remember a time when friends of my father were asked to step down from their supervisory roles because they had high blood pressure. Since that time, research and studies have been done on high blood pressure, and I can think of two men near me that function quite well on their jobs with high blood pressure. That is because it was discovered that the problem could be controlled with medication. This change in attitude just took an awareness of what we were dealing with and placing an importance on keeping it in check.

The same idea could be applied to women and their menstrual cycles, and since more women are going into the workforce and taking key positions, the problem may start to be seen as one that should be addressed. The objective would be to become master of the problem rather than the problem being the master of us, dictating whether or not the workday will or will not be productive.

Rational or Theoretical Basis for the Study

My theory is that the menstrual cycle does affect the work day of many women in negative ways and that contrary to what many I've discussed this with say, it is a biological problem and can not totally be controlled by the women suffering from its symptoms, anymore than people with high blood pressure can control their problem on their own.

Hypothesis or Question to be Answered

My hypothesis, simply stated, is that "the menstrual cycle does have an effect on job performance, and if those effects are negative, there are productive ways to deal with the negative aspects."

Importance or Significance of Study

This study could be quite significant if women across the country could have the opportunity to work to their full potential in their jobs without being hampered by biological problems that affect the quality of work they do, the amount of work they do or whether or not they even go to work.

Assumptions and Limitations of the Study

The limitations of my study are clear-cut. My sample size is small, nonrandom and only incorporates women in the education profession. But, I can look at each of these limitations and turn them into positives.

My concern with not being thorough led me to do a bit of side reading about small sample sizes. In Kurt Finsterbusch's article titled "Demonstrating the Value of Mini Surveys in Social Research" (Sociological Methods and Research, August 1976, 5(1), 117-136), he states that mini surveys can be quite valid and informative. They are an excellent probing instrument to check an unlooked at area to see if further, greater studies are applicable. For someone, like myself, on limited funds and a limited time line, a small sample can get to the heart of my questions and yet show the capabilities of riding tandem with further, larger studies.

Because my study will be nonrandom, I expect my response rate to be quite high. Even though my sample only uses women in the education profession, the sample is still representative because they are all women, they all work and I will assume they all have

or have had menstrual cycles. Thus, they are an excellent mirror of the population of interest.

Organization of the Remainder of the Study

The most positive aspect of my study is the support and interest it has generated where I work. While working on my questionnaire, I started feeling out the people at work as to what they thought about my choice of study. Everyone I talked to was surprisingly excited to find out that someone had taken an interest in a subject often ignored and were quite receptive to filling out the questionnaire. Their response has really motivated me to become knowledgeable about my study so that I can impart information to them.

Besides a literature review and presentation of the results of my questionnaire, my thesis includes an appendix on what is being offered in the general Phoenix area, a bibliographic section with annotations on books I feel worth reading and newsletters worthy of subscription. All in all, working on the total concept that I am helping others has generated a real energized aura around this whole project.

CHAPTER II

REVIEW OF LITERATURE

REVIEW OF LITERATURE

Introduction:

The operational definition of **premenstrual syndrome** used throughout this paper is taken from Laversen and Stukan (1983) which describes P.M.S. as "any combination of emotional or physical features that occured cyclically in females before menstruation, and that regressed or disappeared toward the end of menstruation." The term premenstrual syndrome (P.M.S.) describes the monthly symptoms that women experienced.

More than fifty years of scientific research has been devoted to tracking down the causes of the condition, and many years of further investigation are needed. The literature reviewed will be from the last ten years only. The literature written before that time holds historical significance and is referred to many times in the recent literature, but when dealing with an area where major research is ongoing now, more recent sources are the most useful.

The review will be divided into sections to insure thorough coverage. One section will address the books that were reviewed. Because they tended to cover a wealth of information, each book will be annotated for further reference by the reader. Another section will cover the popular articles done on the subject. Popular articles are significant because they are widely read by a cross-section of people. It is important to see what general idea of the syndrome is being fed to the public. Because the articles tend to be short and usually written to make only a few overall points, this section will be set up in a chart form. The chart will show several generalizations about premenstrual syndrome that will discussed in the concluding part of the review. A section charting newsletters and other sources are added as part of the review.

Even though there are over 300 medical articles written on the subject of P.M.S., they have not been included because their audience is that of the medical profession. Just the titles, like "The Effect of Osmotic Stimuli on Prolactin Secretion and Renal Water Excretion in Normal Man and in Chronic Hyperprolactinemia", says that they are not written for someone outside the medical profession. In fact, the books that were reviewed stated that they have taken their information from the medical journals and put it into layman's terms for their readers. Medical articles have been noted in the bibliographies of several of the books because they have been written for patient and doctor.

Dalton, Katharina, M.D. (1983)

Once a Month,

2nd Revised Edition Claremont, CA.:Hunter House Inc.

BACKGROUND: Katharina was born in England in 1916. Her personal experiences and her interest in the menstrual cycle started in 1953, when she collaborated with Dr. Raymond Greene on the first paper in British medical literature to be written on premenstrual syndrome. Even though her early training was as a chiropodist, she has now become an acknowledged authority on the subject worldwide. "Through her work, research and writing she is advancing medical and lay knowledge of menstrual problems and their effects."

PURPOSE: The books first edition was written to inform the world that the menstrual monthly suffering is not psychosomatic, but is caused by a treatable hormonal disorder. Dr. Dalton also states that it was written to help men to understand and appreciate the menstrual problems of women, so they can work together to overcome those difficult days. The second edition came from a need to deal with emerging issues, such as legal implications and the feminist movement.

Friedrich, JoAnn Cutler, P.A. (1987)

The Pre-Menstrual Solution

San Jose, CA.: Arrow Press

BACKGROUND: JoAnn Cutler is a physician's assistant whose initial investigation into combating P.M.S. was to find a cure for herself. After reviewing literature on the subject for over two years, she contends her treatment program came by way of serendipity. Out of the 392 women who responded from a survey sent out to 3,000 women, no one considered their premenstrual symptoms mild, 7% moderate, 28% severe and 39% marked their symptoms as being incapacitating. She also noted that 19% of the women who had severe symptoms were bedwetters when they were younger and 98% of all the women surveyed had disturbance in sleep patterns premenstrually.

PURPOSE: JoAnn Cutler contends that her book is the first book on record to offer a real solution to P.M.S. Her solution is called **"The Tryptophan Treatment Program"**. Tryptophan is a food supplement which is one of the 22 amino acids which help to augment a certain chemical in the brain known as serotonin. Her program calls for 500 mg. of tryptophan three times per day and to increase dosage two or three days before ovulation to 4-6 tablets. Besides dosages of tryptophan, it is essential the patient receive adequate sleep and take multivitamins and minerals every day or the program will not work.

COMMENTS: JoAnn Cultler thoroughly backs her program with statistics, literature foot notes, background on important chemicals in the brain, a chapter showing how sleep patterns affect P.M.S., nutritional information, existing theories, cures that have been

tried but were not true, and social attitudes then and now about P.M.S. Even if the reader was not interested in the author's prescribed program, the book is worthy reading and is full of useful information.

Halas, Celia Ph.D. (1984)

Relief from Premenstrual Syndrome

New York: Frederick Fell Publishers.

BACKGROUND: Dr. Celia Halas and Dr. Marshall L. Smith, Jr., M.D. and Ph.D., founded the P.M.S. Institute in Phoenix, Arizona in 1982. They believe that P.M.S. has a physiological cause, with both physical and psychological manifestations. Their treatment plan was founded on that premise. Although their program is tailored individually for each patient, there are some general instructions for self-help that they suggest to everyone. These revolve around excercise, nutrition, dietary changes and transient hypoglycemia. If, after 3 months, there is little or no improvement after integration the above regime, medical treatment may be introduced to the patient, along with the self-help care. The clinic is still functioning in Phoenix, Arizona, under Therese Halas, M.A., A.T.R. and Bonnie Shcolnik, Ph.D. It is located at 4541 N. 7th Street, Phoenix, Arizona. Telephone # - 602-279-2233.

PURPOSE: The purpose of the book in addition to familiarizing women and their familes with the nature of P.M.S. is to explain the self-help therapies that will alleviate or reduce their symptoms and to suggest other available avenues of assistance if needed.

COMMENTS: Celia Halas' book takes an in-depth psychological and sociological look at the ramifications of P.M.S. Besides providing diet and excercise tips that help the physical symptoms of P.M.S., she examines extensively the unnecessary stress, self-defeating behavior and guilt feelings women with P.M.S. experience. Her epilogue entitled, "P.M.S. Is a Feminist Issue", is especially poignant in its appeal to all women,

to join forces to alleviate a common problem rather than dividing into those that deny and those who recognize P.M.S.

Laversen, Niels H., M.D. and Eileen Stukane (1983)

Premenstrual Syndrome and You

New York: Simon and Schuster, Inc.

BACKGROUND: Dr. Laversen's interest in P.M.S. was spurred by Dr. Katharina Dalton's research on P.M.S. Radio and television interviews gave him the opportunity to talk to women all over the country. They repeatedly asked for more information of P.M.S. to relieve their suffering. This book was written to give them that information. It is not only geared to the P.M.S. sufferer, but also the concerned symptom-free woman and men who are concerned enough to want to be informed.

PURPOSE: The purpose of the book is to help interested readers understand a complex condition that has become one of the greatest medical and political controversies of our time. It is meant to be a handbook not only to P.M.S. sufferers, but the scientific explanations have been included to aid many physicicans in becoming equal partners with women with P.M.S. "Awareness guarantees a route to health improvement techniques and proper care from doctors".

COMMENTS: Besides an extensive bibliography that includes over three hundred articles and books, Dr. Laversen's book has a comprehensive list of clinics across the country that specialize in P.M.S. treatment. The book provides excellent coverage, by being thorough in its attempt to discuss P.M.S. yesterday, today and tomorrow.

Nazzaro, Ann L., Ph.D., and Donald R. Lombard, M.D. (1985)

The PMS Solution

Minneapolis, MN.: Winston Press, Inc.

BACKGROUND: Ann Nazzaro and Donald Lombard specialize in chronic health problems that respond to nutritional medicine. They found through their research using a nutritional approach to depression was that women who took prostaglandin-regulating nutrients began to experience a marked diminution of premenstrual tension. Nazzaro's experiences with treating her own premenstrual syndrome formed the basis of the program subsequently developed for P.M.S. by means of prostaglandin-regulation through nutrients.

PURPOSE: The purpose of The PMS Solution is to instruct women with P.M.S. as to an effective, medically proven nutrition program that can combat the symptoms of P.M.S. They assert their program to be safe and effective without using potentially harmful drugs or hormones.

COMMENTS: Their are several schools of thought as to how to control P.M.S. Some feel P.M.S. should be dealt with through the medical profession; others feel that is is more psychologically based and support groups and/or counseling produce the best results. Yet, there is a substantially large group that prefer to conquer through holistic ways. **The PMS Solution** is written for this school of thought, although in the foreword of the book it states that the book was designed to augment and/or facilitate direct care by health professionals and tht the authors cannot take any medical or legal

responsibility. Nevertheless, the book holds valuable nutritional information that marks important reading for those with or without P.M.S.

SOURCE: Frank, Ellen (1988, March). The lady and the cramps. Mademoiselle p.108(2)

PURPOSE: Advocating the need to have the reader find out if they really have P.M.S. rather than another disorder.

MAIN POINTS:

*A number of women who believe that they are slaves to they symptoms of P.M.S. actually owe their troubles to another disorder, such as depression, hypoglycemia or migraines. There are 60 possible culprits.

*If you suffer from a clinically treatable case of P.M.S., they will appear 10 to 14 days before menstruation and cease about the time your period begins. If your symptoms appear randomly throughout the cycle, you probably have a disorder other than P.M.S.

OTHER INFORMATION:

*P.M.S. expert Jean Endicott, Ph.D. professor of clinical psychology at the Columbia University College of Physicians & Surgeons in NYC, notes that stress reduction, dietary changes, excercise and P.M.S. education "adequately control or reduce severe cases of P.M.S. in 60%

*The more external stress a woman with P.M.S. has, the worse her P.M.S., says Sharon Rupp, R.N.C. of the Duke Univesity Medical Center's P.M.S. Clinic in Durham, N.C. Stress exacerbates the body's hormonal ups and downs.

SIGNIFICANCE:

*Doesn't rule out underlying (additional) disorders that may need specific treatment.

SOURCE: Randal, Judith (1985, Nov.) Premenstrual Syndrome Update. Glamour p. 262(5)

PURPOSE: The article looks at the up-to-date information on what P.M.S. is, ways in which it is being treated, what knowlegeable people in the field agree on about the syndrome and where the reader can seek additional information of P.M.S.

MAIN POINTS:

What is it?

*may be several types of P.M.S.each requiring different sorts of treatments.

*symptoms may change over the years or even month to month in the same woman.

*70% of woman who have S.A.D.(seasonal affective disorder) also have P.M.S.

*P.M.S. can heighten an emotional disorder that is under the surface the rest of the month.

*P.M.S. is a separate problem from dysmenorrhea (painful cramps)

*most women who have P.M.S. have painless or nearly painless periods.

Treatments:

*Treatments for P.M.S. is as controversial as its cause. No one treatment is universally accepted as being effective primarily because few rigorous scientific tests have been performed on them.

Natural progesterone therapy

Risk: Animal studies suggest that this hormonal therapy may increase chances of breast cancer.

Vitamin B-6 therapy

Risk: In massive doses (2,000 mm/day) B-6may be toxic to the nervous system and cause bad dreams, difficulties in walking, nausea, tingling and numbness of hips, hands, legs and face.

Avoid calcium in milk and other foods

Risk: Even though some doctors feel calcium may interfere with the absorbtion of magnesium, needed for normal brain activity, avoiding calcium may result in osteoporosis later in life.

*Herb Therapy

Risk: Dong quain, tang quai, tang kuel, dang qui and pinyan all contain psoraien that can cause sensitivity to sunlight.

OTHER INFORMATION:

*Most P.M.S. products on market contain (1) acetaminophen (500 mg) (2) pamabrom (25 mg) (3) pyrilamine maleate (15 mg) --(1) nonaspirin pain reliever found in Tylenol and Datril (2) mild diuretic (3) antihistamine

*P.M.S. is a social as well as a medical problem.

*Badge of female inferiority? (1) 90% of all violent crimes are committed by men. (2) Men and women in jobs with the same degree of responsibility have virtually identical absenteeism rates.

*Three experts agree on these basic points: (1) A 3 month, careful, daily record should be done. (2) Treatment should start with change in diet. (3) Recommend high protein between-meal snacks and eat more often. (4) Cut-out refined sugar and alcohol. (5) Regular excercise (6) Minimize stress, if possible (7) Vitamin-mineral supplement called Optivite (8) Drug therapy last resort.

*Authors: (1) Jean Hamilton, psychiatrist who has done P.M.S. research for government (2) Michelle Harrison, M.D. (3) Penny Wise Budoff, M.D.

SIGNIFICANCE:

*Thorough look at the syndrome, what has been done in the area, and what further studies are being done in the future to help women with P.M.S.

SOURCE: Hales, Diane (1987, Jan.) The lowdown on P.M.S. Seventeen p. 116(2)

PURPOSE: The main audience this article was geared to was teenage girls. It emphasized to young girls not to panic whenever there are changes with their bodies, but to be aware of them, keep them in perspective, and take steps to feel better throughout their cycle.

MAIN POINTS:

*3%-10% of women suffer from such severe P.M.S. that they can't function normally.

*Last 10 years, P.M.S. recognized as a biological disorder.

*Rates of crime, suicide and accidents are higher for premenstrual women, but still lower than they are for men at any time of the month or the year.

*P.M.S. may run in families.

*Most P.M.S. cases are reported by women in their thirties.

* Dr. Barbara Perry, who studied P.M.S. at the National Institute of Mental Health, has found teenagers have more physical complaints, such as weight gain and pimples, while women in their twenties and thirties experience more psychological difficulties, particularly mood swings.

OTHER INFORMATION:

*If you suspect you have P.M.S., ask yourself two questions: (1) Do the symptoms recur each month just before your period and then disappear afterwards? (2) Do they disrupt your life?

SIGNIFICANCE:

*Even though the information was written for teenagers, there is significant information that applies to all women that may have P.M.S.

SOURCE: Fortino, Denise (1987, Nov.) Can excercise cure P.M.S. Women's Sports and Fitness p. 44(4).

PURPOSE: To explain ways that excercise may be able to ease premenstrual symptoms.

MAIN POINTS:

*40% of all women suffer at least one P.M.S symptom.

*5%-10% have severe P.M.S. that disrupts personal and professional routines.

*Lifestyle and diet alter P.M.S. severity.

*A number of studies indicate that women who excercise are less likely to suffer extreme symptoms of P.M.S.

*The hypothalamus, the part of the brain that regulates estrogen/ progesterone output, emotional responses, appetite, blood sugar levels and fluid balance, may be the key to understanding how premenstrual problems occur. How exactly the hypothalamus influences P.M.S. is still a mystery. Some researchers believe that the syndrome relates to low levels of serotonin, a brain chemical that may interfere with normal sleep patterns and give rise to anxiety. Low serotonin levels are also linked to early ovulation and shortage of progesterone.

*How does excercise relieve P.M.S?

-releases beta-endorphins that enhance mood

-dissipates muscular tension

-decreases fluid build-up

-increases the effectiveness of insulin

*Excercise that raises your heart rate above 120 for at least ten to 15 minutes several times a week.

*Too much excercise may intensify P.M.S. problems. Adrenalin uses up the calming serotonin and this in turn causes insomnia, agitation, food cravings, fatigue and other classic P.M.S. symptoms.

*About 14% experience a physical and mental high that starts at ovulation and lasts till the flow begins.

OTHER INFORMATION:

Extended Readings:

*Dr. Patricia Allen, New York gynecologist and co-author of Cycles: Every Woman's Guide to Menstruation.

*Dr. Niels Laversen, Premenstrual Syndrome and You.

*Dr. Michelle Harrison, Self-Help for Premenstrual Syndrome.

SIGNIFICANCE:

*Excercise can be one antidote to premenstrual syndrome.

SOURCE: Cerrato, Paul (1988, Jan.) Dietary help for P.M.S. patients. RN p.69(2).

PURPOSE: Those patients diagnosed as suffering from P.M.S. may find help in changing their diet or adding various supplements. The article looks at several of these ways.

MAIN POINTS: *Low-sodium diet-No proof that a low-sodium diet can reduce edema. Yet, many P.M.S. patients swear that it can. Each should experiment.

*Hypoglycemic diet-Reactive hypoglycemia, an abnormal drop in blood glucose after a high carbohydrate meal. Most experts doubt that P.M.S. patients suffer from full-blown hypoglycemia. They may exhibit a mild abnormality in the way they metabolize sugar.

*Vitamin supplements-**B-6** (50-500 mg)\might relieve edema, breast tenderness, depression, nervousness and irritability. More effective with B-complex tablet. More than 250 mg of B-6 should be monitored. **Vitamin E** (150-300 IU daily) might reduce, over 2 month period, over 2 month period, tension, anxiety, mood swings, but a large amount daily could make symptoms worse. Only one study done. Large amounts up to 600 IU limit, were needed to reduce headaches, depression, sweet cravings and mental confusion. No vitamin E if patient suffers from hypertension or heart disease. **Primrose oil** capsules (Efamol) - Three studies have shown it relieves P.M.S. In a Welsh study, 500 mg capsules, six times daily for 3 months reduced breast tenderness.

SIGNIFICANCE:

For a recently published article, it was lacking in any new information on helping P.M.S. victims. It does, although reinforce the important fact that each P.M.S. sufferer must be treated individually.

SOURCE: Andrews, Lori B. (1985, Jan.) The truth about P.M.S. Parents Magazine. p. 51(6).

PURPOSE: Questions the biology only theory.

MAIN POINTS: *In 1970 Edgar Berman, M.D., former Vice-President Hubert Humphrey's doctor, said females weren't fit to be bank presidents because they were subject to "raging hormonal influences". *Stress always makes anxiety and depression worse, in men and women. Anxiety and depression are cardinal P.M.S. symptoms, so there is a strong inter-active factor between life's stresses and P.M.S.

*12%-14% of women are more creative and energetic in the ovulation-through-onset- of-menses period rather than the other end of the spectrum.

OTHER INFORMATION:

*"When doctors name and describe it, it suddenly becomes manageable. P.M.S. is allegedly biological.

*Refers to Michelle Harrison's book, Self-Help for Premenstrual Syndrome (Random House).

SIGNIFICANCE:

*Taps other areas of research that says P.M.S. can be brought on by social factors, stress or that P.M.S. may be learned.

SOURCE: Brutis, Grace (1987, May) Eat to beat P.M.S. Mademoiselle p. 180(1).

PURPOSE: A guide to P.M.S. control through better nutritional habits.

MAIN POINTS: *Ten tips for P.M.S. Prevention: (1) Eat four servings of whole-grain or enriched breads and/or cereals daily. (2) In general, eat more carbohydrates. (3) Restrict your intake of sugar, alcohol. (4) Omit coffee, tea, chocolate and other caffeine products from your diet. (5) Don't add extra salt to food or eat foods high in salt (ham, potato chips) (6) Eat lots of leafy green vegetables. (7) Limit dairy products (low-fat or skim) to two servings daily. (8) Select fish, poulty, whole grains, nuts and legumes--not fatty meats or cheese-as sources of protein. (9) Avoid fried and fatty foods, which can make you feel sluggish. (10) Don't go on severely restrictive diets; keep your food intake varied.

OTHER INFORMATION:

"Cures to be wary of..."

*Overdosing on vitamin B-6 supplements may result in severe neurological problems.

*Primrose oil is often sold with claims that it cures P.M.S. This is false.

*Many nonprescription P.M.S. supplements are now available but whether or not they actually work is debatable.

SIGNIFICANCE:

*Self-help information that helps to educate women with mild P.M.S. symptoms.

SOURCE: Heimel, Cynthia (1986, Feb.) P.M.S. Unmasked. Playboy, p.35(1).

PURPOSE: Takes a light look at P.M.S. by suggesting ways a woman's significant other can make that time of month easier.

MAIN POINTS:

*There is a drastic reduction in progesterone when fertilization does not occur. Its purpose is to maintain the body for pregnancy.

*Estrogen, the other main female hormone, steps up production to get the sex drive operating for next month.

SIGNIFICANCE:

*Very little information. More of a pep talk for coping with "that time of month" for the male population.

SOURCE: (1985, Jan.) Medical root for P.M.S. found Science News p. 24(1).

PURPOSE: Explains the study done that led experts to label P.M.S. as a biological problem.

MAIN POINTS:

*Hormonal levels fluctuate on a cyclic basis.

*Changing hormone levels can effect mood.

SIGNIFICANCE:

*This study is one of the first to say that P.M.S. has a biological basis rooted in the reproductive system.

SOURCE: Carey, Joseph (1986, May) Is P.M.S. mental illness. U.S. News & World Report p. 60(1).

PURPOSE: Looks at the major controversy around labeling P.M.S. a mental illness.

MAIN POINTS: *Pro: A.P.A. officials want to add it to their diagnostic manuals so insurance firms will be encouraged to reimburse physicians for treating this problem.

*Con: P.M.S. as a mental disorder is not based on solid research and could keep women out of important, well-paying jobs.

SIGNIFICANCE:

*How P.M.S. is designated in medical manuals will determine who the insurance company will pay.

SOURCE: Holden, Constance (1986, Jan.) Proposed new psychiatric diagnoses raise charges of gender bias. News & Comment p. 327(2).

PURPOSE: Looks at both sides of the debate over labeling P.M.S. as a mental disorder with changes of gender bias.

MAIN POINTS:

Pro-

*Robert L. Spitzer, psychiatrist of the New York Psychiatric Institute, heads the pro-group.

*Doesn't accept the basic principal that concentration in one sex equals bias.

*Formalization of the diagnosis will make it clear that women do not suffer from "raging hormones".

*Spitzer says diagnosis is justified in view of the fact that the majority of women who complain to their doctors are more distressed about the psychological than the physical symptoms.

Con-

*Feminist critics do not deny the existence of a premenstrual syndrome but contend that it should remain only a gynecological diagnosis, and that its inclusion in the psychiatric lexicon contributes to the stigmatization of normal women.

*Critics say it reinforces the idea that being a woman puts one at additional risk for psychiatric disorder.

*Diagnosis many steps beyond what is actually known about the menstrual cycle.

*Women who fear being stigmatized for mental problems will be less adverse to seeking help.

OTHER INFORMATION:

*Diagnostic and statistical Manual of Mental Disorders (DMS-III), published by the American Psychiatric Association (A.P.A.), is the basic reference book for mental health clinicians. It is generally regarded as representing the consensus of the psychiatric profession on diagnoses of disorders.

SIGNIFICANCE:

*The DSM-III manual provides standardized diagnostic criteria used by insurance carriers.

*The DSM-III manual can reflect cultural attitudes. An example would be when the manual discontinued listing homosexuality as a behavioral disorder.

SOURCE: Quinby, Brie (1986, Sep.) Little menstruation aggravations. Mademoiselle p.166(1).

PURPOSE: Looks at how to deal with several less severe P.M.S. symptoms.

MAIN POINTS:

*If your low-energy bouts tend to come about a week before your period, the high progesterone level in your body may be to blame. Progesterone has tranquilizing effect. High-protein snacks like yogurt could help, while other studies suggest complex carbohydrates, like a slice of whole-wheat bread.

*Backaches may be caused by an increase in the hormone called prostaglandins which also causes cramps. Prostaglandin inhibitors are suggested.

SIGNIFICANCE:

*A little bit more information is given about women's hormones that hasn't previously been covered.

SOURCE: Witkin-Laroil, Georgia (1985, July) All in your head. Health p. 6(1).

PURPOSE: Takes a look at several studies that would strongly indicate that P.M.S. was not "all in your head".

MAIN POINTS:

*Research contest that non-ovulating women who menstruate hardly ever experience P.M.S.

*A study that used artificial hormones to provide constant hormone levels, premenstrual anxiety and hostility increases seemed to disappear.

*Many studies show that headaches are the most frequently reported premenstrual symptom worldwide.

*Studies are also focusing on a hormone called prolactin.

*If prolactin levels increase premenstrually, so do water levels in breast tissue. Prolactin may also lower levels of a chemical called serotonin in the brain. The suspected results are food craving and depression.

*Stress influences the brains emotional control center, the hypothalamus, which in turn influences the ovaries' production of estrogen and progesterone. Premenstrual syndrome can create stress and indicate stress. Either way, the symptoms are real.

OTHER INFORMATION:

Extended Reading:

*Georgia Witkin-Laroil, Ph.D., author of the book, The Female Stress Syndrome.

SIGNIFICANCE:

*Very good information about P.M.S. research contained in this article.

SOURCE: Kotin, Leslie (1986, Dec.) Preventing P.M.S. Essence Magazine p.14(2).

PURPOSE: Stresses body awareness in helping to reduce premenstrual symptoms and explore different theories as to what might cause P.M.S.

MAIN POINTS: *The syndrome affects about 70% of all menstruating women and seems most common among those in their twenties and thirties.

*The premenstrual phase can be recognized by a group of regularly recurring physical and emotional changes that happen from 2 to 14 days before the start of menstrual period.

***The Cycle**--Three glands are responsible for producing and secreting five known hormones that participate in the menstrual cycle. **Phase One**--*Follicular Phase* in which the egg is being nutured. Hormones produced in which luteinizing release factor (LRF) follicle, stimulates hormone (FSH) estrogen. Egg matures and begins journey for fertilization. Hormones produced are more (LRF), luteinizing hormone (LH) and more estrogen. **Phase Two**--*Luteal Phase* or *Premenstrual Phase* in which follicle nuturing the egg begins to disintegrate. Hormones released are estrogen and progesterone (by the ovaries). Hormones continue to be produced for about 12 days, dropping off in last few days. **Phase Three**--Fertilization occurs or membrane that lines the uterus is shed-onset of menses. As menses begins, a chemical message is sent to the brain to begin the cycle again. **Note:** Not every

women has a 28 day cycle. Thus the length of the luteal or premenstrual phase could be shorter of longer.

*Theories based on preceding information:

#1. "Women who suffer from P.M.S. have a longer luteal phase which lasts 17 days instead of 14 days. The phase is longer because serotonin doesn't block the production of (LH) too early, so that there is a surge of the hormone late in the menstrual cycle. The level of progesterone is too low in comparison to the amount of estrogen present during the luteal phase." -- JoAnn Friedrich.

#2. "P.M.S. symptoms are due to a complex chain of events that involves fluctuations in the ratio of estrogen, progesterone and prolactin. The inbalance of these hormones causes an increase in other substances, which could possibly be prostaglandins. These in turn affect the amount of chemical messengers present in the brain which causes pain, tenderness and nausea and neurotransmitters have a direct affect on mood." --Penny Wise Budoff, M.D.

OTHER INFORMATION:

Extended Reading:

*The Pre-menstrual Solution, by JoAnn Friedrich (Arrow Press; 760 Market St., Suite 315, San Francisco, California. 94102; $14.95)

*No More Menstrual Cramps and Other Good News, by Penny Wise Budoff, M.D. (Punguin Books; $7.95)

SIGNIFICANCE:

*An in depth look at the menstral cycle and complex causes of P.M.S.

SOURCE: Caplan, Brina (1986, Sept.) Crazy by definition. Savvy p. 82(4).

PURPOSE: Looks at both sides of the issue in the debate over labeling women with P.M.S.as mentally ill.

MAIN POINTS:

Diagnostic Manual of Mental Disorders

*Industry handbook.

*Courts, insurance companies and the government rely on it.

*Changes in the manual can alter the boundary between mental illness and mental health for millions of patients, most of whom (70%) are women.

*Getting a diagnosis into or out of the manual is as much politics as it is science.

*Disorders listed in the main section of the book are approved diagnoses; those in the appendix are used to establish research standards for disorders that need further definition.

*Periluteal phase dysphoric disorder is is a psychiatric version of P.M.S.

*The feminist critics are being accused by their opponents of sacrificing science for politics. That charge would ring true if psychiatry were an exact science, but it isn't. All diagnoses included in the manual are the result of committees who argue, dicker and horsetrade before reaching a consensus. Women in the profession are simply doing what others have done before them-demanding their point of view be heard.

SIGNIFICANCE:

*The article shows that any gender bias that might be incurred in the psychiatry profession is being diluted by the fact that there are more women in the profession keeping things realistically even.

SOURCE: Weinhouse, Beth (1985, Feb.) Hopeful new treatment for P.M.S. sufferers. Ladies Home Journal p. 42(1).

PURPOSE: Announces a 6 month study done with a new hormonal treatment for P.M.S.

MAIN POINTS: *Using brain hormone called GnRH-agonist (prevents ovulation) an array of physical and psychological P.M.S. symptoms can effectively be relieved without serious side effects. Unfortunately, long-term use of this hormone is not advisable because it inhibits estrogen.

SIGNIFICANCE:

*Article illustrates the amazing chemical factory that makes-up the human body and the complexity of dealing with the multitude of chemicals in research and application.

CHAPTER III

METHODOLOGY

METHODOLOGY

THE SURVEY

The Design

To minimize mistakes, several references were reviewed before writing and designing the survey (Exhibit 1). displayed on page 44. Because each questionnaire is unique to its circumstances, I wanted to tailor it to meet the specific goals in mind, yet limiting blatant errors that could result from overlooking helpful tips easily found in preparatory reading. Checklists in the references were extremely valuable in formatting the questionnaire and stimulating response.

The computer typed survey was divided into three parts, with each part separated on individual pages to group items into logical sections. Part One dealt with non-threatening demographic information about the subjects and their menstrual cycle, Part Two questioned their job and what effect they felt their cycle had on their work and Part Three explored ways they have dealt with their menstrual cycle and if they had any interest in the survey topic.

All three pages of the survey were xeroxed on light pink paper to make it more appealing to the female population being sampled. The study's title was in bold type on the first page with simple, brief directions placed just below. The most important questions were in Part Two before the respondent had time to tire. Each question was worded simply, with only one piece of information being requested at a time.

Survey Implementation

Since my sample size of 60 respondents was small, it was imperative that the response rate be high. To stimulate response, I approached the implementation of the survey with a specific strategy.

Each survey was hand delivered, which made it more personalized and gave me a chance to assure each respondent of confidentiality and a choice of anonymity. A "survey-drop" site was setup where respondents could return the survey unsigned. The "hand-delivery system" also gave me the opportunity to talk about why I was doing the survey and reasons the specified topic was chosen, which avoided the necessity for a cover letter.

A check list of everyone I gave a survey to was filed, and a couple of days later, I checked back with everyone on the list to see if they had returned the survey. This also gave me the opportunity to receive feedback and answer any questions. Because a good rapport had already been established with the sample group, it did not surprise me to get a 100% return rate on the questionnaires.

Label This - Exhibit 1

EFFECTS OF P.M.S. ON YOUR JOB PERFORMANCE

DIRECTIONS: Please respond to each question based on your own personal opinion and experience.

PART ONE:

1. What is your birthdate? _____ Month _____ Day
2. Mark your age range: _____ 20's _____30's _____ 40's _____50's
3. Mark your marital status: _____ Never married
   _____ Married now
   _____ Separated
   _____ Divorced - single
4. How many children in your home? _____ Or _____ None
5. When did you start your menstrual cycle? _____ Years old
6. What type of cycle do you have now? _____ Regular
   _____ Irregular
7. From start to finish, how many days in your cycle? _____ Days

PART TWO:

1. How long have you been at your present job? _____

2. How stressful do you consider your job?
   _____ Never
   _____ Sometimes
   _____ Always

3. How often do you interact with humans during the work day?
   _____ Never
   _____ Sometimes
   _____ Always

4. Check the symptoms affecting your menstrual cycle:

_____	Tension	_____	Irritability
_____	Depression	_____	Anxiety
_____	Fatigue	_____	Cramps
_____	Headache	_____	Backache
_____	Difficulty concentrating		
_____	Perfectionism		
_____	Clumsy		

5. How often does your cycle make you miss work?

_____ Never

_____ Sometimes

_____ Always

6. When are the symptoms the strongest with your cycle?

_____

_____

7. How often do you feel your menstrual cycle affects your job?

_____ Never

_____ Sometimes

_____ Always

8. Where are you now in your menstrual cycle?

_____ Near starting

_____ In my cycle

_____ Just finished

_____ Near ovulation

PART THREE:

1. Check ways you have tried to control your menstrual symptoms:
   _____ Medication
   _____ Vitamin therapy
   _____ Exercise
   _____ Counseling

2. List other ways you have tried to control your symptoms:

   _____

   _____

3. Check the ways that you have used to control your symptoms **that have helped:**
   _____ Medication
   _____ Vitamin therapy
   _____ Exercise
   _____ Counseling
   _____ Other ways listed in question # 2
   _____ None have helped

4. Check what types of information you would like as a result of this questionnaire:
   _____ Newsletters
   _____ Clinic addresses and phone numbers

_____ Workshop/support groups

happenings in the Valley

_____ Any type of information

_____ Nothing

_____ Other _____

_____

_____

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

PRESENTATION AND ANALYSIS OF DATA

EFFECTS OF P.M.S. ON YOUR JOB PERFORMANCE

SURVEY PROFILE

This profile is intended to explore what effects, if any, premenstrual symptoms have on job performance, based on the opinion and personal experiences of 60 women in the field of education. Sixty surveys were distributed and 60 surveys were returned.

The survey asked 19 questions and was divided into three parts. The first part dealt with general demographics, the second part dealt with what effect the menstrual cycle had on job performance and part three explored interest in more information on the topic.

The 60 surveys were hand tallied and three distinct groups surfaced from the 100% surveys returned:

GROUP ONE	GROUP TWO	GROUP THREE
(NEVER)	**(SOMETIMES)**	**(ALWAYS)**
27%	**65%**	**8%**
never felt their cycle affected their job.	**sometimes felt their cycle affected their job.**	**always felt their cycle affected their job.**

Seventy-three (73%) percent of those educators surveyed feel their job is affected by their menstrual cycle.

PART ONE

Group One (NEVER) Out of 16 never responses:	Group Two (SOMETIMES) Out of 39 sometime responses:	Group Three (ALWAYS) Out of 5 always responses:	
4	9	2	Fall births
2	3	1	Winter births
2	12	1	Spring births
8	14	1	Summer births
6	7	0	in 20's
4	21	4	in 30's
5	10	1	in 40's
1	1	0	in 50's
4	3	0	never married
10	32	3	married now
1	0	2	separated
1	4	0	divorced/ single
10	31	5	children at home
6	8	0	none

Age cycle began:

0	0	1	9 years
1	2	0	10 years
3	4	1	11 years
4	20	1	12 years
6	7	1	13 years
2	4	0	14 years
0	1	1	15 years
0	1	0	16 years

Cycle:

13	27	4	Regular
3	12	1	Irregular

Length of menstrual flow:

1	2	0	3 days
3	3	0	4 days
4	11	1	5 days
2	5	0	6 days
1	2	3	7 days
0	1	0	7+ days
5	13	1	Improper response

PART TWO

GROUP ONE (NEVER)	GROUP TWO (SOMETIMES)	GROUP THREE (ALWAYS)	
Out of 16 never responses:	Out of 39 sometime responses:	Out of 5 always responses:	
Years on Job:			
2	5	0	Less 1 year
1	1	1	1 year
3	6	0	2 years
2	3	0	3 years
2	3	1	4 years
1	8	0	5 years
0	1	0	6 years
0	1	0	7 years
0	1	0	8 years
2	3	1	9 years
0	2	1	10 years
0	1	1	11 years
1	2	0	12 years
1	1	0	13 years
0	0	0	14 years

0	0	0	15 years
0	0	0	16 years
0	0	0	17 years
1	0	0	18 years

Job Stress:

0	1	1	Never
16	33	5	Sometimes
0	7	0	Always

Interact with other humans:

0	0	0	Never
0	1	1	Sometimes
16	38	5	Always

Symptoms:

3	25	5	Tension
0	24	4	Depression
6	26	4	Fatigue
2	19	2	Headache
0	7	3	Difficulty Concentrating
0	5	1	Perfectionism
8	25	5	Irritability
1	14	4	Anxiety

5	26	3	Cramps
4	22	4	Backache
0	10	3	Clumsy
1	0	0	No Symptoms

Cycle Caused Absentism:

16	31	2	Never
0	7	3	Sometimes
0	0	0	Always
0	1	0	No Response

Symptoms Strongest:

0	3	0	8-14 days before flow
7	28	5	1-7 days before flow
7	6	0	During flow
2	0	0	Never
0	1	0	No Response

Where in Cycle Now?

3	9	0	Near Start
2	4	0	In Cycle
5	11	0	Just Finished

4	**13**	**0**	**Near Ovulation**
2	**0**	**0**	**No Response**
0	**2**	**0**	**Pregnant**

PART THREE

GROUP ONE (NEVER) Out of 16 never responses:	GROUP TWO (SOMETIMES) Out of 39 sometimes responses:	GROUP THREE (ALWAYS) Out of 5 always responses:
Ways Symptoms Controlled:		
5	23	5 Medication
1	14	2 Vitamin Therapy
6	29	5 Excercise
0	2	1 Counseling
7	0	0 No Response
Other Ways to Control Symptoms:		
Drink lots of water	Rest	Rest
Rest	Diet	Drink Water
Mind over matter	Meditation	Birth Control Pills
Diet	Work-a-lot	Diet

		Hide
		Talk
		Avoid Stress
		Body Awareness
		Elevate legs
		Screaming
		Alcohol
		Think happy thoughts
		Reading
		Shopping

Which Helped?

4	18	5 Medication
0	9	2 Vitamin Tharapy
4	20	4 Excercise
0	1	1 Counseling
2	11	3 Other
1	2	0 None
7	1	0 No Response

Information Wanted:

2	13	2 Newsletter
0	1	0 Clinic Addresses

0	5	0 Workshops
2	13	2 Any type of Information
13	12	2 Nothing
1	2	0 Other: My Survey

CHAPTER V

SUMMARY AND CONCLUSIONS

SUMMARY AND CONCLUSIONS

P.M.S. Yesterday

In the nineteenth century, many women who were about to give birth made out their wills beforehand. It has only been in this century that the incidence of death during childbirth has ceased to be a major threat. If a potentially fatal situation, as childbirth once was, has only recently been dealt with, it is not surprising that a condition such as premenstrual syndrome would be given little recognition in the past.

This is not to say that no one had expressed concern and interest in the condition before now. Although this concern went unrecognized for over fifty years, far back in 1931 P.M.S. was thoroughly described by Dr. Robert T. Frank of New York in his thesis, "The Hormonal Causes of Premenstrual Tension." At that time, no one seemed to care about a paper that made observations reporting such symptoms as fatigue, lack of concentration, epileptic-like convulsions, or nervous tension severe enough to make women want to commit suicide.

In 1953, the distressing symptoms were given a name by two English physicians. Dr. Katharina Dalton and Dr. Raymond Greene, published the first paper in British medical literature on a condition they termed "premenstrual syndrome". In their paper, premenstrual syndrome was cited as a real, hormonally based condition about which women should be informed, so as to initiate treatment from their doctors. Unfortunately, at that time even if women had been informed, the medical profession was not ready to place importance on a syndrome having to do with women's monthly cycle. Women had been well conditioned to accept these monthly maladies as they had accepted possible death with childbearing.

Looking back, menstruating women have been blamed or credited with supernatural powers, blights, harvests of plenty, as causing deaths and numerous other negative occurances. It is not surprising that menstruating women would not have been anxious to complain. In an age where women were trying to live up to society's image of the perfect woman--quiet, self-controlled, uncomplaining even in pain, any women might hesitate to bother her doctor with what might be considered to be a character weakness.

Another reason there may not have been importance placed on the condition was that in comparison to todays women, women of 50 years ago did not experience very many menstrual cycles often enough to think of it as a problem. During the early part of this century being pregnant was a way of life for women during the child bearing years. "If, in a period of ten years, a woman has 3 pregnancies and nurses each child for approximately 2 years, she may have only 12-20 menstrual cycles. But if, given the same time frame, the same woman has no pregnancies, she may have as many as 120 cycles" (Friedrich, 1987). Therefore, it comes to a point where suffering goes beyond tolerance and a definite need for control becomes necessary.

Researchers had looked at P.M.S. in the past, analyzing symptoms and searching for a cause. But, because conclusions have been so varied and numerous theories were reported, physicians became more confused and skeptical.

Scientific theories about P.M.S. included:

*Drs. E.J. Stieglitz and S.T. Kimple, in 1949, reported that an unidentified chemical caused mental, as well as physical, premenstrual symptoms.

*Drs. J.P. Greenhill and S.C. Freed, in 1940, said premenstrual tension was due to excessive salt and water retention.

*Dr. Morton S. Biskind, in 1943, was the first researcher to suggest a connection between symptoms of P.M.S. and a deficency of vitamin B-complex.

*Dr. J.H. Morton of New York, in 1952, conducted a large study that linked hypoglycemia and P.M.S.

*Dr. S. Leon Israel of New York, in a 1938 issue of "The Journal of the American Medical Association", concluded that P.M.S. was caused by a low progesterone level, with a normal or high estrogen level. Drs. Katharina Dalton and Raymond Greene confirmed the estrogen/ progesterone imbalance Dr. Israel had written about in 1953. Dr. Dalton is now an acknowledged pioneer and authority in the field of premenstrual syndrome. She has been able to identify premenstrual changes as relating to criminal behavior, accidents , drug abuse and death.

Many years of research had been devoted to trying to find the causes of this condition, but circumstances both social and scientific were complex and society chose to put it on the back burner.

P.M.S. Today

Acknowledgement:

So, what happened to bring the condition to the forefront? Although the women's movement of the late sixties and early seventies led to an awareness of a woman's body in correlation to her health needs, and even though endocrinologists, gynecologists, and psychiatrists had extensively reported its existence, it took **MURDER** to make society listen. Researchers had realized the extent of the problem, but it took nationwide coverage of the condition, related to murder, to make doctors look at P.M.S. with renewed consideration and importance.

In May, 1979, Sandie Smith, a thirty-year old barmaid from East London, stabbed another barmaid to death. During Ms. Smith's murder trial, Dr. Dalton visited her in

prison and observed her for a year. In May, 1980, Dr. Dalton reported to the court that Sandie Smith had P.M.S., and her violent behavior could be controlled by daily injections of natural progesterone. She was released on probation and ordered to receive daily injections (Laversen, 1983).

Unlike Sandie Smith, who had prior convictions for disruptive behavior, Christine English, thirty-seven years old, had no history of violence or criminal behavior. Yet, in December, 1980, Christine English killed her lover of four years. Dr. Dalton, again was called in and linked Christine's rage and violence to an adrenalin rush from P.M.S.-connected hypoglycemia. The court's decision was to reduce her charge to manslaughter on the grounds of "diminished responsibility".

It is important to note that to be labeled P.M.S. sufferers, Ms. Smith and Ms. English were meticulously evaluated by several doctors for several months. Their behavior followed cyclic patterns that responded to medication. Witnesses for both the prosecution and defense were heard in court and charges in both casess were carefully considered, particularly because everyone connected with the case knew that historical decisions were being made.

These cases have presented P.M.S. in its most extreme form. Most women who have symptoms of premenstrual syndrome are not crazed females, who are emotionally out of control and have completely lost their faculties.

In a 1982 survey in Glamour magazine of over 600 women, 71 percent said they did not believe that courts should accept P.M.S. as a medical condition that produces violent behavior in women. In that same survey 64 percent of the women said they suffered from P.M.S., and 38 percent revealed their P.M.S. was severe enough to disrupt their daily lives.

It is unfortunate that premenstrual syndrome has been given notoriety through the lives of two people, but it has encouraged doctors to regard the condition with seriousness. Awareness is the first step in combating the symptoms caused by the syndrome. The facts are premenstrual syndrome is neither an imaginary condition nor an incurable one.

Research:

Until recently, premenstrual syndrome could not be found in the library's Readers Guide under its own heading. It wasn't until just a few years ago, when subjects were put on computer, that P.M.S. had become significant enough to deserve a topic heading. Thus, a notable amount of literature since the 1980 murder headlines has become available.

Several very important points are made throughout, and reinforced in the literature written on premenstrual syndrome. Most importantly, **that P.M.S. is now regarded as a medical disorder whereas women can acknowledge their symptoms and seek relief.**

Although the debate about the exact cause of P.M.S. continues, most physicians agree that premenstrual syndrome at some point is affected by hormonal fluctuations. The study of P.M.S. is still at the level of descriptive research, which documents and describes all observable aspects of the subject. More and more empirical research is being done now that the mystic fog has lifted around the condition itself.

No two P.M.S. sufferers are alike. Each one is unique in that symptoms vary from woman to woman, and sometimes month to month. Women have, in some ways, impeded the progress of research by being reluctant to discuss their premenstrual symptoms with their doctors. Now, women are working with their physicians to chart

their symptoms, conduct hormonal analyses of their blood, investigate their health history, and formulate a treatment individually designed on a patient-by-patient basis. A by-product of this process is that women are becoming more aware of how their body works from month to month, which will help them recognize when something is wrong.

According to extensive research (Frank, 1988), without a doubt, stress aggravates the syndrome. Stress inhibits the release of hormones and an inadequate amount of hormones can lead to the kind of hormonal imbalance that worsens P.M.S. symptoms. Therefore, a women's hormone levels can switch from normal, to a little off, to severely imbalanced if she is thrust into a particularly stress-provoking situation at work or in her personal life.

Because women do have some secondary power over their biochemistry, the literature strongly supports that medication isn't always the answer to conquering the syndrome. More likely medication should be a last resort.

For instance, studies show (Reid/Yen, 1981) that hormone fluctuation initially is determined by the brain and the brain is influenced by a woman's personal environment. Peptides (Amino acid compounds that orginate in the brain) influence the interaction between the hypothalamus and the pituitary gland responsible for working together to release hormones to the reproductive part of the body.

Outside forces, such as stress, can affect what signals the peptides send to the hypothalamus and pituitary gland. A woman with P.M.S. symptoms can experience more severe symptoms and a woman never having had experienced P.M.S. symptoms can suddenly fall victim to them. Consequently, by dealing with, reducing or removing herself from stress-provoking situations, she could reduce or omit premenstrual symptoms.

Taking actions to deal with stress might take the form of exercise, vitamin therapy, counseling, diet modifications, etc. At any rate, the important point being made in the literature is first be aware of what the premenstrual syndrome entails for each individual and then start with the least extreme remedy.

Simply stated, the research on premenstrual syndrome intersects at these points:

*P.M.S. is a bona fide medical problem.

*Stress definitely affects the syndrome.

*Each P.M.S. sufferer's cure must be individualized.

*P.M.S. remedies should start simple (i.e. diet) and work up to more complex remedies (i.e. medication), if necessary.

Attitudes:

Although the research reviewed did not surface any direct studies showing the effects of P.M.S. on job performance, many indirect references were made...

Case History #1: In David Duff's book Albert and Victoria (about the life of Queen Victoria and her husband Albert) decisions concerning a nation were made by a Queen who we now know experienced premenstrual distress. At that time of the month, the book quotes cabinet ministers flying from her presence, too frightened to follow the rule of withdrawal (Dalton, 1983).

Case History #2: Sarah S. had an extreme problem with low energy premenstrually. She was also depressed and suffered from a loss of motivation. Sarah taught at an elementary school and was disturbed when she did not have her usual tolerance for and patience with the children (Nazzaro/Lombard, 1985).

Case History #3: Nancy is a divorced mother with a ten-year-old son. She works in a real estate office with three other people who know that when she is irritable and frustrated, they had better "back off". Her co-workers adjusted themselves to her changing temperament and even her son left her alone when she was touchy (Laversen, 1983).

Case History #4: Markie's career had definitely been charmed, but as her career was taking off, she found herself plagued by P.M.S. symptoms. Two weeks out of every month she found it impossible to deal with people. It took every ounce of strength she had to keep her emotional turmoil in check at work (Mehren, 1986).

Picking **Case History** after **Case History** from the literatuare reviewed, a thick book could be written of women who site personal experiences where their jobs were affected by P.M.S. It has been estimated that U.S. Industry loses $30 billion annually because of disabilities associated with P.M.S. (Friedrich, 1987).

The survey results in Chapter Four of this paper, a questionnaire given to 60 women in the field of education(Spring, 1989), indicated that 73% of the women questioned felt their job was affected by their menstrual cycle. Another 17% noted that their menstrual cycle sometimes made them miss work. It is important to note here, that studies show women average the same amount of absenteeism each year as men (Randal, 1985),which makes one wonder what the statistics will look like now that women are starting to get help for the condition.

The 27% of the group surveyed who felt their menstrual cycle **never** affected their job cited symptoms of tension, irritability, anxiety, fatigue, cramps, headaches and backaches every month right before their period. The 73% of the group who felt their menstrual cycle affected their work also cited these symptoms premenstrually. The significant difference is that although both groups of women suffer premenstrually from

the same set of symptoms, the survey showed that the group that feels their job is **never** affected by their cycle only suffer the symptoms a few days. The group who feel their job **is** affected by their cycle suffer with the symptoms at least for a week, sometimes longer. Both groups of women could be termed as having P.M.S., by definition, but all women with P.M.S. do not require or want medical attention.

Research supports that women basically have a high tolerance for pain and discomfort (Lauersen, 1983), but now that more women have entered the workforce the attitude appears to be that they cannot afford to tolerate premenstrual symptoms for more than a couple of days. In this age of technology and science that could be considered a fair attitude.

Today, any doctor or employer who does not consider P.M.S. a real and treatable condition would be considered unenlightened. "With modern technology, particularly with the development of the radioimmunoassay, the testing technique that enables doctors to measure minute hormonal levels in the blood, researchers are better equipped to investigate a woman's delicate hormonal fluctuations." (Lauersen, 1983).

The attitudes have changed towards a women's menstrual cycle. Women, doctors, families, friends and co-workers are starting to work as a team to confront and deal with a treatable condition.

P.M.S. Tomorrow

In 1970, Edgar Berman, M.D., former Vice-President Hubert Humphrey's doctor, said females weren't fit to be bank presidents because they were subject to "raging hormonal influences!" (Frank, 1988). It's 1989 and the question of tomorrow is, "will

premenenstrual syndrome be labeled a mental disorder?" The controversey wages on and the literature reviewed was inconclusive for both sides.

Robert L. Spitzer, psychiatrist of the New York Psychiatric Institute, heads the pro side, feeling that diagnosing the syndrome as a mental disorder is "justified in view of the fact that the majority of women who complain to their doctors are more distressed about the psychological than the physical symptoms". He feels formalization of the diagnosis will make it clear that women do not suffer from "raging hormones". He also does not accept the basic principle that "concentration in one sex equals bias" (Holden, 1986).

Feminist critics on the con side do not deny the existence of a premenstrual syndrome but contend that it should remain only a gynecological diagnosis, and that its inclusion in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) contributes to the stigmatization of normal women. They perceive it would reinforce the idea that being a woman puts one at additional risk for psychiatric disorder, a diagnosis many steps beyond what is actually known about the syndrome.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-III), published by the American Psychiatric Association (APA) is the basic reference book for mental health clinicians. It is generally regarded as representing the consensus of the psychiatric profession on diagnoses of disorders. The DSM-III manual provides standardized diagnostic criteria used by insurance carriers, which the pro group feels is another strong justification for the inclusion. However the critics feel the DSM-III can set cultural attitudes, their example being that the manual at one time listed homosexuality as a behavioral disorder. All in all, P.M.S. has also become a lucrative money-making syndrome and one may wonder whom might benefit monetarily by whether it was considered a mental or gynecological medical problem.

So far, the controversy has accomplished dividing women into opposing camps. In the marketplace, where women are just beginning to gain power, it comes as a feminine flaw that might make women emotionally uncontrollable and therefore unfit as decision makers. Celia Halas, in her book, Relief from Premenstrual Syndrome, says we need to see the controversy as an old ploy to make women dispute with one another rather than joining forces to alleviate a common problem. A common problem, that as stated before, affects industry to the tune of $30 billion in losses every year.

It is especially important that an international standard definition be established in the future. Because there is no standard definition, researchers can statistically set anywhere as high as 97% to as low as 20% of the female population in the group qualifying them as P.M.S. sufferers. Although at present no one has been able to declare an official total for the number of women who have P.M.S., most frequently it is heard that 40% of all women between the ages of fourteen and fifty experience P.M.S. Couple that with the statistic quoted earlier in this paper of 66 million women in the labor force by the year 2000, it appears logical that we should start to eliminate problems caused by the syndrome.

First comes an awareness of P.M.S. According to the survey done in Chapter Four, 62% of those questioned were interested in more information on P.M.S. and that percent would indicate interest, which in turn leads to awareness. Following awareness is a respect for the causes of P.M.S. and how it affects work, employers, co-workers, family and self. It is a curable condition, that if treated, has positive effects for everyone.

BIBLIOGRAPHY

CURRENT MAGAZINE ARTICLES:

Andrews, Lori B. (1985, Jan.) The truth about P.M.S., Parents Magazine p. 51(6).

Bureau of Labor Statistics (1986) Women at work: a growing force, Glamour (1989, Feb.) p. 213.

Burtis, Grace (1987, May) Eat to beat P.M.S., Mademoiselle p. 180(1).

Caplan, Brina (1986, Sept.) Crazy by definition, Savvy p. 82(4).

Carey, Joseph (1986, May) Is P.M.S. mental illness, U.S. News & World Report p. 60(1).

Cerrato, Paul (1988, Jan.) Dietary help for P.M.S. patients, RN p. 62(2).

Fortino, Denise (1987, Nov.) Can excercise cure P.M.S., Women's Sports & Fitness p.44(4).

Frank, Ellen (1988, Mar.) The lady and the cramps, Mademoiselle p. 108(2).

Halas, Dianne (1987, Jan.) The lowdown on P.M.S., Seventeen p. 116(2).

Heimel, Cynthia (1986, Feb.) P.M.S. unmasked, Playboy p. 35(1).

Holden, Constance (1986, Jan.) Proposed new psychiatric dianoses raise charges of gender bias. News & Comment p. 327(2).

Kotin, Leslie (1986, Dec.) Preventing P.M.S., Essence Magazine p. 14(2).

Mehren, Elizabeth (1986, May) Markie Post: "Once a month I'm a woman possed.", Redbook p. 86(2).

Quinby, Brie (1986, Sep.) Little menstruation aggravations, Mademoiselle p.166(1).

Randal, Judith (1985, Nov.) Premenstrual syndrome update, Glamour p. 262(5).

Reid, R.L. and Yen, S.S.C. (1981) B-Endorphin stimulates the secretion of insulin and glucagon in humans, American Journal of Obstet. Gynecol. p. 139(47).

Weinhouse, Beth (1985, Feb.) Hopeful new treatment for P.M.S. sufferers, Ladies Home Journal
p. 42(1).

Witkin-Lanoil, Georgia (1985, July) All in your head, Health p. 6(1).

BOOKS:

Berdie, Douglas R. and John F. Anderson (1974) **Questionnaires: Design & Use**, Metuchen, N.J.: Scarecrow Press.

Berdie, Douglas R., John F. Anderson, and Marsha A. Niebuhr (1986) **Questionnaires: Design & Use**, 2nd edition, Metuchen, N.J.: Scarecrow Press.

Dalton, Katharina, M.D. (1983) **Once a Month**, 2nd Revised Edition. Claremont, CA: Hunter House Inc.

Friedrich, JoAnn Cutler, P.A. (1987) **The Pre-Menstrual Solution**, San Jose, CA: Arrow Press.

Halas, Celia, Ph.D. (1984) **Relief from Premenstrual Syndrome**, New York: Frederick Fell Publishers.

Laversen, Niels H., M.D. and Eileen Stukane (1983) **Premenstrual Syndrome and You**, New York: Simon & Schuster, Inc.

Nazzaro, Ann L., Ph.D. and Donald R. Lombard, M.D. (1985) **The PMS Solution**, Minneapolis, MN: Winston Press Inc.

RESOURCES

NEWSLETTERS:

P.M.S Access
P.O. Box 9326
Madison, WI 53715
(1-800-222-4PMS)

Cycles
Box 524
Sharon, MA 02067
$2.00

The National P.M.S. Society
3514 University Drive, Ste. 5
Durham, NC 27707

P.M.S. Action
P.O. Box 19669
Irvind, CA 92713
(1-714-752-6355)

P.M.S. Research Foundation
P.O. Box 14574
Las Vegas, NV 89114
(1-702-731-6476)

ARIZONA CLINICS:

P.M.S. Institute
4541 N. 7th St.
Phoenix, Arizona 85014
(1-602-279-2233)

Flagstaff Women's Resource Center
3 North Leroux Street, Rm. 201
Flagstaff, Arizona 86001
(1-602-774-7353)

P.M.S. Center of Arizona
10565 N. Tatum Blvd.
Paradise Valley, Arizona 85056
(1-602-991-7411)

BIOGRAPHICAL SKETCH

Linda Westcott Hayes was born in Topeka, Kansas on August 21, 1949. Shortly after her birth, she moved with her family to Phoenix, Arizona. As a graduate of Phoenix College and Arizona State University, she has been an elementary classroom teacher and elementary school librarian in the Paradise Valley Unified School District since 1973. A published author, Linda was named Arizona's Educator of the Year in 1986 by the Arizona Congress of Parent and Teachers Association.

Her creative child-centered programs helped Indian Bend Elementary School be named Arizona's # 1 elementary school in 1988. In September, 1987, she entered the Graduate Program at Ottawa University receiving her master's degree in September, 1989.