What counts as a premenstrual symptom?
Exploring contradictory medical definitions of PMS (Premenstrual Syndrome)

Introduction
Hello! I’m Sally King, Director of Menstrual Matters- an information website raising awareness of the link between the menstrual cycle and hormonal medications, with a range of female-prevalent chronic ill-health conditions, especially anxiety, asthma, chronic fatigue syndrome/ ME, depression, IBS (Irritable Bowel Syndrome), and migraine... I am also about to start a PhD on this very topic- ‘What counts as a premenstrual symptom?’ which might sound a bit too straightforward to warrant 3 years of in-depth research, but I hope to be able to show you why this is not the case, and why I am so passionate about a topic that brings together feminist studies, the sociology and history of medicine, and clinical practice.

1. What is PMS?

Most popular and medical sources will generally agree on the following diagnostic criteria for Premenstrual Syndrome (PMS)... However, most of these criteria (in orange) are not strictly true- and they are certainly not universally agreed within diagnostic guidelines for PMS:
a) **PMS can involve any of a wide range of symptoms (physical/ mood)** - First of all, what counts as a ‘symptom’ as opposed to a normal menstrual ‘change’? Plus, the list of ‘symptoms’ varies with each diagnostic guideline; most emphasise the psychological/ emotional ‘symptoms’ and downplay the physical ‘symptoms’ [e.g. 1-5]; some ‘symptoms’ are actually value-judgements on undesirable female behaviour rather than a sign of pathological illness e.g. anger, irritability, aggression, apathy etc. [6, 7]; there is no agreement on the number of determining ‘symptoms’- some sources cite over 100 [2], others 22 [4], or just 7 [1]; and there is no conclusive epidemiological research data to indicate which PMS symptoms are the most common, deterministic, or disruptive – previous attempts to do so have been limited by a bias towards tracking emotional/ psychological symptoms [8], or by asking leading questions, e.g. ‘which menstrual symptoms are... most distressing?’ [8a].

b) **Symptoms range in severity- from non-existent, or mild, to severe**- Whilst this is true, there is no agreement upon when ‘normal menstrual changes’ become ‘symptoms of PMS’- most guidelines simply leave it up to the patient to assess symptoms/ changes as having a significant negative impact on their quality of life e.g. [1-5]; severe physical symptoms/ changes (without mood symptoms/ changes) are more likely to be diagnosed as another chronic ill health condition (rather than PMS) e.g. menstrual migraine, cyclical asthma, Irritable Bowel Syndrome (IBS), or toothache (!) [9]

c) **Symptoms only occur during the luteal phase of the menstrual cycle; from ovulation to menstruation**- Many medical sources agree to this in principle but then state contradictory criteria e.g. ‘5-6 consecutive days before menstruation’ [10], or ‘in the week before menstruation’ [11]; very few explain that symptoms/ changes can also occur around ovulation, or the first 2-3 days of menstruation (see below); and very few explain that a ‘normal menstrual cycle’ ranges from 21-35 days (also a somewhat arbitrary range- simply 7 days either side of the average 28 day cycle- whereas some people have regular cycles of longer than 35 days), to put the luteal phase (the 14-16 days before menstruation) into its relative time context.

d) **Symptoms are relieved by menstruation**- Some people may experience continued menstrual changes/ symptoms into the first 1-3 days of menstruation, and a minority may experience them until day 5 (note: this is based on substantial, albeit anecdotal, data posted on various online patient forums, personal experience, and as mentioned during multiple patient interviews I’ve conducted).

e) **Symptoms are predictably cyclical**- Many external factors can affect menstrual cycle changes/ symptoms e.g. diet, exercise, stress, travel, disturbed sleep patterns, medications, infections, and mineral deficiencies [12]- so it’s not always possible to predict which changes/ symptoms will affect an individual based on the previous few cycles.

f) **Symptoms are caused by changes in sex hormone levels**- Yes, but we don’t yet really understand why or how...!

g) **PMS must only be diagnosed through the use of prospective diary**- Yes, but the ‘daily record of severity of problems’ (most common symptom diary provided by UK doctors) is pretty biased towards psychological changes/ symptoms (see for yourself- [here!]) [13]
2. The historical (and hysterical) context of PMS...

The oldest surviving written document in the world happens to be an Ancient Egyptian list of female reproductive health symptoms/changes and their treatments [14]! The Kahun Gynaecological Papyrus is dated to around 1800 BC. Despite being nearly 4000 years old, the symptom list is all too familiar to those who have a menstrual cycle; sensitivity to light, sensitivity to smell, menstrual toothache, period pain, abdominal bloating, heavy bleeding, headache, and aching lower back & legs.

The cause was thought to be a wandering womb- a malevolent ‘animalistic’ creature with a mind of its own- moving throughout the body - e.g. asthma in the lungs, migraine- behind the eyes/ in the head... Probably informed by the observation of prolapsed wombs, and the fact that these problems disproportionately affected the female population [15].

Cartoon credit: Matteo Farinella http://matteofarinella.com/The-Wandering-Womb

The wandering womb was used as a means to explain the disproportionate prevalence of such symptoms in, and subsequently a justification for the oppression of women, right up to the 17th Century [16]. Time and again we see the same symptoms listed and used to somehow ‘explain’ social ills- for example, demonic possession, & witchcraft...
An interesting side note on the womb’s role in witchcraft accusations [17]:

The Malleus Maleficarum (The Hammer of Witches) written by Kramer and Sprenger in 1487, was by far the most famous book on witchcraft and its influence lasted for more than 200 years. Women were more prone to diabolical possession because they were weaker and imperfect in nature than men: “woman is an imperfect animal, inferior to men”, and a woman’s reproductive system was the proof of this, the uterus being the source of evil [18-20] Women were full of venom during menstruation, so that they were contaminated and capable of contaminating others [21- 23].

Another form of witchcraft was through imagination, a faculty that was believed to be able to produce physical changes in the body. Paracelsus (17th century) thought that women’s illnesses were essentially imagined, but were not unreal. It was believed that the uterus received pathological images that even if they had started as immaterial images, would become real because indomitable
imagination could not be submitted to will. He thought that the process had its origin in the spleen. Because there were two organs that were capable of producing pathogenic images, the uterus and the spleen, women had two sources of evil. That was why women were more powerful witches; however, men could also practice witchcraft through the evil of the spleen. The uterus could also make other organs ill by vicinity, sympathy, or vapours... [24]

3. PMS as a ‘psychological’ issue

PMS as a psychological issue...

“...it is not by chance that the majority of the Dutch ‘Doctor’s Visit’ paintings [depicting hysteria] were produced by artists from the city of Leiden, whose famous medical school invented the specialty of gynaecology.

-Paula M. Dixon

Painting: Frans van Mieris- ‘the consultation’ 1657

It was not until the 17th century that anatomists such as William Harvey (1578–1657) finally proved that the wandering womb was a physical impossibility [25], which, funnily enough, is exactly around the time that hysteria became more associated with the female brain, or mind, albeit somehow ‘poisoned’ or negatively affected by the womb [25]...

Sigmund Freud famously contributed to the myth of ‘female hysteria’, by using it to support his various psycho-sexual theories [25]. Hysteria was real, albeit no longer due to a wandering womb – but was a psychosomatic response to childhood sexual abuse [25]... What we might now call PTSD...

Freud and the re-invention of ‘hysteria’... 1856-1939

The physical symptoms of ‘hysteria’ were downplayed, in favour of highlighting the ‘emotional’ or ‘psychological’ symptoms as the defining aspects of its pathology. Tellingly, through this process of psychologicalisation, ‘hysteria’ also become directly associated with ‘hypochondria’ [25] - perhaps because it was obvious that at least some ‘hysterical’ patients were just pretending (see image below)?
So it is within this context of several thousand years of myth and gender bashing, that Premenstrual Tension (the precursor to PMS) was first described in 1931, by an American doctor called Robert Frank [27]. Interestingly, Dr Frank’s paper initially describes physical symptoms such as severe cyclical asthma, epilepsy, & cardiac irregularity before listing several cases of ‘more typical’ (i.e. psychological) Premenstrual Tension – including the following patient descriptors; ‘almost crazy’, ‘husband to be pitied’, ‘unbearable’, ‘shrew’, and ‘impossible to live with’…

He stated that it was apparently possible to ‘cure’ these social ills through the radiation, or surgical removal, of the ovaries- building on a long history of medical men using genital surgery to curb unwanted female behaviour (sexual, social, or political) [28].

More recently, popular and medical descriptions of PMS have become increasingly psychological, especially since 1994, with the inclusion of PMDD (Premenstrual Dysphoric Disorder) in the DSM (Diagnostic and Statistical Manual of mental disorders) [29]. In fact, many medical sources now describe PMDD simply as ‘severe PMS’ [30-32]. Implying that PMS is largely a ‘mental disorder’- even though it (and PMDD) are both hormonal, by definition.
Revealingly, we don’t see the same categorical confusion over hyper/hypo thyroidism - another female-prevalent hormonal issue that can affect mood changes, alongside a range of physical changes/symptoms (e.g. it is not listed in the DSM). Perhaps this is because the thyroid gland is in the neck, far away from the reproductive organs?

4. **Which premenstrual symptoms count in 2017?**

This definition comes from the latest RCOG professional diagnostic guidelines [1] –

*PMS encompasses a vast array of psychological symptoms* such as depression, anxiety, irritability, *loss of confidence* and mood swings. *There are also physical symptoms*, typically bloatedness and mastalgia.

[I underlined ‘loss of confidence’ because this is a relatively new ‘symptom’ first spotted in 2016 - without any evidence base for its inclusion! Who knew that a subjective sense of self counts as a defining medical symptom?]

The guidelines’ diagnosis infographic also reveals an underlying bias towards ‘psychological’ explanations for PMS...
The box on the far right of the diagram shows what to do if, after tracking, it is found that symptoms also occur during the follicular phase in the cycle… The diagnosis box states that it must be an ‘Underlying psychological disorder, not [a] premenstrual disorder’—the action box suggests ‘Psychiatric referral’… The authors have erroneously assumed that severe PMS-like symptoms are necessarily (exclusively) psychological. So, if your problem is cyclical headaches, nausea, or asthma, this decision tree is of little use…

(See the guidelines, here: http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.14260/epdf)

5. So what?

I’ve basically been showing you how female prevalent symptoms have been noticed and explained over the past 4000 years… With persistent references to hysteria, either in terms of the ‘wandering womb’, or as a psychosomatic or otherwise psychological ‘syndrome’ mysteriously linked to the female reproductive system.

But I am not simply trying to persuade you that PMS is a socially constructed illness that inadvertently (perhaps) provides ‘the evidence’ required by society to perpetuate the myth of the irrational female (in order to justify gender inequalities). In my opinion, that work has already been done very successfully (by some of you in this very room!) e.g. [6, 7].

I am trying to make the specific case that by exaggerating psychological premenstrual changes, and ignoring (or separating out) the physical ones, medicine has (also) failed in its duty to apply scientific rigor to the diagnosis and treatment of multiple female prevalent health issues.
Several chronic health conditions share between 80-91% of the same symptoms as PMS- as currently defined by the NHS- on their strictly evidence-based website [4]. All conditions disproportionately affect people who menstruate; all involve psychological as well as physical symptoms; and all can be triggered or worsened by the menstrual cycle. Research suggests that all are possibly the result of chronic inflammation, too [33-39].

So why are these commonalities not better known or understood? Well, in short, due to the menstrual taboo, the artificial distinction between mental and physical health, and the medicalised myth of the irrational female, expert knowledge about these symptoms and conditions is currently split (somewhat arbitrarily) across different medical research specialties; e.g. obstetrics & gynaecology, psychiatry, gastroenterology and neurology [40]. (For a fuller explanation, please read this - https://www.menstrual-matters.com/about/)

This situation can and does result in misdiagnosis and ineffectual treatment options for both female and male patients [9].

6. What’s the solution?

Well, we just have to dismantle the (medical) myth of the irrational female, once and for all… (!)

“But we’ve already tried to do this!”

Yes, I know- but social constructionist approaches have been limited by not being able to explain the fact that some people really do suffer from menstrual cycle-related changes/ symptoms/ health conditions… Sadly, this apparent contradiction may have inadvertently strengthened the myth of the irrational female, through the use of some flawed logic- i.e. if ‘PMS is not real’, then those who experience premenstrual symptoms must be imagining, or exaggerating them- feeding into existing cultural ideas about female hypochondria and psychological explanations for hysteria/ PMS?

As Lord Alfred Tennyson once wisely said “a lie that is half-truth is the darkest of all lies”- I believe this is what has made PMS so resilient to persuasive feminist critique…
Similarly, the (fantastic) academic opposition of the medicalisation of the menstrual cycle (when normal/natural anatomical changes/processes of the female body become pathologized as ‘illness’ e.g. pregnancy, childbirth, menopause, and the menstrual cycle) has not managed to effectively counter the continued popular/medical perpetuation of the myth of the irrational female...

So, I haven’t done the PhD yet, but I have been researching the role of the menstrual cycle in chronic ill health for the past 4 years (mainly clinical research) and at heart I am an activist (my previous career was in international human rights work, with a focus on gender equality...) So, I have an idea about what might help improve the situation (this is basically the aim of menstrual matters)... But please do feel free to object, or contribute, to my thinking on this (see slide content below)!

I feel that the myth of the irrational female can easily persist whilst we have no comprehensive epidemiological, or endocrinological, data to back up the actual nature, and prevalence, of menstrual cycle-related changes/symptoms in the general population.

Plus, I don’t think that increased clinical attention to the role of the menstrual cycle, in ill health, in itself will necessarily contribute to the medicalisation (i.e. pathologicalisation) of the menstrual
cycle— at least, not if researchers are made aware of the socio-historical context and implications of their work? (Naivety alert?!)

However, I am all too aware of the persistence and adaptable nature of the myth of the irrational female... I cannot guarantee that more precise scientific data will not simply result in a further evolution of the myth, rather than in its destruction...

But I can’t help but feel that we do need to know more about what is going on, if only to help raise the voices of the minority of menstruators who are experiencing ill health and yet are ignored, ridiculed, or misdiagnosed by their doctors and society at large.

Thank you!

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