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The Experience and Positioning of Affect in the Context of Intersubjectivity: The Case of Premenstrual Syndrome

Jane M. Ussher, Janette Perz, and Julie Mooney-Somers, 2007

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Abstract

The experience and positioning of affect is a material-discursive-intrapsychic experience, which can be interrogated through the examination of the intersubjective realm. This paper examines ways in which women experience and negotiate premenstrual change in affect, positioned as premenstrual syndrome (PMS), drawing on in-depth interviews conducted with 58 women. All of the women interviewed described premenstrual changes in affect in a similar manner, as being characterised by intolerance, irritation, emotional sensitivity, feeling more negative towards others, and feeling overwhelmed in the face of life's demands. Without exception, women expressed a desire to be alone premenstrually, in order to escape relational demands and responsibilities, to reduce stimulation, or to avoid conflict. The way that these premenstrual changes and the woman's desire to be alone were positioned by the woman's partner, and dealt with within relationships, provided the material and discursive context for the woman's experience and negotiation of PMS. Women whose partners were accepting and supportive were more likely to take up a position of awareness, acceptance and self-care in relation to premenstrual change, whilst women whose partners were unsupportive were more likely to engage in self-castigation and self-pathologization. This suggests that intersubjectivity, the examination of subjectivity and affect in the context of relatedness, will be a fruitful avenue of exploration for critical psychologists, as well as for researchers interested in the complexity of women's premenstrual experiences.

Premenstrual change in affect as a psychiatric disorder

In debates about the relationship between discourse and affect, women's so-called 'reproductive disorders' stand as exemplars of the problematic of attempting to untangle intrapsychic, embodied and discursive explanations for experience. Engaging this debate, this paper will take the case of premenstrual experience, arguing that a material-discursive-intrapsychic analysis is needed to understand the ways in which women experience and negotiate premenstrual change in affect, in the context of the positioning of such change within medical, psychological, and lay discourse.

Medical discourse positions premenstrual change in affect as a pathology, with the 20% of women who report the most severe levels of distress associated with this change liable to receive the psychiatric diagnosis Premenstrual Dysphoric Disorder (PMDD) (A.P.A., 2000). Women who fall in the moderate to severe range, around 40% of the female population in some estimates (Halbreich, Borenstein, Pearlstein, & Kahn, 2003), can be diagnosed as experiencing Premenstrual Syndrome (PMS). However, as 95% of women are said to experience premenstrual change in affect, positioned as 'symptoms' in the majority of bio-medical and psychological accounts, the diagnosis of reproductive disorder is a spectre which haunts all women of reproductive age.

PMDD and PMS are manifested by a change in affect during the premenstrual phase of the cycle. Whilst up to one hundred and fifty different 'symptoms' have been associated with these so-called disorders, the dominant profile which leads to either self or professional diagnosis is the experience of negative affect, of either a reactive-aggressive nature, consisting of anger, irritability, and impatience, or of an introspective-depressive nature, consisting of sadness, anxiety, introversion, and feelings of not being able to cope (Bancroft, 1993). It is the *change* in affect which leads to diagnosis, with standardised guidelines produced by the National Institute of Mental Health (NIMH) suggesting that women need to experience a 30% premenstrual increase in two or more affective symptoms, as measured by a daily mood diary (Endicott & Harrison, 1990), to be diagnosed as experiencing PMS.

Within the dominant bio-medical model of PMS and PMDD, the explanation for premenstrual symptomatology is located within the fecund body, which is positioned as outside of the woman's control – her difference and deficiency inevitable. In 1931, when 'Premenstrual Tension' first appeared in the medical literature, it was attributed to the 'female sex hormone' oestrogen (Frank, 1931). In the intervening years, many different bio-medical theories of premenstrual symptomatology have been put forward, each competing with the other as offering the 'true' explanation for PMS. These include: gonadal steroids and gonadoptrophins; neurovegetive signs (sleep, appetite changes); neuroendocrine factors; serotonin and other neurotransmitters; □-endorphin; and other potential substrates: including prostaglandins, vitamins, electrolytes, and CO_2 (Parry, 1994). This has led to a range of competing medical treatments, the most recent medical literature advocating serotonin reuptake inhibitors (SSRIs), to correct serotonin imbalance (Rapkin, 2003); oestrogen patches, to correct oestrogen deficiency (Leather, Studd, Watson, & Holland, 1999), or progesterone suppositories, to correct progesterone imbalance (Dalton, 1990).

One explanation for the contradictory nature of these theories is that expert knowledge is socially and historically situated, and thus the aspects of biology and the body we are allowed to 'know' are those which meet the criteria of the theoretical models and measurement tools currently in use. The 'discovery' of sex hormones in 1905 (Oudshoorn,

1990) precipitated hormonal theories of PMS; developments in neuroendocrine research led to serotonin imbalance being put forward as cause, SSRIs as cure; genome explanations cannot be far away. However, bio-medical theories are not unchallenged in the field of scientific research, as a gamut of psychological theories have also been proffered to explain premenstrual change in affect. These include personality; relationship factors; cognitions associated with femininity and menstruation; the influence of stress and life events; and propensity for psychological illness (Ussher, 1992b; Walker, 1995), leading to the suggestion that cognitive-behaviour therapy (CBT) (Blake, Salkovskis, Gath, Day, & Garrod, 1998; Hunter et al., 2002), social support (Morse, 1997), or couples therapy (Frank, 1995), are the most appropriate solutions.

Conducted within a positivist epistemological framework (Ussher, 1996), both medical and psychological discourse reifies premenstrual change in affect as a pathological disorder, implicitly conceptualising PMS and PMDD as static entities, positioned within the woman, with the occurrence of 'symptoms' as the end-point of analysis (Ussher, 2002a). The cultural construction of 'PMS' or 'PMDD', women's ongoing appraisal and negotiation of changes in affect, behaviour, or bodily sensations, the meaning of PMS in their lives, and relational factors associated with the development or course of premenstrual distress, are issues that are marginalised or negated.

Feminist critiques of PMS

In contrast, for the many critical feminist psychologists who vociferously argued against the inclusion of PMDD in the DSM (Figert, 1996), premenstrual changes in affect, if they are accepted as existing at all, are seen as a normal part of women's experience. Feminist critics position PMS as merely the latest in a line of diagnostic categories acting to pathologize the reproductive body and legitimate the attribution of distress or deviance to factors within the woman (Caplan, McCurdy Myers, & Gans, 1992; Nash & Chrisler, 1997; Parlee, 1991; Ussher, 1992a). This view draws on broader post-modern debates in critical psychology and psychiatry where mental illness or madness are positioned as social constructions that regulate subjectivity; disciplinary practices that police the population through pathologization (Fee, 2000; Foucault, 1967; Ingleby, 1982; Ussher, 1991). The 'psy-professions' are seen to define what is normal and what is pathological, providing the means by which people can inspect, regulate and improve the self, invariably finding themselves wanting (Foucault, 1979). We are all subjected to this regulation, with psychiatric diagnosis operating as a primary site of disciplinary control, and thus we all have the potential to be positioned as pathological if we stray from socially constructed norms.

Individuals do not experience the body in a socio-cultural vacuum. The bodily functions we understand as a sign of 'illness' vary across culture and across time (Payer, 1988; Sedgewick, 1987). The positioning of premenstrual changes in affect as 'symptoms' of PMS, rooted in the fecund body, cannot be understood outside of the social and historical context in which women live, influenced by the *meaning* ascribed to these changes by Western medicalised discourses. The representation of premenstrual change in affect as pathology, taken for granted in both popular and medical accounts (Markens, 1996; Ussher, 2003b), is a product of the regimes of knowledge which currently dominate Western conceptualisations of mental health. The notion that subjectivity, affect, and bodily experience *should* be consistent and constant is a social construction, reflecting a modernist position which conceptualises identity as rational and unitary, with deviation from the norm as sign of illness. Equally, it is the discursive positioning of the fecund body as abject and needing to be

controlled, and of menstruation as site of madness, badness, and debilitation (Ussher, 2006), which provides the framework for women to interpret premenstrual changes in affect as pathological 'symptoms', and thus take up the subject position 'PMS sufferer', through a process of subjectification (Ussher, 2003b, 2004a). This leads to practices of self-policing, whereby women engage in practices of self-surveillance, self-sacrifice and self-silencing, as well as self-blame for premenstrual changes in affect or behaviour, which are judged in relation to hegemonic constructions of idealised femininity (Ussher, 2004b). Implicit within these self-judgements are notions of the standards of behaviour women are expected to aspire to: a script of femininity that is calm, consistent, coping, and controlled (epitomising the non-PMS self), contrasted with aggression, impatience, and anxiety (the PMS self) (Ussher, 2002a).

This supports the view that PMS is a Western culture bound syndrome, whose appearance follows unprecedented changes in the status and roles of women (Johnson, 1987, p348; Martin, 1987, p. 117), with the cultural belief that women are erratic and unreliable premenstrually serving to legitimate attempts to restrict women's access to equal opportunities (Chrisler & Caplan, 2002, p300). This has lead to critiques of the regimes of knowledge circulating within Western medicine, science and the law (Ussher, 2003b) and reproduced in self-help texts and the media (Chrisler, 2002; Markens, 1996; Rittenhouse, 1991), which provide the discursive framework within which women come to recognise themselves as 'PMS sufferers', and as a result engage in self-policing of the faulty body which is positioned as causing their 'symptoms'.

PMS as a material-discursive-intrapsychic phenomenon

However, the emphasis on the regulatory power of discourse within feminism and postmodernism can be read as negating agency, and failing to recognise the existence of women's distress (Burr & Butt, 2000). It can also be seen to negate embodied or psychological change across the menstrual cycle, or other material aspects of women's existence that may be associated with their distress. This is problematic, as 'PMS' is not simply a rhetorical construction, a fiction framed as fact created by self-proclaimed experts. There is convincing evidence that many women experience an increased vulnerability, sensitivity to emotions, or to external stress during the premenstrual phase of the cycle (Sabin Farrell & Slade, 1999; Ussher & Wilding, 1992). This is associated with a combination of hormonal or endocrine changes (Parry, 1994), premenstrual increases in autonomic arousal (Kuczmierczyk & Adams, 1986; Ussher, 1987), and differential perceptions of stress premenstrually (Woods et al., 1998). Experimental research has demonstrated that dual or multiple task performance is more difficult premenstrually (Slade & Jenner, 1980), and whilst women can compensate with increased effort, this can result in increased levels of anxiety (Ussher & Wilding, 1991). It is thus not surprising that many women report reacting to the stresses and strains of daily life with decreased tolerance premenstrually, particularly when they carry multiple responsibilities (Coughlin, 1990). This is the one time in the month that many women cannot live up to internalised idealised expectations of femininity. Increased vulnerability, or reduced tolerance, can lead to a rupture in self-silencing in the face of over-responsibility, with the resulting anger or distress being positioned as PMS; the woman positioning herself as 'failing' to be good wife or mother (Perz & Ussher, 2006).

However, premenstrual change in affect, whether it is experienced at a psychological or physical level, or both, isn't 'pure', beyond culture, beyond discourse; it isn't simply *caused* by the reproductive body, by a syndrome called 'PMS'. Premenstrual vulnerability is

positioned as 'PMS' because of hegemonic constructions of the premenstrual phase of the cycle as negative and debilitating (Rittenhouse, 1991; Ussher, 2003a), which impact upon women's appraisal and negotiation of premenstrual changes in affect (Ussher, 2002a). Thus in order to understand the experience and negotiation of premenstrual changes in affect, we need to adopt a material-discursive-intrapsychic approach (Ussher, 1999, 2002b), which allows us to acknowledge that PMS is both lived experience and a social construction (Cosgrove & Riddle, 2003; Swann, 1997).

Insight into the material-discursive-intrapsychic experience of premenstrual affect can be gained by investigating the experience of the women in Western cultural contexts who effectively negotiate and resist the regimes of knowledge which position the fecund body as site of danger, disease, or debilitation, finding alternative frameworks for understanding change in affect across the menstrual cycle (Cosgrove & Riddle, 2003; Lee, 2002). Some women can take up the position of 'PMS sufferer', yet not see this as a pathological position which leads to self-blame, rather, as a position of self-awareness which legitimates self-care and requests for support (Ussher, 2006; Ussher & Perz, 2006). Understanding how and why these women resist the pathologization of premenstrual change is of vital importance to understanding the development and alleviation of PMS, as well as to the broader investigation of the experience and regulation of affect. In order to address this issue, a series of in depth interviews were conducted, with the aim of examining the experience and negotiation of PMS, across a range of relationship types and contexts.

A Qualitative Analysis of Women's experience and positioning of PMS

Method

Participants were 59 Australian women aged 22 to 46 (average age 34) who were recruited through advertisements placed in local media and women's health centres asking for women who experienced PMS to take part in a research project on premenstrual experiences and relationships. These women were purposefully selected for interview from of a larger group of women who were taking part in a mixed method study examining the experience and positioning of PMS. Most interviewees were partnered (70%), heterosexual (65%), and reported having no children (53%).

One-to-one semi-structured interviews were conducted to examine women's subjective experience of PMS, and the negotiation of PMS in the context of relationships. The interviewer began by asking women to describe how they were when they had PMS, then describe a typical experience of PMS, and explore how this varied across relational contexts. The interviews ranged in duration from 45 to 90 minutes. After transcription, the interviews were read by two researchers in order to identify themes relating to the construction and experience of PMS. Themes were grouped, checked for emerging patterns, variability and consistency, commonality across women, and for uniqueness within cases. Described as a thematic decomposition (Stenner, 1993, p114) this close reading focuses on separating text into coherent themes which reflect subject positions allocated to, or taken up by, a person (Davies & Harre, 1990). In this paper, the analysis is focused on the experiences of eight partnered women, both lesbian and heterosexual, who were selected as contrasting examples of self-pathologization and self-care when premenstrual, and whose accounts represented patterns in the broader data set. The analysis presented here centres on their accounts of premenstrual changes in affect and reactivity to others.

Findings

Women's accounts of premenstrual change in affect and reactivity to others

All of the women interviewed described their premenstrual changes in a similar manner, as being characterised by intolerance, irritation, emotional sensitivity, negativity towards others, and a sense of being overwhelmed in the face of life's demands.

> Yep, um… I tend to find that I'm a bit more sensitive to my environment and I'm not as tolerant to the little things and if I combine that with way over-tiredness, that's when I get either really teary or I can be quite frustrated quite easily. I can go one of two ways, I can either sit there and just bawl my eyes out 'cause I'm pissed off, or just be plain pissed off (Heterosexual, aged 34).

These premenstrual changes in affect were positioned as 'PMS', because they were occurring premenstrually, and for many women, were distinguished from affect and behaviour experienced during the remainder of the month. However, whilst 'hormones' were positioned as the cause of these changes by some women, the majority positioned external factors as triggers for premenstrual distress, in particular stress and relational issues at work and home, which were described as exacerbating women's greater vulnerability at this time of the month. As one interviewee said, "when I'm having PMS … I don't cope with the challenges that life can throw at you, as well as I normally would. I'm not saying that at any other time I cope really well, but I find it's harder" (Heterosexual, aged 43). Many women gave examples of this reactivity in relation to children, describing themselves as 'exploding' when they don't get help with housework, or when children 'run amuck'.

> I have less tolerance around adults so you could only imagine that the extent of my tolerance around young children who make mistakes, or make messes and things like that, I just get very stern. Yep. Which is not the way I wanted to be….Everything just felt like it was too much to deal with. Too much extra stimulation, like I had too much um going on inside me to have to deal with like three kids running amuck around the house (Lesbian, aged 29).

The majority of women also gave accounts of being 'cranky' with their partner premenstrually, wherein relationship issues came to the fore and were expressed, or the woman reacted differently to potential sources of friction.

> I tend to get really cranky with my partner, and think about our relationship too much. And wonder about all the ins and outs of things like that (Lesbian, aged 28).

> Everything comes up at that time, yeah. Everything that might just be a slight pinch normally comes up at the PMT time and it's intensified (Heterosexual, aged 44).

Without exception, women expressed a desire to be alone premenstrually, in order to escape relational demands and responsibilities, to reduce stimulation, or to avoid conflict. The way that these premenstrual changes and the woman's desire to be alone were positioned by the woman's partner, and dealt with within their relationships, provided the material and discursive context for the woman's experience and negotiation of PMS. Women whose partners were accepting and supportive were more likely to take up a position of awareness, acceptance and self-care in relation to premenstrual change in affect, whilst women whose partners were unsupportive were more likely to engage in self-castigation and self-pathologization.

Pathologizing PMS – Dismissing Premenstrual Affect

Women who took up a position of self-pathologisation in relation to PMS, described themselves as a 'raging bitch', a 'loony-tune', 'crazy', 'mad', or 'dangerous' premenstrually. Bio-medical discourses were predominantly drawn upon to explain this pathology, with 'hormones' or 'my body' being positioned as to blame, and women describing themselves as "out of control" or "helpless" as a result. The consequence was self-loathing and guilt: "I feel pretty lousy about myself, why would anyone else want to be on side"; "Everything is falling apart and I'm not that good".

> I felt horrible, and I felt angry because I was apologising for something that I really couldn't do that much about that wasn't as a result of me being, um… choosing to be that way or being inadequate in some way and it made me feel inadequate, it made me feel really, my self-esteem just was… pathetic. It was, you know, I felt like a really bad person, like I'd committed a crime (laugh) that I needed to say sorry for (Heterosexual, aged 34)

This self-policing invariably occurred in the context of a relationship where the woman positions her premenstrual experiences as being pathologized by her partner, where there was an absence of support, accompanied by rejection or withdrawal, when the woman felt she needed empathy and acceptance.

> I would often be teary and stuff and rather than him come forward, he would withdraw, too, at the same time, because he was like, "Well, you're not, um... reliable"….And it's like, "But I want to spend time with you," and he was like, "Well I don't know who I'm talking to, so I don't want to…" you know, and so I would feel even like a paranoid schizophrenic even (Heterosexual, aged 34)

> She'll just withdraw or she'll get (..) ohh (..) she'll be silent, but that sort of aggressive silence. (Lesbian, age 29)

If premenstrual change, or PMS, was acknowledged in the relationship, it was in a blaming manner, serving to dismiss the woman's changed affect as resulting from an embodied pathology that need not be taken seriously, even when the woman was not in the premenstrual phase of her cycle.

> Um… ah, yeah, [partner] would blame everything on getting my periods. You know, it's… and so, you know, to me, it seems as if I was irrational all the time… He'd go, "Now, how long till your periods?" and it'd be two weeks away. And he'd pick up on it like that. And everything would be blamed on that. So, in other words, he was saying to me, "Well, I'm not going to take you seriously, because you're premenstrual." (Heterosexual, age 47)

As many women described only raising issues of concern within the relationship premenstrually, this meant that the issues were never addressed, or were always positioned as a problem within the woman.

> That got to the point where I'd brought it up and said, "Perhaps you need to have a look at some of the things you're doing as well because we both need to," and of course I think I opened my mouth at the wrong time and that blew up into a huge argument and he just jumped on me and basically said, "It's your shit, you go deal with it on your own,

> 'cause I have fucking had enough and I can't deal with this shit….get a therapist to sort it fucking out, I don't care what it is." (Heterosexual, age 34)

Common to these relational patterns was reactivity on the part of a woman's partner when she expressed negative emotion premenstrually. One interviewee described herself and her partner as 'yelling', which left her "feeling very hurt… and attacked". Another commented that she would be better off living on her own, rather than with a partner who "can be confrontational if you say the wrong thing or do the wrong thing, anyway, in his eyes". Whilst this pattern of pathologization and lack of support was present in some lesbian relationships, it was more commonly reported by heterosexual women.

Recognition and Acceptance of Premenstrual Affect

In contrast, a substantial number of the women we interviewed described taking up a position of awareness and acceptance of premenstrual changes in affect, resulting in effective strategies of self-care and coping. This position was not one of welcoming premenstrual changes, and indeed, many of these women described significant distress in relation to changes in mood or reactivity premenstrually. However, there was less self-blame and guilt associated with these changes, and in a number of cases, premenstrual changes in energy were described as being channelled positively. As one interviewee commented "If we didn't have to minimise it we could maximise it". Or as another interviewee told us:

> "Instead of trying to say, "Oh, you know, it's just this stuff that happens to me," and once you are, you know, educated in yourself about saying, "Okay, this is a cyclical thing," and you can kind of plot it and also channel it. And yeah, then you become in control of it a little bit more. You know, as well as saying, "Okay, this is a bad time to get really drunk or stoned," you can look after yourself in it…..I do a lot of creative work (then). (Lesbian, aged 28)

Women who took up this position in relation to premenstrual affect invariably described having a partner who was understanding and non-judgemental, allowing the woman, in some instances, to openly name her premenstrual state, without being blamed or criticised.

> I generally preface any conversation with, "Look, oh no, I'm feeling really premenstrual but, look, I'm thinking about this," and usually [partner] will frame everything with that understanding that there's premenstrual behaviour going on, and it might make sense or it might not (Lesbian, aged 28)

Other women gave accounts of their partner recognizing premenstrual changes, but not naming PMS at the time, as this would be inflammatory, or might appear to dismiss a woman's premenstrual emotions. One interviewee commented that her male partner was "smart enough not to say it at the time", but might bring up the issue afterwards:

> He knows not to bring it up at the time, because it is probably a touchy subject then, yes, so he will say it, we will talk about it afterwards, but at the time I think he just tries to steer clear and brings me a cup of tea, (Heterosexual, aged 46)

At the same time, women gave accounts of the issues that were raised premenstrually being taken seriously by their partner, which meant that premenstrual expression of affect had a positive impact within the relationship. One interviewee told us that she pushed her partner into discussions premenstrually, because "I'm feeling more that it's important to me to hear him say something", and whilst her partner didn't always welcome this, he recognised the benefit of it: "Look you know, I would never have any conversations like this if it were up to me, so you know, we can bring it up, even though I don't like it". The balance between acknowledging premenstrual affect as different, with the woman having a greater need for support, yet at the same time taking the woman's concerns seriously, is one which some partners manage successfully.

> the annoyances or the things that might be needing work in the relationship actually get dealt with. I am very fortunate to have a husband who's prepared to deal with it and has learnt the subtleties; it's almost like a dance of moving in and out of… okay, um… "Give her some space now, be tender now, and we'll talk at a better time on this issue." If it's a real issue, he's learned not to engage with the relationship issues, um… by saying it's PMT, he's also learnt to not negate the PMT (Heterosexual, aged 44).

Women who did not pathologize PMS were more likely to give accounts of being able to take time out from responsibilities, and this being accepted or facilitated by their partner. Many women gave accounts of their partner or teenage children encouraging them to take exercise, have a rest, or do something enjoyable when they were feeling vulnerable or irritable premenstrually. At the same time, premenstrual expressions of anger or irritation were described as being met with a calm, non-reactive response, so that discussions would not escalate into an argument.

> He just tries to be more patient, because he is a really sweet patient person, and he will just go, "Oh, OK then, OK, yep, yep" and he just tries to, um, either kick himself or keep everyone calm, or… he just actually knows if there is a reason for it, he just really thinks how can I keep everything just a bit more um … in control, and relaxed. (Heterosexual, aged 46).

Discussion

Critical feminist analyses of the ways in which the fecund body has been positioned and regulated have focussed on cultural representations of the woman as mad or bad because of her womb, documenting the ways in which contemporary bio-medical, psychiatric and legal discourse acts to perpetuate the age old notion that womb is a site of danger and debilitation, with the establishment of reproductive disorders reifying cultural myths and providing legitimated avenues for intervention (Chrisler & Caplan, 2002). At the same time, critical psychology has long recognised the role of discourse and material practice in the experience and regulation of subjectivity. In this paper, it is argued that critical psychology should also pay close attention to intersubjectivity: to discursive and material practices which operates within intimate couple and familial relationships, and which provides the context wherein women position and experience themselves as 'woman'; or in the case of PMS, as pathological and needing to be contained, versus vulnerable and needing support.

Critical psychologists who wish to explore the experience and regulation of affect in an intersubjective context can draw on the resources of psychoanalysis, where there has been a

shift in focus from individual intrapsychic experience, to the 'context of relatedness' (Stolorow, Atwood, & Brandchaft, 1994, p4). It is argued by relational psychoanalysts that the 'mind is composed of relational configurations…experience is understood as constructed through interaction' (Mitchell, 1988, p3-4). In attempting to understand distress, or experiences positioned as psychopathology, it is the interface of 'interacting subjectivities' (Stolorow et al., 1994, p36-37) which becomes the focus of attention, rather than the individual person. This approach is of central relevance to analyses of women's experience and positioning of premenstrual changes in affect, which are negotiated in an intersubjective context, as the research presented in this paper has demonstrated.

Feminist psychoanalyst Jessica Benjamin has elaborated upon this body of intersubjective theorising by drawing on Hegel's concept of 'recognition', in order to explore the need for recognition from the other, as well as the need for the other to have the capacity for recognition, in the development of subjectivity (Benjamin, 1999, p186). She claims that 'the other must be recognized as another subject in order for the self to fully experience his or her subjectivity in another's presence' (p186). It is this recognition which women who experience premenstrual change in affect want - empathy, understanding, and lack of judgement on the part of their partner. As one of our interviewees commented, "I would probably prefer something like 'how are you feeling' or 'do you think this is around your PMS, is it that time of the month?' …and then I'd probably be a bit more responsive …instead of 'rarr' straight back at her". Women want their partner to recognise and accept that they are experiencing premenstrual changes in affect, and not to take this personally, or to react aggressively, as was the case in the supportive relationships described by a number of the interviewees. One of our interviewees exemplified this, in telling us what she wanted from her male partner: "Not to react as aggressively towards the situation. Not to jump in with degrading, derogatory comments. I'd say that's the worst. Not to say those things. To keep those things to himself." This could be interpreted as women wanting their partners to take up the same subject position as they do in relation to PMS – that it is 'real', and understandable – suggesting that positioning theory (Harre & van Langenhov, 1999) can be used alongside theories of intersubjectivity in critical psychological analyses of PMS.

The absence of recognition can lead to distress, and the experience of the self as not existing, as is the case when partners react to negative affect experienced premenstrually with withdrawal or rejection. Benjamin argues that 'when the other does not survive and aggression is not dissipated it becomes almost exclusively intrapsychic' (p192). This provides explanation for self-pathologization of women whose partners do not recognise their premenstrual vulnerability or distress, and who can't 'hold' this distress through offering support. The woman turns inward for an explanation of her experience of negative affect, be it anger or anxiety, and blames her fecund body for her premenstrual state, rather than looking to her social or relational context. She then embarks on a cycle of guilt and self-blame, rather than engaging in acceptance, awareness and self-care, at the same time as avoiding confrontation of the relational issues which may underlie her distress. This can serve to protect her view of her relationship as 'good', in the same way that a biomedical model which positions PMS as embodied illness allows women to position premenstrual negative affect as 'not me', and thus avoid an assault on the self (Ussher, 2003b). However, it also ensures that relational issues, and other discursive or material factors which may precipitate women's distress, are not addressed. Future critical psychological work in the field of affect, and in the field of PMS, should pay attention to the intersubjective context of experience; in particular, the ways in which broader cultural discourse is negotiated within

intimate relationships, the material practices which are associated with this negotiation, and the intrapsychic consequences in relation to development and experience of subjectivity.

It is not novel to argue that premenstrual changes in affect are experienced in an intersubjective context, and that PMS is a relational issue. Feeling out of control and unable to tolerate negative affect in situations where there are overwhelming demands from partner or children has previously been reported to be the most common descriptor of PMS given by women (Ussher, 2003a). Using a short fuse metaphor, women report greater reactivity to family stresses, and altered perception of daily life stresses, premenstrually (Ussher, 2002a, 2003a), with premenstrual expression of emotion often acting as a catharsis premenstrually (Fontana & Palfaib, 1994). Women, and their families, attribute these 'symptoms' to an embodied disorder "PMS", even when alternative explanations can be found (Ussher, 2006), resulting in relationship difficulties being inappropriately attributed to PMS (Steege, Stout, & Rupp, 1988). This functions to disassociate negative emotions or behaviours from the woman or her partner, leading to the reproductive body being blamed for distress or disagreement, and as a consequence, the problem being positioned as a hormonal pathology (Ussher, 2006). It has been reported that direct expression of emotion is lower in families where women report PMS (Kuczmierczyka, Labrumb, & Johnson, 1992), which increases the likelihood of premenstrual affect being positioned as problematic. Women who report PMS also report higher levels of relationship dissatisfaction or difficulties (Coughlin, 1990; Frank, Dixon, & Grosz, 1993; Kuczmierczyka et al., 1992), suggesting there is a materiality beyond the body associated with their distress. The findings from the present study give insight into some of these relationship difficulties; the blaming, negation of substantive issues, and lack of support present in relationships where PMS is pathologised.

The present study lends support to previous findings that partners play a significant role in the exacerbation or amelioration of premenstrual distress. Men's constructions of PMS have been implicated in women's negative premenstrual experiences, with evidence that many men treat women with PMS in a belittling way (Sveinsdottir, Lundman, & Norberg, 2002). Conversely, support and understanding offered by their partner has been found to reduce guilt and self-blame in women who experience premenstrual changes in affect, allowing them to engage in coping strategies premenstrually, such as taking time out to be alone, or self-care (Perz & Ussher, 2006; Ussher, 2007). Inclusion of partners of women with PMS in future research would provide further insight into these practices, as would investigation of couples, allowing for interrogation of the perspective and experience of both partners, and the role of couple communication in the negotiation and positioning of premenstrual change.

It has been argued (Poulin & Gouliquer, 2003) that lesbians may feel doubly disabled by PMS, both their sexuality and their menstrual cycle variability marking them as 'other', leading to avoidance of professional intervention. However, in the present study, lesbian women were more likely to describe a supportive relational context, with empathy and understanding, and a lack of pathologization, greeting their premenstrual changes in affect. This suggests that gendered discourses, in particular expectations associated with idealised representations of femininity, may be negotiated differently in many lesbian relationships, with lower levels of self-policing operating as a result (Perz & Ussher, 2007). It may also be the case that women can more easily provide 'recognition' of premenstrual changes in affect, because of being able to take up an empathic position. Conversely, as there were

accounts of lack of recognition in some lesbian relationships, female gender of partner is not sufficient to guarantee support. This suggests that it is the nature of relationships, and in particular, patterns of relating and negotiating needs for recognition, which influences the positioning and experience of premenstrual affect. This highlights the need for the inclusion of a heterogeneous range of relationship types in research examining PMS, a research area which has previously focussed exclusively on heterosexual women.

In conclusion, it is argued that the experience and positioning of affect is a material-discursive-intrapsychic experience, which can be interrogated through the examination of the inter-subjective realm. As particular manifestations of affect are positioned as sign of pathology, PMS being but one example, this analysis also has implications for those Critical Psychologists who deconstruct psychiatric discourse and practice. As Jessica Benjamin commented, 'an inter-subjective theory can explore the development of mutual recognition without equating breakdown with pathology. It does not require a normative ideal of balance which decrees that breakdown reflects failure, and that the accompanying phenomena – internalization/fantasy/aggression-are pathological. If the clash of two wills is an inherent part of intersubjective relations, then no perfect environment can take the sting from the encounter with others' (1999, p198). This 'encounter with others' is the context wherein cultural discourse is negotiated, and where the willingness, or ability, of both parties to engage in mutual recognition facilitates subjectivity – including the experience of affect. This suggests that intersubjectivity, the examination of subjectivity and affect in the context of relatedness, will be a fruitful avenue of exploration for critical psychologists, as well as for researchers interested in the complexity of women's premenstrual experiences.

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